NHS Highland Healing Process

Independent Review Panel Report on Organisational Learning

Report One: November 2020

Background

The Independent Review Panel (IRP) was set up as part of the NHS Highland Healing Process. The Panel works to the Independent Review Panel: Guidance Framework (the "Guidance").

The Guidance provided five possible outcomes from the IRP. Outcome 1 is an apology and/or a Recommendation for Organisational Learning. The apology outcome is self-explanatory and not the subject of this report. In relation to Organisational Learning, which is the subject of this report, this is where the IRP, having listened to the participant's experiences, often in conjunction with the participant, identifies areas where it believes NHSH could improve its practices, occasionally for the benefit of the participant but more commonly (the participant having left NHSH) for the benefit of others, both to reduce the risk of harm and to create opportunities for positive innovation. As part of the Guidance the IRP may therefore make recommendations to NHSH that organisational learning is implemented, with NHSH delegating responsibility for action as appropriate.

During the course of individual meetings, participants have, given their experience, indicated areas for organisational learning. In addition, members of the IRP on hearing a series of testimonies, have identified themes in relation to organisational culture, behaviour, systems and processes, which would benefit from improvement. This report sets out the IRP's recommendations on organisational learning from the initial hearings in August to 30th September, 2020.

The IRP has been invited to produce a report on Organisational Learning on a quarterly basis. The next Report will be in January, 2021, covering the period to 31st December, 2020, and then in April, covering the period until 31st March, 2021. Further reports will be produced should the IRP continue to consider participants' experiences beyond 31st March 2021, as is likely.

In the majority of cases participants have been keen to ensure that confidentiality is not breached, and members of the IRP are aware of their responsibility in this. Therefore, this report is written in a way to protect confidentiality. However, those whom we met were very keen that NHSH takes on board the organisational learning they feel is critical to the organisation moving forward and rectifying past failings.

2

This Report is produced in accordance with the Healing Principles defined in the Guidance. The IRP is not a judge and jury of the facts. The IRP deals with harm and healing taking into account the viewpoint of the individual accessing the healing process only. Accordingly it would not be fair for the IRP to make a determination of fault in circumstances where it has not heard opposing points of view. As such, while the IRP can make recommendations based on its understanding of the participant's personal experiences, it is beyond the IRP's scope to find, for example, that another individual or NHSH itself is to blame. The IRP's recommendations on Organisational Learning must be read and understood in this context.

1. The Need for Demonstrable Action – Our First Recommendation

The members of the IRP recognise that actions relating to some of the learning may already be in place as a result of the Sturrock Report or other subsequent analysis. However, being independent of NHSH the IRP is not aware of existing actions or initiatives already in place and would wish reassurance that the issues the IRP highlights through this process result in appropriate action or that they are already being addressed.

The Guidance makes it clear that responsibility for action on Organisational Learning is with NHSH and that NHSH is required to maintain a record of all IRP recommendations for Organisational Learning and provide a public quarterly status report in the 24 months after the Healing Process closes on actions taken in response to such recommendations.

The IRP believes it would be in accordance with the Healing Principles for NHSH to develop an action plan to address the IRP's recommendations on Organisational Learning, and that our recommendations and associated action plan are reported to the NHS Board at all of its meetings going forward and shared openly with all staff within NHSH along with an honest account and appraisal of progress, challenges and areas of difficulty.

This report sets out areas for organisational learning and associated recommendations for action. These are set under the headings of Organisational Culture and Behaviour and Systems and Processes. Under each heading there are areas for improvement, and under each area for improvement a recommendation based on the experience and knowledge of the IRP.

At the outset, the members of the IRP need to record that we have heard testimony that bullying behaviour is still evident within NHS Highland particularly on the part of longer serving managerial/supervisory staff whose careers had progressed under the former leadership of the organisation.

We recognise that there will be many legacy issues and that culture change takes time. However, we would encourage the new senior leadership of NHSH to take action in relation to this through demonstrating the expected values and behaviours they wish to see in the organisation, which will improve patient care and safety and, just as importantly, staff safety and wellbeing, while working within the context of challenging targets and finite staffing and financial resources.

It will also be important that a series of metrics are put in place to monitor progress. NHSH may already have adopted such metrics. We are aware that many NHS organisations have developed "a balanced scorecard", which report on patient and

service outcomes; organisational learning and growth, including HR metrics, such as numbers of grievances, disciplinary cases, absence levels, occupational health referrals, and the I-matter engagement score; financial performance; and internal business processes such as complaints, Freedom of Information requests, and Data Access requests.

Our first recommendation therefore is:

- **An action plan be developed to capture the organisational learning identified through the IRP process, and that progress be monitored by the NHSH Board through regular reports and metrics, which can be tracked to monitor improvement, and capture the desired change in culture. (Recommendation 1)**

2. Organisational Culture and Behaviour

2.1 General

Testimonies have referred to an organisational culture in NHS Highland which was centralist and dictatorial with little delegated decision making. This left senior clinical leaders and their managers feeling disenfranchised and disempowered. A number of early testimonies came from the acute sector. Raigmore Hospital appears to have been managed on a hospital wide basis with little delegated authority to divisions/directorates or departments. This centralist approach meant that accountability for decision making was unclear and confused. It was apparent to the panel that the pressure to achieve targets, patient waiting times, service improvement and financial targets led to a culture focused on outcomes and not on what is seen as often the "softer" organisational behaviours required to deliver effective patient care and support staff deliver their best and which research proves is the critical factor to achieving positive outcomes in these areas.

If the organisation follows the principles laid out in the work of Prof. James Reason and The Hon Sir Charles Haddon-Cave[1], it will be able to commit to engendering a generative and participatory safety culture, in what is said, what is done and more importantly what is believed. Such a culture needs to have four primary elements – The Just Culture – referred to later in this report, the Reporting Culture, the Flexible Culture and the Learning Culture, which should include a fifth element the Questioning Culture, being the defence against assumptions and the mechanism for delivering rigour in the organisation's change to both patient and staff safety.

These five elements when combined form a proactive, safety-conscious, informed and engaged organisation.

The centralist culture often manifested itself in inappropriate behaviour. This inappropriate behaviour was exhibited at the level of the senior leadership of the organisation but was then replicated at other levels. Poor behaviour was tolerated. As a result, individual members of staff often felt isolated and exposed. Members of staff who felt under considerable pressure, bullied others to achieve results and ultimately this resulted in serious harm to the wellbeing of colleagues. We heard of examples of inappropriate language in meetings and other interactions. This even on occasion included the non-executive directors of NHSH Board.

There was a fear of raising complaints – doing so was perceived to be career limiting.

[1] Professor James Reason: Managing the Risks of Organisational Accidents, 1997 & The Hon Sir Charles Haddon-Cave: The Nimrod Review (28th October 2009)

This extremely poor organisational culture was extensively covered in the Sturrock Report, but the members of the IRP have heard very detailed personal accounts of the impact this had on people, and we would strongly encourage a culture change programme to address this, based on widely accepted, and owned values and behaviours.

Therefore, the panel recommends that:

- **An ongoing cultural improvement development programme should be put in place for all clinical leaders and managers, including members of NHSH Board. (Recommendation 2)**
- **Individual performance development plans based on agreed actions for individuals should be put in place and performance improvement monitored through effective performance appraisal with the organisation's Values being a key part of the monitoring of the metrics. (Recommendation 3)**

2.2 Leadership

Staff at various levels of leadership in the organisation were perceived to be supportive of the organisation's poor culture, compliant and unwilling to challenge. The panel has now heard many instances where leaders were reactionary and not dealing with difficult relationship issues. We appreciate that we are meeting a self-selecting group of staff but individuals have been significantly harmed by those in managerial/supervisory positions. Often cited responses to difficult issues being raised included "denial", "anger", and "lack of acceptance".

One approach highlighted to us is that of a "just culture", if this could be developed this would mean that if mistakes occur the focus is not on blame. If a "just culture" were to be adopted, individuals would feel more able to report mistakes and the organisation would learn. Several individuals have reported that when incidents happen, investigations were held which were protracted, processes were not followed and outcomes were unclear. Most individuals speaking to us, had felt unsupported within NHSH when raising concerns.

The development of a "just culture", would mean that the use of HR processes such as discipline would be minimised. Genuine mistakes or errors arising from pressure at work, too few staff, and lack of training or competence would be treated as an opportunity for learning. This would encourage concerns to be raised without fear of retribution and be seen as a positive opportunity for staff to learn and improve.

The panel therefore recommends:

- **That the concept of a "just culture" be explored and any learning from this be incorporated into the cultural improvement development programme. Progress should be evidenced through a visible decrease in referrals to HR processes. (Recommendation 4)**

2.3 Equality and Diversity

Despite its geography NHS Highland serves a relatively small population, which is dispersed through a large number of distinct communities. In such areas, relationships extend well beyond the workplace. We heard that this can lead to a series of issues. Resentment of "outsiders" on occasion, less tolerance of diversity, e.g. homophobia or "nepotism" in recruitment practices. We heard one example of a parent being the senior manager of their child.

While the challenge of recognising equality and diversity is a wider societal issue, the responses by NHSH to these issues may require to be more bespoke, given the nature of small communities. The culture within NHSH, as with other NHS organisations needs to be one which promotes equality and diversity.

The IRP therefore recommends:

- **Recruitment processes should be thorough in ensuring that the best candidate is selected, avoiding – and being seen to avoid - any bias, and that those selected have personal values that match those of the organisation. Transparency is key. NHS Scotland has developed a value-based recruitment process which should be adopted for all posts. (Recommendation 5)**
- **Once new starts are in place, induction processes should include training on equality and diversity. (Recommendation 6).**
- **(Recommendation 7) The adoption of seven key principles, which have been proven in having effectiveness in this area:**
  - **Acknowledge the challenge – avoid the temptation to "ascribe more weight to positive information about the service than to information capable of implying cause for concern" (Francis 2013[2]);**
  - **See workforce equality as integral to service improvement not just compliance – as an integral part of providing better services and improving staff well-being, not as a separate discrete task;**

[2] Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, Chaired by Robert Francis QC

- **Insist on detailed scrutiny of data from Employee Staff Records and national staff survey data to identify the specific challenges that Health Boards as a whole, or individual departments or services or occupations may have. Accept that while data can identify patterns and hotspots of good and poor practice – root cause analysis may well be needed to understand it;**
- **Ensure that the narrative underpinning strategy is specific to each organisation and work to ensure it is understood not just by Boards but by managers and front line staff;**
- **Learn from previous failed approaches. A system which relied on individual members of staff raising concerns, complaints or grievances was not a strategy that was ever going to be effective. Leadership means organisations must take prime responsibility, for example, for talent management and career development and be proactive in developing staff and challenging discrimination, in a radical break with the culture of allowing panels to appoint "people like us" or those who might "best fit in";**
- **Specific interventions must be evidence driven and able to answer the question "why do you think this will work?" since unless that question can be answered replication is hit and miss;**
- **Above all, accept that accountability is crucial. Unless leaders model the behaviours expected of others and face uncomfortable truths, and insist on evidenced interventions with locally developed targets, the best intentions will not bring about change.**

2.4 Command and Control

References have been made to the Highland Quality Approach which NHS Highland had adopted. However, unintended consequences of a quality management approach is that quality control can become the focus, and we heard testimony that managers were focussed on a command and control approach. This became the way of working for many, and kindness and compassion to individuals were lost when difficulties occurred or mistakes happened. There was a reluctance to report "bad news", to the extent that NHSH Board was not able to identify where things were going wrong and improvement was required. We heard that difficult issues were discussed in private "Board Development" sessions. We heard that hierarchical power was used to ensure delivery. Senior staff told us that edicts and targets from Scottish Government led to senior and middle managers behaving in ways that reflected a top down target driven approach. While targets and outcomes are important, we believe they need to be delivered in a way that engages staff.

It is recognised in research that managers will default to a command and control style of leadership because it gives them a sense of power and a belief that if staff are left to their own devices they will do something that will reflect badly on the organisation. In these circumstances fearful managers tell staff what to do, and how to do their jobs and by codifying policies and rules for every conceivable situation they believe problems will be prevented. From what individuals have told us, this seems to have been the culture within NHSH. A culture of fear of job security was created. Managers mistreated those they managed, failed to recognise their contributions, and delivered undue criticism. There was a lack of transparency and information sharing. Information was seen as power.

The panel therefore recommends that:

- **The culture going forward should be one based on engaging and empowering, and valuing contribution through effective appraisal and feedback. This can be monitored through the NHS Scotland i-matter engagement process which all Boards are required to use and report on. (Recommendation 8)**

If NHSH Board does make the decision to bring in the five cultural elements outlined in section two it will need to consider implementing an effective programme of analysis, resolution and reporting that is able to join up these different elements to provide real critical analysis and intelligence to its decision making.

2.5 The HR Function

The HR function was the subject of significant criticism, in that it appeared to have become a function which used its processes to support the culture and management practices as set out above rather than ensuring equity and fairness by applying more professional HR practice to improve the effective management of staff and support an improved organisational culture. We heard that serious issues were not dealt with timeously or effectively and that the established HR policies tended to be used to reinforce the bullying culture. A review of the adequacy and deployment of HR resources together with skills development programme would improve the HR service and no doubt increase the confidence of HR staff to challenge poor management practice. It would also assist the individuals within the HR function to have more fulfilling roles, and be a more credible support to managers and staff.

The department needs to shift its emphasis and focus to support the change in culture needed to do things in the "Human Way" which has a life-changing impact on people, which in turn benefits every part of the organisation.

This means that it has to adopt the mantra that "People Matter Most". It means they see the person first and the job role second. It means that it realises that the challenges facing the organisation in this case will not be solved by the staff handbook and its existing policies. These problems are only solved by deeply listening to, connecting to and inspiring people. Skills that have been forgotten, lost or not been available in NHSH.

Training and facilitation will be needed, probably using external expertise so the HR team knows how to challenge the bureaucracy that does nothing but sap the human spirit. It means moving away from outdated HR process driven models which currently are about nothing more than compliance and control. Courage needs fostering to have honest conversations to help people develop better self-awareness and responsibility for performance. Currently people are hiding behind the veil of confidentiality where it is not always applicable.

The HR team needs help and support to embrace and develop a new mindset. It means the willingness to use new language to shape a new culture. It means the Leadership team have to take the leap of faith and start to trust the staff and the staff to put trust in their leaders. The organisation must never treat people as mere resources.

The panel therefore recommends that:

- **The HR function should be subject to a wide-ranging review to ensure that there are sufficient staffing resources within the HR function and that these resources are effectively deployed and members of staff in the HR function understand their roles in supporting changes to organisational culture. (Recommendation 9)**

3. Systems and Processes

3.1 HR Systems and Processes

Given the way in which the culture had developed, we heard that the HR systems and processes were being used to reinforce the established organisational culture rather than provide a check or balance or challenge to inappropriate behaviour. Human Resources Policies were not implemented appropriately, there was a lack of action when grievances or issues around inappropriate behaviour were raised. Where investigations were initiated they took inordinate amounts of time. The brief for the investigation was not always shared with staff being subject to them. Outcomes of investigations in some instances were not communicated with all parties (e.g. those involved in a Dignity at Work complaint or grievance). Staff who were being investigated for potential disciplinary action could be suspended from duty for significant amounts of time. Procedures and processes were not progressed effectively or efficiently. While line managers have the direct responsibility for the management of their staff it is critical that practice is monitored and HR provides appropriate support to managers and staff. HR processes need to be performance managed in relation to timelines and ensure appropriate outcomes. HR staff need to work closely with Trade Unions or individuals involved in the process to ensure that any unnecessary delays are avoided. In other organisations a case management system is followed and monitored and this can help avoid unnecessary delay.

In order to regain trust in HR processes a suggestion put forward by a number of participants was to have an independent element in dealing with complaints and grievances and we feel this requires to be seriously considered.

Current NHS Scotland HR policies based on the PIN Policies lead almost immediately to an adversarial approach to Dignity at Work complaints and grievances. Some organisations we are aware of have moved away from grievance policies to resolution policies in which all parties commit to a resolution process, and acceptance of outcomes. NHS Wales is adopting a Healthy Working Relationships approach, which includes a new "Respect and Resolution" HR policy. These policies tend to be based on effective mediation.

Many of the individuals who spoke with us who experienced bullying have participated in "Facilitated Discussions" or Mediation. Unfortunately, in most instances this has added to harm rather than assisted in dealing with issues where relationships have broken down. A favoured outcome seems to be redeployment of the individual who has requested an intervention, and the person viewed as the perpetrator of the harm remains largely unaffected.

Most of the facilitated discussions, or mediation appears to have been carried out by members of the HR Department. It is not clear what level of training individuals have had in such interventions. More significantly it was not clear what level of authority they had in ensuring that any outcomes agreed were followed through effectively and implemented. Use of root cause analysis might also provide a method to assess the real cause of difficulties.

The panel therefore recommends:

- **A HR case management system is adopted so that all HR processes can be monitored and performance managed. Regular reports on the application of HR policies should be provided to the Staff Governance Committee and Area Partnership Forum. (Recommendation 10)**
- **Serious consideration is given to external independent involvement in Dignity at Work complaints as the default response. (Recommendation 11)**
- **A change from grievance to a resolution based approach, adopted through the HR Policies. (Recommendation 12)**
- **Where mediation is thought to assist, it should be formally entered into by both parties, and be facilitated by a trained neutral mediator, and seek to deal with the relationship difficulties rather than take what might be viewed as the easier option of removing the complainant. (Recommendation 13)**

3.2 Financial Processes

We heard testimony that financial processes were unclear. Budgets do not appear to have been sufficiently devolved to allow leaders and managers to make decisions affecting their services. It is recognised that NHSH was under very significant financial pressure and this appears to have resulted in financial decision-making being taken at Executive team level with, for example, parts of budgets being removed to effect cost savings with little or no engagement of individuals with leadership roles responsible for these budgets. This led to lack of trust in financial decision making and a lack of clarity over the basis for these decisions. Posts disappeared from staffing establishments with little explanation. This contributed to the poor organisational culture. In an environment where permanent savings are a mechanism of cost control, it is important that leaders and managers are involved in financial planning and decision making. Staff at all levels need to be able to at least be aware of the priorities and objectives of NHSH, and if possible to contribute. Many will no doubt disagree

with the decisions being taken but at least there will be greater understanding and awareness, and confidence can be restored in the financial decision making process.

The panel therefore recommends that:

- **The budget allocation process should be reviewed with clarity of budget holder's responsibility and delegated authority within the overall financial plan and financial governance arrangements. (Recommendation 14)**

3.3 NHSH Board

The panel heard that some clinical leaders had little or no interaction with NHSH Board. There was also a suggestion that information relating to clinical services may have been withheld from NHSH Board. It would seem important that members of NHSH Board or its Sub Committees, particularly the Clinical Governance Committee, should be aware of the range and nature of clinical services and issues they may be facing.

The IRP therefore recommends that:

- **NHSH Board, in addition to regular Board meetings, should receive regular briefings where Board members can receive information from those directly providing front line services. (Recommendation 15)**

3.4 Reviews of Services

We heard that reviews of clinical services were undertaken quite regularly to improve performance and/or achieve improved efficiency. The impression given was that these reviews were not carried out in a way which ensured effective engagement of those within the services affected by the reviews. Where these reviews resulted in organisational change, it was unclear if the processes put in place to support were widely understood. We also heard that reviews on occasion were undertaken by close colleagues of those initiating the service review, which compromised objectivity.

The panel recommends:

- **A protocol for service reviews be agreed, and, where they are necessary, they should have a clear remit, engage all stakeholders and be led by an independent expert in the service being reviewed. (Recommendation 16)**

3.5 Accommodation

This may seem unimportant, but we heard that when estate was rationalised, staff were redeployed into inappropriate accommodation. We heard of one clinical service being moved into accommodation which made it impossible to see patients in their

base and unable to provide services effectively. The staff themselves were able to avail themselves of more suitable accommodation.

The panel recommends that:

- **When estate is being rationalised a full appraisal of the needs of the service should be undertaken before a move into alternative accommodation is made. (Recommendation 17)**

3.6 Trades Unions

We heard various reports of trade union representatives being very helpful and supportive. However, we have also heard of situations where trade union representatives were less than supportive.

The role of the Employee Director was mentioned on several occasions. This is not a criticism of the individuals who held this role, but it would appear that their role as Chair of the Staff Side and a board member was compromised by them continuing to take on cases of individual representation. There should be clarity over the role of the Employee Director, who in the IRP's view should not be involved in representing individuals.

The IRP therefore recommends:

- **Training in dealing with bullying and harassment should be made available to all accredited Trades Union representatives (Recommendation 18)**
- **The role of the Employee Director should be clarified to ensure effective leadership of the staff side, and effective representation at Board level. (Recommendation 19)**

3.7 Occupational Health

The majority of cases we have heard so far have involved referrals to Occupational Health, sometimes on numerous occasions. We are left with an impression that a referral to Occupational Health was being used in a way which allowed managers and HR staff to rely on occupational health assessments to avoid dealing with the root causes of an issue, but even then in many instances occupational health recommendations were ignored especially when they involved workplace adjustments or adjustments to working locations or patterns. NHSH Board was at risk, on occasion, of being in breach of disability discrimination provisions of the Equality Act.

Ill health, and in particular mental ill health, diagnoses were used to initiate capability processes. This had a further detrimental effect on individuals and added to harm to

individuals. The IRP acknowledges that in some circumstances this management intervention will be necessary unfortunately.

The extensive use of the Occupational Health service itself must have put it and its leadership under considerable pressure. The service, had it been able to contribute effectively at a senior leadership level, would have been able to highlight the bullying culture within the organisation and influence the organisational culture, and in particular, call-out the way in which HR processes were being used inappropriately and in support of the bullying culture.

It was reported to us that poor mental health was seen as a weakness in the organisation and that individuals were perceived as being weak as a result of stress, anxiety or other mental health conditions, and that a mental health diagnosis of individuals was used to support the failure to deal effectively with bullying behaviour.

The panel recommends that:

- **The role of Occupational Health in supporting the organisational culture should be explicit, and the Occupational Health Lead should report to a Director and provide regular reports to the NHS Board. (Recommendation 20)**
- **Training for managers on recognising the signs of mental health issues and on appropriate interventions should be provided. (Recommendation 21)**

If the Board does bring in and implement an effective reporting, resolution and analysis reporting programme that is able to join up the different elements to provide real critical analysis and intelligence to its decision making, then Occupational Health could use intelligence gathered from this to work with HR on the appropriate well-being programmes that are needed. These would be focused, as the intelligence that can be gathered from such technology based systems now available provides an accurate diagnosis of the issues and avoids organisations' responses being reactive to what they think is the diagnosis rather than what is the actual and real diagnosis and condition.

3.8 Use of Suspension from Duty

We heard several instances where suspension from duty was used to remove someone from the workplace where a complaint had been raised. In one extreme case an individual was suspended for a period of 3 years. Suspension should clearly be carefully considered.

The panel recommends:

- **There should be a clear procedure relating to decisions to suspend staff with the circumstances being carefully considered. Suspensions should be regularly reviewed and reported to the Board. This would be supported by the HR case management system referred to in recommendation 10. (Recommendation 22)**

4. Conclusion

The members of the IRP commend this, the IRP's first, Organisational Learning Report to NHSH. Further reports will be provided. We have now a number of testimonies which could support Organisational Learning as case studies.

We are conscious that this report is of its nature critical, but it is the intention that this is used positively to improve NHSH as an organisation to the benefit of all its staff and patients.

Building trust will be critical and some real thought and consideration needs to be given about how to do that effectively. To define trust, the organisation will need to go beyond the usual practical kinds of considerations. A deeper version involves more of an emotional response. This includes feelings for employees such as knowing that leaders are on "their side," they will be treated fairly and with respect and setbacks will be viewed favourably or at least not with particularly negative consequences.

We believe that in order to change the culture of NHSH and instil positive behaviours, these recommendations are a crucial part of ensuring that the learning from the Healing Process participants will be a force for positive change and demonstrate that their experiences have been genuinely listened to.

November 2020