NHS Highland Healing Process

Independent Review Panel Report on Organisational Learning

Report Two: March 2021

Background

The Healing Process Independent Review Panel (IRP) presented its first organisational learning report to the Chief Executive of NHS Highland (NHSH) in November, 2020. This identified a series of themes which the IRP considered it was necessary for NHS Highland to take action to address if it was not already doing so. This followed 26 individual meetings the panel had with registrants to the healing process. Our first report had 22 recommendations.

This report is based on a further 58 meetings with individual registrants in the period from 1st October, 2020 to 31st January, 2021.

The members of the IRP have had time to reflect on the way in which organisational learning might be used to best effect. Given that the recommendations do not relate to individual cases but are based on the themes emerging through many testimonies, the IRP is particularly conscious that presenting NHSH with another set of recommendations which would require action may have the effect of dissipating their impact.

This report focuses on four key recommendations which require to be addressed comprehensively by the organisation to effect organisational change.

1. Cultural Development Programme
2. Leadership and Management Capability
3. Governance
4. Management Oversight of Clinical Services in Remote and Rural Settings.

We appreciate that there will be governance and reporting structures in place to monitor activity in response to the Sturrock Report recommendations and our work as the IRP. It would be helpful for members of the IRP to be advised of these so that we can reassure participants in the Healing Process, that recommendations from the Sturrock Report and our reports are being implemented.

The IRP has a responsibility on behalf of those who have taken the time, and courage, to re-live their experiences with us, to ensure that the actions NHSH is taking in

relation to our organisational learning reports are visible not only to the NHS Board and its governance committees but also to staff, patients and the wider population. The members of the IRP recognise that this will of necessity have to be done in a way that maintains the independence of the IRP but builds on the co-production principle which underpinned the healing process.

Like our first Report, 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. Cultural Development Programme (Report2: Recommendation 1)

Our first Organisational Learning Report recommended that a cultural development programme should be put in place for all clinical leaders, managers and members of the NHS Board (Report 1, Recommendation 2).

We cannot understate the impact the culture within NHSH (often described to us as toxic) has had on individuals, many of whom have been left with post-traumatic stress disorder, severe anxiety disorders, depressive illness, and in some cases suicidal ideation. The IRP has taken time to review the outcomes of previous high-profile inquiries into failures in care and staff safety in the NHS, in addition to the Sturrock Report, to ensure our recommendations build on the best evidence for effective change. If NHSH were to implement fully the findings of Sturrock and take account of previous NHS inquiries, this would address many of the organisational learning issues leading to harm raised by those who have been affected by the culture in NHSH.

Our first report referred to the work of Prof. James Reason and The Hon. Sir Charles Haddon-Cave, and the need for the organisation to commit to engendering a generative and participatory safety culture with five primary elements:

- the Just Culture,
- the Reporting Culture,
- the Flexible Culture,
- the Learning Culture, and the
- Questioning Culture.

A combination of these five elements combine to form a proactive, safety conscious, informed and engaged organisation, which is what NHSH requires to move to.

This mirrors the Francis Review, *Freedom to Speak Up*, which set out 6 principles for a healthy organisational culture:

- *A culture of safety* – where all staff feel safe to raise concerns and the culture shifts from focusing on blame to focusing on addressing the issue and learning from it.
- *A culture of raising concerns* – where speaking up should be something that everybody does and is encouraged to do. There needs to be a shared belief particularly by supervisors, line managers and HR staff that staff raising concerns is a positive rather than troublesome activity and that concerns are treated seriously and are dealt with appropriately. HR processes need to be

responsive and supportive to those raising concerns not punitive and obfuscating.

- *A culture free of bullying behaviour* – this will require to be worked toward systematically by calling out and dealing with inappropriate behaviours. There should be root cause analysis of bullying behaviours in the same way there is of adverse incidents to enable their causes to be addressed. In addition, there is a requirement for honest and direct feedback to individuals about the impact of their behaviour and, if inappropriate behaviour continues, it is dealt with through disciplinary action. Too often the IRP heard cases where the complainant was moved rather than the bully; occupational health was used inappropriately to deal with the impact of bullying and their advice was often ignored; and HR processes (capability and redeployment) were used to attempt to remove the complainant from their post or indeed the organisation rather than deal with the behaviours.

- *A culture of visible leadership* - there needs to be visible leadership at all levels of the organisation starting with the Chief Executive and Board members. Clinical and managerial leaders need to demonstrate that they encourage and welcome the raising of concerns. Board members need to be accessible and demonstrate through their actions the importance they place on engaging with staff at all levels.

- *A culture of valuing staff* – giving public recognition of jobs well done, encouraging staff to highlight concerns and take actions as a result of these to improve patient care and services. The benefits to patients and the public from the improvements made in response to the issues identified should be celebrated.

- *A culture of reflective practice* – there should be opportunities for all staff to engage in regular reflection of concerns in their workplace. This should be reinforced with teams given the time and space to reflect, where issues are explored, systems are analysed to resolve problems and successes shared.

This change in culture and behaviour the IRP wishes to see take effect will require active and consistent staff engagement.

The panel recommends:

- **that the recommendations in the Sturrock Report and the IRP's Organisational Learning Reports are implemented in full and that by**

regular feedback to the IRP, the Whistleblowing Group, NHSH employees, and the wider public, NHSH show that this is the case and that the actions being taken are being translated into culture change that is seen by staff as positive and that the Culture Programme is being shaped by the voices of affected staff (Report 2: Recommendation 1)

2. Leadership and Management Capability (Report 2: Recommendation 2)

In his report, John Sturrock referred to the role of managers and leaders at all levels on re-setting the culture. The IRP heard testimony that individuals who were part of the bullying culture remain in post or in some instances have been promoted. As part of the organisational culture change it will be necessary to address some deficiencies in the capability of existing managers and leaders, both in general managers and clinical leaders.

Inquiries such as the review of the Bristol Paediatric Surgery service carried out by Professor Ian Kennedy in 2001, highlighted poor teamwork, and a lack of effective leadership…staff were not encouraged to share their problems or to speak openly.

A systematic review of existing capability of all managers and clinical leaders is required with a view to putting in place effective personal development plans, supported by relevant training, for all managers and leaders.

Following on from this, a leadership development programme is necessary in order for the organisation to thrive and grow and plan for any gaps that are identified in the aforementioned review.

This will require sufficient resources to be made available for such a review (to cater for the impact of the additional work, on top of existing priorities). There is also a need to ensure there will be the provision of effective and transparent feedback to the managers and clinical leaders involved. This needs to be done in the right way or those subjected to the review will feel bullied by it and it will have negative consequences rather than positive ones.

This should include the development of clear HR processes to ensure effective recruitment and promotion, with appropriate induction and training to support those recruited or promoted to leadership positions. Such individuals should then be supported through effective annual review and appraisal.

We heard some references to the continued existence of collegiate leadership in clinical leadership. Most NHS organisations have moved away from this adopting the NHS Scotland standard of values-based recruitment to leadership positions. This may already be underway in NHSH but needs to apply throughout the organisation. This will take time and resource.

There is the need to rebuild confidence in managers within NHSH. Managers and leaders need primarily, in addition to other skills, to be effective people managers, handling effectively diversity and difference in a workforce motivated by varying factors which influence their working and living in the NHS Highland area. They need to be able to handle concerns effectively and be able to give appropriate feedback and

take ownership of managing and engaging with their teams and staff without a default reference to the hierarchy within NHSH, or HR or Occupational Health.

The panel recommends:

- **a systematic review of existing capability of all managers and clinical leaders be undertaken with a view to putting in place effective personal development plans, supported by relevant training, for all managers and leaders (Report 2: Recommendation 2(a))**

The panel recommends:

- **that a leadership development programme to address the following areas in order for the organisation to thrive and grow and also plan for any gaps that are identified:**

  - **Cognitive and critical thinking needed to reason, plan, adapt and learn**
  - **The leadership DNA in terms of how that is reflected in the way individuals think, act and feel**
  - **The unique knowledge, skills and abilities required to excel in the leadership of people and teams**
  - **The capacity and willingness to continually learn from experience. Achieving growth through proactive use of feedback and self-reflection.**
  - **The ability to innovate and be a positive force for change and progress.**
  - **Confidence building. (Report 2: Recommendation 2(b))**

The panel recommends:

- **that the NHS Scotland standard of values based recruitment to leadership positions is fully adopted/implemented. (Report 2: Recommendation 2(c))**

3. Governance (Report 2: Recommendation 3)

NHSH will have governance systems in place covering the three pillars of clinical, staff and corporate governance. However, deficiencies in clinical and information governance processes were highlighted to the IRP. These include inappropriate accessing of clinical data of patients and staff members (particularly prevalent in small rural and island communities); lack of effective appraisal and personal development planning; a lack of systematic clinical involvement in service reviews and development; some deficiencies in the management of the Consultant Discretionary Points process; lack of systematic professional support and supervision; no systematic approach to the review and learning from significant adverse incidents; lack of clarity on patient safety reporting.

The IRP also heard of instances where patient safety concerns being raised by staff members resulted in HR processes being instigated to manage the staff member. This is inappropriate and sends a clear message to staff that patient safety is not a priority or taken seriously by NHSH. It is not always clear that there is systematic review of serious adverse events using root cause analysis.

The panel recommends:

- **The Clinical Governance Committee reviews the governance and reporting of information governance incidents, patient safety reporting and the reporting and monitoring of adverse events with benchmarking against other health boards in Scotland. (Report 2: Recommendation 3)**

4. Management Oversight of Clinical Services in Remote and Rural Settings (Report 2: Recommendation 4)

A theme has come through in relation to the management of services and staff in remote and rural communities. The IRP heard that leadership of services in these areas tends to be "remote" and lacks visibility. Difficult issues are not dealt with effectively or timeously. Professional staff are left without adequate supervision and a feeling that they are not engaged or taken seriously when issues are raised. We heard particularly concerning issues regarding *rural general hospital*, and primary care services on *two islands* and in North Highland. Raigmore was described by one participant as being an "island" within the mainland. It is not evident that NHSH has sufficient oversight of the governance of clinical services in the Argyll & Bute Integration Joint Board (IJB). The IJB is not a legal entity and NHSH still has governance responsibilities for the services delivered by the IJB.

Whilst we understand that the geography of NHSH is such that it is remote compared to other NHS mainland Boards, we believe oversight of services in remote and rural communities should be more visible and reported to the NHSH Board as well as the Argyll & Bute Integration Joint Board.

The IRP was also made aware that staff who are not from the area often locate in the NHSH area for lifestyle choices. Panel members heard that integrating into the NHS in such settings is not always easy. In these circumstances it will be necessary to tailor recruitment, induction, and ongoing support to reflect this. Whilst the "Once for Scotland" approach to many issues adopted by Scottish Government and NHS Scotland should be followed, there may be instances where we would encourage NHSH to ensure a more bespoke approach is taken to address the particular circumstances and issues faced in the remote and rural communities served by NHSH.

The fact that staff work and live in small communities' presents unique challenges in managing relationships in the workplaces. Nepotism and favouritism in recruitment and promotion have been referred to. The members of the IRP have been particularly struck by the way in which if relationships deteriorate in the workplace this spills over into everyday life, with individuals reluctant to leave their homes for fear of meeting others or being subject to reprisals. A lack of openness and transparency with the community when things go wrong adds to this feeling.

The panel therefore recommends that:

- **An assessment of the resources required to provide visible and meaningful leadership for services in remote areas should be**

undertaken, and changes made to existing management and leadership arrangements. This will also require an analysis of the support required for staff working in small communities to be undertaken and additional support put in place, including appropriate professional supervision where this is lacking (Report 2: Recommendation 4)

5. Conclusion

The IRP has now seen over 90 individuals who have accessed the Healing Process. The themes we reported in our first report are still being brought to us by staff members and the issues raised are not only historical but being experienced up to 2020. Worryingly, many individuals do not see that any positive changes have been made during 2020, which the IRP appreciates is a time-period beyond our remit.

The IRP urges the NHSH Board to focus on our recommendations and ensure that positive developments are reported through staff governance routes to all staff members and that leadership is active and visible to ensure staff feel engaged and that their contributions are valued and they are encouraged to confidently speak up and raise concerns without fear of reprisal or bullying.

Importantly, there should be full participation and direct involvement of trades unions' and professional bodies' representatives and the Area Partnership Forum as well as local partnership fora in taking forward the recommendations in the IRP reports.

Enabling staff to be part of the solutions to the culture and behaviour that has been endemic across NHSH would make a huge difference to staff confidence that measurable change can be achieved and sustained for the future.

March 2021