**Appendix 3**

# Consolidation of Lessons Learned and findings of the Independent Review Panel

1. The purpose of this document is to consolidate lessons and learnings from both the first two reports of the Independent Review Panel (IRP) and the root-cause diagnostic sessions that have been carried out as part of the Culture Programme.

2. The Independent Review Panel is one of the options available in the NHS Highland Healing Process, to support those who experienced bullying whilst working for NHS HIghland in the past. In listening to and understanding the experience and circumstances from the applicant's perspective, it is tasked with finding the resolution that is most likely to aid healing for the individual and organisation. The IRP deals with "harm" and "healing" taking into account the view point of the individual accessing the Healing Process only. It does not deal directly with "fault" and "loss". The IRP makes recommendations based on its understanding of the applicant's personal story only.

3. The Independent Review Panel has heard testimony from a number[1] of former and current members of staff who have suffered harm, and the evidence gathered has been consolidated into a set of themes and recommendations. Root cause diagnostic sessions[2] have been held in both North Highland and Argyll and Bute, focused on identifying the systemic failures which led to the requirement for the Sturrock review; and the lessons to be learned from these failures. The numbers of current or former staff involved in the IRP or the root-cause sessions therefore total 105, with the focus being on the events and issues across a substantial time period up until the end of 2019.

4. Whilst the findings and recommendations from these two sources are not identical, there is sufficient synergy for them to be consolidated into an integrated set of analysis and actions. There are, however, a set of specific findings for Argyll and Bute which were identified during the root-cause sessions held with primarily colleagues from Argyll and Bute. The first two reports from the Independent Review Panel are included in Appendix 1 and 2; and an assessment of progress made against each of the recommendations in Appendix 4 to this document.

5. It is clear from these sources, and the significant evidence gathered by Sturrock, that the cultural issues in NHS Highland developed and became embedded over a period of years, with a number of opportunities to address the issues missed or ignored. Changes in leadership from 2004 – 2010 were identified in the root

[1] The first two IRP reports which have informed development of this document includes testimony from 84 individuals, around 55% former employees and 45% current employees..

[2] 21 current and former colleagues from across North Highland and Argyll and Bute participated in the root cause diagnostic sessions

cause sessions as the catalyst for deteriorating behaviours across the organisation, with a sense of a different way of working becoming the 'norm'. A number of red flags were raised in the following years: the Area Clinical Forum (ACF) response to the Francis Report in 2013 identified issues of bullying; the 2015 Polley Review recommended strengthening the NHS Highland Board Governance, a Board diagnostic review in Jan 2017 highlighted dissonance between CEO and Board and the Executive team and the NEDs, which led to the resignation of three NEDs in 2016/2017, followed by challenge from the Chair of ACF around handling of concerns raised by radiology clinicians. The 2018 Brown and Walsh Report identified further cultural issues and the GP Sub-Committee, Area Medical Committee and ACF presented allegations of bullying again in 2018. The Gallanders report was commissioned by NHS Highland in 2018, identifying issues across the organisation, but it wasn't until the subsequent Whistle-blowing that the Sturrock review was commissioned by the Scottish Government.

6. Argyll and Bute (A&B) colleagues identified that it was the merger with NHS Highland in 2006 that signalled a change in the A&B culture. It has been noted by prior reports, including Sturrock, that the integration was poorly executed, and the impact of this remains to this day.

7. The findings from the root-cause analysis and the IRP have been categorised into the following themes, and each are explored in turn:

    a) Governance and Decision-Making
    b) Organisation and Behaviours
    c) Systems and Processes

There is no one factor that caused the cultural and behavioural issues faced by NHS Highland. Large organisations are complex systems, with people, processes, roles, structures, rewards and information reinforcing or enabling a certain 'way of doing things'. That is why the scope of the Culture programme must be broad; with interventions to address all of these aspects.

## A) Governance and Decision-Making

8. The failure of organisational governance is possibly the most significant root cause, with those overseeing NHS Highland unable or unwilling to address the cultural issues that had been raised. An imbalanced Executive / Non-Executive relationship was cited, with the NEDs unable to effectively hold the Executives to account, compounded by a perceived failure of the Scottish Government to address the known issue of Board effectiveness. The Committees of the Board were also hindered in executing their duties as reports and information were 'diluted' as they progressed through the many layers of governance with a general reluctance (or fear) to report bad news.

9. A lack of organisational strategy, and a clear plan for decision-making throughout this period led to a focus on tactical, rather than strategic activity. An increasing sense of pressure to achieve financial and clinical targets was cascaded from Government, to the Executives, down to managers and staff at

all levels of the organisation. A lack of engagement from those impacted by key decisions was identified, leading to less robust decision-making and reduced support across the organisation for the direction of travel. A “centralist” and “dictatorial” decision-making culture was cited, leading to disenfranchisement and disempowerment.

10. This sense of disempowerment was still evident in the groups engaged in the workshops. Colleagues reported a lack of consistency and clarity of authority and autonomy across the different staff groups and service areas, with the freedom to act being very manager or team dependent. Staff reported feeling held back from making change or progress, and the desire to feel “unlocked”.

11. Colleagues in A&B described a highly complex governance model, which exists to this day, with the HSCP ‘squashed’ between North Highland, A&B Council and NHS Greater Glasgow and Clyde. There remains a lack of clarity as to ownership for decision-making, with significant frustration from staff at the multiple sign-offs required for decisions which can take months (or even years). The financial pressures have exacerbated this hierarchy, but the cost of decision-making (in terms of absence of progress or change and the multiple review processes) should be considered.

12. As noted by both Sturrock and the A&B Culture Survey, there remain issues in the A&B relationship with “Headquarters” (Inverness). There is a sense from staff that “nothing happens without approval from Inverness”, or “things only get progressed if they come from Inverness”.

## B) Organisation and Behaviours

13. The centralised approach to decision-making that evolved over this time period impacted role clarity and accountability, with unclear remits for managers and senior clinicians. This issue was exacerbated by the fact that managers often lacked the skills and knowledge to perform their duties effectively, owing to insufficient training, learning and development. A loss of NHS Highland-wide induction (beyond e-learning) was noted as an issue, as new managers and clinicians joining the organisation were not introduced to the vision, values and ways of working in a common way.

14. As the organisation came under increasing pressure to juggle service and financial targets, inappropriate behaviour became more prevalent, with poor behaviour being tolerated and stress cascaded down the line. A focus on command and control became the way of working for many, with a loss of focus on kindness and compassion.

15. There is a sense there was ‘complicity’ across the organisation in accepting poor standards of behaviour. Unions and Professional bodies were not sufficiently proactive in challenging the status quo, and leaders at various levels were perceived to be compliant, possibly due to fear of repercussions or challenge. Threats of reporting colleagues to Professional Bodies (e.g. the GMC) were tools used to avoid challenge or disagreement.

16. Colleagues described a reluctance to speak up or challenge the status quo, either because they felt repeatedly ignored or for fear of repercussions, such as being side-lined or missing out on opportunities to progress. A lack of speaking truth to power therefore promulgated across the organisation, with those who did speak up viewed as “trouble-makers”.

17. Sturrock covered the geographical challenges faced by NHS Highland extensively in his report, with the particular issues related to the fact relationships often extend well outside the workplace. These challenges were also identified in the Argyll and Bute culture survey. Staff can be discouraged from speaking up or raising concerns, for fear of the repercussions this could have on their lives outside work. The Healing panel heard that the remote and rural working environments can lead to less tolerance of diversity; with a lack of inclusive behaviours and people coming from outside the area finding it difficult to assimilate. It was also reported that poor mental health was seen as a weakness in parts of the organisation, and individuals were seen as being weak as a result of stress, anxiety or other mental health condition.

18. The structure of NHS Highland remains confusing or “murky” for staff. There is a lack of clarity of structures and leadership teams, even at quite a senior level, and many individuals could not identify the management chains to which they belonged beyond their immediate locality. The lack of widely shared organisation charts and governance arrangements compounds this, but the issue goes wider than this as it relates to the wider sense of identity and belonging across the organisation.

## C) Systems and Processes

19. The systems and processes which should support positive ways of working failed to apply checks and balances to the emergent culture. People metrics and processes did not highlight the behavioural issues across the organisation; with cases taking a significant time to progress and a lack of organisational trust in the people process efficacy. Staff who were being investigated for potential disciplinary action could be suspended from duty for significant periods of time.

20. Departments, teams and individuals in distress were not visible at an organisational level, and there was no aggregate organisational temperature, as the annual iMatter survey failed to surface the cultural issues (due to question design and a reluctance in some areas to complete this). Occupational Health was reported to be extensively used throughout this period, meaning that the service was aware of the issues, but was unable to highlight the bullying culture in the organisation at a Board level.

21. The recruitment and promotion processes have been identified as lacking transparency, with promotion being used as a “reward” for compliance within the organisational system. Nepotism was identified as an issue in both the A&B Culture Survey and the recent A&B root cause workshops. It was also identified

that talented individuals left the organisation, or chose to not progress, given the perceived need to compromise integrity.

22. A lack of equity in career deal was identified, with inconsistent approaches to investment (both time and money) applied to learning and development and differing approaches to flexible working across types of job families and teams. Staff noted that learning often had to be undertaken in their own time and at own expense.

23. Financial processes and decision-making also impacted trust and created a sense of disempowerment. Whilst it needs to be recognised that NHSH was under significant financial pressure, this translated into a lack of budget devolution (therefore affecting service accountability) and parts of budgets being removed without engagement from those affected. The lack of a 'strategy-led' approach to cost savings was noted as an issue, with staff citing the flat savings targets applied across services as impacting the ability to innovate and execute longer term service re-design and improvement. Service transformation was stated to mean a requirement for cost saving; typically executed without clarity of vision and strategic direction.

24. Finally, a lack of support and transparency of process for Whistle-blowing (also at a national / professional body level) meant that the raising of concerns was challenging, and individuals who did try to escalate issues were discouraged or unsupported to progress.

**Lessons Learned and Recommendations**

25. The recommendations from the IRP are included in Appendix 4, with commentary on the actions taken and planned to address the recommendations. The consolidated recommendations from the IRP and root – cause analysis are summarised below under the same headings as the findings:

a) Governance and Decision-Making
b) Organisation and Behaviours
c) Systems and Processes

**a) Governance and Decision-Making**

The recommendations are as follows:

- The 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
- Evaluate clinical and care governance across the organisation; ensuring clarity and transparency of the network of committees and decision-making accountabilities
- Improve organisational engagement in decision-making processes; with clearer options appraisal and decisions aligned to the organisational values

- Improve the clarity and functioning of core governance forum across the organisation with stream-lined committee structures and a focus on vital decisions and supporting paper-work
- Improve the support and processes for Whistleblowing, including improving the profile of the Whistleblowing champion
- Develop a collaborative, realistic (and integrated) strategy and plan that is clinically based, involving all services in design
- An action plan be developed to capture the organisational learning identified through the IRP process, and that progress be monitored through regular reports and metrics, which can be tracked to monitor improvement, and capture the desired change in culture.
- 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.
- 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
- Where estate is rationalised, a full appraisal of the needs of the service should be undertaken before a move into alternative accommodation is made

**b) Organisation and Behaviours**

The recommendations are as follows:

- 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 People processes
- An ongoing cultural improvement development programme should be put in place for all clinical leaders and managers, including members of NHSH Board
- The culture going forwards 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
- Invest in civility and behavioural change, rewarding the right behaviours that are aligned to our values
- Embed the NHS values in a meaningful way across the organisation; focusing on dignity and respect in the workplace
- Improve the interface between clinicians and managers, clarifying decision-making accountabilities and creating greater visibility of managers on the front-line
- Design and implement proper and authentic patient engagement, and embed within the approach to strategy and service design
- Increase leadership visibility and engagement, and demonstrate active listening across the organisation
- Design and roll-out a system for peer supervision or support, enabling managers to connect with one another across the organisation
- Develop a clear articulation of the organisation structure and governance models, and ensure all staff are briefed and supported in understanding how the organisation 'works'

- Clarify accountabilities and discretion to act across grades and job families; with a drive to empower individuals and teams. Role model delegation and empowerment at senior levels to foster culture change.
- Focus on creating a culture where it is acceptable to say “no” (or to de-prioritise other activity) when additional work is needed / requested, through role modelling by senior leaders (saying no; not sending work out of hours)
- Training in bullying and harassment should be made available to all accredited Trades Union representatives
- 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
- The role of the Employee Director should be clarified to ensure effective representation of the staff side, and effective representation at Board level
- 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
- The adoption of seven key principles, which have been proven in having effectiveness in this area (i.e. equality and diversity – listed in Appendix 4)
- Training for managers on recognising the signs of mental health issues and on appropriate interventions should be provided

### c) Systems and Processes

The recommendations are as follows:

- 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 values-based recruitment process which should be adopted for all posts.
- Once new starts are in place, induction processes should include training on equality and diversity.
- An 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 the Area Partnership Forum.
- Serious consideration is given to external independent involvement in Dignity at Work complaints as the default response
- A change from a grievance to a resolution based approach, adopted through the HR policies
- 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.
- 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.

- Improve the support offer for those who speak up or raise concerns.
- 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
- Creation of safe spaces for people to feel vulnerable and share, linked to a wellbeing and support offer
- Greater use of values-based reflective practice and supervision (along the models used in effective clinical supervision)
- Improve the monitoring of culture and bullying, including sharing, using and acting upon the information provided in complaints
- Develop and roll-out a consistent approach to improvement, which includes the ability to learn from other NHS Boards and organisations
- Clarify the learning and development offer (including dedicated time and financial support) for all cohorts of staff to develop greater consistency of career deal
- Greater proactivity through longer term planning, supported by effective service design and workforce and financial planning.
- COVID has enabled us to move forwards with improved technology and different ways of working; we need to ensure we take this forwards and use technology to enable more efficient ways of working
- Better planning for projects and changes; ensure before starting a pilot or a project that the scope is clear and understood and that financing is available for wider roll-out if successful.

**Future Activity and Next Steps**

26. As indicated in Appendix 4, a number of the recommendations either have been addressed or are in 'progress' It is planned to give a full update on progress made against recommendations, and in particular those made in the Sturrock Review, at the Board meeting in May. This will be accompanied by the 21/22 Culture Programme plan and the pipeline of activity for future years.

27. However, there are also a number of recommendations made by the IRP that will require further action from NHS Highland. Those that are not currently within scope of the Culture Programme include the following:
    a. Development and roll-out of a performance management and development approach across NHS Highland
    b. A wide-ranging review of the HR function and resource alignment
    c. A review of the delegated authority and accountability for financial decision-making
    d. Roll-out of a consistent and engaging approach to service design / service reviews
    e. A review of clinical governance and the committee structures

f. An assessment of the resources required to provide meaningful clinical and managerial oversight in remote and rural areas.

28. As noted in Appendix 4, the NHS Scotland approach to performance management is under-developed at present so this recommendation cannot be fully addressed in the upcoming financial year. Recommendations c – f listed above will be referenced as part of the 3-5 strategy development process which will commence in 21/22. Resourcing and structure of the HR function is also under review with additional capacity planned.