

Disciplinary processes and the management of poor performance among UK nurses: bad apple or systemic failure? A scoping study

This paper aims to use the findings of a scoping study to investigate the management of poor performance among nurses and midwives in the United Kingdom within the context of rising managerialism in the UK National Health Service (NHS) and globally. The management of poor performance among clinicians in the NHS has been seen as a significant policy problem. There has been a profound shift in the distribution of power between professional and managerial groups in many health systems globally. We examined literature published between 2000 and 2010 to explore aspects of poor performance and its management. We used Web of Science, CINAHL, MEDLINE, British Nursing Index, HMIC, Cochrane Library and PubMed. Empirical data is limited but indicates that nurses and midwives are the clinical groups most likely to be suspended and that poor performance is often represented as an individual deficit. A focus on the individual as a source of trouble can serve as a distraction from more complex systematic problems.

KEY WORDS: National Health Service; poor performance; professional misconduct; workplace discipline, literature review

INTRODUCTION

The rise of managerialism within public services and particularly healthcare systems has been noted globally. This paper investigates one possible manifestation of the conflict between managers and the healthcare professions and the state's encroachment into professional regulation by

examining the findings of a study of the management of poor performance among nurses and midwives in the United Kingdom (UK). It interprets these findings within critical policy literature on the changing power relationships between clinical professionals and the state and its managerial agents. It is based on a scoping study commissioned by the National Clinical Advisory Service (NCAS), part of the UK National Patient Safety Agency, into the management of poor performance and focuses on current practice regarding the suspension and disciplining of nurses and midwives within NHS organisations and by the UK regulator, the Nursing and Midwifery Council (NMC). Two policy-orientated questions are explored in this paper:

1. What evidence is there that the management of poor performance in healthcare organisations acts as a mechanism to control the traditional autonomy of clinical professions – in this case nurses – by the managerial structure of such organisations? In other words, do managerial groups tend to act in their own structural interests around the area of the discipline of nurses?

2. How far, in government policy guidance, formal organisational procedures and actual practices within the NHS and those undertaken by the NMC is 'poor performance' understood in terms of system failure or of individual disposition and culpability?

Background

The management of performance issues in nursing and midwifery takes place in the UK in a highly politicised context and in an international setting where the power of traditional professions has come under increasing challenge with claims of the 'proletarianisation' of medicine for example {McKinlay, 1985 #3313}. We will discuss the three main aspects of this context: the rise of

managerialism or New Public Management (NPM) in healthcare; the increasing involvement of central government in the measurement—and management— of clinical performance and changes to the regulation of nursing and midwifery.

Conceptual and policy context

The new public management project and healthcare

The term 'new public management' (NPM) was originally coined in 1991 to describe managerial reform in public services promoted with increasing vigour initially by Neoliberal governments, such as the Regan and Thatcher governments, from the 1980s to the present. Central to the concept of NPM is the notion that public sector managers, like their private sector counterparts, should be 'free to manage' {Hood, 2000 #2946}. This has offered managers an explicit mandate to redraw the frontiers of control between themselves and health professionals. Instead of working alongside them—or even supporting their work—managers were invited to believe that they should have the power to manage them. The loss of power of the health professions is part of a global decline in the power of professional groups in the face of the state and capitalist institutions {Krause, 1996 #2919}.

A number of arguments have been advanced by critics of professionalism including that professions protect their own interests and cannot be trusted to deal with poor performance in their ranks {Freidson, 1970 #2645}. Such critiques of professionalism have paved the way for the bureaucratisation of professions alongside the 'attenuation of professional self regulation' {Harrison, 2007 #2944 p 251} p 251. These processes can be demonstrated by understanding recent changes in professional control within the UK NHS as part of a wider movement.

Central control of professional performance within health systems

Timmermans and Berg have identified the rise of a drive toward the standardisation of medical practice across the United States {Timmermans, 2003 #2733}. Similarly in the UK, Government control over the activities of health professionals has been increased by the rise of agencies and mechanisms of scrutiny and standardisation. The Labour Government published the first Performance Ratings for NHS acute Trusts in 2001. This was followed by enforcement of various targets for performance. Some have seen such scrutiny as a weapon in a long-running battle between doctors and health service managers {Degeling, 2003 #2731 p.650}

Changes in nursing and midwifery regulation

A second area where commentators have identified the encroachment of the state into professional affairs has been state endorsed professional self-regulation {Allsop, 2002 #3148}. In 1998 the UK Labour government undertook a review of the regulation of nurses and midwives. Their report was highly critical of nurse regulation. As a result the United Kingdom Central Council for Nursing, Midwifery and Health Visiting was replaced in 2002 by the Nursing and Midwifery Council (NMC). This was as part of an overarching reform of professional regulation with increasing powers moving to the executive function away from the professions. The new body was to have additional powers to deal more effectively with misconduct, poor performance and health issues. An overarching body, the Council for Healthcare Regulatory Excellence (CHRE), was created in 2002 to regulate the regulators on behalf of the government with the power to recall cases where it considers the regulator to have been 'unduly lenient' {Council for Healthcare Regulatory Excellence, 2010 #2937}.

The combination of these forces – the changing frontiers of professional

action and status, increasing central scrutiny and control of health service activity and legislation which has changed self-regulation of the clinical professions – have reshaped relations between health service managers and clinical staff in many developed countries. The power of the medical establishment has enabled it to resist this challenge to some extent {Salhani, 2009 #2790}. Nursing and midwifery, however, despite representing a larger workforce in every industrialised country, does not have access to such power and therefore has a greater vulnerability to managerial action {Traynor, 1999 #528; Nelson, 2006 #2922}. Strong and Robinson give a detailed account of such a loss of influence as a result of changes to management structures {Strong, 1990 #8} and many have identified lack of power and status in nursing as leading to horizontal violence

THE STUDY

Design

Our brief was to gather available evidence about the current management of poor performance among nurses and midwives within the UK NHS and by the nursing regulator. In order to do this we undertook a broadly thematic review {Barnett-Page, 2009 #3147} of available literature and analysed publicly available NMC case reports {Nursing and Midwifery Council, 2010 #2924} from the most recent 6 months (November 2009-April 2010). This paper focuses on the literature review.

Search strategy

A search of both published and grey literature was undertaken. A search strategy was devised to ensure access to as wide a scope of the available literature as possible.

Inclusion/exclusion criteria:

Pilot work had alerted us to a possible scarcity of literature on this topic therefore we placed no restriction on the type of literature and no research quality or design criteria were used.

Databases searched:

The following databases were searched: Web of Science, CINAHL, MEDLINE, British Nursing Index, HMIC (Health Management Information Consortium), Cochrane library and PubMed. All abstracts of the articles retrieved from the initial extraction process were read carefully and if matching the topic criteria were included. Efforts were made to obtain all relevant studies. Some 7 electronic databases and 11 Internet sites were searched. Journals expected to be of importance, the Journal of Nursing Management, Nursing Times and Nursing Standard were hand-searched and the authors also used the data collected by the National Audit Office, the NMC and Department of Health.

Keywords:

Our search terms are shown in Table 1:

TABLE 1 ABOUT HERE

Languages and dates search:

We searched English language papers though these could be published internationally. Because our brief was to identify current evidence we retrieved papers published only from 2000 to April 2010 when the search was carried out.

RESULTS OF THE SEARCH AND ANALYSIS

The search process produced 6137 references not including duplicates. After

examination of abstracts and in some cases the whole publication by two members of the team, 146 were considered relevant to the review. However there were relatively few studies *directly* addressing the ways in which poor performance is handled among nurses and midwives, giving an indication of the lack of a body of research on the topic. The literature discovered was so diverse in character and small in volume that only the broadest thematic analysis was undertaken.

Lack of data on suspensions

Because no centrally collected data existed on UK suspensions we had to rely on other sources of data and a number of research studies, some of which were more than five years old in order to gauge the size of the problem. The National Audit Office (NAO) report {National Audit Office, 2003 #2833} on the management of poor performance of clinicians in NHS hospital and ambulance trusts was the only recent major national study on the topic. The study found that between April 2001 and July 2002, 562 nurses and midwives were suspended for at least one month. This amounted to 53% of total NHS staff suspensions. The average gross annual cost of a suspension of a nurse or midwife was £17,600 (at 2001-2 prices). The average length of suspension was nineteen weeks. Fewer than 20% were suspended for reasons of professional competency while 45% were suspended in relation to professional conduct issues and 20% for personal conduct reasons. At the end of the suspension 27% resigned or retired, 44% returned to work 18% of these without any imposed restriction and 29% were dismissed. Some 1063 clinical staff were excluded for at least one month between April 2001 and July 2002 at an estimated gross annual cost of £40M. Of these, nurse or midwife suspensions accounted for approximately £10M of the total cost. It is possible that numbers of suspensions underestimate disciplinary action for performance issues as a whole as there are many disciplinary cases which do

not involve suspension either because staff are disciplined whilst continuing to work or because staff are on sick leave or pressured to resign {Cooke, 2006 #2853}.

Murray examined the experience of suspended nurses {Murray, 2005 #2838}. Her research involved a survey of nurse suspensions known to the Royal College of Nursing (RCN) in England during 2002, an audit of 637 sets of RCN Counselling Service data, and analysis of individual interview and focus group data from a subset of 63 nurses who had experienced suspension. Survey results indicated that there were 207 known suspensions of RCN members in England in 2002, equating to 1 for every 1,500 members. Some 45% of these were the result of complaints from colleagues. Murray found that the majority of suspended nurses returned to work after the disciplinary hearing and only 18% were dismissed (though the detail of other outcomes is not known). The length of suspension varied from two weeks to over six months and an inconsistent approach to the use of suspensions was discovered. Recent NMC data indicate that its investigating committee concluded that in 36% of the cases brought to it, there was no case to answer {Nursing and Midwifery Council, 2010 #2924}. Such figures suggest over-use of disciplinary procedures by managers.

Use of suspension: final resort or first response?

Guidance maintains that suspension should be the last resort to be used only where patient safety might be compromised yet suspensions appear to be used inappropriately. In 2006 the English Department of Health set out a consensus statement on good practice. The overriding advice was that patient safety should be the primary consideration, that healthcare organisations should have policies in place and act quickly when there are staff performance concerns and that unnecessary suspensions of practitioners

should be avoided {Department of Health and National Patient Safety Agency, 2006 #2841}. Attempts to gauge the effect of such guidance, and actual practice, are hampered by the lack of obligation upon NHS trusts to collect this data. What evidence we have gathered points to the continuation of inappropriate individual disciplinary action and failure to address organisational shortcomings. The NAO study outlined above concluded that the majority of trusts (86 per cent) did carry out an initial investigation before making the decision to suspend a clinician. However, the rigour and quality of these varied. Speedy suspension may be appropriate where patient safety is at risk, but in the majority of cases reported to the NAO by trusts, 'patient safety was not an issue, and the decision to exclude is sometimes a knee-jerk reaction made by NHS management without sufficient investigation' (p25).

Although two thirds of Trusts in the NAO study based their procedures on guidance from the Department of Health, respondents in a quarter of the Trusts felt that this guidance was of little use considering it too lengthy, complex, or legalistic. Some Trusts had developed their own guidance for initial investigations and the consideration of options prior to suspension. Some trusts also used the Arbitration Conciliation and Advisory Service (ACAS) guidance (issued in 1997) as the basis for local policy. The lack of or confusion regarding guidance for nurse suspensions was found to have led to procedures that were open to individual manager interpretation and abuse. The report concluded that the management of suspensions and exclusions from work in hospital and ambulance trusts was inconsistent and sometimes extremely poor, with managers showing widespread ignorance of national guidance on the topic. There was also highly incomplete reporting of the costs of suspensions, with trusts consistently under-reporting this cost to the investigators.

Murray {, 2005 #2838} identified poor practice surrounding preliminary investigations with some nurses being suspended after a complaint was received without being told of the nature of the allegations. Her counselling audit results pointed towards psychological distress as higher in incidence and effect for nurses being investigated for alleged misconduct (whether suspended or still working) than for other working nurses. The likelihood of suspension appeared to increase for nurses who were aged over forty, and/or were male, and/or from a black minority ethnic group. Murray's literature review included studies that linked suspension with bullying, often by managers and with low morale. Low morale was an emergent theme for pre-suspension nurses in her study. Her interviews and focus groups revealed that staff shortages, increased workload, bullying and harassment, and discordant interactions with colleagues or managers increased the likelihood of complaints and as a consequence, suspension. The low number of subsequent dismissals called into question the need for many suspensions with their attendant psychological and financial cost. She found that managers' varying interpretation of gross misconduct was a crucial issue. She recommended that disciplinary systems needed streamlining with better accountability.

Cooke examined aspects of healthcare management and disciplinary processes through observation in three healthcare Trusts in the north of England. She also carried out interviews with ward sisters, staff nurses, directorate managers and others discussing any form of involvement in disciplinary procedures {Cooke, 2006 #2853;Cooke, 2006 #2853}. Her informants reported that punishments were commonplace though not necessarily documented. It appeared that to avoid high numbers of disciplinary actions and high costs for disciplining nurses quasi-official procedures took precedence keeping the actual figures of poor performance

out of the public domain. Her respondents also remarked on an apparent defensiveness within NHS culture concerning this topic which she speculates was a result of the newly established self-governing Trusts whose managements were able to discipline and suspend staff based on their own guidelines rather than national ACAS guidelines.

In spite of the tendency towards punitive use of discipline, there is some evidence that managers are uncertain about assessing competence. In a critical review of evidence and current practice in 18 Health and Social Services Trusts and 4 Health and Social Services Boards in Northern Ireland, Hamilton {, 2007 #2862} found that many managers found assessing performance difficult, and highlighted challenges to adequately defining poor performance.

‘Bad apple’ or system failure?

Guidance from the UK Departments of Health and ACAS on the management of poor performance and the use of suspensions from work has focused on encouraging organisational self-examination and urging employers to analyse the context in which apparently individual problems have arisen in order to identify possible system failures (see, for example, the Incident Decision Tree adapted by the NPSA from James Reason’s work reproduced in {Meadows, 2004 #2839}). It is also widely accepted in studies of errors in nursing that most errors occurred not because nurses were reckless or lacked training but because organisational systems were not designed to prevent errors occurring {Oulton, 2003 #2863}. Our literature review supports this conclusion and we have found examples of individual suspensions where organisational and managerial factors appear to be stronger predictors of suspension than characteristics or performance of the individual nurse {Cooke, 2006 #2853}.

Despite widespread agreement about the importance of organisational factors in interpreting what constitutes 'poor performance' and in how it is managed, an individualistic conception of the problem – an individual nurse as 'bad apple' - still appears to dominate. NCAS literature, for example, shows awareness of the organisational background to performance issues though its definition of poor performance {National Clinical Assessment Service, 2010 #2837} focuses on individual failings. The presentation of NMC case data also focuses on individual characteristics rather than organisational factors. It shows for example the frequently cited statistic that men are highly overrepresented in fitness to practice cases {Clover, 2010 #2923}. Our own data-analysis supports this. In the 6 months of NMC data that we reviewed it is apparent that male nurses accounted for nearly one third of cases while they represent only 11% of registered nurses. However, further analysis revealed that registered mental health nurses (RMNs), among whom men form a disproportionately large part of the workforce, were overrepresented in the context of all registrants (0.05 of all RMNs were the subject of cases compared to 0.03 of general nurses). This suggests that setting also plays a part in how 'poor performance' is identified and responded to. Other statements from the NMC continue to emphasise the body's concern with 'bad character' traits of nurses and midwives {Santry, 2010 #2925} rather than organisational or systemic factors that might make 'poor performance' more likely or disciplinary action more likely to occur. Furthermore, although the NMC has recorded gender and setting, it has not recorded and does not report analysis of the ethnic background of nurses called to its disciplinary hearings.

DISCUSSION

Limitations and strength of the evidence

The key issue when reviewing evidence on the management of poor

performance among nurses and midwives is the lack of empirical data on the topic, as, in the UK, NHS trusts have not been obliged to report data on staff suspensions and the regulator has not reported ethnicity data. Paradoxically this is both a limitation of the study and compelling evidence of a problem.

The small number of UK research studies on this topic point to variability in the way that poor performance is managed in NHS trusts with evidence that it has been managed in an unsatisfactory and costly way. It is hard to resist the conclusion that the lack of public data has worked to the advantage of organisations whose procedures may not bear scrutiny. Indeed, Cooke's work points to apparently considered failures of proper record keeping within organisations with managers adopting quasi-official approaches to disciplining staff. There is a great deal of personal anecdote, for example collected by Fagan – (Suspension Failure in the NHS (2004) <http://www.suspension-nhs.org/Reportonfailure.pdf>), that also appears to point to poor managerial practice and managerial action designed to conceal processes. Managers are expected to represent and promote corporate objectives and to 'lead' in a way that transcends the limited interests of any individual professional group within the organisation. The implication is that because management as a group is free from professional interests, it can be seen as acting in the best interests of patients and the public, and is appropriate to take on the role of stewardship of public funds.

There is a great deal of international literature, however, revealing that the authority of managers is contested by clinicians, particularly by doctors {Berg, 2006 #2906} and that relationships between them are characterised by differing priorities and conflict. For many managers, the main issue is control over professionals, their spending and, increasingly, their activities and its apparent quality. In the United States insurance companies have been the

main drivers toward control of medical costs {Marmor, 1994 #705} but it was the introduction of an 'internal market' in the early 1990s and UK Labour government's establishment of bodies of scrutiny that realised a vision of a health service totally visible to its managers. However, the perhaps welcome ability to monitor NHS performance that flourished in the UK under New Labour was matched with a less benign approach to performance management. NHS managers themselves have become increasingly vulnerable to central government pressure in the form of increased use of targets (which have encouraged some to 'game' out of fear of penalties {Bevan, 2006 #2927}), increased monitoring (the number of bodies inspecting hospitals was estimated in 2004 as over 100 {Lister, 2004 #2928}) and also the need to avoid being the centre of a media scandal, particularly those to do with failures to treat patients safely and with dignity {Womack, 2006 #2726}. Within such a context the management of poor performance can be seen both as a sanction that management can exercise over recalcitrant staff, for example whistleblowers, and as a recourse in the face of potential bad publicity over patient dignity issues, a way to demonstrate that such issues are being handled strongly. It could also be argued that, as members of a relatively weak professional group, nurses who are disciplined carry the individualised blame for organisational failings such as poor resources, poor training or target-driven cultures. Nurses have been seen to collude with organisational failures {Matthews, 2008 #3127}. From this perspective the solution of better training for managers managing poor performance does not address the systemic and political aspect of this problem.

Implications of the review findings

We have noticed an ambiguity in our review that while poor performance is widely acknowledged as a possible organisational issue, it is often defined and responded to in terms that are individualistic. We identified contextual

research that indicates that nursing and midwifery work is characterised by workplace stress and sometimes poor relationships with managers {Yildirim, 2009 #2880} and cases where the individual appears to have been scapegoated for system failures {Cooke, 2006 #2854}. There also appears to be a widespread reluctance to report poor performance witnessed for fear of inaction, a general tolerance of mistakes and a fear of adverse effect on the person reporting {Currie, 2009 #2873}. Cases which suggest that whistle-blowers have been treated unfairly seem to support this {McDonald, 2002 #2899}. Public inquiries into healthcare 'failures', such as that which examined the unusually high numbers of deaths and reports of poor care at Stafford Hospital 2005-2008, have identified 'system failure' and a culture of secrecy and lies from managers in this trust. The first independent inquiry which reported in February 2010 claimed that the Mid Staffordshire NHS Trust had become driven by targets and cost-cutting {BBC News, 2010 #2960}. Individual doctors and nurses who 'whistleblow' are often themselves disciplined by managers or their regulatory bodies (for example Dr Rita Pal at City General Hospital, North Staffordshire NHS Trust <http://sites.google.com/site/ward87whistleblower/home>). The status of whistleblowers however can swing dramatically from transgressive professionals problematic within their own profession to heroes in the media. For example, British nurse Margaret Haywood, who was struck off in 2009 for secretly filming patient neglect in a UK hospital was later reinstated by the NMC and subsequently named the Patients' Choice at a national awards ceremony. The NMC itself is under renewed pressure from CHRE to be seen to 'protect the public' effectively. Changes in the appointment of members of the NMC, to standards of proof required in its cases, to fitness for practice procedures and the explicit introduction of procedures for 'lack of competence' in addition to misconduct point to increasing political control over professional discipline {Allsop, 2002 #3148}. CHRE not only examines the management of

fitness to practice cases but has, since 2009, audited the regulators' decisions in relation to complaints that are not referred for formal hearing. The NMC's remit, is of course individual in focus, nevertheless its existing literature does not extensively explore or report on the possible contribution of organisational factors.

CONCLUSION

Our review has exposed disciplinary processes characterised by lack of systematic recording and reporting, instances of poor practice, and some examples of deliberate concealment. The size and variability in role of the nursing workforce, along with its lack of status and power, has rendered nurses vulnerable to less than optimal employment practice. It is hard to resist the conclusion that in many cases individual nurses have become the focus for chronic or widespread problems in a way that may enable organisations to continue to function without the expenditure of energy required to address complex systemic problems. The element of concealment within managerial practice and the exercise of power over relatively weak members of the workforce can be seen as the 'shadow side' of NPM practice that presents itself as rational, benign and free from vested interest. For professional regulators, disciplinary action placed under the public gaze functions as spectacle which continually sustains the positive regard that the professions need to maintain before the public and political leaders. With regulators themselves under scrutiny from inspectors it is in their interests to continue to use the language of individual 'bad character' and, perhaps unwittingly, collude in a theatre of punishment of transgressive individuals that provides a certain satisfaction and a distraction from more complex and hidden problems with the funding and delivery of health services. It appears that the full nature of such problems becomes apparent in inquiries after serious failures, such as

that which occurred in Stafford Hospital in the UK between 2005 and 2008.