

**MINUTE OF INTEGRATION JOINT BOARD (IJB)
held in Council Chambers, Kilmory, Lochgilphead
Wednesday 27 March 2019 at 1.30pm**

Present:

Robin Creelman	NHS Highland Non-Executive Board Member (Chair)
Councillor Kieron Green	Argyll & Bute Council (Vice Chair)
Joanna Macdonald	Chief Officer, Argyll & Bute HSCP
Dr Rebecca Helliwell	Associate Medical Director, Argyll & Bute HSCP
Alex Taylor	Head of Children and Families & Criminal Justice
Linda Currie	Lead AHP, Argyll & Bute HSCP
Elizabeth Higgins	Lead Nurse, Argyll & Bute HSCP
Kirsty Flanagan	Interim Chief Financial Officer, Argyll & Bute HSCP
Elizabeth Rhodick	Public Representative
Dr Angus MacTaggart	GP Representative, Argyll & Bute HSCP (VC)
Fiona Thomson	Lead Pharmacist, Argyll & Bute HSCP
Sandra Cairney	Associate Director for Public Health, Argyll & Bute HSCP
Sandy Wilkie	Head of People & Change, Argyll & Bute HSCP
Heather Grier	Unpaid Carer Representative
Kirsteen Murray	CEO, Third Sector Interface
Sarah Compton-Bishop	NHS Highland Non Executive Board Member
Gaener Rodger	NHS Highland Non Executive Board Member
Councillor Aileen Morton	Argyll & Bute Council
Councillor Sandy Taylor	Argyll & Bute Council
Fiona Broderick	Staffside Lead for Argyll & Bute HSCP (Health)

In Attendance:

Iain Stewart	Chief Executive, NHS Highland
Boyd Robertson (VC)	Interim Chair, NHS Highland
Stephen Whiston	Head of Strategic Planning&Performance, Argyll & Bute HSCP
Lorraine Paterson	Head of Adult Services, Argyll & Bute HSCP
Phil Cummins	Interim Head of Adult Services, Argyll & Bute HSCP
George Morrison	Head of Finance, Health
David Forshaw	Principal Accountant, Argyll & Bute Council
Charlotte Craig	Business Improvement Manager, Argyll & Bute HSCP
David Ritchie	Communications Manager, Argyll & Bute HSCP
Sheena Clark	PA to Chief Officer

Apologies:

Denis McGlennon	Independent Sector Representative
Kevin McIntosh	Staffside Lead for Argyll & Bute HSCP (Council)
Councillor Gary Mulvaney	Argyll & Bute Council
Catriona Spink	Unpaid Carer Representative

ITEM DETAIL

1&2 WELCOME and APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made. Apologies were as noted above.

3 DECLARATIONS OF INTEREST

No declarations of interest were intimated.

4 APPROVAL OF MINUTE OF INTEGRATION JOINT BOARD 28-11-19

Page 3 : 4.2.1 Budget Monitoring, line 8, overspend noted as £4.398m.

Page 6 : Quality & Finance Programme Board – request for the Terms of Reference be updated to reflect the group as a constituted committee of the IJB.

The Standards Officer advised today's IJB that he has discussed with and advised the Chief Officer and Business Improvement Manager the identified gap in IJB governance and this is being addressed.

With the above amendments and noting the Standards Officer's comments, the IJB approved the Minutes of 30-01-18.

5 BUSINESS

5.1 HSCP Strategic Plan 2019/20 – 2021/22

The Head of Strategic Planning & Performance presented the draft 2nd HSCP Strategic Plan, developed and produced taking account of statutory requirements and the outcomes of the public, stakeholder and staff engagement and formal consultation. The plan did not include the final budget information, which is to be delegated by the parent bodies to the IJB and is captured in agenda item 5.3(iv), Budget Proposals 2019-20, and if approved today will be incorporated into the plan.

The plan details how it will govern, direct, allocate and operationally manage health and social care resources within Argyll & Bute. It outlines how services will be transformed over the next 3 years and the objectives for delivery and the outcomes to be achieved.

The Strategic Planning Group (SPG) oversaw the development and production of the plan, concluding that the core principles of the plan were unchanged but a number of clarifications and changes to several sections were required in order to produce the final draft version. The SPG conducted a final gap analysis of the plan which identified outstanding information and further pieces of work required :

- Housing Contribution Statement – developed and provided by the Argyll & Bute Council Strategic Housing Forum and approved on 12/3/19 and included in the appendices.
- Equality impact assessment – stage 2 completed.
- Inclusion of the delegated budget – to be included subject to IJB approval of the Budget Proposals paper presented today.

The Head of Strategic Planning & Performance :

- noted the feedback regarding the accuracy of the list of equality characteristics on page 6 of the appendices.
- provided assurance that all feedback and responses will continue to be interfaced into the next phase of the plan.
- noted for further planning that the population growth for Jura continues to grow.
- noted that the concerns raised at the SPG that the housing population statement in the plan did not accurately cover Smart Homes, with no link to investment. He acknowledged that there is no defined standard for the types of SMART Homecare Assisted technology to be supported by the Scottish Government funding and gave assurance that the HSCP is clear that the technology is a key component for future planning.
- Noted the requested update and to apply consistency of equalities representation

The IJB endorsed and approved for implementation the Argyll & Bute Strategic Plan for Health and Social Care covering the period 2019/20-2021/22.

5.2 Ministerial Reform of Health & Social Care Integration Progress Review

The paper provided an overview of the report commissioned by the Cabinet Secretary for Health & Sport. This is an important piece of work and the proposals set out indicate a significant focus on shared and collaborative working to support the challenges and the increase in pace and effectiveness of integration.

A self-evaluation of the work to be undertaken will be reported at the Senior Members/Officer Group (SMOG) in April and progress update taken to the IJB in May.

The IJB noted the final report.

5.3 Finance

The papers were presented by the Chief Financial Officer (CFO).

5.3i Budget Monitoring 2018-19

The February position was still being finalised when the circulated report was prepared for the Board. A verbal update advised an overspend of £4.118m. This is made up of an overspend on the Health side of £1.376m and an overspend on the Social Work side of £2.742m.

NHS Highland confirmed that the brokerage from the Scottish Government will cover the 2018/19 Health overspend and will not require to be repaid. The 2018-19 Social Work overspend will required to be repaid to the Council. Negotiations will take place between the HSCP ad the Council to agree the pay back arrangements.

Members of the Senior Leadership Team continue to meet daily to gain 'grip & control' of the financial position.

Due to the short timescale to resolve the Service Level Agreement (SLA) dispute with NHS Greater Glasgow & Clyde it is likely that the estimated overspend will increase by £1.2m, significantly affecting the forecast outturn position.

The IJB :

- *Noted the verbal update of an overspend of £4.118m as at end February 2019.*
- *Noted that the forecast overspend is likely to increase by £1.2m in relation to the dispute with NHS Greater Glasgow & Clyde SLA.*
- *Noted that NHS Highland have confirmed that the brokerage from Scottish Government will cover the 2018-19 Health overspend and this will not require to be repaid.*

5.3ii Existing Quality & Finance Plan 2017-19 Update

The report outlined progress with the 63 savings options revised by the IJB on 30 January 2019. 61 options are either delivered or are on track to be delivered. The 2 options reported as not achievable in full are EFF26 Mull Medical Group – not achievable until implementation of the new GP model in Mull and CORP1 Co-location – on further review the scale of saving was lower than originally anticipated.

Taking account of the 2 options that are not deliverable, the IJB considered the progress with the Quality & Finance Plan as at 28 February 2019.

5.3iii Budget Outlook 2019-20 to 2021-22

The report updated on the budget outlook reported to IJB on 30 January 2019 and the agreed funding arrangements from NHS Highland and the Council over the next 3 years, reflecting the updates and adjustments outlined in the report.

The updated estimated funding from NHS Highland within the mid-range scenario was outlined. It is anticipated that NHS employer pension contributions will be funded but this is still to be confirmed by Scottish Government.

Funding from the Council for 2019-20 has been confirmed along with indicative funding for 2020-21 and 2021-22.

The IJB considered the current estimated budget outlook position for the period 2019-20 to 2021-22 and noted that there is a separate report on the agenda detailing savings options to deliver a balanced budget in 2019-20.

5.3iv Budget Proposals 2019-20

In presenting the report the CFO advised that the savings proposals to address the significant estimated budget gap over the next 2 years are within the strategic objectives of the HSCP. Work needs to commence immediately on identifying savings proposals and the separate templates attached to the report for each savings option outline plans for deliverability.

If endorsed, the four areas for review identified by the Senior Leadership Team to deliver savings in future years will be brought back to the IJB to approve any proposals identified :

- Potential cost reduction in co-location of General Medical Services including hospital out of hours and rural out of hours services.
- Proposal to scope dementia inpatient services. The Chief Officer acknowledged the concerns expressed by IJB members around the review and the reference in the template to “decommission” of the service. She gave assurance that there will be a scope of the service as a whole in Argyll and Bute and advised on the proposal to reinvest in community services in line with government policy.
- Review of radiography service to establish if 24/7 provision is necessary.
- Continued review of community hospitals.

Each savings Project Initiate Document (PID) which indicate the need for engagement due to possible service change, will be accompanied by a completed Engagement Specification.

The IJB :

- *Noted and endorsed the management/operational savings amounting to £5.058m in 2019-20 rising to £6.078m by 2021-22.*
- *Approved the policy savings amounting to £1.736m in 2019-20 rising to £1.934m by 2021-20*
- *Welcomed the work undertaken by officers which has resulted in proposals to deliver a balanced budget in 2019-20. Noted that in endorsing the management/operational savings and approving the policy savings, this will deliver a balanced budget in 2021-20. Instructed the Chief Officer to proceed to accept the funding from NHS Highland and Argyll & Bute Council and issue formal Directions delegating resources back to the Partners.*
- *Noted and endorsed that further development work should be undertaken on the review of areas within paragraph 3.3.3.*
- *Noted the high level timetable for the budget preparation 2020-12*

5.3v Financial Risks 2019-20

The report introduced the process for identifying and reporting financial risks and gave an awareness of the type of risk to monitor and mitigate. Each risk will be assessed on a relatively standard matrix and grouped within financial ranges. There are currently 34 risks identified, with 26 possible and 8 classified as likely. The CFO noted the request that pay awards are recorded in the next update report to the IJB.

The IJB :

- *Considered the financial risks identified for the Health & Social Care Partnership*
- *Noted that financial risks will be reviewed and monitored on a 2 monthly basis and reported back to the Board.*
- *Requested the report is presented to the Financial Governance with the overview highlighted in the supplied minute.*

5.3vi NHS Greater Glasgow & Clyde (NHS GG&C) Service Level Agreement (SLA)

NHS GG&C has requested an 2018/19 SLA payment of £54.3m and NHS Highland has offered £53.1m. This has resulted in a dispute over £1.2m which, following a recent meeting between the HSCP Chief Officer and senior managers and representatives from NHS GG&C is unresolved. Discussions will continue with external support being requested from the Scottish Government. Both parties Boards have agreed to working together to review the commissioning model for 2019/20.

The Head of Strategic Planning & Performance acknowledged the good access to NHS GG&C by Argyll & Bute patients and the equitable basis they are seen. As a result of working with NHS GG&C, there has been a significant improvement in the number of delayed discharges.

The IJB noted the position regarding negotiations with NHS GG&C in relation to the 2018/19 Patients' Services Service Level Agreement value.

5.3vii Quality & Finance Programme Board Minutes 29-2-19

The request for a paper on capital spend by both parties was noted for the SMOG and IJB agenda.

The IJB noted the Minutes of 29-2-19

5.3viii Draft Audit Committee Minute 8-3-19

Membership of the group to be reviewed. The Terms of Reference are being revised under guidance from the Standards Officer as requested at Committee.

The IJB noted the Minutes of 8-3-19.

The IJB emphasised the requirement for oversight and confidence in the arrangements and the responsibilities of the governance groups reporting to the IJB.

5.4

HSCP Performance Exception Report

The overall performance for FQ2 showed a reduction in performance with 34 indicators being on track compared to 38 in FQ1.

In response to concerns regarding the accuracy of the information being reported, the IJB were advised that information presented is trend data due to a data lag in terms of performance data as only validated data can be reported. It was agreed that the IJB Chair will raise this with Scottish Government through the IJB Chairs' Executive Group.

It was requested that the next report to the IJB includes a clear picture of any operational issues impacting on the delivery of community services.

Discussion of the operational data at other governance groups will be progressed and formalised.

It is planned that the HSCP Performance will be a topic at the IJB Development Session in May and will include further context around trend data.

The IJB :

- *Noted the overall scorecard performance for the FQ2 reporting period.*

- *Considered and noted the HSCP performance against National Health & Wellbeing outcome indicators: 6,7,8,9 and the Ministerial Steering Group (MSG) measures of integration for the HSCP.*
- *Noted the Head of Services performance commentary with regard to local actions to address exceptions against indicators 6,7 and 8.*
- *Noted the recent decision by the Senior Leadership Team to agree the MSG Performance Framework targets for 2019/20 and this will be presented to the IJB at its next meeting with reporting to comment in FQ3.*

5.5

Staff Governance Report

An integrated format for reporting continues to be challenging due to the broad range of reporting within NHS and Council parameters. The format of the report is being changed and improved to provide improved data presentation and clarity of the figures presented.

The report highlighted the focus on the recruitment drive and managing attendance.

The IJB requested that the next report focuses on :

- the levels of absence and a consolidation of the data to advise on causes and trends.
- data on return to work interviews.
- iMatter update and the steps taken as an outcome of the external evaluation.
- clarity on employee relations cases.

The first HSCP Workforce Plan for 2019/120 continues to be developed and will align with the timescale of the Strategic Plan.

The Head of People & Change will ask the Organisational Development Lead to connect with TSI CEO to discuss inclusion of TSI information in the plan.

The IJB were asked to email any further comments on the plan to jane.fowler@argyll-bute.gov.uk.

The IJB :

- *Noted the content of the report.*
- *Commented on the structure and content of the report.*

5.6

Argyll & Bute HSCP Workforce Plan

Discussion on the Plan was noted as above.

The IJB :

- *Noted the update on improving workforce planning and that this direction of travel is intended to support the next iteration of the HSCP Workforce Plan.*
 - *Noted the national developments on workforce planning and the integrated Health and Social Care workforce plan and the implications.*
- 5.7

Progressing Values & Culture

The paper presented by the Head of People & Change outlined the planned introduction to progress the values and culture work in the HSCP.

The IJB :

- *Noted that the HSCP is now ready to implement the CIRCLE Shared Values Framework.*
- *Approved the approach proposed to CIRCLE spread and embedding.*
- *Supported work to measure and develop the HSCP using the Cultural Values Assessment (CVA) instrument.*

6 Multi-Agency Public Protection Arrangements (MAPPA)

The report provided an overview of the current MAPPA arrangements in Argyll and Bute and the challenges to the partner agencies to meet their duties and priorities in this area of work. The lines of governance and accountability to the HSCP, as well as the NHS and Council, were outlined and assurance that active steps are being taken to address the challenges.

The IJB :

- *Noted the continued work of MAPPA within Argyll & Bute.*
- *Noted a meeting is scheduled with MAPPA representative on 9 April to discuss appropriate NHS Highland representation to effectively support the challenges in this area of work.*

7 Communications Framework

The Communication Framework described public, staff, service users and partners and the wider public.

Section 4 illustrates how the HSCP utilises a wide range of communication channels in order to meet the needs of different target audiences and to ensure that the relevant message is disseminated as

widely as possible. There is also a focus on communicating with the element of people who are not on social media through the use of other available sources.

Section 9 provides a template to form the basis of the annual communications plan for reporting back to the IJB.

The framework supports the HSCP's Engagement Strategy to provide a consistent process and governance throughout Argyll & Bute.

The IJB approved the Communications Framework.

8 Chief Officer's Report

The Chief Officer reported on her attendance at the recent Carer's Conference held in Inveraray. This was a positive experience for those attending the event and enforced the fundamental need to support carers.

She highlighted the Attend Anywhere project in the report, which brings together Communications to assist in supporting people to attend appointments via video link and reduces travelling times for patients.

The IJB noted the report.

9 IJB Chair/Vice Chair Transition

Following the tenure of the current IJB Chair ceasing on 31 March, the paper set out the transition arrangement for the Council's nominated Chair, Councillor Kieron Green and NHS Highland's nominated Vice-Chair, Sarah Compton-Bishop to take up their roles at the end of March.

The IJB noted the transition to the new Chair and Vice Chair in accordance with the Integration Scheme and the Public Bodies (Joint Working) (Integration Joint Boards)(Scotland) Order 2014.

Councillor Green thanked Mr Creelman for his contribution to the IJB and the various Argyll & Bute Committees during his term in office as the Argyll & Bute HSCP Chair and the NHS Highland representative and expressed the IJB's best wishes for the future.

Date of Next Meeting :

Wednesday 29 May 2019, 1.30pm
Council Chambers, Kilmory, Lochgilphead

A&B | Transforming HSCP | Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board Action Log 2019-20

ACTION LOG –Integration Joint Board April 2019 - March 2020						
ID	Meeting	Area	ACTION	LEAD	TIMESCALE	WORK STATUS (open, in progress, complete)
2		IJB	Strategic Risk Register topic for Development Session	CC/Scott Moncrieff	May-19	Complete
2	30/01/2019	IJB	Commissioning Position Paper	Stephen Whiston	Nov-19	In progress
3	30/01/2019	IJB	Draft HSCP Commission Plan	Stephen Whiston	Dec-19	In progress
4	30/01/2019	IJB	Review of Carer's Centres to ensure the criteria of the Carer's Act is being managed	Linda Currie	Mar-19	Complete
5	27/03/2019	IJB	Update Visible Changes IJB draft Implementation Plan	Joanna MacDonald	May-19	Complete
6	30/01/2019	IJB	Complaints report	Jane Fowler/Sandy Wilkie	Mar-19	In progress
7	30/01/2019	IJB	Updated HSCP Workforce Plan	Jane Fowler/Sandy Wilkie	Mar-19	complete
8	27/03/2019	IJB	Visible Changes Improvement Plan – report on mapping of values and link to Visible Changes Improvement Plan	Sandy Wilkie	May-19	Complete
9	27/03/2019	IJB	Staff Governance Report <ul style="list-style-type: none"> the levels of absence and a consolidation of the data to advise on causes and trends. data on return to work interviews. iMatter update and the steps taken as an outcome of the external evaluation. clarity on employee relations cases. 	Jane Fowler/Sandy Wilkie	May-19	Partially addressed
10	27/03/2019	IJB	MSG Performance Framework targets for 2019/20 presented to the IJB at its next meeting with reporting to comment in FQ3.	Stephen Whiston	May-19	complete
11	27/03/2019	IJB	2020-21 Budget Preparation	SLT	Aug-19	open
12	27/03/2019	IJB	Review of progress of Integration Self Evaluation	SLT/IJB	May-19	Complete
13	27/03/2019	IJB	Committee Appointments	IJB	May-19	
14	27/03/2019	IJB	Terms of reference update	KF/DH/CC	May-19	In progress
15	27/03/2019	IJB	Program of development sessions	CC	May-19	In Progress
16		IJB	Review meeting schedules 2020/21	CC/SC	May-19	In progress
17	27/03/2019	IJB	Publication of the Strategic Plan	SW	Mar-19	complete
18	27/03/2019	IJB	Financial Risk Report to Financial governance with highlight presented to the IJB	CFO	Jun-19	ongoing
19	27/03/2019	IJB	Capital Spend paper to the Quality and Finance Board	CFO	Jun-19	In progress

Report to Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland – John Sturrock QC

Scottish Government Response to the Sturrock Review

Report by Dr Boyd Peters, Interim Medical Director

The Board is asked to:

Note the Sturrock Report and the three main requests made in a letter to NHS Highland from the Cabinet Secretary Jean Freeman.

1. Summary

In September 2018 allegations of bullying in NHS Highland were made by four whistleblowers in a letter published in the press. A report by an independent QC, John Sturrock was commissioned by the Cabinet Secretary on 23rd November 2018. 340 people made contact with Mr. Sturrock, coming from a broad cross section of the staff employed with NHS and some independent contractors. The report was finalised in draft form in late March 2019 and the publication date was 9th May 2019.

2. Background

An external independent review into the allegations of bullying at NHS Highland was conducted over several months with a remit to “consider all the circumstances that have led to the allegations and make recommendations.” The Cabinet Secretary expressed the hope in the Scottish Parliament on 27 November 2018 that Mr. Sturrock would at least present her with interim recommendations in early 2019. These were submitted on 5th February 2019. Following publication of the report in May 2019, Chief Executive Iain Stewart apologised on behalf of NHS Highland for any hurt or harm caused to anyone who was bullied or affected by inappropriate behavior.

3. Assessment/options/issues for consideration

Proposals are made in the Sturrock Report. Additionally Cabinet Secretary Jeane Freeman has asked that by 31st May 2019 NHS Highland give details of immediate actions the Board has taken/plan to take on the back of the recommendations made in the Sturrock report, of what support the Board has put in place/will put in place for any member of staff who has been affected by bullying and harassment and details of the Board’s plan for staff engagement and a timeline of when this will be carried out.

NHS Highland will make plans to provide pastoral care, mediation, occupational health support and an appropriate communication framework. HR processes will support the response plan for the Sturrock report and there will also be organisational learning and improvement through review of structures and leadership, through training and information for Board Members and learning from other Boards and from previous reports including the Gallanders report, the Audit Scotland report and the John Brown governance report. Plans will be drawn up and where appropriate broadly consulted on, for organisational and workforce development to include support for teams in difficulty and plans to embed values and behaviour standards throughout NHS Highland. Partnership working with trades unions and staffside representation, including clinical engagement via the Area Clinical Forum and its component advisory committees will be integral to the way forward. Specific plans may

require to be considered for particular areas which were identified in the Sturrock Report, including Argyll & Bute but as a founding principle it is recommended to the Board that where possible there is a consistent and full implementation of actions across the whole of NHS Highland.

4. Contribution to Board Objectives

NHS Highland must not accept bullying, and must be a place where all colleagues behave appropriately towards one other and where bullying is not tolerated.

5. Governance Implications

Assessment of all governance implications will be required throughout all stages of the Board's planning and implementation of actions linked to the Sturrock report.

6. Risk Assessment

Assessments of risks to compliance for data protection legislation will be made. Other risk assessments as required.

7. General Data Protection Principles Compliance

There are no known risks to compliance with Data Protection Legislation, but this will nonetheless be assessed.

8. Planning for Fairness

Where specific cases of bullying are identified, appropriate processes will be applied to support the individuals concerned.

9. Engagement and Communication

Active plans for engagement and communication in the short, medium and long term will be made. The Short Life Working Group for promoting positive workforce culture will now be dissolved in favour of a small group that will steer and be responsible for delivery of meeting the actions arising collectively from Sturrock, Gallanders and other reports, including emerging national guidance on whistleblowing. Further reports will be made to the Board on progress with response to the Sturrock Report and the development and implementation of plans.

Report Author: Dr Boyd Peters Interim Medical Director

Date: 21st May 2019



**Report to the Cabinet Secretary for Health and Sport
into Cultural Issues related to allegations of
Bullying and Harassment in NHS Highland**

April 2019

John Sturrock QC

“There was never any physical violence. Only the fear. That nauseous feeling in my stomach. Hyper vigilance. It would start on a Tuesday and culminate on the Friday when we met. The intimidation was horrible. I would do everything I could to avoid it. I was blamed for leaving early. I never told anyone at the time. They, those in charge, must have known. But I felt powerless. Ashamed. As if it was my fault. It affected everything. I suspect it has had a huge impact on my life.”

“I found it really hard being called a bully. It was shocking in fact but I couldn’t admit it to anyone outside. I hadn’t been trained to take on this role. I had tried my best. But there was huge pressure to conform, to do things a certain way. I knew I was hard to work for at times and would tend to be demanding. In reality, I was struggling. I couldn’t show that or tell anyone. I didn’t mean to cause harm. Sometimes, it felt like I was the one being bullied even though I was supposed to be in charge. Even now, I feel ill at the thought of it...”

(see Personal Note at paragraph 1.17)

“We can’t solve problems by using the same kind of thinking we used when we created them”.

(attributed to Albert Einstein)

“The key to doing well lies not in overcoming others, but in eliciting their co-operation.”

(Robert Axelrod)

“We have far more in common than that which divides us”

(Jo Cox MP)

“There is no us and them, only us.”

(Ken Cloke)

“When in doubt, do the kindest thing”

(unattributed)

“We are mirrored not by concepts, but by faces delighting in us—giving us the face we can’t give to ourselves. It is “the face of the other” that finally creates us and, I am sorry to say, also destroys us. It is the gaze that does us in....”

(Richard Rohr)

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

(Maya Angelou)

Questions

“Everyone thinks of changing the world, but no one thinks of changing him or her self.”

(adapted from words of Leo Tolstoy)

It is perhaps only by asking, and continuing to ask, ourselves and each other difficult questions that a constructive way forward will emerge.

Before you read this report, I invite you to ask yourself some questions:

- What am I hoping to find in this report?
- What assumptions have I made before I start?
- What do I hope to learn from reading this?
- How open am I to new perspectives?
- How willing am I to see another side of the story?

After reading the report, you might ask:

- What have I learned?
- What needs to change?
- Who do I now need to talk to?
- What else do I now need to do?
- What do I need to let go?
- How can I help to change things for the better?

If you are affected by what has happened in NHS Highland, I invite you to ask these further questions:

- What was my role in things which happened?
- What might I have done differently?
- What do I now regret doing or not doing?
- What do I need to acknowledge in myself or about others?
- What might it be like to be the person I dislike or fear most?
- How might others see me?

“O wad some Power the giftie gie us, to see oursels as ithers see us!”

(Robert Burns)

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Introduction and Summary

1. Introduction to the Report

1.1 On 23 November 2018, I was asked by the Cabinet Secretary for Health and Sport to undertake a fully independent external review into allegations of a bullying culture at NHS Highland.

Remit

1.2 The stated purpose of the review was to:

- Create a safe space for individual and/or collective concerns to be raised and discussed confidentially with an independent and impartial third party.
- Understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally.
- Identify proposals and recommendations for ways forward which help to ensure the culture within NHS Highland in the future is open and transparent and perceived by all concerned in this way.

Public Announcements

1.3 The press release announcing my appointment included these words from me:

“My primary role, therefore, is to provide a safe and confidential place for people to be heard and to explore with them what the underlying issues might be.”

1.4 In publicising the review, I added that I hoped to make recommendations and proposals with a view to helping to improve culture and behaviours both now and in the future and restore the trust between the management of NHS Highland, the clinical community, and local staff-side representatives, in order to build and maintain a culture of cooperation and respect.

1.5 I note also that following a meeting hosted by Shirley Rogers, Director of Healthcare Workforce and Strategic Change in the Scottish Government, with union representatives on 19th November 2018, a statement was made

by the Scottish Government that an externally led independent review into the allegations of bullying at NHS Highland “*will consider **all the circumstances** that have led to the allegations and make recommendations*” (my emphasis).

1.6 The Cabinet Secretary expressed the hope in the Scottish Parliament on 27 November 2018 that I would at least present her with interim recommendations in early 2019. That guided my conduct of the review. I submitted interim findings and recommendations on 5 February 2019.

Review and Report

1.7 This full report was submitted in draft form on 27 March 2019. I am conscious that this means that the review was conducted in approximately eighteen weeks (which included the Christmas break). I am mindful that such a relatively short period of time places some restrictions on the scope of the review but hope that this report does sufficient justice to what I have heard and read in that time to enable others to build on it.

1.8 I have been able to revise the report to take account of representations made since the first draft and I am also aware that, since I gathered information in late 2018 and early 2019, matters have moved on with a number of changes at senior levels.

1.9 I should also record, as I expand on later, that the number of responses I received greatly exceeded what had been anticipated when I was appointed and this has impacted on the management of time and resources. Nearly all respondents had serious contributions to make and concerns to express, and the majority requested meetings with me.

1.10 Against that background, this report is designed to enable the Cabinet Secretary to reach conclusions about the matters I have explored in connection with NHS Highland and, if she wishes to do so, to act on my proposals and invite others to do so. It is also written with a wider audience

in mind including those in NHS Highland who will need to take matters forward and all those interested in the circumstances which I have been asked to review.

- 1.11 This is by no means the final word. I fully appreciate that some of those with whom I met, and others with whom I have not met, will have views to express about the content of the report. That should be part of the continuing dialogue. I have sought to reflect what I have heard and how I have seen things. This report reflects a stage in a longer journey of consideration and discussion about these important issues.

Report Sections

- 1.12 To aid navigation through the report, it is presented in six broad sections:
- (I) Introduction and Summary (from page 12)
 - (II) Context (from page 22)
 - (III) What the Review was Told (from page 49)
 - (IV) Understanding the Cultural Issues (from page 65)
 - (V) & (VI) Ways Forward for NHSH (in two parts, from pages 134 and 147)
- 1.13 Some readers may wish to skim through the Context section which contains a number of general observations not all of which, I acknowledge, will be of interest to every reader.
- 1.14 There are a number of chapters in each section. Inevitably topics and themes overlap and intersect.
- 1.15 For those who wish a quick overview, the Summary of the Report, which follows after this Introduction, provides that. Please do bear in mind, however, that the full explanation of, and context for, the points made there are found in the detail of the report. There is also a Quick Summary of Main Points and Proposals towards the end, in Chapter 37.
- 1.16 For ease, I refer in this report to NHS Highland as “NHSH”.

Personal Note

- 1.17 I have some limited experience myself of what is called bullying. The two quotations on page 2 relate to my own life experience: at school in the early 1970s and some years ago as the founder of a small business. Bullying affects many of us in many ways.

Gratitude

- 1.18 I am grateful to my colleague Miriam Kennedy for all her hard work behind the scenes and to my colleagues Charlie Woods and Liz Rivers for bringing compassion, insight and wisdom to the process. Ainsley Francis also provided invaluable support in the presentation of this report.
- 1.19 However, my biggest thanks go to the 340 people who came forward, often reluctantly and with some trepidation, most of whom candidly shared their experiences and offered their views. While I have not been able to incorporate or reflect all that I heard, I hope they feel that this review does some justice to what they said.

A Reflection

- 1.20 We often wish that things had not happened in our time. But we have to deal with what we have been given. If challenges seem impossible and overwhelming, all we can do is look to the present and the future. We each have the choice to do something, to make our contribution, however small. In that way, *our sense of powerlessness can be converted into empowerment.*
- 1.21 It is often said that “*little things can make a big difference.*” I hope that this report will empower many people in NHSH to choose to accept the challenge to make contributions, however small, to a better future for the organisation.

2. Summary of the Report

Overview

- 2.1 NHSH is and has been for many a great place to work. There are thousands of well-motivated, caring and supportive people providing excellent caring services to thousands of patients in the area served by NHSH, often sacrificially and well beyond the call of duty.
- 2.2 This has been a very hard time for many employees of NHSH and those connected with NHSH. It may be that focus on the primacy of patient care and safety in recent years, through quality and performance initiatives, has not been matched in all situations by care for those delivering the services.
- 2.3 Patients and others in the NHSH community need to be reassured that the day to day work of the organisation is designed and able to do the very best it can for all concerned.
- 2.4 The only way to optimise the use of limited fiscal resources is to draw upon and acknowledge the deep well of goodwill that exists in the NHSH workforce. That goodwill has been seriously tested in recent years for a number of those working in NHSH.
- 2.5 There is a great opportunity now to create an open, safe and inclusive organisation in all of its component parts, perhaps even to be a leading exemplar to other organisations. If real learning can be taken from what has happened, and if kindness and compassion can be restored in NHSH, there is a great opportunity to build a new kind of organisation.
- 2.6 There may be no greater leadership challenge in 2019 than to help people under pressure to feel valued and for everyone to appreciate the benefits which come from rebuilding strong relationships, bringing out the best in each other and enabling everyone to be more effective in every way.
- 2.7 It seems necessary, at a deep level, to explore and understand why individuals and organisations behave as they do, especially when

under pressure, and to find enduring remedies, not transient sticking plasters. Current research into behavioural psychology and neuro-science provides an excellent resource to draw on.

- 2.8 This is an organisation with an £800 million budget funded by the taxpayer. The current situation merits serious analysis. This report reflects a stage in a longer journey of consideration and discussion about these important issues.

The Review

- 2.9 Of the 340 people who made contact, the review engaged directly with 282 respondents in face to face meetings and in written form. They came from a broad cross section of the staff employed by or associated with NHSH, from most departments, services and occupations, mostly current and some former.
- 2.10 In total, the review has enabled a total of 186 individuals to express their views personally on a one to one basis or in a group setting. This was not easy for many. Most people expressed satisfaction with the opportunity afforded to them.
- 2.11 Those coming forward in response offered a wide range of views, from those who wished to say that they are not aware of bullying in NHSH at all to those who provided details of their own and others' experiences of bullying behaviour, both individually and collectively.

What the Review was Told

- 2.12 The majority (66%) of those responding to this review wished to report experiences of what they described as bullying, in many instances significant, harmful and multi-layered, and in various parts, at all staffing levels, and in many geographic areas, disciplines and departments of NHSH.

- 2.13 There are issues common to the whole of NHS, some which are particular to the Inverness area and Raigmore, and some which are particular to more rural areas and to Argyll and Bute. These affect wider communities too.
- 2.14 A significant minority of respondents expressed views with varying degrees of firmness to the effect that there is not a problem, or at least that there is no bullying culture as such, and that any conduct of concern is nothing other than what might be expected in any similar organisation with day to day pressures. They have been hurt and angered by the adverse impact of the allegations which have been made, on patients, staff and local communities.
- 2.15 A significant majority of those with whom the review engaged have, over a number of years suffered, or are currently suffering, fear, intimidation and inappropriate behaviour at work. The issues raised are also wider and more complex than “bullying”, however that is defined. Bullying cannot be assessed in a binary way.
- 2.16 While it is not possible to conclude conclusively that there is or is not a bullying culture in NHS, it may be possible to conclude that the majority of employees of NHS have not experienced bullying as such. Having said that, extrapolating from the evidence available to this review, it seems equally possible that many hundreds have experienced behaviour which is inappropriate. That seems far too many.
- 2.17 The number of individual cases in which people have experienced inappropriate behaviour which falls within the broad definitions of bullying and harassment described earlier is a matter of the utmost concern. Many appear to have suffered significant and serious harm and trauma, feel angry and a sense of injustice and want to have their story heard.
- 2.18 A number of those against whom bullying allegations have been made are also, or have been, the subject of inappropriate behaviour themselves.
- 2.19 Many people have been afraid to take steps to address issues internally or to speak out, currently and over a period of many years. Many feel that no really effective, safe mechanism to do so has existed.
- 2.20 A significant number of employees, at all levels of seniority, have resigned, moved to other jobs or retired as a direct result of their experiences in NHS and inability to achieve a satisfactory resolution, some to their financial detriment.
- 2.21 Themes emerged for staff who feel they are not valued, not respected, not supported in carrying out very stressful work and not listened to regarding patient safety concerns, with decisions made behind closed doors. They feel sidelined, criticised, victimised, undermined and ostracised for raising matters of concern. Many described a culture of fear and of protecting the organisation when issues are raised.

Understanding the Cultural Issues

- 2.22 The experiences of many NHS staff are likely to be attributable to a number of factors which have built up over many years, a number of which have also created difficulty in raising and addressing matters locally.
- 2.23 Some factors could be described as cultural and are possibly unique to the specific local and geographic circumstances of NHS and its employees. Other matters are relevant in general to the NHS in Scotland and to the provision of health care overall. There are other significant factors which will be common to all large organisations.
- 2.24 These are explored in detail in this Report.

Management and Leadership

- 2.25 Many of the difficulties experienced in recent years in NHS are said to be attributable to a management style which has not been effective in the challenging circumstances of the modern NHS, and relate also to the effectiveness of the governing body to provide effective oversight.
- 2.26 A significant number of respondents expressed concerns about the role of senior management. The senior leadership of NHS has seemed to many, though not all, to have been characterised over some years by what has been described as an autocratic, intimidating, closed, suppressing, defensive and centralising style, where challenge was not welcome and people felt unsupported.
- 2.27 A significant number of managers who engaged with the review reported operating

in circumstances in which they felt unable to manage effectively because of the uncertainties and pressures presented by the current situation. There is a real concern that allegations of bullying can be used to avoid or deflect appropriate management of performance and other difficult issues.

- 2.28 It appears that the intersection in decision-making between management and clinicians is not working well enough and is a cause of much frustration and sub-optimal performance.
- 2.29 Issues were raised about appointment, recruitment, promotion, training, diversity and relationships of managers.
- 2.30 Many who were concerned at director and senior management level and who themselves experienced bullying behaviour have left the organisation. Some people have been very damaged by the experience.
- 2.31 It is understandable that some have concluded that what was being experienced at the top of the organisation led to a situation in which identifying and addressing inappropriate behaviour was difficult.

Governance

- 2.32 For a number of reasons, including inadequate provision of information to the Board which was not conducive to effective and informed decision-making and a culture which tended to discourage challenge, it appears that the Board has not functioned optimally in its governance and oversight role leading to a situation where allegations apparently could not be raised and responded to, adequately, locally.
- 2.33 Over a period of time, concerns have been expressed about a style of management and type of behaviour which many contended was not acceptable in a large and complex organisation. It seems clear that people in leadership positions were or should have been sufficiently aware of the concerns expressed as late as mid-2017 and probably earlier.
- 2.34 Both the Board and the Scottish Government were, or should have been, sufficiently alerted by developments to act more decisively at an earlier stage.
- 2.35 In a public service with a budget of £800 million, new leadership should look seriously at the learning arising from what has occurred, especially in connection with holding to account. If this is done, it should be possible to assess and respond to allegations, such as those of bullying, more fully at an earlier stage.
- 2.36 The absence of a proper strategic vision with specific goals and timelines seems to be a contributor to the current sense of lack of direction.
- 2.37 The governance structure seems extensive and impenetrable to many. It does not seem conducive to open, transparent and effective operation.
- 2.38 The role, appointment, training and support of, and provision of information to, non-executive directors appears not adequate in practice to meet the needs of the Board of a large publicly funded organisation with an £800 million budget.
- 2.39 Unless people with the necessary skills, knowledge, expertise and experience (and ability to ask the right questions in the right way while understanding financial, risk and other management issues) are appointed to NHS boards, there is a danger that governance will not be effective and national policies will not be implemented effectively.
- 2.40 Many people expressed their concerns about the partnership agreement for staff involvement in decision-making and the role of trade unions and staff-side representation, which appears to many employees to have failed adequately to represent the interests of employees of NHS in regard to bullying claims.

HR and Other Processes

- 2.41 It appears there has been, and continues to be, serious delay in addressing many of the issues of significant concern to members of staff in NHS. This is often because of failures and delays in recording, reporting and investigating, and in grievance and other procedures and policies for dealing with complaints and other concerns (including the inconsistent and inappropriate use of suspension and capability assessments, breaches of confidentiality and perceived loss of impartiality).

- 2.42 While there is a lot of criticism of “HR”, that may be a catch-all which conflates management roles and the HR function and does not fully acknowledge the wide-ranging nature of the dysfunction across management generally.
- 2.43 The view has been expressed that there is a strong need to improve diversity awareness and bring the NHH culture into line with attitudes and practice in the rest of the UK.
- 2.44 It has become clear that mental health should be a major management issue for the NHS and NHH in particular. A significant number of people employed in NHH have suffered and some continue to suffer from significant mental health issues as a result of their experiences, many of which can be described as traumatic given their repetitive and intrusive nature in disruptive and damaging situations.
- 2.45 There are a number of more specific concerns which the report comments on in some detail.

Scottish Government

- 2.46 Senior officials in Scottish Government were aware of the dysfunctional situation with the Board and at senior leadership level for a considerable period of time prior to matters becoming more public in the autumn of 2017.
- 2.47 There is a tension for Scottish Government between intervening and encouraging organisations and individuals to deal with issues themselves. Government is often accused of over-involvement. Yet, when things go wrong, it is held responsible. Judging when and how to intervene is not easy.
- 2.48 The Scottish Government is an essential part of the system. How it acts and reacts also impacts on those in NHS boards and executive positions in local areas. Now seems like a good time to review this relationship.

Whistleblowers

- 2.49 Those involved as whistleblowers genuinely felt they had no option but to do what they did and that this was the only way to address matters, even with the costs which arose. None of this would have been necessary or would have developed as it did had the Board and management appeared to be open to a full

exploration of the issues. The report’s findings are not hugely influenced by the whistleblowers’ allegations; they were ultimately a catalyst for others to come forward.

- 2.50 Many people have been hurt and feel misrepresented and offended by what has appeared to them to be a brutal step by the whistleblowers. Individual reputations in a close community have been adversely affected. There seems little doubt that certain assertions were too broad and without the support claimed.
- 2.51 The existing system for whistleblowing does not seem to have functioned as effectively as it needs to.

Ways Forward for NHH

- 2.52 In NHH, steps can be taken, both restorative and preventative, to reset the whole organisation and to promote an institution-wide healing and reconciliation initiative, supporting and liberating the workforce. This is likely to have a positive impact on patient care and outcomes too.
- 2.53 Better staff relationships will lead to better clinical outcomes, especially when the tasks are complex and interdependent. To achieve this, there is an urgent need to collaborate and work together rather than to compete, based on a deeper and wider understanding of the shared interests that allow people to cooperate more effectively and efficiently to find solutions.
- 2.54 This necessarily entails a move away from trying to control everything to a more distributed, multi-disciplinary or collective leadership and decision making.

People-Centred Culture

- 2.55 There needs to be an enabling culture from the top. Culture change needs to be owned by the leaders. That means leaders who are not afraid, who have high self-esteem and a great deal of humanity and compassion. Kindness is a critical component of the leadership which will be needed going forward.
- 2.56 A new style of people-centred leadership will be crucial, with a more effective and competent management team and board, and a more compassionate, honest, courageous, humble,

empowering culture, open to respectful challenge, communicative and accepting of the realities of operating in a very pressurised and financially challenging situation. Fear cannot be the driver.

Other Considerations

- 2.57 An honest conversation is needed more generally in the NHS, and with the general public and employees, about realistic expectations and the perhaps inevitable tensions between clinical delivery and financial reality.
- 2.58 Fault-finding and a culture of blame will not be a productive way forward. Wherever possible, NHSH will need to look forward constructively to the future.
- 2.59 Looking ahead, it will be necessary to find ways to acknowledge the circumstances of the past, to recognise the impact on individuals, processes and services, to demonstrate acceptance of some personal responsibility, to show that lessons have been learned, to reassure staff and indeed the general public that there is a genuine willingness to grasp the need for change and that things will be different in the future, to rebuild confidence, and to move forward with greater competence in the years ahead.
- 2.60 More attention should be paid to early intervention, when a difficulty or conflict is first identified. Nipping matters in the bud is critical. This can be addressed by education and training, by empowering those affected and bystanders to raise concerns early, and by introducing other different approaches which move away from adversarial or binary processes.
- 2.61 Many of the issues currently being addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, early intervention through mediation and other facilitated conversations.
- 2.62 The time has come to place mediation firmly at the centre of a preventative strategy in the NHS in Scotland. That could start in NHSH.
- 2.63 Leaders and others will wish to reflect on and seek to align how things are done in NHSH with the National Performance Framework and its outcomes.

Leadership, Governance and Management

- 2.64 It seems essential for the new chief executive to exhibit an ability to engage with people at a personal level, to listen well and to seek to understand, to value contributions from all parts of the organisation and to be alert to the human effect of the inevitable tensions and constraints which funding limitations and other challenges bring.
- 2.65 He will benefit from the support of like-minded and like-acting colleagues who can help lead by example and demonstrate real empathy, insight, self-awareness and vision in practice. He will need the support of an appropriately qualified Board chair who has a similar mindset.
- 2.66 There is a real need for an authentic, meaningful acknowledgement and acceptance of how serious matters have been for many people in NHSH over a number of years, together with recognition of the impact on them of these circumstances and a reassurance that matters will be addressed now with rigour going forward.
- 2.67 At the same time, there should be recognition of the impact on those who have not experienced adverse behaviour but who have been affected by the fact that the allegations themselves have been made. Healing can only occur if the different experiences are recognised and acknowledged.
- 2.68 Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation. Consideration might be given to adopting something akin to the Commitment to Respectful Dialogue of Collaborative Scotland.
- 2.69 The Board must be able to hold senior executives effectively to account, in the sense of supportively enabling and ensuring effective leadership rather than blaming or coercing. A review of governance structures, the committee network and culture will enable the kind of clear communication and taking of responsibility which this report commends. Allied to this, the Board will wish to oversee a review of the management structure also.
- 2.70 Other detailed proposals regarding governance should be acted on, particularly in connection with non-executive directors.

- 2.71 Reassessment of the relationship between and among clinicians, GPs and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. There should be reflection on the manner and benefits of clinical involvement in leadership.
- 2.72 Clearer management structures, a better understanding of the needs and motivations of both management and medical staff and a positive approach to the greater good, will all benefit staff and patients alike.
- 2.73 The role of trade unions and staffside representation, including the partnership agreement, merits review in order to ensure really effective representation of employees' interests.
- 2.74 By reason of its geographic and possibly other specific circumstances, a separate review in and about the functioning of management in Argyll and Bute should be commenced, conducted by a person or persons from outside that area.
- 2.75 In so far as staff have any specific concerns about patient safety, these should be referred to the chief executive or to a specified independent person if preferred.

Support for NHS Employees

- 2.76 Support is needed, in a number of ways, for individual employees in NHS (at all levels), who have experienced inappropriate behaviour and who have suffered distress, harm and other loss. This should include providing safe and independent spaces for many current and outstanding physical, emotional and psychological issues to be addressed fairly urgently.
- 2.77 It is likely that these initiatives will result in a need to address specific complaints, disciplinary matters and grievances, many of which appear to remain outstanding and/or unresolved. The cooperation of the unions, especially the GMB, will be important in this. A strategy to resolve the many outstanding cases as speedily as possible should be devised.
- 2.78 Other specific proposals are made in this Report.

Training and HR

- 2.79 Longer term, a carefully designed ongoing comprehensive training programme addressing appropriate behaviour (including a well communicated, simple and clear definition of what constitutes bullying and harassment, together with diversity and discrimination awareness) could have a profound impact.
- 2.80 There is a need to rebuild confidence in and of managers. A programme of action learning, training, review, coaching and support is essential at all management levels, including for those preparing for recruitment, induction or promotion into management positions.
- 2.81 Among a number of specific recommendations to build relationships and confidence, the introduction and/or enhancement of well facilitated team meetings on a regular basis, possibly across boundaries on an inter- and/or multi-disciplinary basis, with opportunities to express concerns, to brief and debrief safely, and review events and experiences in a supportive culture, could help greatly. Managers could be trained and encouraged to undertake and facilitate these.
- 2.82 There needs to be an organisation wide clarity about and understanding of the role of HR, and its limitations, and it and Occupational Health need full-time direction at the highest level. Appointment of a full-time HR Director is essential.
- 2.83 All HR and other policies and procedures should be reviewed, updated and simplified, in the context of national reviews – and properly publicised. Systems for accurate and robust recording of complaints about alleged bullying and harassment should be maintained so that understanding of the extent, nature and distribution of bullying and harassment in the organisation is improved.
- 2.84 Grievance and other formal procedures, when used as a last resort, must be redesigned to be speedy, transparent and fair to all.
- 2.85 It is suggested that all NHS staff should be educated about the effects of bullying, the trauma model, the Adverse Childhood Experiences study and how they can address

unprocessed trauma leading to consequences for the alleged victim and to themselves. Other steps to address dealing with trauma are recommended.

Whistleblowing

- 2.86 While one would hope that the steps above would minimise the need, and that “whistleblowing” would be very much a last resort, further steps should be taken to provide a properly functioning, clear, safe and respected wholly independent and confidential whistleblowing or, more helpfully, “speaking up” mechanism.
- 2.87 All staff should be aware of how to use this and in what circumstances its use is relevant so that individuals with concerns are able to express these confidently in the future.
- 2.88 Provision of an independent, confidential, trained “guardian” or guardians seems essential both for those who experience and wish to report inappropriate behaviour and for those against whom such behaviour is alleged.



Context

3. NHS Highland

A Place of Work

3.1 It has been an enormous privilege to conduct this review. NHSH is a central and vital part of the Highland community. It extends from Caithness to Campbeltown, from Kingussie to Portree and from Nairn to Tobermory. But, interestingly, not to Elgin or Stornoway, Kirkwall or Perth! It has its central focal point at Raigmore in Inverness. It is a large, diverse, complex and sometimes fragile organisation. NHSH is and has been for many a great place to work. The following observations by some of the respondents to the review emphasise this point.

“I am immensely proud to work for the NHS and NHS Highland, I love my job and I think that the majority of people working within the NHS go above and beyond every day when they are at work.”

“My over-riding impression is that staff are trying their very hardest to provide the best standard of care for their patients.”

“My experience of working as a nurse in NHS Highland is a very positive one... Where ever I go and whoever I interact or work with I am filled with a great sense of pride to see such great staff delivering really excellent care.”

“Raigmore is the nicest, friendliest hospital I have ever worked in.”

“Generally speaking, it sometimes feels like the organisation is under siege. One of the things that keeps me going is how many good things one can see in the organisation. Being able to see that there are positive things happening.”

The People who Work in NHSH

3.2 There are thousands of well-motivated, caring and supportive people providing excellent caring services to thousands of patients in the area served by NHSH, often sacrificially and well beyond the call of duty. I have met many very fine, high quality professional people, trying – and doing – their best in their jobs, which they

love, in often really difficult circumstances. The public’s expectations of them (and of the NHS as a whole) are huge. We must acknowledge that fact and its effects.

3.3 I have admired the professionalism and humanity of individuals whose primary role is either to provide care for others in the community at times of stress and pain or to support colleagues who do so. I am struck by the essential goodness of those employed by NHSH and also by the adverse impact on many of them of the allegations which have been made, including on those for whom the allegations came as a shock.

3.4 This has been a very hard time for many employees of NHSH and those connected with NHSH. It may be that focus on the primacy of patient care and safety in recent years, through quality and performance initiatives, has not been matched in all situations by care for those delivering the services. The two are of course inseparable.

3.5 Overall, I am sure that NHSH staff wish to do well for and to support each other and the patients and others they seek to serve. This can and should be the foundation going forward. Patients and others in the NHSH community need to be reassured that the day to day work of the organisation is designed and able to do the very best it can for all concerned.

Pressures and Priorities

3.6 I am aware that there are other pressures and priorities too, not least financially. The organisation is under huge financial pressure. While that is so, it seems really important that the people side is given full consideration. While cost constraints are a part of life in a publicly funded organisation, ultimately people must be the priority. Indeed “*People are the Priority*” might be a useful slogan for the year ahead. I am told that prioritising people is a central tenet of the Nursing and Midwifery Council Code.¹

1 Nmc.org.uk. (n.d.). Read The Code online. [online] Available at <https://www.nmc.org.uk/standards/code/read-the-code-online/#third> [Accessed 8 Mar. 2019].

- 3.7 Financial targets will only work well if people are thriving. Human dignity is an infinite resource; public finance is not. Indeed, perhaps the only way to optimise the use of limited fiscal resources is to draw upon and acknowledge the deep well of goodwill that exists in the NHSH workforce. That goodwill has been seriously tested in recent years for a number of those working in NHSH. Ironically the damage to, and waste of, human resources surely adds to the financial cost.
- 3.8 If people, and achieving their full potential, become the priority, the converse is also likely to be true. Real compassion in and towards the workforce is an investment, an example perhaps of preventative spend.
- 3.9 The value of all this coming to the surface, as it now has, must be that it creates an opportunity to learn, to try to do things differently in the years ahead and to turn a crisis into a better future. At some point, a line will need to be drawn under the past and I hope that this report will play a modest part in enabling that to be done. There is a great opportunity now to create an open, safe and inclusive organisation in all of its component parts, perhaps even to be a leading exemplar to other organisations.

A Word about Patients

- 3.10 I am aware that it was hoped that allegations of bullying against patients would also be included in this review. However, given the time constraints, it was agreed at an early stage that these would not be included. Purely for the record, we received very few such allegations, even from the outset.
- 3.11 Everyone is agreed that patient safety is paramount. Patient safety is not something I can cover in detail in this report. However, a number of concerns have been expressed to me about the consequences for patients of unhappiness and poor relationships among staff and it seems inevitable, given the extent of dysfunctioning upon which I report below, that there will be issues to address, of which I was given some examples.
- 3.12 On the other hand, and in keeping with my earlier comments, the vast majority of patient care is likely to be of a very high standard. In so far as this whole situation has caused concerns for patients and their communities, confidence needs to be restored. I hope that this report, and the actions following it, will play a part in helping to do so.

4. My Approach to Conducting the Review

“Clear is kind. Unclear is unkind...Feeding people half-truths or b.....t to make them feel better (which is almost always about making ourselves feel more comfortable) is unkind.”²

General

- 4.1 It was made clear from the outset that the review could not specifically address individual complaints or concerns, whether resolved or unresolved. I emphasised that the review’s objective was to explore matters more generally. Those responding understood that readily. Of course, individual matters are very important as they represent experiences and examples to take into account in considering the overall situation in NHS. I refer to a number of these to exemplify the issues raised.
- 4.2 I am not an expert in the workings of the NHS nor in allegations of organisational bullying. I am better informed now but I am more of a generalist than a specialist. That needs to be borne in mind by the reader. In order to inform myself better about the context of my review, I have taken into account a number of other reports and reviews. Some are specific to NHS and others are more general, such as the reports by Sir Robert Francis in England³ and the Bowles Report on NHS Lothian⁴. I have also been aware of the BMA’s recent expressions of concern about bullying more generally in the NHS in Scotland⁵ and of other reports commenting on bullying elsewhere.
- 4.3 However, I have endeavoured not to be unduly influenced by the fact or content of reports relating to matters elsewhere and to focus my attention on what has been and is said to be occurring specifically in NHS. It will be for others to discern a pattern or to draw comparisons, if any, with what is happening elsewhere or more generally.

- 4.4 In forming views, I have listened extensively and tried to assess and distil what I (and my colleagues) have heard and read. I have noted the sources of information, and the apparent veracity of what has been said. I have been interested when multiple strands of information have come together and disclosed a trend or a theme. I have endeavoured to assess the credibility of what I have been told. The wide-ranging nature of the review has given me a substantial body of material to draw on. When making a statement of fact, I do so when I am satisfied that what I have heard and/or read reasonably entitles me to do so. Generally, however, I am reflecting the views expressed to me by others and have not sought to check every statement made for its factual accuracy.

Content

- 4.5 In accepting this appointment, I made clear that I would not conduct a form of inquiry in which I would find fault or allocate blame. However, inevitably, my report contains commentary which implies criticism of individuals in some cases. I cannot do justice to the many views expressed and the experiences so many have shared with me without doing so. This is unfortunate but it is an inevitable consequence of such a review.
- 4.6 I have not recorded all of the detail with which I was provided. That would have filled an even larger tome. Necessarily I have tried to acknowledge what I have heard and to assess the bigger picture. That also means that others



- 2 Brown, B. (2018). *Dare to Lead*. 1st ed. Random House.
- 3 Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and Francis, R. (2015). *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS*.
- 4 David J Bowles & Associates Ltd (2012). *Investigation into Management Culture in NHS Lothian*.
- 5 Freeman, T. (2018). Bullying ‘widespread’ in NHS Scotland, claims BMA. *Holyrood*. [online] Available at <https://www.holyrood.com/articles/news/bullying-%E2%80%98widespread%E2%80%99-nhs-scotland-claims-bma> [Accessed 12 Jan. 2019].

will need to take forward and give effect, if they wish, to the specific proposals and suggestions which I make, and indeed develop these even more specifically.

- 4.7 There is a sense in which my review is more qualitative than quantitative, offering a broad analysis based on observations, meetings, and written submissions, without scrutinising every detail of every claim, situation or case brought to me nor placing precise numbers on all aspects. That provides a strong basis for initial understanding and insights and for a range of broad initial proposals.
- 4.8 As I mention above, the review is not forensic in the sense of testing every statement and assertion. More specific inquiry may be necessary in some areas and individual cases. Some of my suggestions may seem overly general, naïve or untested. Some proposals may already have been expressed or implemented elsewhere. So be it. Repetition may be useful. Reinforcement may be essential.

Confidentiality

- 4.9 There is a vast resource in the thoughtfulness and insights of NHS staff. I am aware that I am privy to a very large amount of hugely helpful information about the workings of NHS and I am concerned to try to ensure that the richness of what I have heard and read is not lost altogether when it might be useful to others. On the other hand, most of the information has been disclosed confidentially and I intend to respect that above all. In line with our undertaking to Scottish Government and our data protection responsibilities, data which we have gathered will be destroyed within two months of the publication of this report. I comment further on this in my proposals.

Getting Under the Surface

- 4.10 I have tried to approach this review with an open mind. I am very aware of the biases that affect us all (and I write more extensively about that later in the report), however careful we try to be. Many of these biases are unconscious and I need to accept that I cannot eliminate them wholly myself. I can only see through the glass

darkly... and recognise that my own knowledge is imperfect. As has been said: *“In human affairs there is no certain truth and all our knowledge is but a woven web of guesses.”*⁶

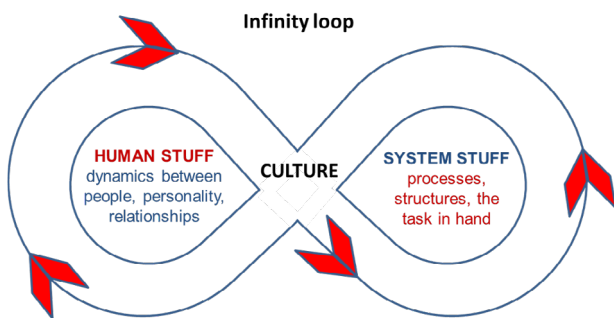
- 4.11 My own main bias may be that my life’s work is to try to find ways to understand why conflict arises and remains unresolved in so many places in society - and to endeavour to help people find ways to overcome their differences and communicate effectively about what matters to them. In doing this, I may err on the side of trying to help or to fix things when my role is only to understand what is really going on and to make suggestions.
- 4.12 To take a possibly oversimplistic medical metaphor, I have been aware that there are many reported symptoms of a problem in NHS which have been presented as bullying, and that one of my tasks, rather than merely accepting what appears on the surface, is to explore underneath and try to understand and diagnose the underlying causes of those symptoms.
- 4.13 In other words: *What is happening? Why is it happening? What lies under the surface? What is really going on? And why? Only then can a general remedy or set of remedies be proposed for consideration and testing, after which it may be possible to prescribe a way forward in specific terms. This may be both restorative and preventative. What can be done to make things better? How can that be achieved? Why might that work better?*
- 4.14 Even then, there may be a real need for trial and error until the best solution or solutions is found. It is unlikely that there will be easy fixes. Perseverance and patience will be required. To adopt a cliché, if the patient is really hurting, the application of a sticking plaster on the surface is unlikely to suffice.
- 4.15 Words from a report by the Organisation for Economic Co-operation and Development (OECD) resonate in NHS:
- “We’re beyond quick fixes to address the discontent of people. There is no returning to the past. Too many things are not working for too many people. The only way forward is not to patch up ..., but to shake it up.*

6 Xenophanes, Fragments as translated by Popper, K. (2002). *Conjectures and Refutations*. 2nd ed. London: Routledge.

We are confronting a similar foundational moment: one that demands decisive cures, rather than palliatives. These times require the same boldness, innovation, and above all, the long-awaited action to recreate, with our employees and stakeholders, a fair and prosperous future for all.”⁷

Scotland’s National Performance Framework

4.16 During my work on this review, I became aware of the details of the National Performance Framework (NPF). These are intended to guide public sector authorities in the conduct of their organisations. Social, economic and environmental indicators are designed to measure national wellbeing with a view to enabling all citizens to flourish. It is designed to be open, transparent and non-political and to encourage a shift from “business as usual”. It draws attention to the complex interplay between the human stuff and the system stuff, illustrated as follows:



4.17 NPF recognises that we live in a VUCA world, one which is volatile, uncertain, complex and ambiguous:

THE VUCA WORLD

Volatility – The nature, speed, volume, magnitude, and dynamics of change

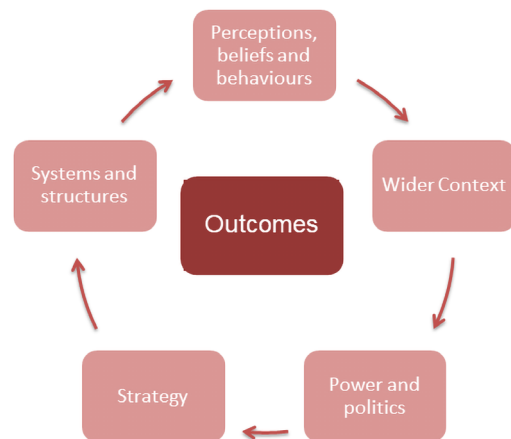
Uncertainty – the lack of predictability of issues and events

Complexity – The confounding of issues and the chaos that surrounds any organisation

Ambiguity – the haziness of reality and the mixed meanings of conditions

All of this is certainly true of the modern NHS and, as I have discovered, of NHSH.

4.18 The following further illustration shows the complexity of the world in which the NHS and other public bodies operate:



7 Gurría, A. (2017). Globalisation: Don’t patch it up, shake it up - OECD Observer. [online] Oecdobserver.org. Available at <http://www.oecd.org/newsroom/globalisation-do-not-patch-it-up-shake-it-up.htm> [Accessed 28 Feb. 2019].

4.19 Among the values of the NPF are being a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way. Among the expectations about how the National Outcomes will be achieved (see below), one particularly caught my attention, as I noted in the list of quotations which opened this report: *“We grow up loved, safe and respected so that we realise our full potential”*. This should strike a chord as we explore what needs to happen in NHSH.

4.20 I have found all of this to be a helpful benchmark as I review what has happened in NHSH. It seems likely that NHSH will benefit from following the approach set out in the NPF as part of its leadership in the public sector in Scotland. The Purpose, Values and National Outcomes of the NPF are illustrated here:



Dignity

4.21 Above all, in conducting this review, I have been guided by the requirement to recognise that a sense of dignity is a fundamental need and right for all of us.

4.22 Donna Hicks has written eloquently ...

“All human beings are unique; there is only one copy of us around. Something so precious deserves to be treated as invaluable, priceless, and irreplaceable. Yet, not a day goes by when we don’t experience some kind of violation to our dignity—a rude remark, a critical tone of voice, a dismissive gesture intended to make us feel small. We all know the crushing and intolerable feeling of being shamed.

We human beings have an uncanny way of knowing how to psychologically hurt one another, and the attacks are always aimed at the most vulnerable aspect of our being—our dignity, our sense of worth. We share this vulnerability, just as we are all prone to physical attack and injury. Whether we are aware of it or not, when we inflict wounds on one another, they are meant to make us doubt the very core of who we are. They leave us with the question, “Am I good or am I bad?”

The truth about wounds to our dignity is that they don’t go away. They accumulate within us until we do something radical, like scream at someone, walk off a job, leave a marriage, or start a revolution.”⁸

4.23 I sense that these words will resonate with many of those in NHSH who engaged with this review - and with others too.

8 Hicks, D. (n.d.). Declare Dignity. [online] Declaredignity.com. Available at <https://declaredignity.com/dignity-project/> [Accessed 28 Feb. 2019].

5. Creating a Safe Space for Confidential Discussions

Responses

- 5.1 In fulfilling the remit, in December 2018 and January 2019, this review has enabled a total of 186 individuals to express their views personally on a one to one basis or in a group setting.
- 5.2 In total, I met with 53 individuals on a one to one private and confidential basis and spoke to another 8 on the telephone, usually at some length. As the number of responses greatly exceeded that which was initially expected, two senior colleagues, Charlie Woods and Liz Rivers, assisted me by conducting further meetings. Between them, they conducted a further 27 private meetings with individuals and reported on each of these to me.
- 5.3 We also met a further 98 individuals in group settings, with groups ranging in size from 2 to 18.
- 5.4 In addition to the meetings discussed above, I also received 96 submissions in writing from people whom we did not meet, both in detail and simply by email correspondence. Many of those with whom we met also submitted detailed further written submissions.
- 5.5 In total, therefore, of the 340 approaches we received, my colleagues and I engaged with 282 respondents directly and in written form.

The Meetings Themselves

- 5.6 We conducted most of our meetings in a hotel in Inverness which provided an independent and discreet location, where we worked hard to avoid overlap or any embarrassment for those attending. I also conducted meetings at NHS headquarter at Assynt House, at Raigmore Hospital, Inverness, and in a rural community.
- 5.7 I regret that, in the time available, I was not able to travel to other locations or to engage with more people at their places of work. However, most people wished to meet outside of their workplace in any event. Many travelled a distance to meet me. Given the number of meetings, and constraints on time, meeting in the way we did was the most efficient way to use time.
- 5.8 Our approach in meetings was to encourage people to speak candidly and frankly about their experiences - and to listen without judgment to what they wished to tell us. Each meeting lasted for about an hour, some taking a bit longer, others less. We asked questions to clarify certain matters and to understand more deeply what each person had experienced and was concerned about. Where it was relevant to do so, we asked about ways forward in the future. Again, where necessary, we carefully challenged conclusions or inferences drawn.
- 5.9 I was aware that, for many people, being able to tell their story to someone face to face was important to them and that having someone independent and impartial to listen was also very important. For some, it was cathartic. For others, there was a sense of obligation in trying to ensure that what had happened to them did not happen to others; for yet others, stepping forward now eased the pain of the guilt they felt about not having spoken up before. For some, it was an opportunity to make sure I heard all sides of the story.
- 5.10 I am aware of course that, for many people, speaking up and speaking out is not easy to do. Many of those who approached me have not spoken before and many were anxious about doing so. Indeed, I was struck by the level of fear that some respondents exhibited about participating (in any way) with the review and their perceptions of the possible adverse consequences of doing so. Taking part was all the more commendable.
- 5.11 Some of the meetings were difficult and emotional for the individuals concerned, for a variety of reasons. I am aware that many people confided in me in a way that they had not done with anyone else. For these reasons, I have only referred to specific examples when I have received specific permission to do so. Otherwise, and generally, I made clear that views expressed would be reflected in the report in an entirely non-attributable way.

- 5.12 The relief felt by many was expressed by one respondent in these words:

“I feel I’ve told someone. I praise the bravery of the colleagues who made this an issue and opening the door for me to finally say how I felt. At least I feel less alone, thanks for hearing me out.”

Feedback about Meetings

- 5.13 This response is mirrored in anonymous feedback which we obtained through a questionnaire sent out by email after the one to one meetings to all those with whom we met:

- 96% said they felt listened to in the meetings
- 89% found the meeting useful
- 97% found that the atmosphere was conducive to a frank conversation
- 91% felt able to express all concerns and points of view
- 76% said the meeting had given them confidence in the independent review process and
- 75% felt that the meeting itself had helped them process their experiences.

- 5.14 In the anonymous feedback for meetings of groups, 92% of those who attended group meetings expressed the view that the meetings had been useful while 100% said the atmosphere was conducive to a frank conversation, that they felt listened to and that they felt able to express all of their concerns and points of view.

- 5.15 I am sure that a mere electronic feedback process has limitations (and some respondents observed, for example, that confidence in the review could only come later) but these results offer some reassurance that the approach was worthwhile for many of those who participated.

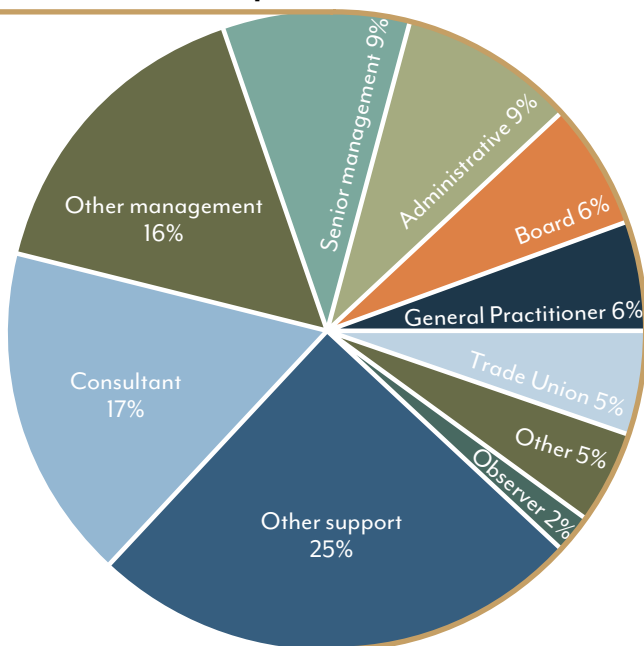
6. Adequacy of the Review

Extent of Response

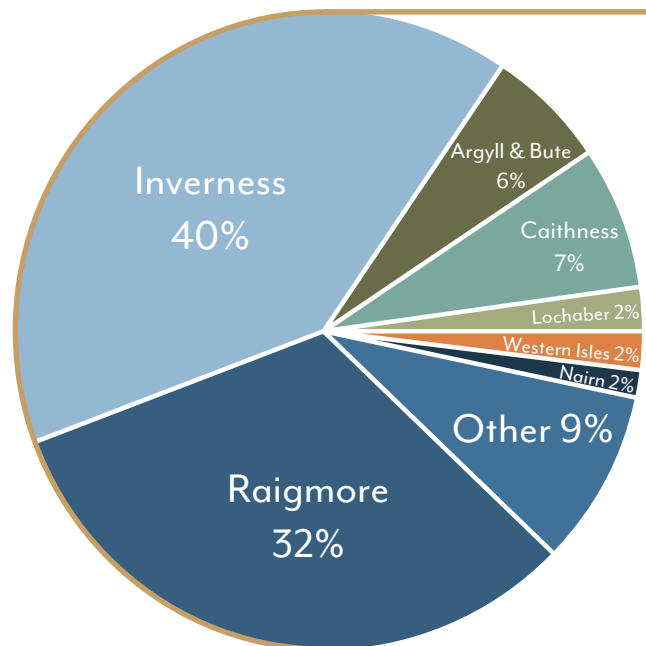
6.1 Overall, as noted above, a total of 340 people engaged with the review. They have come from a broad cross-section of the staff employed by or associated with NHSH, from most departments, services and occupations, mostly current and some former. To give me some context, I spoke to a few outside observers also.

6.2 Geographically, the respondents came from across the region covered by NHSH, including Argyll and Bute. As can be seen in the graphics below, they span support staff, doctors and nurses, GPs, senior and middle management, board level, allied health professionals and others.

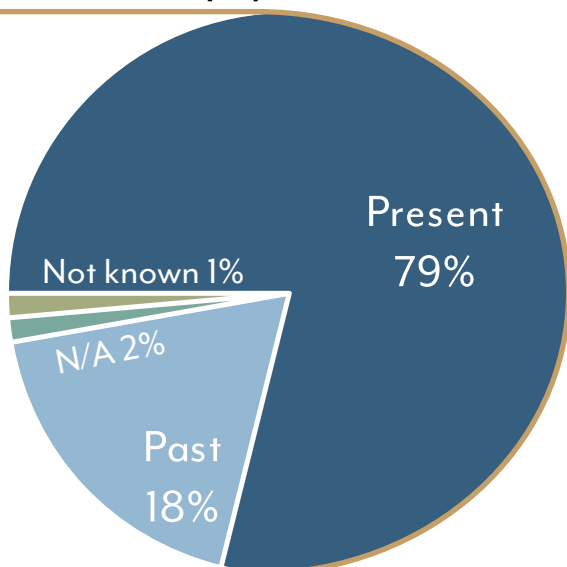
Respondent Role



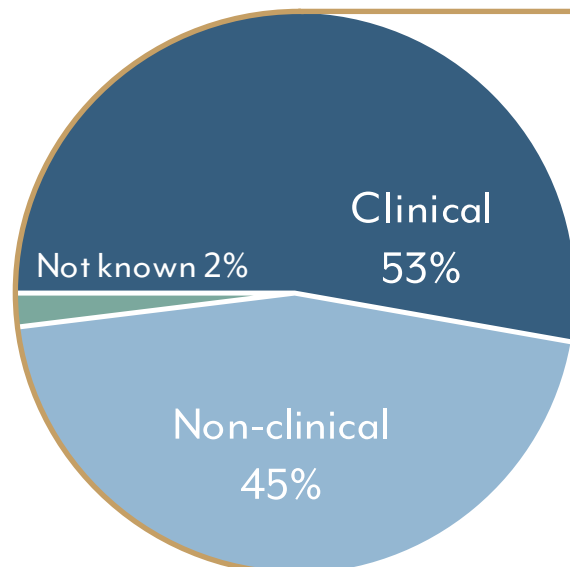
Place of Work



NHSH Employment Status



Clinical and Non-Clinical Staff Ratio



6.3 In total, again as noted above, my colleagues and I engaged with 282 of these respondents directly and in written form. Altogether, approximately 40 days were allocated to meeting and information gathering, together with substantial support and administrative time. Writing up the report has taken many additional days.

Publicity for the Review

6.4 An “all-user” email was circulated by NHS publicising the review and advising of a dedicated email address to which to write to make contact with the review. Other interested parties were also informed by Scottish Government and they circulated details. People who wished to do so made contact with me using the email address. I responded personally by email to nearly every person who made contact with the review.

6.5 One group who may, at least to some extent, have been missed may be those employees who do not use or have access to email as they may not have received communication about the review. I refer to this in my proposals.

6.6 I am aware that there was a view in some quarters that more could have been done to publicise the review and that there was a danger of selection bias in that only those with a grievance to express would respond. However, after the first two or three weeks, it became clear that the response was significantly greater than anticipated and with a very broad range of views, as will be obvious later in the report.

Limitations

6.7 The response was such that, in the time and with the resources available, I could not meet with all those who had responded and who wished to meet, even with help from my colleagues. Therefore, I agreed with the Cabinet Secretary that I would write to those who had made contact after the initial communications and advise them that I would endeavour to provide an initial report in February. If individuals wished to comment on that, or if they still wished to meet and be heard by someone in private after its completion, provision could be made for a possible further stage of the review.

6.8 While the timescale has changed, it is very important that this is not lost sight of. Many NHS employees have commented on promises being made and then not kept. This should not happen with this report, which I accept is much fuller than anticipated at an earlier stage. There may be others who I did not meet, seek out or hear from who may wish to comment on the report when they see its terms.

6.9 A number of those to whom that particular message was sent have made written submissions to me instead, often at my request. Throughout, people have been understanding of the potential (and actual) enormity of the task in the planned timescale and have sought to accommodate my requests for assistance in managing the volume of material. I am very grateful to everyone for their thoughtfulness.

MSPs

6.10 At their request, I also met with two local MSPs. I was aware that local politicians need to take care in how they characterise situations like these. There is an understandable frustration and a need and indeed duty to draw attention to perceived wrongs. However, where patient confidence is so important and matters so fragile, a degree of discernment and balance will always be necessary.

6.11 As one respondent put it, “*political grandstanding by MSPs or others and resolving disputes through the media*” is not conducive to a long-term solution. I hope discernment will continue to be applied in the aftermath of this report.

Criteria for Meetings

6.12 I am aware that concern has also been expressed about the criteria I applied when arranging to meet people. To be honest, I undertook to meet many of those who got in touch at an early stage before the size of the project became clear. I felt it fair to honour my commitment to them whenever I could and to fit in as many others as possible in the timescale. There were certain people with whom it seemed particularly important to meet. There was a judgment to exercise and also a certain randomness in the process which, paradoxically, has achieved a very wide spread of views and minimised the bias that trying to identify set criteria could have built in. In any event, as I make clear later, provision should still be made for those who feel that they still wish to be heard.

Spread of Views

- 6.13 As noted above, concern was expressed that, given my remit and its wording, I would only hear one point of view and that the other side of the story would not be heard. However, I am able to say that those coming forward in response offered a wide range of views, from those who wished to say that they are not aware of bullying in NHSH at all to those who provided details of their own and others' experiences of bullying behaviour, both individually and collectively.
- 6.14 One of the challenges is that experience was often mixed and, indeed, sometimes contradictory. As one respondent observed: *"It is possible to have two co-existing experiences"*. Another commentator said: *"It slightly shocks me how thin the dividing line can be between one person's experience of someone as a robust manager who gets things done and another person's experience of them as a bully."*
- 6.15 There is much to wrestle with. In some ways, ambiguity can be useful: *"...in the intersection between [multiple] perspectives, real insight can be gleaned"*.⁹ It is hoped that real insights will be gleaned in this report.
- 6.16 Others speak of the *"coincidence of opposites."* The theologian Richard Rohr once said that holding contradictions and resolving them in ourselves and in our organisations are *"the only real agents of transformation, reconciliation, and newness"*. In any event, the fact remains that there is no one perspective on any of this. There is a variety of viewpoints.

Reasonable Cross-Section

- 6.17 While the number of respondents to the review is low relative to the overall number of employees in NHSH, I have taken the view that they represent a reasonable cross-section of the workforce.
- 6.18 Given the volume of information I have received, I am comfortable that I can form views which have general applicability. In any event, there should be an opportunity for those who disagree with my conclusions to do so. Others can decide whether, in an organisation of approximately 10,000 employees, the information here is sufficiently relevant and important to warrant action. I have formed the view that it is.

9 Heffernan, M. (2012). *Wilful blindness: Why we ignore the obvious at our peril*. London: Simon & Schuster.

7. Initial thoughts

Understanding

7.1 I accept that a report like this cannot meet everyone's expectations. Indeed, it should not try to do so. Some people have been so affected by events that they seek retribution or revenge. Others see no need for change. In all respects, we need to understand why that is and, in the review, I have been mindful of the need to try to understand at a deep level what happens when some individuals and groups experience trauma of some sort, especially when for some it seems to be embedded, to a degree at least, institutionally. As I have indicated earlier, there is both restorative and preventative work to be done.

7.2 Nicholas Janni writes:

*"We understand the essential nature of trauma to be energy that could not be and has not been processed and therefore stays stuck as frozen layers within our personal and collective structures. By learning to work directly with these layers, we create together a journey of restoration, allowing large amounts of core life energy, intelligence and relational capacity to be released."*¹⁰

Process

7.3 Unpacking these words is a part of the process. It is unlikely that the value of this report can be measured by people's immediate reactions. There are some "quick wins" to be sought. However, a lot of thought will be required over a long period of time to produce meaningful longer-term benefits. As I mention above, there is no magic instant fix, or a binary right/wrong solution. The real value may lie in enabling thoughtful people - and a new leadership - to take responsibility for matters going forward in ways that they understand and can deliver.

Relationships

7.4 There may be no greater leadership challenge in 2019 than to help people under pressure to feel valued and for everyone to appreciate the benefits which come from rebuilding strong relationships, bringing out the best in each other and enabling everyone to be more effective in every way.

7.5 That probably means letting go, enabling people to thrive and for people to be given responsibility. In an infinitely complex world, not everything can be controlled or micro-managed from the top.

7.6 This is a journey. It will be better to focus on how to travel than on a hoped-for end point. The goal may simply need to be endeavouring to work more effectively together in tough times – and creating the environment for that to occur. If so, relationships will be a vital part of this. Ultimately it is usually all about people and relationships: why have they broken down and what can be done to restore them? Indeed, as I observe later, prioritising good relationships at all levels is likely to make the biggest difference. People will need to walk with - and care for - others, including those with whom they have fallen out in the past or by whom they feel undervalued.

7.7 People must feel valued in NHS and that will only occur if it is done from all perspectives: from the leadership in NHS Scotland to those involved with the day to day intersection with the patients. This will need a lot of patience and tolerance. The future cannot be viewed as a series of one-off transactions but must be seen as a pattern of new behaviours and approaches, providing growth and healing as an antidote to the pain and loss which so many have experienced. This will take time.

10 Janni, N. (n.d.). Healing Personal, Ancestral & Collective Trauma. [online] nicholasjanni.com. Available at <https://www.nicholasjanni.com/societal-work/> [Accessed 28 Feb. 2019].

Change

- 7.8 Change is not easy. Growth cannot occur without pain. Healing can be a hard thing to achieve. Letting go of grievances and grudges may not be appropriate in all cases but it is likely to be necessary in many. Giving up that which has defined us or in which we have placed so much hope or expectation is a tough thing to do. We may fear many things, including loss of face and relevance, with a sense of emptiness and even hopelessness. To be open to our own shortcomings, as well as those we perceive in others, takes courage, especially if we have been or feel wounded.
- 7.9 A change of heart, as well as mind, will be the biggest challenge and yet that seems the only way to achieve release and a new way forward. This must be demonstrated by leadership from the top. Humility, authenticity, vulnerability, openness, courage, responsibility, accountability, self-discipline – these are all essential components and are likely to be important touchstones in the future.
- 7.10 A number of these, and other attributes, are apparently recognised as leadership qualities in the NHS Highland Senior Manager and Executive cohort annual appraisal. It is time for the words to be demonstrated in practice. I note that a top-selling book at the time of writing is *The Language of Kindness*¹¹, written by a nurse, Christie Watson. Kindness is what is needed in NHS.
- 7.12 As I mention above, I acknowledge that not everyone will recognise all of the findings or accept all of the proposals in this report. I am also aware that both the Board and management have begun to take steps to try to address some of these matters already, albeit it is probably necessary for them to have a much fuller understanding of the depth and breadth of the concerns in order to do so really well. Whatever is done should be undertaken in a way which brings, and by those who can bring, credibility, confidence, compassion and competence to the tasks.
- 7.13 I pick up on these themes towards the end of this report in the final chapters. In the next chapter, I set out some general observations about human nature. Some readers may prefer to pass over this but I include it and commend it as part of the context for what follows.
- 7.14 It seems important to understand the emotional, psychological and neuro-scientific aspects of what has happened – and to find compassionate ways to address the issues. As the University of Edinburgh Global Compassion Initiative reminds us: *“Developments in neuroscience and psychology are providing evidence-based insight into the importance of values and character building to health and well-being in an increasingly secular age. Compassion is a defining human ethic.”*¹²

Learning

- 7.11 If real learning can be taken from what has happened, and if kindness and compassion can be restored in NHS, there is a great opportunity to build a new kind of organisation, a beacon of hope in the NHS, in which good relationships, collaboration, fairness and a welcome for courageous conversations and constructive challenge, together with mutual respect and dignity for all, are experienced throughout. I explore this further later in the report.

11 Watson, C. (2018). *The Language of Kindness*. Chatto & Windus.

12 The University of Edinburgh. (2018). Global Compassion Initiative. [online] Available at <https://www.ed.ac.uk/global-health/global-compassion-initiative> [Accessed 20 Mar. 2019].

8. A Few Words about Human Nature

*"It's not our differences that divide us, but our judgments about each other."*¹³

Introduction

- 8.1 In this chapter, I offer some general views on the underlying psychology which tends to fuel so much conflict. I believe that understanding some of this fast-growing area of science is helpful as context for what follows in the report.
- 8.2 It seems necessary, at a deep level, to explore and understand why individuals and organisations behave as they do, especially when under pressure, and to find enduring remedies, not transient sticking plasters. Current research into behavioural psychology and neuro-science provides an excellent resource to draw on. This deeper work is, it seems to me, critical to a sustainable future.

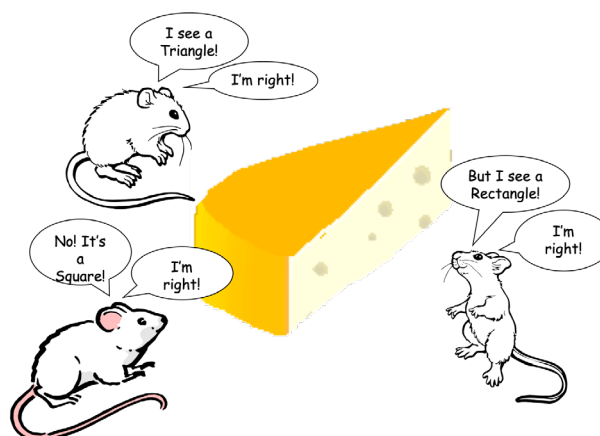
Nothing is black and white. For me on each step of the way, another layer of the onion was revealed. There is no straight binary conclusion to be reached. The situation is better viewed along a continuum, with a spectrum of experiences and realities, often dependent on time, place and circumstance.

- 8.4 In my day-to-day role as a mediator and facilitator, I have a working assumption that nearly everyone is trying his or her (or their) best in the circumstances in which they find themselves, even if they struggle to do so. We are told that there is a positive intention behind most behaviour and that most people make the best choices they can given the information available to them at the time.

Complexity

- 8.3 In this review, I have been struck by the reality that this is all much more complex and multi-layered than anyone might wish, or like it to be, and reflects the ambiguous, paradoxical and uncertain nature of so much of human life.

- 8.5 How many of those reading this report would not acknowledge that most of us are trying our best most of the time? I also find it useful to take the view that very few people are motivated entirely by ill will. Life is complex and there are usually several sides to a story. Much depends on where you start from, your perspective, as this rudimentary illustration shows:



13 Wheatley, M. (2002). *Turning to One Another: Simple Conversations to Restore Hope to the Future*. Berrett-Koehler Publishers. P36.

Fight, Flight or Freeze

- 8.6 People's perceptions become their reality. Perceptions, we know, are shaped by many factors. And what people say may not always be what they really believe, feel, mean or need. Modern neuro-science and behavioural psychology help us to understand well that we tend to be shaped by our experiences, our biases, our prejudices, our need for protection, our fear of loss of face and so forth.
- 8.7 Our survival instincts, fight, flight or freeze, override the rational mind very easily. Our self-preservation instincts are very strong. These may lead to covering up what is embarrassing, threatening or causes us to look bad. After all, looking bad, public exposure, can be among the most painful and humiliating of human experiences.
- 8.8 Under pressure, our default setting is to protect ourselves from external threat, whether physical, psychological or social. We seem to have no choice – our brains are wired that way (see, for example, Daniel Kahneman: *Thinking, Fast and Slow*¹⁴). This stems from the survival behaviour (located in the primitive part of our brains) inherited from our early ancestors who faced constant physical threats to their very existence. Fear is a strong force and triggers defence and/or aggression. We are complex creatures, each capable of acts of great kindness and also of acts of cruelty to others, often in close proximity to each other.
- 8.9 Though physical threats are less relevant now, we are still hardwired to feel shame and to fear blame when the threats are social and our dignity or sense of self is challenged. Our basic instinct for self-preservation, often by using force or dominating in other ways, can be stronger than our instinct to preserve a relationship.

- 8.10 Relationships may break down when the need for individual self-protection overrides our need for connection. We tend to denigrate, belittle and criticise others, who in turn may experience loss of esteem, misery and abandonment – and react accordingly. Colleagues are undermined. We avoid contact with those outside our group. We rush to judgment. Uncertainty prevails. Others around us are adversely affected.

Mixing People and the Problem

- 8.11 As the writer Ken Cloke has observed, “it seems easier to turn each other’s lives into a living hell than to apologize, rebuild trust and restore intimacy and collaboration in conflicted relationships.”¹⁵
- 8.12 Or as an NHS staff member put it: “I despair of the culture where a sincere apology is not even considered as a first option even in respect of just good manners. Rather fear of showing weakness and fear of comeback or litigation is the overriding reaction.”
- 8.13 So, we end up mixing up the people with the problem, when what we really need to do is to try to separate the individuals involved from the underlying issues, even if the individuals themselves appear to be the problem. Small matters can be quickly blown out of proportion. Our energy can easily focus on adopting our particular position and blaming or shaming others with whom we disagree. We become entrenched. Our anger may be directed towards the “enemy”.
- 8.14 Behaviour can become – or be perceived to be – threatening, aggressive, intimidating, domineering and emotional. We all recognise how easily we use the scapegoat mechanism as a foundation for the formation of many social groups and cultures. We need another group to be against in order to form and sustain our own group, our tribe.

14 Kahneman, D. (2012). *Thinking, Fast and Slow*. New York: Penguin Books.

15 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

- 8.15 Scapegoating occurs too easily: We hate or blame others, projecting our pain elsewhere, rather than recognising our own weaknesses and negativity. “*She made me do it.*” “*He is guilty.*” “*He deserves it.*” “*They are the problem.*” “*They are evil.*” We seldom consciously know that we are scapegoating or projecting. It’s automatic, ingrained, and unconscious. Because of our wiring, people literally “do not know what they are doing”.
- 8.16 Many readers will be familiar with the Drama Triangle¹⁶ in which people can fall into, choose and rotate the roles of victim, rescuer or persecutor, perpetuating a crisis rather than breaking the cycle. So easily can the language of the persecuted in turn appear to others to be that of persecutors. Even describing someone as a “victim” brings with it inherent risk. Perhaps in the NHS, with its traditional role being one of seeking healing, matters are more complicated for “rescuers”.
- 8.20 On other occasions, we will subconsciously devalue what is said by people we dislike or by whom we feel shamed or threatened, while overvaluing the words of those we admire or who are part of our group or tribe. Our human tendency is to judge the behaviour of others with whom we disagree as a reflection of their character and ill will towards us; in contrast, we describe our own (and our tribe’s) behaviour as acceptable, and attributable to the circumstances in which we find ourselves.
- 8.21 There is apparent safety in being with apparently like-minded people, especially if we feel under threat. Silos are built. It feels better to be part of the group than to be excluded, not to rock the boat or speak out, for fear of being ostracised. This is all entirely understandable. However, when the environment is not a safe one, these aspects of human nature can lead to disorder and dysfunction.
- 8.22 In an organisation where self-protection has come to dominate, it seems that relationships may inevitably breakdown. Alternatively, people may compromise their own dignity to try and preserve relationships. Consequently, as Ken Cloke puts it, we often elect to remain silent and suppress our true beliefs and feelings, or pretend to agree when we really don’t, or even leave the organisation rather than risk a loss of intimacy and connection with people we care about - or challenge the thing we fear.¹⁷
- 8.23 It can all become cyclical and self-fulfilling. Relationships suffer, communication is poor (or non-existent), nobody seems to listen, information is concealed, concessions appear to be a sign of weakness, common interest and mutual respect is lost. And all of this is enormously costly in time, morale and money. It increases risk and is truly a zero-sum situation.

Assumptions, Perceptions and Biases

- 8.17 I suspect that the cognitive or unconscious biases (institutional and individual) operating in all of us have been at play in what has been happening and is alleged in NHS. It is said that we jump quickly and intuitively to conclusions, assuming we are correct, based on our own incomplete knowledge of the world, our prior experiences, our prejudices, our expectations, our fears and hopes, our assumptions.
- 8.18 We can become wilfully blind to the bigger picture or to contradictory information as what is known as confirmation bias takes hold. Our seeing and hearing become selective. We acquiesce in inappropriate behaviour in order to avoid conflict.
- 8.19 To survive, we may simply not see or hear what should be obvious to us. Our responses to a situation are shaped by those prior assumptions and perceptions. Very often these are wrong but, if something is asserted often enough, we may come to believe it - even if it is not wholly or even partially true. We may then end up trying to persuade others of its truth and adopting measures to maintain the fiction.

Why Does Any of This Matter?

- 8.24 Why are these points relevant to this review? Because it is likely that all of this is just as true for those involved in NHS as elsewhere. It helps us to understand many of the situations described in this report. In particular, we should not underestimate the role of fear in much of what

16 Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39-43

17 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

has occurred at many levels. More importantly, perhaps, it seems to me that we all need to understand these facets of human behaviour if the underlying issues are to be addressed and resolved with long term sustainability. One cannot separate this theory from the real world.

- 8.25 In this regard, I note an excellent book entitled *Embodied Conflict* by a mediator colleague from Oregon in the United States, Tim Hicks (no relation to Donna Hicks, quoted in paragraph 4.22). He writes: “*It’s interesting to think about the violence we see in the world, whether at the level of interpersonal relationships or at the societal and global levels, as a public health issue.*”¹⁸ These words resonate particularly with this review.

Choices

- 8.26 We can choose to behave differently. To do so, we need to find and welcome ways to overcome the automatic, unconscious, easily triggered fight or flight instinct located in our reptilian/limbic “old” brains and to engage the neo cortex, the “new” part of the brain, which helps us to think and act in a more measured, thoughtful way. We know that this takes conscious effort and is energy consuming. We need the right environment to do this. Creating that environment is the key to a successful modern workplace and to a successful NHSH.
- 8.27 We may think we know much of this already but it is not so easy to apply. It needs to be learned and understood. We have the capacity to be self-reflective and to change behaviour. We need to take responsibility to do so. What follows can be read with all of this in mind.

18 Hicks, T. (2018). *Embodied Conflict: The Neural Basis of Conflict and Communication*. Milton: Routledge.

9. Navigating the Substance of the Report

Symptoms, Diagnoses and Remedies

- 9.1 My approach to the substance of this review is to describe what I have heard and read and to try to identify the circumstances which have led to the allegations of bullying and harassment, and to add my observations about these. This includes what, in terms of my remit, I *“understand to be the cultural issues, if any, which have led to any bullying or harassment and [to a situation] where such allegations apparently cannot be raised and responded to locally.”*
- 9.2 Thus, simplistically, I am dealing with symptoms and diagnosis in this report (noting that things will often be more complex and multi-faceted). These refer both to events in the past over several years and to current circumstances. I am conscious of the exhortation not to “overwrite” or “underwrite” in such a report. Given the quality and substantial nature of so much of what I have heard, if I have erred it will be to overwrite. I do so in an attempt to ensure that, wherever possible, people feel that they have been properly acknowledged and enabled to move on – and also to give the Board and management a clear indication of what people in NHSH are saying.
- 9.3 This is an organisation with an £800 million budget funded by the taxpayer. The current situation merits serious analysis. The review has received an enormous amount of information, all of which will be destroyed soon for reasons of confidentiality. This report, therefore, is a distillation, a summary and what will soon be the only record of what I have been told.
- 9.4 I also seek to *“identify proposals and recommendations for ways forward which will help to ensure the culture within NHS Highland in the future is open and transparent and perceived by all concerned in this way”*.

- 9.5 Thus, I seek to suggest possible remedies. As I have mentioned, these include both the restorative (seeking to address past and present issues) and the preventative (looking to the future and avoiding continuation or repetition of problems). These proposals are however merely signposts for others to follow in what needs to be an organisation-wide collaborative project of renewal.

Themes and Topics

- 9.6 Inevitably, what I have heard and read has caused me to consider the terms of my remit. I have taken the view that it would be helpful to take a broad rather than narrow interpretation of my remit, when I have heard and read so much which could help the organisation to learn and move forward.
- 9.7 Thus, to take words referred to in connection with remit, I *“will consider all the circumstances that have led to the allegations and make recommendations”*.
- 9.8 This leads me to address matters in this report according to themes and topics, following I hope some sort of logical order. I have quoted liberally from my meetings and from written submissions as these speak more eloquently than any words of mine. However, as agreed with respondents, remarks have been used in a way which is non-attributable unless I have specific agreement to the contrary. Where I have been concerned about any possible risk of attribution, I have sought to check with the authors. If any have slipped through the net, I apologise. I have endeavoured to correct typographical errors but have not corrected grammar, except where necessary to make sense of the words used.
- 9.9 I am aware that extracting excerpts from longer submissions may deprive words of their context and I acknowledge that this may occasionally be a cause for concern. I have done my best to try to understand and place contributions in their wider context. I take full responsibility for the way in which this report is presented.

A Note of Caution

- 9.10 Finally, again, I need to reinforce the important point that matters are complex and not amenable to binary, simplistic analysis. There are many sides to most stories. I was presented with many contradictions and inconsistencies. Care needs to be taken in reaching overall conclusions and making apparently universal statements. I am conscious that I shall have slipped into doing so myself on occasions where the circumstances are probably more nuanced. My report should be read with all that in mind.
- 9.11 I start with some general observations about bullying and culture before moving on to the symptoms experienced in NHSH.

10. Bullying and Harassment

Definition

- 10.1 It is alleged that there has been a culture of bullying and/or harassment in NHS.
- 10.2 According to the Oxford Advanced Learner's Dictionary bullying is "to frighten or hurt a weaker person"¹⁹ or group, and a bully "uses her or his strength or power to frighten or hurt weaker people."²⁰
- 10.3 Other definitions refer to a persistent pattern of mistreatment from others that causes either physical or emotional harm and includes tactics such as verbal, nonverbal, psychological, physical abuse and humiliation. This can also, according to some definitions, include harassment which itself can include intimidation.
- 10.4 The Health & Safety Executive refers to a pattern of behaviour happening "repeatedly and persistently over time."²¹
- 10.5 While I note that there is a statutory definition of harassment in the Equality Act 2010, for the purposes of this report I do not find it necessary to distinguish between bullying and harassment. These words by themselves describe conclusions from primary facts, namely the actual behaviour which is likely to cause concern. The following excerpt (taken from the report by Dame Laura Cox into bullying and harassment in the House of Commons²²) adequately describes that behaviour and I find her descriptions useful in this review:

98. "The terms "bullying" and "harassment" can mean different things to different people ... it is important to bear in mind that it is not always possible or sensible to try and compartmentalise misconduct of this kind. Some of those contributing to this inquiry described behaviour which would fall within more than one category."
101. "There is obviously considerable overlap between the terms "bullying" and "harassment", and employment policies that address them often use the terms interchangeably."

- 10.6 She further reported:

106. "ACAS have described bullying and harassment together as "offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. It may be persistent or an isolated incident. It can also occur in written communications, by phone or through email, not just face to face. Whatever form it takes, it is unwarranted and unwelcome to the individual."

- 19 Oxford Advanced Learner's Dictionary. (n.d.). Bully (Verb). [online] Available at https://www.oxfordlearnersdictionaries.com/definition/english/bully_2 [Accessed 26 Mar. 2019].
- 20 Oxford Advanced Learner's Dictionary. (n.d.). Bully (Noun). [online] Available at https://www.oxfordlearnersdictionaries.com/definition/english/bully_1 [Accessed 26 Mar. 2019].
- 21 Health and Safety Executive Northern Ireland. (n.d.). Workplace bullying and harassment - Good Practice. [online] Available at <https://www.hseni.gov.uk/articles/workplace-bullying-and-harassment-good-practice> [Accessed 8 Mar. 2019].
- 22 Cox, L. (2018). The Bullying and Harassment of House of Commons Staff.

Dame Laura Cox Descriptions

10.7 For further useful guidance and as a reference point, I find it helpful and relevant to set out more fully some of what Dame Laura Cox has written, as so much of what she reports has relevance to what has occurred in NHSH, as subsequent sections describe:

102. “Under the Protection from Harassment Act 1997 it is unlawful for someone to pursue a “course of conduct” (thus involving two or more incidents), which they know or ought to know would be harassment. The term “harassment” is not defined in the Act since it can take so many different forms, but section 7(2) provides that it “includes alarming the person or causing the person distress,” and “conduct” includes “speech.” The actions complained of do not need to be violent. The courts have stated that “harassment” describes conduct targeted at an individual, which is calculated to cause alarm or distress, and that to be actionable it must cross “the boundary between unattractive or even unreasonable conduct and conduct which is oppressive and unacceptable” (Conn v Sunderland City Council [2007]CACiv1492).”
105. “The term “bullying” covers a wide spectrum of behaviours and a degree of flexibility is required when classifying such behaviour. In my view one of the most helpful descriptions of bullying at work is that formulated by the late Tim Field and those at the Andrea Adams Trust, who carried out much of the pioneering work in this field, namely that it is “behaviour that cannot be objectively justified by a reasonable code of conduct, and whose likely or actual cumulative effect is to threaten, undermine, constrain, humiliate or harm another person or their property, reputation, self-esteem, self-confidence or ability to perform.”
107. “The typical features of bullying and harassment are therefore that the behaviour is unwarranted, unwelcome, intimidating, degrading, humiliating or offensive. The important question is whether the actions or words are viewed as detrimental and unacceptable to the target. It is the deed itself and its impact on the target that matters, not the intention of the perpetrator. And it is usually preferable to describe someone being bullied as a ‘target,’ rather than a ‘victim.’ The latter term tends to be associated with negative notions of someone unable to take responsibility for themselves, or needing to be ‘rescued’ from a situation. Bullies often respond to complaints about their behaviour by describing the target as having a “victim mentality,” with all the negative imagery that phrase invokes.”
108. “Bullying and harassment can affect anyone, in any career, at any time, at any level and within any workplace... Such behaviour can take the form of easily noticed, physically threatening or intimidatory conduct with immediate impact, or it can take place behind closed doors, or be much more subtle or camouflaged and difficult to identify, at least at first. It can start, for example, with what appear to be minor instances, such as routine ‘nit-picking’ or fault-finding with someone’s performance, but which become cumulative or develop into more serious behaviour over time, enabling the perpetrator to isolate and control the person and eventually, on occasion, to apply conduct or capability proceedings inappropriately in order to bring about their dismissal.”
109. “Some bullies lack insight into their behaviour and are unaware of how others perceive it. Others know exactly what they are doing and will continue to bully if they feel they are unlikely to be challenged. Bullying and harassment can sometimes be overlooked, as a result of common euphemisms being used by way of explanation or justification, referring to someone as having a “poor management style” or a “bad attitude,” for example, or to the problem being due to a “personality clash.” The information provided to this inquiry has demonstrated all these different features.”

111. “In relation to the allegations of bullying made against House staff, a number of people referred to the need to distinguish between behaviour that is truly bullying and behaviour that is no more than “assertive” or “firm” management. They referred, similarly, to the need to distinguish between harassment and legitimate supervision. I agree that it is important to recognise these distinctions, although there can sometimes be a fine line and both managers and those whom they manage need to be trained to spot the difference.”
112. “A good line manager can manage or supervise someone firmly and be assertive without bullying or harassing them... Firm management does not demand an overbearing or oppressive style. Firmness and resoluteness are not inconsistent with an open and inclusive style, encouraging direct communications with employees and regular feedback on performance, which are invariably more motivating.”
113. “It is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct, or to poor performance by an employee. A few contributors described instances when managers who had instigated appropriate conduct or performance management proceedings found themselves on the receiving end of a grievance accusing them of bullying. This had immediately brought a halt to the proper management of the employee’s conduct or performance. The original deficiencies were then lost during the months taken up in dealing with the grievance, expending precious resources, causing distress to the manager accused and inhibiting other managers from tackling poor performance. Sometimes there had been earlier failures to manage the employee effectively and they had simply been moved on to other departments, where the manager who eventually sought to address the poor performance was then unfairly accused.”²³

Sir Robert Francis Report

10.8 Sir Robert Francis in his report “Freedom to Speak Up”, provides these examples offered by ACAS of bullying or harassment:

- spreading malicious rumours
- insulting someone by word or behaviour
- exclusion or victimisation
- unfair treatment
- overbearing supervision or other misuse of power or position
- making threats or comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing individuals progressing by intentionally blocking promotion or training opportunities.²⁴

10.9 I mention these examples as again they seem relevant, and to give context, to what has been experienced in NHSH as this report will outline. In other words, these are common experiences.

Language

10.10 Language and definitions are inevitably fraught with difficulty. Sir Robert Francis recognised that bullying is often “in the eye of the beholder” and that the term can be misapplied but also that *“To an extent, whether people’s experiences meet an objective standard definition of bullying or not is beside the point. If someone believes they have been bullied or harassed and the perception of others around them is that they have suffered or will also suffer in a similar way as a result of speaking up, then they will be less likely to raise a concern in future.”* As he observed: *“The perception of bullying can have the same detrimental effect as deliberate bullying conduct.”*²⁵

23 Cox, L. (2018). The Bullying and Harassment of House of Commons Staff.

24 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.4.

25 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.5-5.5.8

10.11 For the purposes of this review, I use the expression “bullying” to describe behaviour which has been experienced by staff that may fall within the terms “bullying” and/or “harassment”. I have on occasions preferred the term “inappropriate behaviour” to describe what people have experienced.

10.12 I noted this comment about the very use of the word “bullying” by one of the senior figures in NHS:

“If people could measure us now, they’d get a detectable change in us when you say the word. It’s a violent-impact word. As a communicator, if I choose to use that word, I know it’s a dart and will not land well. So I choose not to use it.”

This seems a useful reminder which readers should bear in mind whenever the term “bullying” appears in this report.

10.13 Another observer commented:

“... there may be people who are generally unhappy with people who do not enjoy the work. Things have changed. They don’t feel in control or their voice is being heard. But they haven’t been bullied or intimidated. It’s teasing out these different things and having an understanding of why people feel the way they have, in a situation that has caused them distress.”

10.14 One respondent to the review observed how difficult it is to identify bullying:

“B&H is difficult to deal with generally. It’s a very personal thing. Harassment is easier as it can be obvious. Bullying can be an undercurrent – can make people feel in a certain way and takes them time to even come to the conclusion that they feel or are bullied. It’s not just managers and employees, but as an organisation we’re not necessarily clear about respectful behaviours.”

10.15 Another respondent put it in the context of NHS:

“There are various definitions of what is meant by the phrase “bullying and harassment”, but none are well-known to the wider workforce. Most people will be unaware of the standards of behaviour to which their employer will hold them.”

10.16 This seems to be an important point. NHS has its own policies on bullying and harassment; there are descriptions of what is included and what action can and should be taken. If these are not known and/or have not been followed, it seems essential to explore why not.

Why Bullying is Bad

10.17 Sir Robert Francis stated the obvious perhaps but, under the heading “Why Bullying is Bad”, he commented:

5.5.9 “The impact of bullying on individuals, on teams and on organisations as a whole are well known. Examples include:

- avoidable stress and resulting illness
- increase in sickness absence leading to stretched teams and/or increased spend on temporary staff
- poor morale and difficult staff relations
- loss of respect for managers and leaders
- difficulties in staff retention
- reputational damage
- patients suffering harm or receiving less than optimal care.”

10.18 For him, the “most important consequence is the fact that workers who are bullied, or who see others bullied, are much less likely to raise the safety concerns which any well-led organisation needs to know about and act on.”²⁶

Again, this has resonance in the experiences in NHS.

26 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.9-10.

11. Culture

Definition

11.1 While I have toyed with an extensive analysis of what we mean by culture, a short definition is “a combination of behaviours which are repeated”. Boxall and Purcell describe organisational culture as: “... a system of shared values and beliefs about what is important, what behaviours are important and about feelings and relationships internally and externally.”²⁷

11.2 An article in the BMJ²⁸ was drawn to my attention which seeks to tease out what culture means and how this relates to service performance, quality, safety and improvement. Its key messages remind us that:

- Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations.
- Healthcare organisations are best viewed as comprising multiple subcultures, which may be driving forces for change or may undermine quality improvement initiatives
- A growing body of evidence links cultures and quality, but we need a more nuanced and sophisticated understanding of cultural dynamics
- Although culture is often identified as the primary culprit in healthcare scandals, with cultural reform required to remedy failings, such simplistic diagnoses and prescriptions can lack depth and specificity

Many Different Cultures

11.3 Sir Robert Francis notes that:

“There can also be various cultures within the same organisation. Different teams, different departments,

and different hospital sites can all ‘feel’ different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command and control style with ‘an individualistic dynamic and a blame culture.’”²⁹

11.4 In his discussion of the definition and exploration of culture in a healthcare context in the Mid Staffordshire NHS Foundation Trust Public Inquiry Report, Sir Robert reports that:

20.5: “Professor Charles Vincent sums up culture as meaning “how we do things round here”, “here” being anything from a small group or team, to a whole organisation, a profession or a health system...”

20.6: “As Professor Vincent points out, an organisation may aspire to a common culture throughout, but in practice, in anything as complex and large as the NHS, culture can vary from organisation to organisation and from department to department.”³⁰

11.5 Again, this analysis has a strong resonance with the findings in this review, especially the idea that many different cultures may exist in one organisation, as this respondent told us from a rural area:

“I do also acknowledge that the size of the NHS makes it an unwieldy organisation and there is no doubt in my mind a pack/gang mentality can be easily formed in any department, staff grouping, committee etc. and that is what I felt was up against.”

27 Boxall, P and Purcell, J. (2003). *Strategic Human Resource Management*, Palgrave Macmillan, Basingstoke

28 Mannion, R. and Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ*, p.k4907.

29 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.1.3

30 Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Vol.3, p1358

- 11.6 Of course, there can be cultures that contribute to or create a set of circumstances (positive or negative) and cultures which address or fail to address these circumstances. It is multi-faceted.

An Iceberg?

- 11.7 Sir Robert refers to this observation:

“There exists a culture of bullying within the organisation that was largely covered up. For every case that comes to light, there is an iceberg of events that are simply not reported.”³¹

- 11.8 It is possible that what is reported in this report is the tip of a larger iceberg in NHS. Only further exploration will elicit whether that is so.

31 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.10



What the Review was Told

12. A Culture of Bullying and Harassment?

General

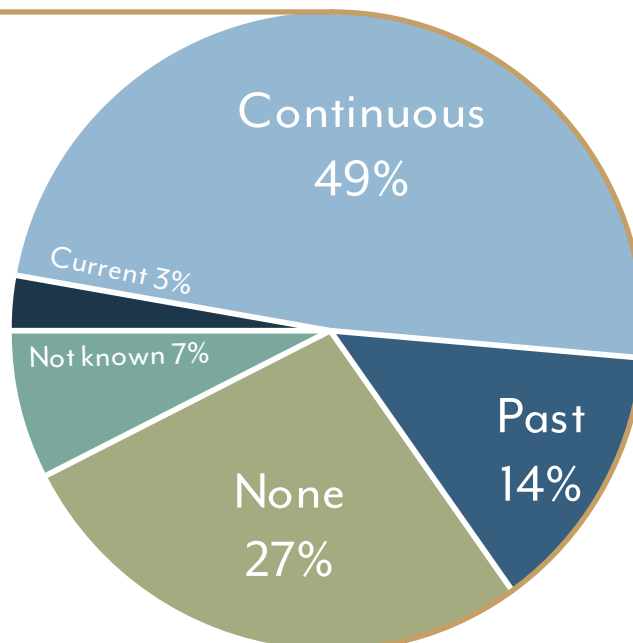
- 12.1 In this chapter, I provide an overview of what I heard about allegations of bullying in NHS, describing both the minority and majority views expressed, the range of views, and commenting on whether a “culture of bullying” existed.
- 12.2 The majority (66%) of those responding to this review wished to report experiences of what they described as bullying, in many instances significant, harmful and multi-layered, and in various parts, at all staffing levels, and in many geographic areas, disciplines and departments of NHS. There are issues common to the whole of NHS, some which are particular to the Inverness area and Raigmore, and some which are particular to more rural areas and to Argyll and Bute. These affect wider communities too.
- 12.3 As illustrated below (in a pie chart which should be taken as illustrative only and not definitive), these are a combination of very recent experiences, experiences over years

and experiences from the past. Some people sense recent improvement compared to the past, while others believe that matters remain unsatisfactory.

- 12.4 Many experiences have not been adequately addressed at the time and the lack of closure continues to dominate some people’s lives. I am satisfied that the number of examples given to me is sufficient to warrant real concern. The issues raised are also wider and more complex than “bullying”, however that is defined. There are many issues to be addressed, understood and avoided in the future. I explore these further later.

The Minority View

- 12.5 However, it is very important to record that a significant minority of respondents expressed views with varying degrees of firmness to the effect that there is not a problem, or at least that there is no bullying culture as such, and that any conduct of concern is nothing other than what might be expected in any similar organisation with day to day pressures.



Respondents' Descriptions of a Bullying Culture

12.6 Many people, from many different and diverse vantage points within NHSH, report that they are not affected by any such concerns and feel fully supported by the organisation. Indeed, they have been more affected by the allegations made by the whistleblowers that they do not understand and have not themselves experienced. They have been hurt and angered by the adverse impact of the allegations which have been made, on patients, staff and local communities. For many of these people, reading this report may be shocking.

12.7 In order that these views are well represented, what follows is illustrative of some of what I have been told:

“I am disappointed and upset at the way NHS Highland has been portrayed in the media over recent months. I feel that the actions taken by a small number of individuals will have damaged the reputation of and public confidence in the organisation.”

“These individuals are not speaking for me.”

“I do not recognise that there is a culture of bullying in Highland.”

“I was absolutely shocked by the press statement about a bullying culture in NHSH. I experienced years of bullying myself by a GP colleague so I am fully aware of the effect bullying can have on health and morale but, when things came to a head in my own situation, senior management in NHSH were exceptionally supportive and helpful and I don't feel I would have got through it without them. I haven't always agreed with decisions and plans over the years but have, equally, always felt able to express my views and have felt that my voice has been heard. I have never witnessed bullying in any of the clinical situations I have worked in, which was why I was so surprised and shocked by the allegations made about NHSH.”

“We have never at any time experienced anything other than courtesy and professionalism from the myriad managers we have worked closely with, over the years.”

“Yes, we are working in pressured and busy environments but I have not, in all my time, been part of a bullying culture. In fact, I would say the quite opposite, I have worked and continue to work with dedicated and supportive health professionals, managers and directors whose ultimate goal is that we deliver quality patient care to the population of Highland, as they deserve nothing less. I am realistic that in an organisation of this size there will be bullies and

I have come across one or two but these are rare and isolated cases. Of course, it is completely unacceptable that anyone is bullied but it really concerns me is that NHS Highland has been portrayed as having a bullying culture. In my view, NHS Highland is one of the best Boards in Scotland to work in (and I have worked in and link closely with a number of Boards in my current role) and it concerns me that potentially will be forever associated and tarnished with this bullying story.”

“...nothing worse than I would expect from an intensely pressured healthcare environment operated by imperfect human beings.”

“... just because a person describes this process (of being questioned about their performance or working pattern), as victimisation or bullying, does not **necessarily** mean it is.”

“I do not perceive the culture here to be one of sustained and systemic bullying, however there may be one of benign/not so benign neglect, lack focus on core service delivery and lack of values and reflective based practice.”

“The main point I wanted to make is that while I know that bullying goes on in NHS Highland, I don't believe that there is an orchestrated culture of bullying as was suggested by the clinicians who initially contacted the press.”

“I'm in no doubt that in an organisation of 10 000 individuals there will be instances of individual bullying and harassment. There may also be small pockets in some services or localities. I have not seen anything that suggests it is endemic across NHS Highland.”

“I have also managed staff in NHS Highland, and am managed by more senior managers and what is being described is not something I have seen any evidence of. On the contrary, where there are staff who can be more difficult to manage, or who are not particularly good at undertaking their job, the ultimate full support is given to them, I would say to the detriment of NHS Highland. I have been involved in managing some staff who in all honesty I felt were trying to play a game and trying to avoid having to do a day's work, but we as managers are bound by our policies to support these staff who are usually the ones to involve their Unions. All the evidence I see in my role is NHS Highland support their staff to high levels which would not, I believe, happen in the private sector. I have huge concerns these allegations have empowered some staff inappropriately who see this as an opportunity to blemish our organisation.”

Other Similar Views

- 12.8 A group of consultants from one specialty wrote to me as follows confirming what they had told me in a meeting, namely that they were surprised to hear of the allegations:

“Cumulatively, we have over 70 years of experience in NHS Highland, through various service changes and management arrangements. We have experienced disagreements and conflicts, but our overwhelming experience is of dedicated staff working together to deliver care to the best of their abilities. We accept that some staff have had different experiences, but we have not personally experienced or witnessed bullying. We have found NHS Highland a friendly and supportive environment in which to work.”

- 12.9 The diversity of experience and viewpoints is marked with these comments from the South and Mid Division Senior Leadership team. They told me that *“in the senior management team, we have spoken about the allegations that were made. The feel from this team was complete shock and disbelief. What we have struggled with is the whole view of a culture of bullying and harassment that we just do not recognise.”*

- 12.10 Similarly, a group of senior nurses at Raigmore Hospital expressed the collective view that, *“while there may be isolated incidents and communication issues, there is not a culture of bullying.”*

- 12.11 Frustrations allied to general contentment was summed up by one clinician in this way:

“I have been very happy working in Raigmore and have lots of positives to say about Raigmore which include team working, good colleagues, good relationships with other teams in the hospital, opportunities in developing personal interests. There are frustrations about working in NHS Highland but I imagine this is not unique to Highland given the financial constraints. I feel management do not always listen to concerns raised... and that there is a lack of information coming down from senior management. There are many decisions I do not agree with; however I do not see this as a bullying culture.”

Confusion

- 12.12 The state of general confusion and impotence in which a number of employees found themselves is reflected in this:

“I am unaware of the detail of the concerns that have been raised, I have not been party to any NHS Highland Board or senior executive level discussions. I have been in an uncomfortable position with a complete lack of information available to me. I have as a result been unable to fully understand what the issues are other than hearing snippets from medical staff who have clearly been having much discussion through WhatsApp. One Consultant advised me that there was talk of a need for organisational cleansing – quite what that involves I am not clear but it felt threatening! For myself as an individual I feel I have been severely undermined and disrespected, and I have been completely unable to support the staff that report to me effectively with regards to the current situation.”

A Spectrum?

- 12.13 In reality, given the range of responses and experiences, there is probably for many people a continuum or spectrum. For them, the existence (or not) of bullying cannot be assessed in a binary way. As noted earlier, it is likely that pockets exist. Other observations support this:

“I’ve observed people with supreme experience handling very difficult situations in an exemplary way. I’ve seen the complete opposite as well.”

“My experience working within NHS Highland is that there is not a bullying culture. There are bullies and there are incidents of bullying. There are also those who seem susceptible to bullying. I personally do not see it on an everyday basis which means I don’t think it is endemic.

It may be that the specific instances where I think conflict has become bullying will be repeated to you time and again and this may represent focal pockets attributable within certain departments, certain individuals or when certain stresses hit the system. There are also people throughout the clinical, support services and management of the organisation who are excellent people with great skills and attitudes who do a fantastic job day in day out.”

- 12.14 Interestingly, in our meeting, the clinician who expressed the latter views spoke of a number of instances of behaviour that were not acceptable and we agreed that there may be two ways of

seeing the same thing and that, in fact, when one thought about it and pieced together different events, a broader picture of unsatisfactory behaviour emerged. This was not necessarily systematic or deliberately commissioned but the result of a culture which was replicated and adopted because (a) it achieved certain financial and other targets and (b) it was the way others behaved and was a safe way to protect oneself.

- 12.15 Other respondents also modified their views upon reflection and in discussion, especially as they reflected on their own experiences. This represents an often-expressed emerging acceptance:

“At the time that the press release went out about a bullying culture I felt that this was wrong without consultation and that it might do more harm than good. I am glad though that this is being investigated in this way and will be interested in the outcome of the report.”

- 12.16 Another, who had challenged the allegations about bullying because of their source and at whom they were apparently directed, came to the view that he himself had actually experienced what would be described as bullying but from a different angle.

“I feel very bruised by the four. But something has been released in the organisation, so it served its purpose.”

- 12.17 A nursing member of staff acknowledged that many people had not spoken up:

“I feel let down by a system that didn’t care until it felt the pressure to atone after being publicly shamed in the press. My experience is that there are a wealth of good people in the organisation who have stood by and done nothing, because that’s easier than speaking out.”

The Majority View

- 12.18 Further along the continuum, this summary of the behaviours which have caused so much concern comes from a senior member in an important supporting role:

“Over the past ten years, I have supported [a number of] Senior Managers in NHS Highland, who reported being bullied and intimidated in their work, some to the point of tears and sickness through stress and most of them having now left the organisation. I have also supported many more in middle management who reported

the same kind of bullying happening to them.

It became apparent to me that models of bullying behaviour at the highest levels of the organisation, were being copied throughout. These included ignoring people, belittling them, treating their ideas with contempt and talking about them negatively to other members of staff. Often when staff have spoken out against this, or against what they perceive to be poor decisions, they are taken aside and interviewed by two or more Senior Managers and cautioned or threatened with disciplinary action. I have seen the abuse of ‘suspension processes’ and trite or trumped up charges being levelled at staff in order to take them through protracted disciplinary processes, during which time they are off work and instructed not to speak to their colleagues. In my mind, there is no doubt whatsoever that there is a culture of bullying in the organisation, and not just isolated incidents.”

- 12.19 This, which bears a striking similarity to definitions provided in chapter 10, is a perspective shared by many of those who responded and who welcome the review, as the following comment from another senior and recently retired member of staff reveals:

“... I am in no doubt that NHSH has operated under a veil of fear and intimidation for many, many years. Anecdotal evidence indicates behaviours in keeping with this to be at the highest level of the organisation. Sadly, I have had confidential discussions with many colleagues who have had similar experiences to my own and have been left with no adequate resolution to their concerns and in some instances have chosen to leave the organisation. Early retirement sadly, is a very popular option...

There are many, many dedicated, highly professional and committed people working for NHSH. This review does offer a real and important opportunity to get to the bottom of why things have gone so badly wrong, make recommendations to ensure that the organisation can move forward positively and effectively enabling a happy, confident and stable workforce. This is the essence of ensuring patients receive excellent clinical, holistic, person-centred and compassionate care.”

- 12.20 The final paragraph above summarises the value many NHSH employees place on the decision to carry out this review.

A Bullying Culture?

- 12.21 While, as I noted at the start of this section, the view that there is no bullying culture is represented by a minority of respondents to this review, it may be possible to conclude that the majority of employees of NHSH have not experienced bullying as such. Having said that, extrapolating from the evidence available to this review, it seems equally possible that many hundreds have experienced behaviour which is inappropriate. That seems far too many. I explore examples of this more fully in the following sections.
- 12.22 If it was within my remit to do so, it would not be possible to conclude conclusively that there is or is not a bullying culture in NHSH. Everything depends on context and circumstances. It depends on where and who you are. As Sir Robert Francis and others have pointed out (and as noted in the remarks on culture in an earlier section of this report), there may be pockets, sub-cultures and hotspots; one department could be perfectly satisfactory while, next door, the situation could be unbearable.
- 12.23 However, as noted earlier, in terms of my remit, I need to explore what, if any *cultural issues* have led to any bullying, or harassment, and a *culture* where such allegations apparently cannot be raised and responded to locally, and identify proposals and recommendations for ways forward which help to ensure *the culture* within NHS Highland in the future is open and transparent and perceived by all concerned in this way. I do so later in this Report.

The Gallanders Report

- 12.24 In passing, it is fair to note that, in November 2018, an Independent HR Consultant, Sandy Gallanders, reported to the Board.³²

- 12.25 The Draft Report stated that:

60. “The prevalence of bullying and harassment in NHS Highland is not significantly different to that in other NHS organisations or elsewhere in the economy. The problem is growing across organisations and it is something that all employers will have to address.”

- 12.26 The report concluded that:

19. “Whilst 28 respondents expressed concerns regarding having witnessed or experienced bullying, the overall number of respondents was small and the evidence, whilst a useful indicator of further analysis being required, is insufficient in itself to warrant a conclusion that there is systemic bullying/harassment within the organisation.”

- 12.27 The Report noted:

23. “A review undertaken by the Clinical Governance Team found that in the great majority of cases there was a proactive approach from the handler/manager to address the incident and concluded that there was no indication of specific trends for concern. This conclusion is considered reasonable on the basis of the evidence available. It is also consistent with the relatively low number of cases which are in process under the “Preventing Bullying and Harassment” policy.”

32 Gallanders, S. (2018). Allegations of Bullying and Harassment in NHS Highland.

12.28 In reviewing an “iMatter” Survey (an online process), the report observed that:

37. “The high level iMatter responses are encouraging. There are no “red flags” which would suggest the presence of systemic bullying and/or harassment. However, only lower level team based data would show if potential problems exist at a more localised level. This would require a higher survey completion and measures to encourage this for future surveys should be considered.”

12.29 In connection with a Dignity at Work Survey, it was said:

43. “On the balance of the information available, the reported overall prevalence of bullying and harassment in NHH reported in the DAW Survey, whilst obviously of concern and warranting more detailed examination and intervention, does not appear out of the ordinary.”

generally, it is helpful to note that the gathering of information about allegations of bullying needs careful thought and insight. Mr Gallanders recognised this himself quite explicitly:

65. “The desktop analysis of survey and other data considered earlier in this report does not provide the qualitative information which lays behind some of the headline figures for NHH. It is important that this information is mined. This will inevitably mean engaging directly with people rather than sending them another survey form. It is important to do this for two main reasons – firstly to get a better understanding of what the issues are where they are occurring and what the common themes are. This will provide a much richer source of diagnostic information to inform future planning and targeting. Secondly, engaging people is the right thing to do – a direct face to face interaction with an employee or group of employees will both provide information to the organisation to help improve things and help that employee or group feel that they are valued and cared about by the organisation.”

The Gallanders Report in Context

12.30 There are a number of criticisms of the report. The GMB union expressed the view that the surveys cited fail to give an accurate picture of experiences on the ground, with most of the statistics coming from iMatters “*which has a notoriously low staff response rate, so their numbers are skewed from the start*”.

12.31 The GMB also commented: “*The survey is done electronically and the questions do not allow you to report, for example, incidents of bullying by saying there is a management issue, so it is skewed in that way too.*” It was not a proper reflection, was limited in its scope, “*not representative, too quick, too easy.*” According to another respondent, it did not reach “*an operational level where the bullying and harassment has impacted*”. I am told that it did not involve any discussions with individuals or seek to look at any underlying relationship or cultural issues.

12.32 I mention all of this not to criticise Mr Gallanders or his report but to help gain an understanding of why that piece of work did not uncover the issues which this review has uncovered. More

Use of the Gallanders’ Report

12.33 For completeness and because Mr Gallanders’ report is full of useful suggestions which could easily be lost in the headlines about it, I have included, in Appendix 2, some more of his findings which seem to me to be helpful. I also commend the Report’s list of short, medium and longer term tasks and priorities. They contain much which is of importance and utility. I pick this up in my own proposals later in this report.

13. Experiences of Inappropriate Behaviour

A Matter of Concern

- 13.1 A significant majority of those with whom the review engaged have, over a number of years suffered, or are currently suffering, fear, intimidation and inappropriate behaviour at work. In this chapter, I set out what I have been learned from many sources.
- 13.2 The number of individual cases in which people have experienced inappropriate behaviour which falls within the broad definitions of bullying and harassment described earlier is a matter of the utmost concern. Many appear to have suffered significant and serious harm and trauma, feel angry and a sense of injustice and want to have their story heard. There are, it appears, serious concerns about the mental and physical wellbeing of a significant number of members of staff. There are, I am told, links to anxiety, depression, withdrawal, alcoholism, drug abuse, suicidal thoughts and other serious consequences.
- 13.3 A number of those against whom bullying allegations have been made are also, or have been, the subject of inappropriate behaviour themselves. Bullying can be both upwards and downwards – or both. Many people have been afraid to take steps to address issues internally or to speak out, currently and over a period of many years. Many feel that no really effective, safe, mechanism to do so has existed.
- 13.4 One comment offered was that:
“Many individuals have come to serious harm over these years in addition to the destruction of a highly motivated staff base at what used to be a fantastic hospital.”
- 13.5 A clinician told me:
“I’ve seen scores of people who have worked for the organisation who have said their distress is such that they have enacted or considered self harm to deal with the pressure. These are people who work for the organisation who have cut themselves or seriously attempted to take their own life by overdosing. Over the years this has not been an uncommon occurrence. Bullying has a really corrosive effect on a person’s life,
- not just at work, but on how they feel about themselves, and on how they interact with their families. Feeling oppressed, under the scrutiny of a manager, this really affects people. Perfectly able, intelligent people can become unable to cope. Over the years I have met many people who describe experiencing those sorts of emotions. It’s not just within NHS, although I think NHS is the largest employer in the area, so it’s not surprising I see this as often as I do.”
- 13.6 A significant number of employees, at all levels of seniority, have resigned, moved to other jobs or retired as a direct result of their experiences in NHS and inability to achieve satisfactory resolution, some to their financial detriment. Many of these situations and their direct relationship to the work situation at NHS are, I am told, vouched by independent medical reports and other evidence. The following remarks sum up the situation experienced by many:
“My decision was not taken lightly. Although I loved my job I felt it was impossible to return to this unhealthy, toxic environment and with an extremely heavy heart (I cry now as I type this), I asked if I could take early retirement from service.”
- 13.7 One member of staff who felt compelled to depart described how she had felt and the indignity which she experienced:
“Yesterday was a dreadful day in the office and I feel that managers were avoiding any contact with me whatsoever! I was dreadfully upset and I decided at that point that I could not continue to work under this veil of indifference. I had hoped to leave the organisation with some degree of dignity and recognition of my dedication to NHS Highland.”
- 13.8 Another member of staff in a rural location described the impact on herself and colleagues:
“The main issue was the process in which it was managed and how [a number] of us ended up being left with no outcome, no apology. We felt

completely overwhelmed by it all and definitely under appreciated by an organisation to which we have given a collective work life of [over 60] years ([and many more] years to the NHS).”

Range and Scale

- 13.9 After the whistleblowing occurred in September 2018, there were apparently 90 calls to a trade union support line in two weeks. That union advised me early in my review that it had nearly 150 cases, many of which were unresolved. One union official told me: *“Over 20 years of working for a trade union, I have never seen the reaction we got when this went public.”*
- 13.10 I cannot reflect the full range and scale of concerns expressed but I do wish to acknowledge the candour and clarity with which people wrote and spoke to me. The volume and specificity could leave no one in any doubt about the seriousness of the problems, many of which remain outstanding. As mentioned earlier, a significant number of these cases arise in rural areas and local departments as well as in the major centres.
- 13.11 Themes emerged for staff who feel they are not valued, not respected, not supported in carrying out very stressful work and not listened to regarding patient safety concerns, with decisions made behind closed doors. They feel sidelined, criticised, victimised, undermined and ostracised for raising matters of concern. Other respondents cited a clique or pack mentality, being kept out of the loop, abuse by email, leaking of sensitive information and being briefed against. Many described a culture of fear and of protecting the organisation when issues are raised.

Views Expressed

- 13.12 In this section of the report, the words of a few individuals, suitably anonymised, speak for themselves. These are not random remarks. I have selected them because they express views I heard repeatedly. I have formed the view that it is important for these voices to be heard (a) to make clear how serious the problem has been and continues for many to be and (b) in the hope that by bringing this out now NHSH can begin the journey to a better place. Further views are expressed in other sections of the report. As I have said repeatedly, they are not offered for

their wholesale factual accuracy but to enable the reader to build a picture of the depth and extent of how people have felt. I have not attempted to investigate responses to all of these views.

- 13.13 I am aware that, for many, this degree of specificity is painful and frightening. It creates a situation where individuals are fearful that what is recorded is directed at them, rightly or wrongly. Responses to bullying can themselves seem or feel intimidating and inappropriate. I am also aware that for some of those who feel they have suffered inappropriately, reading all of this may also be traumatic. Therefore, in recording these views, I ask readers to be sensitive to the impact of what follows on individuals. And to remember, throughout this report, that there will often be several sides to a story.

A Rural Practice

- 13.14 For me, much of what I heard was encapsulated in a meeting I held with fifteen members of staff in a rural medical practice. My anonymised record of the comments made at the time summarises what I have heard about how many people feel at work generally in NHSH.
- “We’ve put up with it for so long”*
- “Our manager has made our life hell for years”*
- “He shows no respect, it’s his way or no way”*
- “He intimidates us, speaks to us like children”*
- “It’s one rule for us, and one for him”*
- “He owns us like slaves”*
- “Higher up management backs him up – it goes all the way up”*
- “His line manager knows – he is scared of him”*
- “They all know, they’ve heard it all before”*
- “It’s an abuse of power, it’s all about control”*
- “He gets away with it”*
- “What’s the point in taking it up?”*
- “HR held a meeting with us but there was no proper follow up”*
- “HR cc’d the person I was complaining about!”*
- “I wrote to his line manager confidentially but my letter was passed on to him and I had to meet with him; Datix is the same”*
- “I got no response to my letter”*

“iMatter is a paper exercise, a tick box; he takes the meeting and decides what we discuss”

“We don’t take it up because we fear recrimination”

“There are inconsistencies in how they apply the policies”

“They are manipulating the outcomes of application of policies”

“Policies are not followed; instead they apply local interpretations in an arbitrary and discriminatory way – it’s unfair”

“If we stand up, we get shot down”

“There’s nothing we can do”

“This is management style of 30 years ago – bossing us around”

“We have lost many staff over the years as a result”

“Senior management needs to support the staff not the line managers when legitimate complaints are made”

“They keep cancelling meetings they promised us”

“They don’t seem to care about us”

“Senior managers need to understand their role – many are in the wrong job; they need training or to change job”

“Those appointed to management need to have the necessary skills as facilitators”

“We would like adult conversations and to be treated with respect”

This last remark perfectly captures what many respondents feel has been missing in NHS.

An Individual View

13.15 Another individual described experiences over many years:

- “Throughout my career (spanning over 20 years) I have been subjected to bullying and harassment by a colleague
- I have on several occasions addressed and escalated this with senior management, this did resolve issues temporarily
- Formal mediation was agreed and sought, no follow through on this, colleague avoided and not followed up by HR.

- Felt excluded, disrespected and inadequate, and in some cases still do.
- Professional lead role not respected or at times included within decision making processes.
- Have had to work hard to remain at work, high stress levels but have utilised coaching (external) to support.
- Experienced humiliation at times from senior management when presenting or contributing to meetings.”

Historic Concerns

13.16 That this situation has prevailed for a number of years seems fairly clear. The following was brought to my attention as examples taken from a survey carried out in 2014:

- “Although concerns are expressed they are dismissed, staff feel unsupported.
- Unsupportive management focus only on negatives and problems, there is no recognition of good work. There is a total lack of inclusion or consultation in any proposed changes.
- Anyone who attempts to raise legitimate concerns is victimised and targeted
- I was shouted at by the trainer, witnesses were shocked by this and managers heard about it and did nothing (3 other people made similar comments)
- Anyone who tries to raise concerns regarding management is subjected to unfair treatment and things are made difficult
- Please, please listen and act on our concerns
- Team spirit and cohesiveness has been destroyed by negative management. Morale is very low and no-one is sure who they can trust
- There is a bullying culture here that has never been eradicated. Genuine concerns should be addressed rather than swept aside
- Unrealistic expectations from senior management and treatment by managers with an autocratic style is really stressful.
- Staff are too scared to raise a grievance, a concern or even report something that is clearly wrong. We’ve seen what happens to those that do
- I don’t know why I’m bothering to fill this in, other than I was told to! But nothing ever happens anyway, it all gets covered up.”

A Former Employee

13.17 A former employee who had felt unable to continue with NHS summarised what she told me in a meeting in these words:

“Previous history of allegations made by the two individual nurses in the team, which had led to the suspension of the previous Senior Nurse, who later retired as she was unable to continue working in the service due to her traumatic experiences.

Perpetual bullying by the Nurse who was redeployed stating that he would ‘have my job’, directing the nurses to follow a particular practice pathway in the absence of professional/team discussion, taking on tasks that were not appropriate and undermining my professional status and role.

Professional disrespect and lack of understanding of roles and responsibilities. This created significant barriers between, for example, Nurses and [clinicians] in the service. There was an attitude that prevailed of superiority and inferiority and working together across disciplines was particularly difficult for some.

Oppressing certain professionals, the Service Manager undermining and making derogatory or negative remarks in front of other team members without justification, about certain colleagues, who were competent in their work, usually those who challenged others (seen as a threat). An experienced [clinician] was transferred out of the service, following her allegations about ‘bullying’ as she was seen as ‘problematic and divisive’.

A culture based on fear and intimidation, blame, mistrust, covert practice, ‘cliques’, defensiveness and indiscreet recrimination, without an actual evidence base.”

Other Experiences

13.18 Another nurse put it this way in our meeting:

“A wee group including charge nurses, other nurses, auxiliaries etc. treated [me] badly, talking behind [my] back, being unkind, using harsh tone, questioning [me] in front of patients, not made to feel part of the group etc. Felt intimidated, undermined, disregarded, ill informed and that [I] was a scapegoat for all the ward’s ills.”

13.19 One of my colleagues reported to me the experience of a bank auxiliary nurse who described consistently being treated in a derogatory manner by ward nurses:

“They speak to him in a brusque and patronising manner and do not value his expertise and experience. He estimates this happens more than 50% of the time. He thinks the belittling is driven by stress due to time pressure and the failure to make full use of him is driven by a hierarchical mindset that devalues auxiliary nurses. He recognises the nurses in turn are probably experiencing this treatment from doctors and managers. When he raises the derogatory behaviour with more senior nurses they tend to excuse it as being down to stress and do not tackle it robustly. He thinks that a team culture is needed.”

13.20 A hospital worker told me:

“The degree of low-level and at times almost direct intimidation and bullying was very marked, with a pervasive feeling of fear and being unsettled in the job. What we as practitioners did each day was brought into question, with more and more constraints, and if we tried to explain how impracticable a new dictate was we were met with disregard, and an increase in feeling of being singled out, with her raising increasing “concerns” against individuals. Grievances were taken out against the manager, and although no evidence was found to back up the manager’s “concerns” regarding practice, these were still upheld and our grievances against her given little credence, but the line taken was not to worry about it. My concern is that even when going through the official routes, if it is a manager a concern is raised against, it feels almost as if there is a closing of ranks, and even the unions did little to fight against this.”

13.21 A junior member of staff described in detail her concerns in one unit:

“This has created a very fragmented and divisive culture across the unit. Junior [staff] are being blamed/scapegoated for mistakes they were not involved with and errors being made by senior [staff] are being covered up and collusion is occurring to blame junior [staff] for these errors.”

13.22 A former employee had this to say:

“... in the NHS Highlands they burdened me with an excessive workload, made unilateral decisions without discussion, treated me like a robot rather than a human being, isolated staff (divide and conquer), emotionally blackmailed staff, put targets over patient care and safety, did not treat me with respect or appreciate me and severely affected my health and well being and ultimately made me seek employment elsewhere.”

13.23 A laboratory assistant told me:

“I have never seen any workplace managed in the manner that this laboratory is now, it thrives on bullying at all levels as well as favouritism and gossip. There is no adequate staff training at all and I have been set up to fail on so many occasions.”

13.24 A little vignette sums up the feelings of many who experienced a kind of cognitive dissonance:

“NHSH invested in promoting dignity at work policies. They organised this dignity at work workshop/meeting. I went to it, they paid all of this money out on mugs etc. then there was a presentation from two people at HR. At one point, one of the speakers was not confident – what are we doing next? And the other snapped saying “well I don’t know, it’s your bit!” It was right before my eyes.”

13.25 An administrator described her experience in one department as being “*kept out of decisions made by senior managers and then expected to communicate and defend unpopular decisions to staff*”, who would see her as the problem. She experienced bullying both from managers and from staff she was trying to manage. “*I kept being handed a loaded gun*”. If she tried to tackle underperformance she was not backed up by management and then was criticised by staff for letting underperformers get away with it. She expressed concern that HR offered little support when she asked for help with bullying – options were either to live with it or raise a grievance, which would take a long time. In any formal meeting “*HR only support the manager, so the staff member gets no support. Also, HR isn’t confidential*”.

13.26 The damaging impact was described by another administrator who told me:

“I now find myself in complete limbo with no specific job role,... I am excluded from all staff

meetings and have no contact with the actual local dept ...The support staff still will not speak with me or acknowledge me in any way. I am struggling with immense feelings of rejection and isolation.”

13.27 A former senior manager vividly described a series of experiences of what is known as “gaslighting” perpetrated by an even more senior manager. I am told that gaslighting is a form of “*psychological manipulation that seeks to sow seeds of doubt in a targeted individual or in members of a targeted group, making them question their own memory, perception, and sanity. Using persistent denial, misdirection, contradiction, and lying, it attempts to destabilise the victim and delegitimise the victim’s belief.*” Gaslighting was a word I became more familiar with during my review as respondents described their experiences.

13.28 This sort of unpleasant experience was corroborated by a former support manager:

“A number of staff complained about [a particular event], including myself, and this is when I started to be managed out of the business. Within a relatively short period of time my self-belief had been undermined so comprehensively that I would never have employed myself and was eventually signed off with stress (this is common in this department). When I was under treatment by my GP (none of those who signed the letter in the press) they were entirely unsurprised by my experience and said that stories like my own were common from NHS workers.”

13.29 The experiences seem to be widespread across NHSH; this example comes from a rural community:

“It is widely felt by staff that there is an institutionalised culture of bullying management on [this island] but nothing can be done about it.”

An Experience of the Board

13.30 I conclude this section with a completely different situation to those described above, in which a senior clinician describes an experience with “the Board” (which is used as a collective term here and may not refer to all members or an actual Board meeting). I do not offer this for its

factual accuracy (as ever, perceptions will vary in a very pressurised situation) but record it as an indication of how dysfunctional things appear to have been and the resulting impact:

“What we experienced on that afternoon was both eye-opening and frightening. We were looking into the dark soul of the NHS organisation. Our team was shocked by this. Senior clinicians – three of them – moved to tears during the meeting. A lot of anger expressed about the way we were treated. The body language of board members was very unpleasant. There was an attempt to undermine us, make us look foolish. The behaviour was threatening. They left, we agreed to nothing. We agreed to meet the next day to discuss further. All shell-shocked. One colleague left during the meeting. Another tried to leave but was told to sit down. What took place was well beyond our collective scope of experience, and as such it was powerfully disorientating. I had never witnessed anything like it. In this way the Board broke the collegiate will of our clinical team. They left behind a fragmented, confused and angry remnant. In ways we found difficult to discuss I think we all felt ashamed of ourselves. Many of us were traumatised and remain so. Most of us felt that we had failed to defend the interests of our service and our patients. The methods of ambush, intimidation, isolation and undermining reflect the themes raised by those who requested an investigation into “bullying” at NHS Highland. It demonstrated a Board that is not listening to the concerns of its staff, driven by its own agenda and believing itself to be above the law. At a subsequent meeting arranged at my request, the Board Chairman asked me a very direct question: “did you feel bullied?”, to which I answered “yes”. That meeting ...was never acknowledged, and to my knowledge no steps were taken to investigate the issue of high level bullying that the Chairman and chief executive had identified. What I perceived as formulated organisational subjugation allowed inconvenient truths to be concealed. As seen in other instances within the NHS, this kind of behaviour presents a risk to patient safety and to the long term reputation of the service. My concern is that that behaviour, which they probably don’t recognise as being bullying, has a very significant influence on the safety of our service. Has allowed us to brush under the carpet the opinions of senior clinicians and very significant risks across NHSH.”

Managers’ Concerns

13.31 The allegations of bullying go both ways. Managers are also said to be the recipients of inappropriate behaviour from members of staff. This from an island community:

“My experiences are actually of NHS Highland Managers being bullied not the other way around. I have seen a very concerning increase in ‘bad behaviour’ from my colleagues over the past 3 years. I have been shouted at, screamed at, sworn at, lied about, accused of being unprofessional and uncaring too many times to keep track off. I feel as an organisation NHS Highland have lost their way a bit by not being assertive enough when managing services, the public and staff.”

13.32 Similarly:

“I have had instances of managers being bullied by their nurses. This manager was accommodating the nurse’s availability only and then scheduling everyone else around that one nurse. When I asked her if she felt bullied, she burst into tears and left.”

13.33 This from a manager in a middle management situation expresses clearly the difficulty for someone in that position:

“During my employment as a Manager I found myself managing an unprecedented situation involving a member of staff I line managed. I found HR to be completely ineffective, my senior managers showed little interest. The end result of this ghastly situation was finding myself at the centre of grievance by the member of staff – unfounded accusations were made against me. I was made aware of this way of a phone call on a Friday evening from a very senior manager. Although I continued to work, I was under investigation which took many months to resolve. The outcome was ‘no case to answer’; the situation was not dealt with appropriately. My experiences are not in isolation within NHSH....

I have also found myself being accused of bullying & harassment by a member of staff I lined managed. I took my role as a manager extremely serious and ensured I followed due process ...I have evidence of this. The staff member involved did not want to be managed, had been used to ‘doing her own thing’ due to lack of structure within the area of responsibility. I viewed her as a risk, had significant concerns re her capability including clinical competence. She

chose to accuse me of bullying her – again lack of support from HR was evident and the outcome was unsatisfactory. Again this not unusual in NHS – people do not want to be managed, nobody takes responsibility contributing to compromising patient safety.”

13.34 This comes from a long-serving senior manager who feels vulnerable at work:

“This has been a distressing time for me and I don’t feel that there has been support for me as a (wrongly accused) manager within the organisation. I know the truth will out so to speak though so I just have to hang in there until it does. Fortunately my immediate line management know that the accusations are untrue and there is evidence to substantiate this however it concerns me that people can just make up stories on the bullying bandwagon and because NHS Highland is currently in the position it is in, the stance feels along the lines that managers must be at fault and need to improve as opposed to supporting managers who find themselves wrongly accused. I feel that I am in a very vulnerable position and this unresolved situation has the risks of impact on my ability to continue to manage effectively without fear of accusations.”

13.35 One manager described the impact on him of the recent accusations as a form of bullying itself:

“There has been an overwhelming feeling by myself and managerial colleagues that we have been labelled as bullies. Various individuals have had open access to mainstream media, social media and other avenues to express their allegations of bullying and labelling all levels of NHS Highland structure as bullies, including [one MSP] in open questioning at the Scottish Government. To me this could be considered as indirect intimidation and bullying without the right to reply. I have had to personally defend myself against various comments and assumptions outwith work as a result of the allegations made which includes my ex line manager. This may seem “par for the course” considering the serious nature of the allegations but unacceptable as an individual where I have no control of how the allegations were made to the press.”

13.36 These views are clearly of great importance and reflect both the multifaceted nature of the situation and concerns about the way matters have been handled, together with the implications, on which I comment elsewhere.

14. Unwillingness to Raise Concerns

Introduction

- 14.1 It is relevant and important to discuss why people felt unable to report their experiences and the adverse effects if and when they did.
- 14.2 It is said that, in general, the main barriers to reporting allegations of bullying or other inappropriate behaviour are the perception that nothing will change, not wishing to be seen as a troublemaker, the seniority of the bully, the fear that bullying will get worse, and the fear or real risk of being dismissed or side-lined. The legal and other remedies are not easy to pursue, often leaving a choice between leaving the job (with all that entails) or continuing to suffer.
- 14.3 Sir Robert Francis identified a number of factors which may lead to fear of speaking up as being:
- blamed or made a scapegoat
 - discriminated against
 - disbelieved
 - seen as disloyal
 - seen as disrespectful in a hierarchical system
 - bullied
 - fear of wider consequences for a career.³³
- 14.4 As noted already, these have been the experience in NHSH. In this short chapter, I offer some more illustrations of reasons for people feeling unable to raise their concerns.

Themes

- 14.5 A consultant told me of a variety of impediments:
- “Potential repercussions – need to keep my job, pay my bills. I’ve watched what happens to others who challenge. People’s careers sabotaged – cannot work again- will never work again – no pension...If I were to go and make a complaint – who would I go to? I don’t have an answer – I won’t turn up at the new CEO’s door...”

- 14.6 This is a recurring theme:

“People are unwilling to step forward and say this is a problem. I’ve spoken to a number of colleagues who, when I told them I was coming, they said, “good for you” and when I asked if they thought about it, the majority of responses were “I’ve got a mortgage, I’ve got children.””

- 14.7 A senior staff member wrote in these terms:

“Those who have gone to formal grievance have come away feeling like they are in the wrong, that this manager is having to deal with them and their faults. This tends to give the message to others that going down this route puts them at risk of being deemed as either a trouble maker, not coping with their work and therefore at fault themselves. Until this bullying behaviour is acknowledged, staff supported, and communication improved I can see many experienced staff leaving if they can’t hold out till x retires. This is not my impression of a supportive forward-thinking organisation who cares for the wellbeing of their staff...”

That really summed up how I feel about Bullying within NHS Highland and in particular in the [x] department. Before putting in my grievance I had been warned that “management stick together so don’t expect your grievance to have a very good outcome” and I have unfortunately found this to be my experience.”

- 14.8 A former local MSP told me:

“I had many cases of NHS bullying over the years. The one conclusion that I reached was that there was a common denominator in the vast majority of cases. Generally speaking, most of the staff who had been bullied had ‘dared’ to raise concerns regarding patient care or suggest ways to improve patient care. They tended to be well qualified, experienced and conscientious in their professional capacity. Having raised an issue, they were often redeployed to a

33 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.3.19

post with lesser responsibilities or taken from specialised posts to general work. It was not only bullying that was involved, but a fair amount of humiliation was also used, often in front of patients and particularly with other staff present.”

14.9 These views echo the observation of Sir Robert Francis that workers who are bullied, or who see others bullied, are much less likely to raise their concerns (see paragraph 10.18), as the following passages underscore.

14.10 A former manager in a support role told me:
 “What NHS Highland fails to recognise is that most people who are bullied will not report it and perhaps don’t even realise that they are being bullied until they have left that situation. If someone does eventually raise a complaint... they will quickly realise that a record has been kept of things that you’ve done and said that can be skewed to seem negative and, as you haven’t kept an equivalent record (not knowing that you needed to), you can’t counter the negativity.”

14.11 From a care worker in Argyll and Bute:
 “My case is not isolated, I have met many people who have raised a concern and been shunted from post to demoted post until they leave. There is a fundamental lack of understanding by NHS Highland of the nature of bullying, it is generally secretive and there is little evidence. People who witness bullying will rarely corroborate a complaint for fear that they will be the next target. When people see what happens to someone who raises a complaint it is little wonder that bullying goes unchallenged. Senior and Middle management close ranks and say there is no issue.”

14.12 The feelings of a number of those who came forward are summed up here:
 “It is common knowledge that this particular manager openly boasts in the staff dining room about the number of grievances against them and has said that it doesn’t matter because “nothing ever happens about them”. Staff ... feel that this manager is “untouchable” and are afraid to complain further due to the poor outcomes of previous complaints & the open victimisation of those who have previously complained. Several members of staff have actually resigned their posts as they felt unable to continue working under these conditions.”

14.13 There seems to be a strong theme around victimisation, a fear that, if someone raises an issue, the person complained of will use their power to harm the person raising the issue further. Staff fear reprisals.

14.14 I was asked to note that doctors are less likely than other staff to report incidents of bullying and harassment; trainee doctors are among the least likely to speak up. They fear repercussions if they do. They believe that nothing will change by raising concerns. There is also a mistaken perception that doctors do not suffer bullying. They are often seen as powerful, successful and self-confident people, and therefore somehow immune. I was told that this is not the case.



Understanding the Cultural Issues

15. Possible Causes: Health Sector Generally

Introduction

- 15.1 There are undoubtedly multiple causes of the symptoms described in this report. Finding a simple reason is not always possible. An observer commented: *“There is often no explanation or reason one person subjects another to the type of behaviour defined by ACAS...”* as bullying.
- 15.2 Diagnostically, the experiences of many NHS staff are likely to be attributable to a number of factors which have built up over many years, a number of which have also created difficulty in raising and addressing them locally.
- 15.3 Some would say these have created a perfect storm in NHS. Many of the features described in a “VUCA World” (see paragraph 4.17) and referred to in my chapter on human nature are manifest in NHS. A number are outside the control of an organisation such as NHS. We should not underestimate the effects in recent years of the general sense of isolation and alienation felt in some parts of society.
- 15.4 Some factors could be described as cultural and are possibly unique to the specific local and geographic circumstances of NHS and its employees. I am mindful of emphasis on the importance of “place” in recent years. These factors play an important role. Other matters are relevant in general to the NHS in Scotland and to the provision of health care overall. There are other significant factors which will, I expect, be common to all large organisations. Yet others have to do with a management style which, it is perceived, has been prevalent in NHS in the past several years and relate also to the effectiveness of the governing body to provide effective oversight.
- 15.5 I seek to address these and other possible reasons in this and the following chapters of the report. This chapter seeks to cover more general issues. The next chapter discusses matters related to NHS itself. The succeeding chapters

cover further topics which are relevant, including management, governance, HR issues, the role of trade unions and the Scottish Government and other topics.

- 15.6 In some of this, there is an inevitable amount of conjecture on my part, allied to the views of well-informed respondents, upon whose words I have again placed considerable reliance as authentic and authoritative sources upon which I can legitimately draw. However, this analysis will inevitably throw up questions and comments by those who understand the organisation intimately. If so, that is a good thing. There are matters which deserve to be wrestled with as NHS seeks to move forward.

Changes in Expectations and Behaviour

- 15.7 As Mr Gallanders noted in his report, what is or should be tolerated as acceptable behaviour has changed in recent years³⁴. It is likely that, more generally, society is experiencing a lower tolerance of behaviour which is perceived to be intimidatory, disrespectful and hierarchical, as we have seen in other areas of public life. There is growing evidence of increased levels of awareness of workplace bullying generally – either because more is happening in fact or because attitudes are changing and mounting evidence reveals more of its existence.
- 15.8 Workplace bullying is not exclusive to the NHS or to the public sector. We know from recent examples that it occurs in the private and charity sectors, affecting productivity and increasing absenteeism in all organisations. The increased power of social media with no apparent parameters or checks is, I was told, another significant factor:

“Emails and social media have been fatal. People have a glass of wine and then write it all down. I have seen in the past two years, my staff’s behaviour change and deteriorate quite dramatically.”

“Social media spreads like a disease.”

34 Gallanders, S. (2018). Allegations of Bullying and Harassment in NHS Highland. Para 61.

15.9 Further, health care provision across the developed world is increasingly complex and expectations of improved services in the NHS continue to be high among patients, the media and society generally, alongside medical and technological advances. One commentator said:

“Some policies have undoubtedly contributed to the NHS pressures, most recently around patients “rights” to have drugs even when extremely expensive ie rationing/control is now very difficult precisely at a time when extremely expensive drugs are being made available.”

Medicine and Hierarchies

15.10 In any event, it seems that the culture in the medical world has probably historically been rather hierarchical and power-based, with a sense of entitlement and status and a corresponding element of bullying behaviour, aspects of which still remain. Lack of respect among and by clinicians still seems to be the norm in some places. A culture of deference may be an associated feature. Changing circumstances can feel like a challenge to ego and authority. The move from the autonomous, heroic “clinician with power” model to a more complicated and shared power / teamwork approach is not easy.

15.11 The perceived rise of managerialism and the clash with clinical leadership is a significant feature I am told. Younger doctors may be more at ease with a changing culture but this can itself lead to internal tension. One senior manager described it in this way:

“I’ve described it as being ante-diluvian. It’s being in James Robertson Justice’s Carry-On Doctor. Not everybody, but some consultants who are longer in the tooth. I think that’s coming from a place of stress.”

15.12 As one senior person put it:

“In terms of structures, I think sometimes some doctors have got an unrealistic idea of the extent of their autonomy and entitlement to do as they wish. Some people can be pretty inflexible and resist what the manager is trying to do. I wouldn’t characterise the whole organisation like that, but I think part of it is the doctor’s disinclination to step up. It’s the model of being an advocate for individual patients being the primary concern, fitting in with traditional medical autonomy. But it doesn’t fit into modern view – medicine is now a team game in delivery

for care. Constrained resources. Someone has to make decisions about prioritisation. Our doctors sometimes don’t step up into that more modern role. If put under pressure, can retreat into that traditional role.”

15.13 A former board member told me:

“I found the hierarchy and clinical domination, and in particular deference to medics, noteworthy when I joined NHS Highland. There are tensions and conflict around how individual clinicians and teams manage ‘their’ patients whereas the board and senior manager’s responsibilities span across all services as they apply to the entire population.” An HR staff member commented: “There is a superiority thing that informs how people behave. There is a lot of emphasis on patients being important – “I’m saving lives today, what are you doing?” The staff feel that they don’t matter...”

15.14 One senior manager commented:

“We have a culture in the NHS which lapses into categorisation of people by their profession, grade, job title or background. It’s far from straight forward, however, because senior clinicians (of all backgrounds) have also described how virtually overnight they went from being respected and valued to one of abject disrespect when they moved into management roles.”

“I have seen great progress in this regard since joining NHS Highland but medical dominance (in particular) still prevails throughout the NHS. Of course in many ways this is positive but there is a balance to be struck to ensure a healthy culture, where everyone is valued, particularly based on their contribution. Doctors don’t always know best, and can and should be respectfully challenged, in the same way as other colleagues would expect to be.”

15.15 Power is an important driver. Another former manager told me:

“I’ve worked in lots of organisations and there are pockets of people who are on the edge. ...But in NHS, there was nobody catching it. It was the behaviour that was wanted. It’s what people wanted to see. There weren’t isolated incidents, but an underlying current of it all the time. ... I was told to just “manage it”. But it was bigger than me, I need help to manage it. We

had a good clinical manager and we took a lot of abuse. But ultimately, the power wasn't with us and nobody was willing to help wrestle that power away."

- 15.16 Issues about education, training and selection may arise which are beyond the scope of this review and which I understand bodies such as the Royal College of Surgeons consider actively. It was pointed out that the NHS was based on a post-World War 2 model of command and control based on a military template, with "officers", divisions, uniforms, hierarchies, unquestioning deference and other attributes, many of which may have seemed valid then and which still remain. (Ironically, some respondents pointed to changes in the way the military handle bullying as a model for NHS to follow as a necessary stage in its evolution in the 21st century).
- 15.17 In a later chapter, I address the tension between clinicians and managers and indeed those clinicians who have become managers. It is a complex situation.

Resistance to Change

- 15.18 It is fair to note that one experienced former director pointed to the difficulty of introducing change in the medical world:
- "I mean the unenviable task for managers in managing these disparate groups, but more importantly managing a group of staff who earn salaries far in excess of that of their line manager. This produces a dynamic and power base that is not always conducive to change and can indeed thwart progress. The challenges in recruitment and retention across some staff groups may enhance that power base at times strengthening resistance. In my time in NHS I have witnessed many managers struggling with budgets, increasing demand for services and expectations in relation to new interventions or medications. Not all staff understand or support these struggles and may wrongly interpret firm and fair management as a result. I believe ... that NHS has a culture of continuous improvement and that resistance to change is a natural consequence of this. NHS has always had processes in place to support those who resist change and I believe the organisation has always aimed to be open and transparent in implementing these processes."

- 15.19 A professional lead put it his way:

"You'll get people who can be aggressive in actually saying "you haven't discussed that with me" when we have through consultations. But because the outcome is not what they wanted, they plead ignorance. They become aggressive and then try to undermine you in other ways. I see myself as an isolated voice although there are other ways. People are afraid to put their head above the parapet. Any change is fearful. In the change model, the status quo is the place they know even though they don't like it."

- 15.20 Again, system inertia is a well-recognised feature of an organisation and affects individuals under strain and who are fearful of the consequences of change. One observer reflected on the result:
- "Organisational inertia, which is linked to many things. People get used to nothing happening and get frustrated or give up. This leads to some of the behaviours, whether by those managing or those seeking change or explanation."

Government Targets

- 15.21 It is perceived that there is significant and increased pressure to perform and meet targets throughout the organisation. This, perhaps underscored by a fight or flight response, has probably often taken precedence over people issues. It was argued that Scottish Government policies such as treatment time guarantees and waiting list targets press NHS Boards to deliver without enough regard for affordability and other resource issues. Unrealistic or unachievable expectations can lead managerial staff to pressurise clinical and other staff to improve performance.
- 15.22 Thus, these policies may have an adverse impact on the people charged with delivering them, leading to dysfunction and loss of morale which can tend to cascade down through the system. By their nature, they may emphasise a more transactional approach, to the detriment of relationships. Rather than criticising the targets themselves, there may be an absence of the necessary skills to implement them – or realistic conversations about them.
- 15.23 The emphasis on targets seems to be one reason for tension between management and clinicians. As I mentioned at an earlier point, there may be an inevitable, perhaps irreconcilable, tension between clinical obligations to patients and

the management need to cut costs and/or increase efficiency. I am told that this is further exacerbated by the gathering and collation of data for reporting to the Board, which is used to assess targets and measure waiting times rather than shared operationally to enable those on the ground to adapt services.

15.24 One clinician observed:

“Targets are useful, but if all one is doing is working to the target, everything else becomes secondary. Particularly when the directors, CEOs and the like are managed against that target.”
And that creates problems for others: “People tasked with implementing the approach/regime are not necessarily knowledgeable or skilled enough to do this. Culture of training someone to do something and immediately assuming expertise. That cannot be easy. A large part of our role is to justify the role of management and administration to produce figures for them.”

“Management, from the very top down, remain fixated with targets, both for delivery of services (e.g. waiting times) and financial. They have retreated to the lowest common denominator, leading to poor clinical standards, acceptance of poor behaviours and lack of candour. Clinicians have become the tool of management, we exist to allow them to produce reports to demonstrate they are meeting targets. This has led, in some places, to a culture of bullying, often as a response to fear, this is top down. Morale is very low, highly skilled and experienced people are leaving the NHS.”

15.25 An employee representative commented on the political pressures and impact:

“But we have also to acknowledge the external pressure on all NHS Boards which comes from above/outside. Political discourse in Scotland around the NHS is largely centred around the meeting/breaching of targets, and success (or otherwise) in delivering a premium service within limited budgets. Government and opposition alike use this as the default for discussion and for measuring success, and that context is mirrored in media reporting. If the workplace culture in the NHS is to change, the effect of this wider context needs to be recognised for the impact it has.”

15.26 One GP summarised the effect: “*You see the management firefighting all the time. Their reaction under pressure is a bullying one.*” Firefighting is a description that arose several times.

15.27 Overall, there was a feeling of NHS boards under pressure:

“It is right that the Scottish Government (not just the current administration) places high expectations on Boards to deliver – Governments are after all answerable to the people that elect them. Equally it appears to me that the current administration is not willing to have the difficult conversations with the public over what can be expected from a resource limited public health care system – I see this daily with medicines where I feel we could get better value from investing our resources in other therapies/care. It has provided little constructive leadership and left the Board exposed when making difficult decisions.”

15.28 One director expressed the frustration felt by many:

“It’s the most unrewarding organisation I have ever worked for. How do you measure success? You’re here to deliver care – how do you measure the care? I can tell you how many people are in a queue – how many we have failed. A good day is when you don’t fail as much as a bad day.”

15.29 The impact on NHSH may be more acute:

“I think the government target driven health service in an under-capacity NHS causes major issues and I have seen this for years with ill feeling and upset. It may work better in central belt with private hospitals with separate managers/nurses and secretaries but in Raigmore it distracts from the capacity we have.”

15.30 A senior consultant commented on measurement as against clinical outcomes:

“Financial stringency brings with it challenging issues and the need to make difficult decisions. The way that targets have been achieved has not always been acceptable. There has been a preoccupation with the measurable whilst ignoring clinical important issues. Eg the push to meet cancer targets results in funding for facilitators and clerical staff who monitor performance and chivvy clinicians. Sometimes this can be to the detriment of more clinically pressing cases that do not attract targets and associated funding. Improved funding for staff performing the work might be better for patients in the long term.”

15.31 He also said: *“Financial stringency has had a major effect on the NHS but it should be possible to run a patient centred and staff friendly organisation even in the face of limited budgets.”* That is surely the challenge for the NHS generally and NHSH in particular.

Economic and Resource Factors

15.32 To all this can be added more general economic circumstances: over the past ten years, in times of austerity, with budget restrictions and reduced spending, financial constraints can often lead to people feeling overwhelmed at work, with too much to do, and not enough time or resource. This is likely to cause stress and may lead to behaviour which is inappropriate.

15.33 I have heard a number of examples of this, with senior (and other) employees at breaking point. Where there is significant and increased pressure to perform throughout the organisation, this may have taken precedence over people issues.

“Austerity has been a major factor. The NHS was used to solutions made out of additional investment from Government. When this became no longer possible the pressure within the entire NHS system increased.”

“These are coming with cuts being made to resources, staff being asked to do more beyond their accountability, experienced staff leaving, newer staff not realising that being stressed at your work was not always a feature, managers becoming process led...”

15.34 The impact on staff morale and the lack of acknowledgment was recorded in these terms:

“I perceive a lack of interest and understanding on behalf of the health board in the day to day experience of staff and patients. I hear many staff expressing the view that their work is not appreciated by the organisation; the organisation does not understand the pressures they are under and does not recognise the impact on patient care. I see good people trying their hardest to provide high quality care in very difficult circumstances with ever fewer resources. We all recognise that resources are very limited and there is no spare money but given the reduction in resource which I have experienced in my own specialty and is mirrored in many other areas, the pressure from the organisation to not only continue with the same level of service, but to increase service provision creates a sense of

inevitable failure. Never being able to achieve the standard of care aspired to, leads to low morale and this is manifest in the increasing levels of staff stress and sickness.”

15.35 Ironically, the resulting breakdown in relationships may well lead to behaviour which is experienced as bullying:

“There are also the inevitable financial pressures. Currently we are several members of staff down due to problems with recruitment. The perception is that senior management are only interested in saving money and are happy to let the remaining staff pick up the work. This again leads to a general perception that this is not a caring and supportive organisation. In this atmosphere unpopular decisions or inability to progress can be viewed as uncaring and bullying.”

15.36 The resulting disconnect was further highlighted in this observation about the impact on front line staff from a team leader who emphasised his understanding of the need for tough decisions and innovative thinking to produce a sustainable and cost-effective service:

“Within NHS Highland and particularly in Argyll and Bute the message coming from senior management has changed as the financial savings targets have increased. The message of changing services to save money but maintaining quality has subtly changed over the past few years so that frontline staff now hear only ‘save money’ with decisions made arbitrarily and opportunistically which clearly do not fit with the Highland Quality Approach - wholesale cuts to services for more vulnerable patient groups such as mental health are becoming more common. Concerns raised about such cuts are deflected with assurances that services have simply been ‘redesigned’. The lack of openness and denial that services have been cut without significant consultation or risk assessment is contributing to the disconnect between staff and senior managers and leaving the staff feeling that cost saving is the only priority of the Health and Social Care Partnership in Argyll and Bute. This disconnect has been highlighted in iMatters staff questionnaires over the past two years.”

- 15.37 He goes on to capture the impact of all of this on perceptions of the leadership and loss of compassion and understanding:

“Overall, morale among frontline staff is pretty low and although not a typical picture of ‘bullying’ there seems to be a drift towards an oppressive approach to management as the financial savings appear more and more unachievable. Recent managers job descriptions have included phrases like ‘manage conflict with assertive responses’ and ‘assert self in contentious issues’ which seems to support the idea that leadership only involves showing strength, excluding compassion and understanding as important aspects of leadership.”

- 15.38 A consultant wrote to me in these terms about the impact on service managers who are caught in the middle:

“The most vulnerable amongst us, as a group, are our service managers. The ... department where I have worked now for [a number of] years has had [a number of] service managers, most of them bearing a load of multiple services to manage and being buffeted by our clinical demands from below and financial pressures from above. In my mind, the demand to balance books while ensuring quality comes from the government and is the driver of this bullying culture. Whilst the government may not mean to do so, this is how it comes across.”

- 15.39 A senior consultant reflected a more general frustration with indecision and a poor leadership model:

“...there are frustrations whenever new funding is required. There appears to be a culture amongst some decision makers that they neither say no this is not possible or yes we can achieve this. Instead you find indecision as a way of managing budgets. This means you continue to work up ideas and chase funding over and over again without much luck. This is at best frustrating and can create a deep sense of frustration.

I know there are areas where we are wasting money but nobody really wants to release time to make significant change happen, certainly not at a medical level. Instead unappealing clinical

leadership jobs are designed where failure, or at least limited achievement, is almost guaranteed. This is particularly in the medical directorate, there are individuals who work hard and have achieved a lot but I’m certain that this is due to their individual resourcefulness and not driven by structured clinical leadership model.”

- 15.40 Of course, all of these factors can contribute to behaviour which becomes generally unacceptable, especially when in combination or accumulative. One director observed:

“As a senior leader I have felt bullied and harassed by the organisation, by the Scottish Government. What I do believe is that in the NHS now people are feeling so pressurised. It’s a horrible environment. It’s targets. It’s finance. It’s political. Populist policies but don’t have the resources to fill them. NHS is just one health board of many that are suffering.”

Clinical Governance and Quality Improvement

- 15.41 It has been suggested to me that there is something to be said about clinical governance and quality improvement when these are carried out as technical skill sets rather than as an adaptive leadership activity. An example would be the way incidents are recorded and episodes of care – or deaths – are investigated with the aim of learning and improvement. If there is a focus on criticising people rather than on the systems that give rise to individual actions, there can be an unsafe outcome. That may occur if clarity of accountability and psychological safety is neglected and activities are perceived to have a blame culture at their centre. This is perhaps another example of the transactional trumping the relational.

- 15.42 A consultant put it this way:

“There is a need for NHS Highland to shift from a person-centred approach to a systems based approach to risk... Recent thinking³⁵ (Reason 2000) highlights that ‘patient safety cannot be improved by focussing only on the ‘person approach’ with ‘active failures’ of the individual practitioner such as forgetfulness, inattention, carelessness and focussing on reducing variability in human behaviour through

35 Reason, J. Human error: models and management. BMJ. 2000; 768-70.

fear, disciplinary measures, threat of litigation, naming blaming and shaming. By focussing on only persons, the unsafe act of the individual is uncoupled from the systems context.”

Other General Factors

15.43 There are other regional and national influences mentioned to me which are beyond scope of this report, such as the no redundancy policy and the number of, and variation in, health boards and support services and the variable degrees of collaboration among them. Concerns were expressed about the amount of time and money invested in the supporting infrastructure.

16. Possible Causes: NHH and the Highlands

Geography and Scale

- 16.1 As I mention above, there are also factors which are likely to be unique or specific to NHH. I explore some of these in this chapter, starting with geography. The area covered by NHH is a vast one and very diverse (41% of the land mass of Scotland; possibly the largest area covered by any health body in the UK?).
- 16.2 A senior employee commented on “a service under pressure”:
- “There is no doubt that NHS Highland feels like a Board under great pressure to achieve a balance between acceptable quality, performance and financial outcomes across a large area. It is neither a large but geographically contained Board nor a small island Board and is a difficult challenge to achieve satisfactory outcomes for all populations across all three of those domains. It is my view that as a consequence staff, patients and the public are left feeling dissatisfied with what is achieved/not achieved. That is expressed by the public in their dissatisfaction and mistrust with the way services could be restructured for the better eg in Skye and Caithness. Inevitably this has an impact on staff in both remote and central services.”
- 16.3 To this he added observations about “a workforce under pressure”:
- “Trying to keep up with larger boards whilst operating across the geography of a rural Board is a significant challenge. The economies of scale available in a large Board to do work do not exist, which when added to travel across distance places significant pressure on staff/services both clinically and managerially. That said NHH has a dedicated and innovative workforce that in my view is committed to providing the best service it can for each and every patient.”
- 16.4 The national and political context in which NHH sits is reflected here:
- “Any actions by NHS Highland Management have to be seen in the context of the national picture, with huge pressures on both primary and secondary care, some the result of fiscal pressures but many resulting from workforce

shortages. All Boards face these pressures but it is clear that the further north the Board, the more significant the workforce pressures become. Over time, these pressures have increased. In NHS Highland, the pressures of sustaining the service to remote geographical locations have not been helped by party political pressures as well as the pressures from politicians who have remote constituencies. There is an impression that these pressures, and what some might describe as a bullying culture, start in Edinburgh and perhaps the way that chief executives are treated by their superiors gives some of them a comfort zone in dealing with their subordinates in a similar manner.”

- 16.5 A team lead in a more rural setting said this about the adverse effect of location:
- “At the highest level we have a government which is advocating financial prudence and value for money and rightly so; however there is no allowance made to rural health and social care boards for the higher cost per person in delivering these services. This immediately places a relatively greater financial burden on rural health boards and their senior management team. Rural areas are also struggling to attract clinical staff adding additional costs to already stretched budgets. I do realise that city and urban health services are struggling too but wanted to highlight the additional burden NHS Highland has in comparison.”
- 16.6 The effect on communication may be marked:
- “However, perhaps NHS Highland faces additional challenges with staff spread across such a large area counting against face to face communication and visibility, certainly at board level.”

The Highlands

- 16.7 The following further factors have been suggested to me:
- NHH is the largest employer in the region
 - the relative insularity of the organisation geographically and culturally as distinct from other organisations

- there is no alternative NHS body in the area to which disaffected or unhappy employees can transfer – *“leaving is not an option”; “being a monopoly employer in the area prevents staff finding easy employment elsewhere”*
 - there is little opportunity for career progression, so people are very protective of their position and tend to hang on to their jobs for a long time: as a result, norms develop which can allow ‘the unacceptable to become idiosyncratic’
 - lots of promotions are due to reorganisation and posts are not advertised externally where better candidates could possibly be found
 - it may not be so easy to attract staff from elsewhere; there is a smaller pool of potential staff and some may be over-promoted
 - lack of leadership development and management training means it is “dead man’s shoes” – even if they have aspirations, *“people are sitting and hitting their head off a brick wall. Little things become more important and have more currency, as does history.”*
 - staff are often related to one another and conflicts of interest can arise
 - people tend to live and work in the area (and even one department) for many years and are committed to it culturally, socially and economically so that the workplace can assume great importance as a community
 - preservation of jobs, livelihoods and status in the community is very important at many levels
 - communities are smaller and more tightly knit, people know each other, memories linger, trust may be harder to build; conversely, the fact that everyone knows everyone can be a positive – bringing more closeness and understanding rather than anonymity
 - NHSH staff, especially doctors, are very visible in communities and influential in how they represent NHSH: a “goldfish bowl” as it has been described
 - there is a “*culture of silence*”; in the Highlands, folk are more reticent about coming forward; ironically, it’s also *“very gossipy and if you don’t join in you are seen as an outsider”*
 - there are stronger religious affiliations than in other parts of Scotland
 - there may be tensions between those who stay and those who leave - and those who are perceived as “incomers” with a different view of the NHS from those who are local
 - NHSH can be viewed by some as a modern institution, different from “the Highland way”
 - there have been big population changes in recent years: Inverness is apparently one of the fastest growing cities in Europe
 - Raigmore is a disproportionately large, somewhat anonymous, even oppressive, facility and attracts news stories
- 16.8 One person summed it up as follows:
- “There’s a thing about Highland, it’s not like the Central Belt. When people get good jobs, they tend to stay in them for a long time. There are a lot of individuals who have been in roles for a long time. Our recruitment process is that we can’t replace people. There’s a worldwide shortage. When you’re competing with the Central Belt and the opportunities there, it’s difficult. People come here for a lifestyle choice. They see potential in our HQA and links to the university. But I think that whole dynamic is an issue.”*
- ### Many Positives
- 16.9 At the same time, I am told that high-quality people are attracted to NHSH and often come to the Highlands because they want to live and work there. I understand that Inverness has been ranked very highly for its quality of life and has been described as the happiest place in Scotland.
- “When friends and family ask me what is it like working in the Highlands? I invariably reply – “It’s like being on holiday but going to work through the day”. I really like living and working here.”*
- 16.10 For some, uniqueness works well:
- “Across NHS Highland, notwithstanding some of the complexities I have described, the vast majority of working relationships are really positive. My experience is there is much mutual goodwill, respect and commitment across the whole board area, and would suggest there is much that is uniquely positive in NHS Highland.”*

- 16.11 As ever, there is a need for balance and an encouraging view comes from another senior consultant:
- “I would like to highlight some of the others positives of working here. Since August we have been working on NHS Highland based senior medical training, this is mushrooming with many trainees keen to stay in Inverness due to the clinical experience, teaching experience and opportunities here in Highland. We have increasing strengths in research and development and the introduction of new undergraduate curriculums all of which have been positively received.”

Insiders and Outsiders?

- 16.12 Diversity of origin seems to be an issue:
- “Differences even between Scottish staff, eg Highlanders and Lowlanders, East coast and West coast. Inherent nature of Highlanders (to feel put upon, taken advantage of good nature and gentle ways) ousted by others (Highland clearances and now ‘incomers’ buying up property, changing the community dynamics). The sense of being ‘taken over’, ‘outsiders can do it better’.”
- “Been thought of as slow and stupid.” “Lack of respect for the locals.”
- “These issues are not being raised for fear of being seen as racist, prejudiced, unwelcoming. ‘Need to be careful when you ask where someone is from’.”
- 16.13 These remarks capture the impact of behaviour regarding “out of area” staff:
- “Although the publicity so far appears to concentrate on bullying coming from senior staff one must also be aware that there is another form of bullying which has a detrimental knock on effect right across the Organisation. Although there are many good and kind staff working within NHS Highland they are afraid to speak up against a small portion of staff who were not only resistant to change but disliked/resented any staff who came in from out-with the area particularly if placed in a more senior role. If their behaviour was challenged they became offensive, intimidating or made claims of bullying, therefore creating a situation in which the person they accused would lack credibility if they tried to defend themselves or made their own complaints.”

- 16.14 Some of this has to do with language:
- “Misunderstandings in language, the way people talk, phraseology, terminology, manners. Misconstrued as being ‘bossy’ or arrogant just by different mannerisms and ways of speaking.”
- ‘Lots of different accents’, ‘hard to find someone local’. ‘Quite a few ‘foreigners’ from different cultures and religions’.
- “Communication issues, misunderstandings in ways people speak, their delivery might sound angry or rude, but is just the way they talk. Highlanders tend to be soft spoken, polite, sometimes speak slowly, can sound laidback.”

Communication

- 16.15 As ever, many issues come down to communication within and throughout NHSH. As one member of staff observed:
- “Communication with staff tends to be on a need to know basis. Changes made tend to be done with little consultation and an expectation that they will not be questioned even if problems are experienced by staff or patients with the changes. It appears that questioning decisions even if it’s just to gain information is seen as disrespectful and reacted to badly. Simple things like changes to tone of voice, a certain way of answering etc gives the impression to staff that they are being scolded and there is a definite treatment of staff that mimics a parent child type relationship. This authoritarian way of dealing with people is certainly not the way most adults want to be treated at work.”
- 16.16 As one respondent suggested, NHSH would benefit from having a clear direction and momentum, strong clinical engagement and financial realism which comes from more effective organisation-wide communication. I am told by others that communications systems are not “fit for purpose”; that all user emails do not reach (some) GPs, electronic communications and newsletters are not read and digested appropriately and “verbal cascade is patchy”.
- 16.17 A senior nurse observed:
- “Senior management wouldn’t be known by my staff if they tripped over them in the corridor. They are not physically present. Things being done to you and not with you. That’s what I mean by communication issue.”

Rural Communities

- 16.18 As noted above, the geographic element has its impact in rural areas. Generally, I heard a number of reports of people in small rural communities being affected by the behaviours of management both locally and centrally. There is a feeling that communities themselves have felt bullied because of promises made and not kept, giving a feeling of being lied to and deceived. Although the evidence is variable, there is a tangible sense that some rural communities feel undervalued and let down by “the centre”.
- 16.19 Poor communication and lack of appreciation/awareness by the centre, in this case “those folk in Inverness”, seems to be a theme. One senior manager commented: *“There’s quite a distance. And we’re only five minute’s walk away. How must it feel for someone living in Ullapool who must feel very disconnected.”* It was pointed out that urban health care solutions may not work in rural locations.
- 16.20 The divergence between Inverness and the surrounding area and the more distant rural communities can seem marked:
“Inverness and the Inner Moray Firth have been transformed in the last twenty years while the outer remoter geographies remain the more vulnerable due to loss of industry, vulnerable rural economies and a changing demography. This can make the design and delivery of services uniquely challenging, particularly when we take the importance of place to the communities we provide services to.”
- 16.21 This from one very rural GP reflects a view I heard on a number of occasions from people who feel on the periphery:
“I am afraid that after the false promises and time that has passed, I do not trust NHS Highland management.” “The truth has been twisted throughout this time and I have been badly treated by NHS Highland. I feel as though I have been led on by NHS management, but ultimately they have turned round and kicked me in the teeth.”
- 16.22 Another GP practice in a remote area (salaried PMS) spoke of a letter informing them of a large cut in budget coming *“with no warning, no personable covering letter and made no allowance*

for our circumstances”. They were told to submit a practice plan of how this would be achieved, which they did but subsequently some seven months later, they eventually

“received a copy of a rather meaningless letter ...which basically said that we didn’t need to bother after all that! We did not even get a letter addressed to us. This second-hand response in no way acknowledged the stress, worry and work that the original letter had caused us and by not even writing to us directly is treating us with contempt. We feel that this was intimidation on the part of NHS trying to squeeze money from our Practice as a soft and easy target. There was no discussion with us but a complete lack of understanding of our situation and a woeful lack of sensible or respectful communication or indeed any communication to our original plan that we had submitted.”

- 16.23 It is well known in the Highlands that communities far removed from Inverness can feel isolated. It takes hard work to acknowledge that fact and provide the necessary recognition and reassurance.

Social Care

- 16.24 I note also the effect of the integration of social care which is unique to NHS. It appears that the integration of social care has been a particular factor of concern.
- 16.25 One respondent opined:
“Adult social care was a glass bowl from Highland Council to NHS. It shattered, we cannot pick up the pieces...I would say the bowl being smashed has put an enormous burden on an already overburdened system.”
- 16.26 Whatever metaphor is used, it certainly seems to be the case that integration has placed significant strains on an already stretched organisation and at a time of reducing resources.
- 16.27 There seems to have been and may still be significant misalignment between expectations within NHS and Highland Council over social care, at least in some areas.

“Being managed by someone that does not know or understand job role, comes from a different background. Most obvious when Social care and Health care joined forces.” “This profession has

had a bit of a hard time with managers put in due to integration, who do not understand the profession.”

This aspect is beyond the scope of this review but may be important to address.

Importation of Ideas from Virginia Mason Hospital in Seattle

- 16.28 I heard comments about the appropriateness, effectiveness and transferability of management ideas from the United States. I am not able to comment specifically but wonder to what extent the importation of ideas from one culture to another may have had an impact on NHS's ability to deal with some of its local issues.
- 16.29 The impact may be marked: one senior consultant commented:
- “NHS has followed the ethos of the Virginia Mason unit in the USA. Our managers have visited Seattle many times, as recently as November 2018 at significant cost to NHS. Forming a large part of the Highland Quality Approach, success in Seattle followed confrontation with clinical staff and the active reduction in engagement of clinical staff in hospital management. NHS has followed this trend and reduced the influence of working clinicians in decision making. Individuals with an alternative viewpoint are marginalised and ostracised and have no recourse to the decision-making apparatus. This has been a management tactic ...”
- 16.30 It is easy for the enthusiasm for a new idea to prevail over the discernment needed to apply it in a way which takes account of local conditions and of changing priorities and pressures. Indeed, having committed to it, with substantial sums of money having been spent and with saving face a possible issue for the proponents, there may have been resistance to challenge on, and review of, these matters. If so, and in any event, it may place in context some at least of what has occurred.

Highland Quality Improvement

- 16.31 Related to this, it seems that those responsible for programmes to enhance staff and team performance experienced the cognitive dissonance of promoting values and beliefs which were not being implemented in practice

by the very people who were supposed to be leading on them. I was told there was emphasis on implementing policies but without empathy, honesty or openness.

- 16.32 It has been pointed out that there may have been over-reliance on the technical aspects of improvement without the focus on creating the culture and conditions for quality and safety to flourish at the frontline. Quality improvement would be seen as a method that can be used at board level rather than as a method that required distributed leadership and clinical/managerial engagement in owning the services.
- 16.33 This is reinforced in this comment:
- “There was no time for leadership from senior staff, who were too busy with day-to-day staffing and admin issues, strategic planning and meetings, and did not work with or understand the Band 5 staff's individual roles. Consequently initiatives such as QI were poorly understood on the floor, people, morale was low, and the stronger personalities were allowed to ignore processes that they did not like.”
- 16.34 I was told that:
- “The rhetoric within the Highland Quality Approach was merely that - we ticked boxes and encouraged a chosen few to pursue ambitions which often left them burnt out because of too great expectations placed on them.”
- 16.35 A director expressed this view:
- “Over-emphasis in past 5 years on financial targets dressed up as quality improvement. This message hasn't worked and has in fact created distrust.”
- 16.36 That said, there are mixed views (“Some love it, some hate it”) and perhaps there is still real potential under thoughtful leadership.

Collective Trauma?

- 16.37 I was interested to note that, during my review, the media reported on a research paper which was published by NHS which apparently attributed some health problems in the area to the inter-generational impact of the Highland Clearances. Whether that is a factor which would be relevant to this review is beyond its scope, but the very existence of such a view does

highlight the fact that there are unique aspects to this part of the world, some of which are not easy to speak about. Indeed, as I conducted my review, I became aware of the importance of research on epigenetic, transgenerational implications of trauma and its aftermath. I explore the issue of trauma further later in this report.

Some Specific Observations about NHSH

16.38 That NHSH is marked out as different is underscored in the following remarks, which tend to corroborate and expand upon some of the factors above, from a member of staff who has experience of working elsewhere in the NHS. Again, this reflects views which appear to be fairly widely held among those who engaged with the review. This employee feels that *“there are some stark differences in NHS Highland and the culture, specifically with regards to the management of staff.”* In outline, these are as follows:

- “NHS Highland has a very insular feeling to it. Everyone knows everyone else, they have a history or are friends. This is made clear to staff. This means that should you have a problem or worry about a situation with your manager then you feel like there is no one else to go to. If you speak to someone senior, then this would be raised with the manager and discussed in what I would call an ‘unprofessional manner’. By this I mean it becomes a personal attack on the person rather than a professional discussion about an issue.
- This leads me to my next issue, a lack of confidentiality between managers and staff. I will use an example I have witnessed to explain. The individual had applied for a job and informed his/her manager as per the usual process when looking at changing positions. However, the individual was congratulated on getting the ‘new job’ by another member of staff the same day, interviews had not even taken place. It was a case of this individual’s situation being discussed outside their confidential meeting with someone else. Though not related to bullying this has now created the feeling that information shared with managers is not confidential. This has broken the trust between staff and managers and made individuals feel as though they cannot speak openly to their manager for fear of who else this may be shared with. This creates isolation and leads to people keeping quiet about many things for fear of how this will be handled.
- Gossip – I have heard managers gossiping about other staff, passing what I would call derogatory comments and making their feeling of dislike for the staff quite clear. I also relate this to the point above, staff’s private situations and discussed with other staff members who are their ‘friends’. A level of gossip and chatter amongst staff, especially junior staff is common, and when working in close quarters you are inevitably going to overhear things you would rather not or shouldn’t hear. However, when these come from managers and staff are seeing managers gossiping, it creates a culture that this is unacceptable.
- Discrimination - I feel that processes/ policies are implemented for certain staff when they feel the need, but this is not uniform across all staff. I have witnessed in certain situations staff are asked to take annual leave whereas others are offered compassionate or special leave, sickness policy implemented with some staff and not others despite these staff having significant sickness. This inequality between staff leads to low morale and bad feeling between staff. This feeds into the gossiping and that circle is continued.
- Lack of support – generally my feeling is that there is a lack of support for staff. There often seems to be a lack of management in office, a lot of staff complain about a lack of induction and this creates problems going forward, it also makes staff feel ‘neglected’ and unsupported. Staff needs in terms of supervision is limited and supporting staff development and growth is not a focus of management. There is a lack of career development and minimal support for staff in seeking these opportunities.
- Communication is poor at all levels. Concerns that are raised never seem to be fully appraised and what I would call ‘placating emails’ are sent to try keep staff happy for the interim. This makes challenging issues difficult as you have followed process and nothing has changed or been actioned, a dead end is reached.”

16.39 A well-informed respondent offered these views about some of the causes:

- “There is a clear disconnect between the top of the organisation and the service delivery parts of the organisation.
- Lack of clear direction for departments, with lack of clarity about budgets and resource constraints

- There is no clinical strategy. This translates further down the organisation as a lack of clarity about what NHS Highland should or shouldn't do, will or won't provide.
- There is a weak clinical voice at the top of the organisation.
- Reactive approach to issues is commoner than pro-active; this starts at the top and is replicated down through all of the organisation
- Crisis management causes an increase in likelihood of interpersonal conflict or bullying.
- Lack of ownership at department level of issues/problems/challenges.
- Ineffective or under-effective organisational meetings structures, and people attending them do not properly represent or participate, people attend unprepared and uninformed.
- Behaviours. Many people do not behave well in meetings. This applies across the board. The underlying cause of this is a mix of personal conduct, poor chairing and a lack of defined proper behaviours.
- Managers are given responsibility for department performance even though it is invariably clinical outcomes which are being measured.
- Learned helplessness of clinicians at all levels but most importantly at senior level.
- Incomplete leadership structures in hospital plus vacant management posts, high manager turnover, eclectic/odd management portfolios."

Contrasts with Other NHS Bodies

16.40 Finally, the view that the experience in NESH is different from elsewhere is reinforced by others:

"Appalling, environment toxic, people could do what they wanted, disjointed, so unlike other NHS bodies, much worse, no collaboration..."

"I now work for [another NHS body in Scotland]. I am confident that if these behaviours occurred there they would be called out for what they are and would be managed."

"I have observed the management culture within Highland and contributed to quality management reviews in Boards throughout Scotland... This experience tells me that while NHS Highland may not be alone in having problems of morale, the gulf between

management and clinicians within the Board is deeper and wider than I have seen elsewhere in Scotland."

"I have faced stressed/upset/angry/depressed colleagues throughout my career, both as a registrar and in my current post amongst more senior physicians. But in the Highlands, and only there, did I see many of them slowly change over the years. Their posture changed and they developed this shell shocked, wide-eyed look about them and clearly didn't know which way to turn anymore."

16.41 The problem was summed up by one NESH employee in a rural area with personal experience both of bullying and unsatisfactory treatment for a family member:

"With all the bullying allegations, recruitment problems, stress and pressure on staff within NHS Highland one has to wonder if the shortage of staff and ridiculous waiting times within some departments are a consequence of these long term problems within NHS Highland and is due to the style of management and an inadequate board who are unwilling to listen or adapt. Potential new staff will not apply or accept a post within a region with a poor reputation and bad treatment of staff. Word of mouth is very powerful in more rural areas."

16.42 A full time official for one of the Trade Unions wrote to me about his experiences of NESH:

"On a general point I do sigh when I hear that a member has a problem within NHS Highland as I know it will be a long tortuous process. There is clear evidence of unnecessary delays in any investigation process and with issues around bullying and harassment it means that, regardless of any outcome, the professional working relationship is beyond repair. Highland does have a raft of policies the same as any other Health Board, however it is a continuous fight with management and HR to actually follow these policies. In particular timescales are drawn out whereby investigations take place 9 months after allegations of bullying have been submitted in writing, no one is trained on a particular policy (Gender based Violence), members do not hear about a complaint that has been lodged

4 months prior, contact with managers and HR are ignored and often members and myself are passed from one person to another and even then the answer that comes back is inconclusive. This always leads to an escalation and lack of faith in the Board to deal with anything....

He concludes:

“In my role, I cover the whole of Scotland for the last 17 years, I have had to deal with more allegations of bullying and harassment in NHS Highland than all the other health boards put together.”

16.43 I pick up the themes of the management, board and HR in subsequent chapters.

Last Word?

16.44 On the peculiarities of NHHH, this was offered as a summing up:

“I love living in the Highlands and have enjoyed working for NHS Highland, however it is struggling both financially and staffing wise. In all areas, ageing staff are retiring, recruitment is difficult and remaining staff are struggling to deliver a service with fewer resources. People become stressed and frustrated so it’s easy to see why these allegations come about.”

16.45 For those who wish to look forward and rejuvenate the organisation and enable its staff to flourish, these words should not be a conclusion but a challenge to change things for the better.

17. NHSH as a Dysfunctional Family

- 17.1 One senior member of staff described the situation eloquently with a family allegory which I am authorised to share:

“I would describe the current leadership crisis in NHS Highland to that of a dysfunctional and distressed family. The adults (Executive team) over the years were often distracted by the acquisition of wealth (operational area/budget/staff or professional group represented) and status (Highland Quality Approach). The parenting style is in the main, chaotic disinterested in the children (staff) and authoritarian as required. The extended family of aunts and uncles (non-executives) are variously concerned and troubled by the behaviours of the parents but lack the confidence to challenge, it is easier to acquiesce, recalling what happened to some who previously raised concerns and who chose to leave.

The various children (staff) serve a purpose when they meet the needs of the parents, particularly when they do this without challenge, even if this involves ignoring the dysfunction and power play. While the older children (senior managers) are left to manage the day to day of the little ones and if they do harm no one is really that interested, just so long as the needs of the parents are met. Sibling (staff) pressures and relationship challenges are not well understood or well managed. The more vulnerable or smaller children have been known to come to harm. No one is really that interested, as long as no one outside the family gets involved. No one looks for this, as there are likely to be consequences. A child every so often might be picked for special attention, particularly if they are attractive in some way to the parents. They might be given special opportunities and privileges, unless they cross the parents in which case they can fall from favour. This can be a very unpleasant and isolating experience. Some leave, others find a place to work at a distance from the parents, out of sight and mind.

The parents at times, can overstep the mark with inappropriate parenting styles that can leave some of the children in day to day contact with them really quite vulnerable (administrative and clerical staff). No one takes action to address these indiscretions and those affected have small voices and no power. Some manage to get away,

others stay and somehow get by, but at a cost to their wellbeing. Few seem to notice or care about this.

No one is really interested in naming or addressing these issues. Even when there are family meetings that children are fearful or anxious about attending, because they do not want to be ritually humiliated, or left exposed by the parents if they have not met their needs in the moment: too complex and risky because some of the parents will not allow or tolerate dissent. Somewhere / somehow, the parents with less influence are distracted and caught up with meeting the more important needs of the more powerful. They can be vulnerable and needy, even tearful at times, especially when the pressures of parenting a large family become too much.

The wider family (Scottish Government) might, or might not, be aware of some of the difficulties/challenges in the family. They might have tried to intervene, offer some relationship support, however they have found it is easier and safer to appease rather than follow through with more formal measures. The consequences of following through are seen to be too risky and too great for the wider reputation of the family at large. Some personality/relationship dynamics do not lend themselves to mediation, which requires a willingness, capacity and a mutual desire to understand and redress harms done. For some, this is just too threatening or exposing to entertain and those involved are made subtly, or not so, aware that if this is required there will be a price to pay.”

- 17.2 Again, the challenge is to change the setting, the relationships and the responses so that the family begins to function again in a psychologically and otherwise mature and safe way. Some of the issues which arise are covered in the next chapter on management roles and behaviours.

18. Management Roles and Behaviours

Introduction

18.1 I have found this and the following chapters among the most difficult to write as so much of what I heard in my review focussed on perceptions of inadequacies in management throughout the organisation. I am sure that there are many sides to this and, while I seek to capture some of these here, I am equally sure that those better informed than I am will be able to identify other aspects to this and indeed point to misunderstandings on my part. So be it. This is a contribution to be built on.

18.2 I have sought to identify specific areas in connection with which concerns have been expressed and where many managers and others have felt unable confidently to carry out their duties. The views expressed here also help to explain why the concerns about bullying have become so prevalent.

18.3 At the outset, I am concerned that many of the difficulties experienced in recent years in NHS are said to be attributable to a management style which has not been effective in the challenging circumstances of the modern NHS. This poignant summary captures much of what I have heard about the management of NHS:

“I’ve just left a meeting where a colleague I hold in considerable regard has effectively collapsed as the ineffective organisation and culture in the ... management team leaves him vulnerable to a colleague who can only ‘react out’ rather than face their weaknesses. This person already has an unresolved staff issue with a team member off work ... because of ineffective systems to manage them out of the service. He now faces another charge of bullying that is unlikely to stand scrutiny.

This is what plays out in real time when systems... are managed by people who lack the insight and perspective to manage well. In effect, a collective failure of both leadership and management. Where individuals who are unable to deliver the tasks required of their role are chronically undermanaged because they create fear and

confusion for their managers. They perpetuate harm on others as the only way they can stay ‘safe’ is to ‘kick back.’ It becomes a tangled mess of chaotic if not bullying behaviour, culture and practice with judgements of Solomon required to make sense of it.

I do not think it unreasonable for civil servants, senior managers and directors to be able to demonstrate such awareness, skill and competence in managing these scenarios.

It bothers me to watch these situations play out in full sight with an organisational culture of inertia as to how to respond. Something needs to fundamentally shift for NHS Highland to move on. We diminish service delivery and perpetuate harm on the majority when a minority in positions of power and limited awareness (insight, integrity, perspective, compassion, empathy) hold sway.”

These are telling words. I explore aspects of this “fundamental shift” in a chapter on leadership in the final section of this report. Meantime, I explore further perceptions of the current situation in this chapter.

18.4 More simply, perhaps, one specialist in Raigmore Hospital emphasised that poor management rather than bullying itself may be a significant cause of the present situation:

“The greatest issues which have been expressed to me by colleagues in medicine in Raigmore Hospital...is of poor management of bullying, and staff not being listened to. I think the consequences of poor management may well outweigh the distress caused by the initial bad behaviour....staff feel they have concerns and these are not registered or understood. This could be because the options which they wish to follow are not achievable or are unrealistic, but without documented reason, and/or registering of the decision, individuals seem to feel disempowered and undervalued. This then affects teamwork and morale. I do not think this is an intentional policy, but may to some degree be a cultural or historical issue.”

Concern about Senior Management

- 18.5 I need to record that a significant number of respondents expressed concerns about the role of senior management and its ability to recognise and address the issues which have arisen in connection with inappropriate behaviour in recent years. Some senior managers are viewed with suspicion and resentment. I have had concerns expressed to me about a number of the director level executives and their ability to function coherently, individually and collectively.
- 18.6 I do not go into detail but I am told that many people feel that, unless there are changes at that level, much of what has been occurring will continue. That may be associated with a view that executives *“are not visible, rarely at the coal face. Who are they? Disconnect, not understand, done to not with”*. “Done to, not with” is a telling remark. It signifies the feelings of a large number of those who responded to the review.
- 18.7 A commonly held view is expressed thus:
“Many believe the senior medical leadership are complicit in the development and maintenance of the ongoing issue of bullying within NHS Highland and it is perhaps inappropriate for them to be leading on the restorative work that will be so very necessary going forward.”
- 18.8 I comment further on this in my proposals for the future. Clearly, a demonstrable change in leadership is necessary and has, of course, already begun.
- 18.9 An employee in a rural community commented on the perception that this is a pervasive tendency:
“NHS Highland management were more than aware of multiple policy failures and continual breaches of them. They allowed for multiple staff member(s) to repeat the same as the staff member(s) before. NHS Highland management themselves became bullies and harassers by isolating me and by covering up the bullying and harassment that I was subjected to for so long. They have tried to cover everything that had happened up and tried to encourage me to just forget all about it. This was not limited to just the .. original bullies/harassers named in grievance one, but by all the management involved, right up to senior management; I was passed around from pillar to post, told conflicting and contradicting information each and every time.
- It has all been a horrific nightmare and sadly I don't believe I am the only staff member in which has been subjected to this kind of behaviour.”*
- To be clear, I offer this view not for its factual accuracy but for the perception it expresses, in the hope that doing so will help in the healing process going forward.
- 18.10 Describing intimidation, fear and reprisal against NHS staff in a number of settings, a GP told me (prior to recent senior changes):
“I fear that unless those few individuals in Senior management are called to task over their behaviour and leave their posts that nothing will change. The fact that until recently they denied there even was a problem but are now wanting to meet together to improve things fills me with despair that by pretending to work together to solve the problem they will be seen in a different light.”
- 18.11 Perception is so important as I discussed earlier in this report. Making a few superficial changes is unlikely to be sufficient to restore confidence.
- 18.12 One director astutely summarised the position:
“If I managed people the way I'm managed then we'd be in a lot of trouble.”
- 18.13 An experienced team leader wrote in these terms:
“Within the HSCP we have a few senior managers who have what could be described as an autocratic approach to management, I have personally been in meetings where there has been an audible gasp from the room when someone has challenged ideas put forward by certain senior managers. Some seem to revel in their public image as cold and ruthless managers which negates any ‘open door’ policy they may profess to have. There also seems to be a lack of clear strategic planning with many decisions being made hastily in response to the latest reports of potential quick fix solutions. As a result, the overall image of senior management from the clinical staff is one of ruthless determination to make saving at any cost.”
- 18.14 Autocratic, fearful to challenge, ruthlessness, lack of strategy, undue haste: these are all powerful images which reappear in later chapters. Further concerns and the effects are captured in the following paragraphs.

- 18.15 An occupational therapist described the situation in this way:
- “Although I do not feel bullied as an individual, I do have to engage with processes and systems which I find uncomfortable both ethically and professionally. Many systems and processes are being introduced which are not effective and have a detrimental effect on clients, service and staff. I personally feel that it is incompetent senior management and the lip service which is given to consultation and feedback from front line staff which is the problem. Senior management seem to devise systems which as well as not being effective, waste resources and staff retention and recruitment are a major issue.”
- 18.16 A long-standing clinician said:
- “... you should be aware that these issues have had a very significant detrimental effect on patient care and in my case have also impacted on my own health and personal life. I think there are two main problems at play here
1. Dysfunctional management structure, with very limited clinical input to board level.
 2. Behaviour and attitude of senior management.
- I think this combination has resulted in a disconnect between the front line staff and senior management leading to the former feeling disenfranchised and powerless at best. I have been a consultant here [for many years] and can honestly say how saddened I am by the current state of affairs.”
- 18.17 Another long-standing observer, this time a GP, described experiences and observations of mishandling of complaints in this way:
- “Perhaps the institutionalised incompetence and arrogance has led to a rise in bullying. As I said – I have never seen it. However, I have seen a progressive deterioration in what was once a great Board to work for, to a Board that does not care about its staff.”
- These words capture the underlying nature of many of the concerns about a deterioration in management and governance which many have experienced.
- 18.18 This from a now-departed consultant bears upon the bullying allegations:
- “To conclude, I believe that NHS Highland has a leadership culture which does not wish to hear views which differ from its own. It gives privileges to those who say what they want to hear and it is willing to allow people with hierarchical privilege to abuse their position. Lastly, the managers of NHS Highland do not know how to recognise or to address bullying when it occurs in the institution.”
- 18.19 The impact can be serious and the implications resonate with the findings in this review:
- “It is very hierarchical and senior management (above grade 8B) are always believed and supported. This leads junior staff to feel too scared to raise concerns. Any concerns are dealt with through a formal process of investigation, when a more informal conversation or approach could foster better relationships.
- There is reluctance to challenge or deal with people like x because it will take so much time, cause major disruption to senior management and would perhaps encourage more staff to make complaints, taking more time.
- This leads to people behaving like bystanders, almost glad that it’s not them or hoping that the situation will resolve itself.”
- 18.20 Some of these concerns are picked up elsewhere in this report; I am mindful for example that these points could equally arise in the earlier chapter addressing why people feel unable to raise concerns.
- 18.21 The problems with the management culture are summarised here:
- “I’ve worked for the NHS for [many] years now... Over the last 10 years, I’ve seen significant changes in the behaviour of senior management, some of the attitudes towards staff has been of a bullying nature. This ‘top down’ attitude has become more prevalent since HSCPs were established legally, I fully appreciate the financial pressure however that does not, nor should be an excuse for treating staff so appallingly. It’s almost become an accepted organisational culture, primarily because staff do not feel able or willing to challenge it.
- Staff morale everywhere is the lowest I’ve ever witnessed. I am aware of a few individual

members of staff who have spoken privately about being subject of inappropriate behaviour. Some have been close to submitting formal grievances however they have been worried about the ramifications of doing so to the extent they have either sought employment elsewhere or they just learn to tolerate it which does little to encourage people to perform effectively or indeed support their health & wellbeing. In one instance, a member of staff felt 'leaned on' to prevent a grievance being submitted.

This was quite a common tactic used by NHS management: they isolated one person to discuss an unpopular decision and then went silent until everyone involved simply gave up."

- 18.22 It is difficult not to conclude that a new "management culture" is essential if NHS is to thrive and the behaviours and effects experienced by many are to change.

The Medical Director

- 18.23 The role of Medical Director is clearly a pivotal one. As one respondent put it: *"...a Medical Director is a highest link and connecting position between medical colleagues and the Board."* It is a role which requires sensitivity, confidence and real leadership, and a combination of skills and aptitudes which are not necessarily easy to exhibit. It is necessary for me to say that a number of specific concerns were expressed by a number of respondents about the way in which the Medical Director has handled matters over a number of years. These were summed up by one respondent:

"If I had concerns, I could not take them to the Medical Director."

- 18.24 The role has not necessarily been an easy one; as ever there are differing views:

"He's extremely well motivated. He finds it very tough. He's been wilfully misrepresented. Deliberate traps set for him."

- 18.25 The Medical Director has intimated his intention to retire and I judge it unnecessary to go into these matters in further detail. Suffice it to say that, in later sections in this report on the future and leadership, I describe the attributes

of openness, engagement, listening, empathy and support that seem essential in the key management roles to take NHS forward into the future.

Middle Management

- 18.26 Just as the workings of senior management are a matter of regular commentary by those with whom I engaged, there was awareness of the challenges for those in middle management roles.

"I've always had the sense that something wasn't quite right. This comes through in comments made, awareness of staff turnover. Sense that middle management are given tasks to implement without any sense they can be listened to. Command and control approach."

- 18.27 A retired consultant said:

"Hospital managers have a difficult task. Several competent and conscientious managers have been forced out over the last 15 years. Medical staff often don't hear the details until much later. One technique employed in NHS is to create another tier of management and to hold the manager below you to account for failing to meet targets and so create a scapegoat."

- 18.28 One consultant, with many years working elsewhere in the NHS and who recognises issues in NHS to an extent that he has not previously experienced, told me:

"Middle-management (clinical and service) are not empowered to effect changes and defer to senior management on the majority of issues. When combined with a lack of senior management presence (clinical and service) this leads to a lack of transparency and a feeling of not being heard amongst consultant staff. Service Managers continue to be given unrealistically high workload and only have time for fire-fighting. Service manager illness rates appear to be high with the knock on effect of covering for missing colleagues significantly impacting the remaining managers' workload."

- 18.29 From a rural GP practice, the impression of top down, command and control is reinforced:

"Our experience over that last 15 years has been of a good deal of incompetence, and a great deal of lack of engagement from NHS managers

with us as a practice. We have not found that management see their role as enablers of clinical practice, but of reducing budgets and meeting targets. This has produced a very negative culture in which it has been difficult to thrive.

It is my opinion that the middle management of the NHS in Highland are in general underqualified for the work that they do, and that although in the main good people they lack the experience in management to provide effective support to clinical staff. This means that decision making is often deferred, that lines of communication are indistinct and that the organisation is very “upward looking” rather than responsive to the opinions of front line staff. There is a “top down, centrally driven” culture.”

- 18.30 The difficulties for local and middle managers were captured in this way by a director reflecting on a particular situation to illustrate a point:

“What respect does the clinician have for the local manager? They see them as administrators rather than managers. That poor local manager, who’s trying to do the best they can, has a group of staff they have little influence over. The dynamic we have is that now is that every manager who has been trying to manage doctors thinks “oh hell, I have no chance now”. Those middle-managers now feel completely disempowered. Anything they try to “force through” will be perceived as bullying.”.

- 18.31 Another respondent was concerned that I should make clear that the voice of these managers needs to be heard in the current discussions. This further comment reinforces that point:

“That group of people – service managers – not senior people but do an important job to keep things together and making it all happen. Some of the hardest working people in the organisation who are asked to put up with a lot. They don’t have a voice.”

Vulnerability of Managers

- 18.32 This leads on to the issue that a significant number of managers who engaged with the review reported operating in circumstances in which they feel unable to manage effectively because of the uncertainties and pressures presented by the current situation. There is a real concern that allegations of bullying can be used to avoid or deflect appropriate management of performance and other difficult issues.

- 18.33 I mentioned earlier that many managers feel that the situation places them in a vulnerable position as exemplified by these remarks:

“Because NHS Highland is currently in the position it is in, the stance feels along the lines that managers must be at fault and need to improve as opposed to supporting managers who find themselves wrongly accused. I feel that I am a very vulnerable position.”

- 18.34 Two senior managers expressed the anxiety of many managers that allegations of bullying serve to disempower them from carrying out their roles effectively:

“Managers and clinical/service leads within the NHS have a designated responsibility to keep others accountable for their work. If poor performance exists then one must address this as part of Clinical Governance. This would also apply to situations where there might be a lack of transparency about what a person is doing in their work – the leader or manager may need to ask questions to ascertain whether the working practices of that person need to be changed in some way.”

- 18.35 However:

“I am concerned that I and others will now be limited or defensive in the difficult and challenging context for [this department] in particular and health services generally in having appropriately assertive, adult and honest communication for fear of being accused of bullying.”

A Very Real Concern

- 18.36 Loss of confidence, disempowerment and distrust underline the linkage between cause and effect:

“I feel a significant amount of damage has been done and for those that are expected to provide leadership, support and application of organisational policies, there will I feel be a lack of confidence in the support that will be provided by the organisation where managers are applying policies and doing their best to manage difficult situations.

The biggest issue we are possibly left with as a result of the way in which this has been raised and handled is to rebuild a trusting and safe environment for staff to both work and manage in. We have significant risk and there has been a significant disempowering and shattering of confidence at senior manager and senior HR level in the organisation. This may add to the

current feeling of lack of direction which I think has caused the current situation.”

- 18.37 A senior management representative captured the vulnerability of, and danger for, senior managers in the exposure which is now occurring:

“My concern about the complaints made against senior managers at NHS Highland is that they are public, would appear to be designed to name and shame the senior managers, to stigmatise them publicly, cause division, and encourage blame. There is no opportunity for the employees both those named and those associated to take the issues levelled against them and discuss and resolve them in a fair, open and adult manner.

There are very many excellent dedicated senior managers within NHS Highland, past and present yet they have been attacked without chance to defend themselves. This behaviour is profoundly unfair and I would hope if you are able to make recommendations about the importance of following NHS Highland policies and raise concerns with dignity, integrity and a degree of confidentiality in the first instance. We are concerned that there has been a tendency to use the media to attack colleagues in public. Staff side and management agree policies to enable better communication and manage expectations between one another and it is fairer to all if these are used. A future public shaming must be avoided. If employees feel they are not listened to by their employer then it is best to agree a secondary link with the Scottish Government where concerns can be escalated and acted on. The print and broadcast media is not the best environment for this at all.”

- 18.38 It is important to recognise the significance of this contribution among all the comments and criticisms which I have been bound to record. The thrust of these comments probably provides the only sensible way forward.

The Future

- 18.39 Looking ahead, however, it will be necessary to find a way to address these complex issues. The serious issues raised in this report will need to be faced openly, directly and clearly. I discuss some of this in later chapters.

- 18.40 I was interested to hear the point of view of those who have operated within the current structure. The forward-looking approach of the following remarks is helpful to note and is indicative of the type of radical thinking that is perceived to be needed to create meaningful change. A consultant told me:

“There is a continuous thread of management inefficiency, bullishness and a culture of not listening and giving in to narrow tribal considerations. Only a root and branch reform of the management structure would be able to move this organisation from a ‘blame the individual’ to a ‘just culture’ where people can work with confidence and deliver the best healthcare possible to the local population.”

- 18.41 A former director made a number of apparently useful suggestions to address suboptimal performance:

“The present deployment of the Medical Directorate is suboptimal in terms of cohesive working, clinical-strategy development and interchangeability of roles. Addressing these issues would strengthen the team and in turn bring greater robustness to bear in leading... At both territorial board level and at national level this network is currently functioning sub-optimally, due in part to inadequate or poorly timed engagement over issues of substance relating to strategy and delivery.

Furthermore, adequate investment in administrative support and communication could enable clinical staff to feel a greater sense of ownership of decisions made by their organisation and could be a vehicle for

reporting dysfunctional or adverse culture and/or behaviour which was not being satisfactorily dealt with by other (eg HR) routes and thus would provide an additional safety-net.

All along the health service continuum, from Parliament/Government right through to every clinician, one of the major factors which increases stress levels (in turn potentially increasing dysfunctional behaviour) is real or perceived inadequacy of time to perform tasks or deliver outcomes properly or satisfactorily. If NHS cultural values are taken seriously then there should be an onus to share or co-operate over the delegation of new work and tasks at all levels in order to establish how the additional capacity for implementation will be found. Such additional capacity can be found by either relinquishing another task, working differently or allocating more staff hours to the new task.

Establishing this as the **normal** modus operandi will reduce stress at all levels.”

19. Management and Clinicians

Introduction

- 19.1 Linked to previous chapters, I am aware that the relationship between managers and clinicians is a critical one. It appears that the intersection in decision-making between management and clinicians is not working well enough and is a cause of much frustration and sub-optimal performance. Of course, many managers are clinicians who are promoted to the management role, perhaps without requisite training.
- 19.2 I do not feel that I have got fully to the bottom of how this affects service delivery and impacts upon behaviours but I have gathered the views of a number of respondents in this chapter in the hope that, by drawing these out now, something can be done to change the mood, tone and relationships for the better.
- 19.3 Generally, I heard from some clinicians who felt they were not valued, not respected, not supported in carrying out very stressful work, not listened to regarding patient safety concerns, that funding issues affected performance, that decisions were made behind closed doors and that they were undermined when managing staff issues. As we have seen already, and is further developed in this chapter, many managers are also under immense pressure.

Observations

- 19.4 The sensitive interaction of management and clinicians is captured here:
- “There are departments where clinicians have been under huge clinical pressure and have reacted in ways, which while not the most constructive, are understandable. They have been labelled as being difficult. Instead of acknowledging that these problems are structural national problems and not the fault of any group of clinicians, they have been rewarded by being managed, not by the most able managers available, but by the weakest. These difficult problems have now become critical.”

- 19.5 A highly respected senior clinician told me that matters are exacerbated in NHSH:
- “At times I have found working in NHS Highland extremely frustrating and stressful, not because of the clinical work but because of the dysfunctionality of the interface between clinicians and managers and because of the lack of senior decision making and lack of clarity of decision making. One might argue that this is a common theme across the NHS in the UK but in NHS Highland there has been very poor leadership and lack of decision making when implementing possible solutions that would relieve some of this pressure.”
- 19.6 Another clinician, who reported not being sure he had ever been directly bullied but had “*been ignored, side-lined and forced to work in a consistently negative working environment*”, went on “*....the combination of staff marginalisation in decision making, the lack of a clear clinical plan for NHS Highland and the ‘head in the sand’ approach to managing the clinical risks has gone on too long and I have found it tiresome and demoralising.*”
- 19.7 From another consultant:
- “The bullying appeared to represent a top-down culture with a consistent approach to clinicians raising clinical concerns: isolating, marginalising and discrediting individuals coupled with reprisal actions. There were several examples of this leading to sickness absence followed by resignation.
- Managers used jargon like ‘golden thread’ and ‘catch ball’. When they came to speak to us about the HQA and told us that ‘patients are at the centre’ it was one of the most demeaning things I have ever been told by a manager – why do they think we became doctors?”
- 19.8 Once again, the tensions created between clinicians and managers are highlighted in this contribution:
- “These [local area] managers are in a position where they have little decision-making power but are the link between clinical staff and the senior managers who can make decisions regarding services. It is become clear that many are choosing to filter information from clinical staff to avoid delivering ‘bad news’ and are

instead tending to report only good news. The result of this is that clinical staff are being told to implement 'top down' directives for service change and when it is clear that those directives cannot be implemented or made to work there is a reluctance to report potential failure and instead increased pressure is applied to clinical staff to 'make things work' often without the appropriate resources to deliver. In some instances resources have been promised to support service change and then been withheld with the clinical staff being berated for failure to deliver despite not having the resources made available."

- 19.9 This captures some of the broader issues already mentioned elsewhere:

"The pressure on Raigmore management to stay within a budget that some might say was always set too low, in the face of increases in activity year on year, has eroded the morale of both the clinicians and the middle managers. It has also resulted in a relatively rapid turnover in the individuals at the top of the management structure in Raigmore, many of whom have been able and hardworking people who have subsequently gone on to success in other jobs, inside or outside the NHS."

- 19.10 From one clinical department comes commentary about the increase in manager numbers, changes in structure, and destabilising impact:

"There was over 100% increase in managers during my time in Raigmore, decisions were becoming remote from clinical departments and managerial decisions were being taken without a working knowledge of the services provided or any detailed analysis to back up changes. I have and always will be an advocate for patients; I was regularly reprimanded for using the word and advised that the term was clients.

Over that period of time there was a regular series of poor leadership decisions, leading to negative service impact. It started to become clear that some of these changes were also having a financial impact. During this time the management structure was regularly changing: this caused, across all staff groups, a level of unease as decisions and directions were regularly being changed on an ad hoc basis ultimately destabilising the whole structure in many departments. Many of these changes had a clinical impact on patients."

- 19.11 A professional lead told me about lack of trust and integration:

"When I came in, they were on the offensive – senior managers and other professionals. I sit between the senior managers and everyone else. It's a difficult point – managers want to cost cut but want to increase efficacy with less resources, and the people on the ground dealing with that. Because there was so much distrust, which seems to have been repeated in other areas around Highland. Because of the geography, you can't help but have some fragmentation, but they have not learned to work in an integrated way despite locations. They have done a good job with what they have, but they got caught up in this."

- 19.12 A change in attitude is perceived; the language of enmity expressed in the following remarks reinforces the strength of feeling:

"For my own perspective, there's been a change in attitude towards the people working on the ground. Working on budgets. At some point, the staff become the enemy. The dialogue between staff and managers changed. It used to be about listening to what we thought – that's gone...They've stopped listening to us as professionals. If I have a professional judgment and it's not what wanted to be heard, it's closed off and you feel that you've done something wrong...Partnership working between senior management and nurses is gone. I don't trust them. It's not just me. It's about the way they try to manage me – I think I need to be empowered. I don't need to be micromanaged or feel intimidated by into doing what they want me to do. I'm quite a strong person – but it's what they do to my teams. By not developing them, by driving them into the ground. These are good, caring [members of staff]. They deserve better than to be run into the ground, retire, be on the sick. We need someone to work with us and not against us. We're not the enemy, we're their solution."

- 19.13 There is sympathy for managers placed in difficult positions:

"I recognise that the behaviour I was subjected to is in part related to the individual in question, but also acknowledge that he would be under pressure to maintain a service. For several years our consultant group have raised concerns to management about inadequate staffing to maintain a safe service. Inevitably, if rotas are

always stretched, then there is no resilience for unforeseen events such as prolonged ill health of a colleague and the impact on a department, without support from managers, may drive unsupportive or bullying behaviour.”

- 19.14 Looking ahead, a senior manager expressed the views of a number of people in saying that:

“We still need to secure more clinical engagement and leadership. We are still challenged by increasing demand, limited capacity & difficulties in recruitment to key areas that are vital to the function of an acute service eg diagnostics. I remain positive this is a good place to work, with significant challenges but at the risk of being idealistic it is a time to come together not be divisive and critical of each other. Many of the clinical and management colleagues I work with are dismayed about the current situation, fearful of the future impact on attracting people to work here and worried about the impact of patient and the public’s confidence in our services.”

- 19.15 A consultant described problems in smaller departments and the need for better long-term planning:

“I feel that in the past there have not necessarily been adequate systems in place to ensure that any allegations of bullying are taken seriously and I think it will be important that this is the case in the future. From my perspective I feel that consultants working in smaller departments need to be given more of a voice to bring about change. In view of the recent lack of medical managers I have not really known whom to turn to help bring about improvements and in particular to raise concerns around patient safety issues. Time pressures mean that these issues are often not addressed in a timely fashion. The fast change over in personal of the service managers has at times perpetuated this problem as it can take time for them to understand the workings of the department. Financial pressures are often blamed for not being able to bring about change, but I feel better long-term planning is needed.”

- 19.16 This probably provides a good reminder that systems, time pressure, lack of understanding, the financial situation and the desirability of strategic planning are recurring themes.

Addendum

- 19.17 I record here the views of one consultant on how matters might be improved; this may simply serve as a useful provocation of new ways of thinking:

- “Move to a GP practice model: give a department a budget and autonomy on how they spend it. Let clinicians make decisions and give them a good departmental administrator implement them. This allows those who are close to the needs to make decisions
- Get senior managers to attend departmental meetings rather than expecting service leads to go to the senior management to ask for something.
- Senior managers to bring an accountant to those meetings so there can be clarity about what is in the budget.
- Invite clinical leads to attend board meetings and speak to management directly rather than being filtered by another manager. It’s easier for a clinical lead to speak up as they have tenure whereas a manager will be looking for promotion.
- With accountants and good departmental administrators, could probably do away with most middle managers who create extra layers of bureaucracy by reviewing clinical decisions where they have nothing to add.
- Treat departments consistently. Don’t reward overspend and take away from departments that manage themselves better.
- Create job plans (time budgets for standard tasks) and use this as a planning tool across the hospital.
- Do away with ... quality initiatives such as Highland quality approach and rapid performance improvement..... Replace with good departmental administrators.
- CEO to thank and appreciate staff as well as addressing problems. The job is getting harder and staff need support.
- CEO to visit the hospital.
- Consider the tone of CEO communications.”

20. Some Broad Management Issues

Introduction

20.1 As one considers further the details of what is happening in a management context, the following extensive observations come from someone working as a departmental secretary. I repeat them here as this summarises many views I have heard and raises issues about job creation and protection, appropriate placing, redeployment, funding, overstaffing and bullying:

“The main management tone is generally divide and conquer, belittle and undermine your staff so that they are too scared to trust anyone with their issues. You are made to feel that you are the only one with an issue.

There has been a huge explosion in management, so much so that the people who end up in the managerial posts are often staff who don't know how to manage/don't know the job as they have come from outwith the NHS or are staff that another directorate is trying to offload (because as we know in the NHS if you are not fit for a job they create another one for you and move you along, more than likely with a pay rise to sweeten the deal). This means that once you are in a post and you can't cope with it or are just bad at it you can be redeployed or indeed request redeployment into any position that is equal in pay-band or below, you will be on a protected salary. This also means that someone who was bullied in one department can redeploy to a higher band as a line manager and then become the perpetrator and keep the higher banding.

Jobs appear to be created out of thin air, to the curiosity of lower banded staff who have to struggle on due to lack of money to get the staff that are needed on the lower pay grades, only to discover that staff have been taken on elsewhere either in management roles that have no problem getting funding or on the back of Government funding, the problem with this is that when the funding runs out what do you do with the staff? They can't go back to the job they had as it has been backfilled. They are redeployed more often than not into a position

that has been created, quite often managerial and not in the discipline they are trained for.

If you count in all the “time saving departments” and their managers, there is a vast amount of overstaffing. Every manager is managing on a dog eat dog basis and protecting themselves and a job that either they are incapable of doing and should have gone from long ago should not even have as it was a created post as they couldn't be sacked.

There is a mentality of protect their job at all costs and this is where the bullying comes in. It is their way or the highway. There is no listening to staff who are in post and try to make things easier for everyone. I am sure that a lot of the pressure is coming from higher up than my administrator and service manager and sideways from the peer groups who are also trying to cover themselves, which is where the link to the board and what has already been made public is.”

Bullying in NHS Highland is in the managerial DNA, there is constant pressure on bands 4 and below to get targets met, targets that are actually not of our making and can only be solved by paying consultants or other hospitals to treat the patients. These are actually to the benefit of the managers as they are paid bonuses for getting them met.

At the end of the day it is the patients that suffer the consequence of this. NHS Scotland needs a roots and branches clearout of managers and the money saved diverted to where it is needed.. patient care.”

There is much to consider and review just in these few paragraphs.

Appointment and Recruitment

20.2 I have been told repeatedly that there are significant deficits in the appointment, promotion, support for and training of managers at many levels, resulting in many unhappy relationships (for managers and those being managed), poor communication and unsatisfactory decision-making, which is likely to be costly in both staffing and financial terms. It is also likely to be the source of inappropriate behaviours which are experienced as bullying.

- 20.3 Recruitment to management is a recurring issue. This view from a mental health practitioner reflects the views of many who engaged with the review:

“Generally, I feel that management is poor in some areas, with people being recruited/promoted into posts that they do not have the skills for. This has a direct effect on the service delivery to our patients but also to staff morale and sickness levels within services. It is difficult to recruit to some of the more remote and rural areas. Staff development is not a priority. This is one of the factors that affect our ability to recruit and retain people within NHS Highland.”

- 20.4 The issues pertaining to appointment processes to senior positions arose on a number of occasions: According to a senior consultant:

“A number of senior medical posts within NHS Highland do not appear to be advertised to relevant staff. There is evidence that some of these posts may be created to favour key individuals in favour with senior management; those individuals are appointed to them without open competition. Together with the release of research monies this behaviour looks like patronage, and may be expected to buy favour or silence opposition.”

- 20.5 As we have seen earlier in this report, favouritism is an issue of concern. This from a nurse:

“The lack of equal support for [Clinical Nurse Specialists] is profound. There is definitely a culture of apportioning blame, and career progression blocking for the least favourite staff.

It worries me, as I can see that junior staff nurses, or even senior staff nurses do not want to enter into specialist roles as there is too much responsibility put on these CNSs with little or no recognition. The lack of forward planning and future workforce planning to invest in staff is debilitating to the service, and I believe that there is a complete lack of awareness, from those who could make these changes, that changes need to be made.”

- 20.6 If nothing else the perception of favouritism is harmful. Another nurse referred to staff and friends of a Service Manager being “given upgrades irrespective of their ability and privileges (office space, desks, equipment), whilst the Senior

Nurse was informed that there was no money for the promised upgrade and the Nursing budget was also threatened in relation to the number of posts and overall workforce”.

Promotion and Training

- 20.7 As noted above, the promotion process for managers was raised on numerous occasions: it seems that management training for those who are promoted is perceived to be inadequate and that this, understandably, could lead to mis-handling of difficult employment issues. Another related concern is the promotion to manager of people without relevant experience in or understanding of the discipline they are being asked to manage. The “grow our own” policy was the subject of criticism.

- 20.8 The following comments capture the concerns expressed by a number of respondents:

“Throughout NHS it is common practice for staff to be promoted into supervisory/managerial positions with absolutely no grounding in people skills, managing people skills, etc. It seems that once one reaches a certain banding, perhaps Band 7, they become autonomous and non-accountable. For example, sending out totally inappropriate letters to staff.”

“How do applicants get an interview for a post they aren’t fit to do? It horrifies me that a Band 6 gets promoted to a Band 8A. How can we be sure that it is safe to employ these people if they haven’t got the knowledge and understanding. That’s a concern.”

“Let’s be honest for what skills we are looking for in our managers and if it is line management, then recruit them for that.”

““Growing our own” and advertising lower grade posts so that higher up staff get promoted does not work if those promoted are not competent”

“...a lot of service managers are promoted into posts that they don’t have the skills to do that work. They fall into dictatorial techniques. It doesn’t lead to getting the workforce on board. When I was recruiting new people, I was being pressurised to move people up the scale and advertise for the lower post. “Grow our own”. That’s great but doesn’t matter if they’re not ready to do the job. Need new people in post with different thinking.”

“There is a theme of “growing our own” in NHS – they get slotted into posts they are not ready

for and don't have the experience for. They need more management training and beyond their specific qualifications. Nurses go into managing roles, but they don't have the management training."

Lack of Diversity

20.9 One manager offered this view which is self-explanatory:

"There is very little diversity in the senior managers, mostly white, middle class, 50-60s and in last job before retirement. They have old fashioned, dictatorial management styles and do not listen, know what's happening on the ground, trust staff or know how to engage them in decisions."

Friendship and Family Ties

20.10 As anticipated in the chapter on causes which may be particular to NHS, I am told that many managers are friendly with colleagues (often people they manage) outside of work and that this can get in the way of holding colleagues to account for their behaviour. Training about how to manage multiple roles and relationships (and confidentiality) appears lacking. There are also criticisms of conflicts arising when family members are employed in sensitive positions, as characterised here:

"NHS Highland is a small environment with many staff being related to senior staff, which resulted in other staff being afraid of repercussions if they spoke up about inappropriate behaviour."

21. The Board and Governance

Introduction

- 21.1 My remit invites me to try to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally. In that context, I have been told that what has happened at NHS Highland is a failure in staff governance which should be treated as seriously as a failure in financial or clinical governance. If this is not done, *“it sends out the wrong message in terms of the way staff are regarded, both in NHS Highland and in NHS Scotland”*.
- 21.2 By way of preface, I recognise that, in what follows, there is inevitably adverse comment about some of what has occurred in the recent past. I do wish to emphasise that these remarks are intended to help explain the situation in which NHSH has found itself and to enable it to move on. I am sure that those in leadership and governance roles have generally tried their best in relation to the serious issues raised. Future progress will come from a healthy recognition of things that have not worked as well as they should in the past. And I recognise that the benefit of hindsight was not afforded to members of a Board under a lot of pressure.
- 21.3 Concern has been expressed that this report may conflate concerns about “the system” generally and individual or collective actions by Board members. I refer to my earlier remarks that this is not an exercise in finding fault or allocating blame but an attempt to ascertain what can be learned from the past and what might be done differently. I hope that a thoughtful Board will accept this commentary in the spirit in which it is offered and build on it, not through guilt but with a sense of leadership responsibility.
- 21.4 It is important going forward that the Board is held in high regard by patients, staff and the wider community. What follows bears on the general situation and not any specific case. I have drawn on what I have been told and readily recognise that there will be nuances and other perspectives of which I am not aware.
- 21.5 For a number of reasons, including inadequate provision of information to the Board which was not conducive to effective and informed decision-making and a culture which tended to discourage challenge, it appears that the Board has not functioned optimally in its governance and oversight role leading to a situation where allegations apparently could not be raised and responded to, adequately, locally. I address some of the issues which arise in this and the following two chapters.
- 21.6 This review prompts a question: given what has now come to light and the concerns expressed by so many people, why were steps not taken to address this earlier? The Board’s response to the public announcement by the whistleblowers in September 2018 recognised that there were issues (for completeness, I append this as a note at the end of this chapter). The question has been asked why it took so long to do so and whether this response was an adequate one in the circumstances.
- 21.7 A former board member described:
“...an organisational culture that was not open and supportive but was one in which bullying had become institutionalised to a point where it was unrecognisable as an issue. Now with the benefit of hindsight I believe we almost all conformed to it in our daily relations with other members of the organisation complicit in the belief that these were the behaviours expected of us operating at such a level. It was however not only at board level: my role took me to all parts and places within the organisation and all too often I witnessed behaviours which did not support and encourage input and discussion from staff, rather the reverse.
- The impact of such a culture had two important consequences:- bullying of individuals who felt unable to voice their concerns other than in strict confidence to me and a very poor system of governance and accountability at board level. It is both that led to an institutional culture of intimidation and individual bullying and are therefore inseparable in terms of an analysis as to how we ended up in such a position.”
- I note that in theory at least “the system of governance and accountability at Board level” in NHSH is the same as in other health boards in Scotland.

21.8 Another observed:

“How much of this about bullying, how much is about governance? There is a culture of suppression - if you’re not the right person, it won’t happen. Or being labelled as a trouble maker. That leads to bullying.”

A Failure of Governance?

21.9 I heard that, over a period of time, concerns have been expressed about a style of management and type of behaviour which many contended was not acceptable in a large and complex organisation. It seems clear that people in leadership positions were or should have been sufficiently aware of the concerns expressed as late as mid-2017 and probably earlier. At times, it appears that opportunities have arisen to address these and that steps which could and should have been taken were not taken.

21.10 One must remember, as I note again below, that this is an organisation with a budget of £800 million of public money. There will be very few Scottish businesses or organisations with budgets of that scale and with the complexity this entails.

21.11 A non-executive director told me:

“The issue of a bullying culture was first raised with the auditors, Audit Chair and Board Chair in late 2016. SG knew about it. Nothing was done. NEDs advised SG in August 2017: “We feel the culture and leadership is a risk to our stated values and objectives.” When John Brown³⁶ came in, he did a verbal report to us that was dynamite. He said it as it is. “Your board do not trust you or have any confidence in you”. In essence, we knew about it, we tried to do something about it. But in the meantime, the bullying was going on.”

21.12 I suspect that some senior executives and some board members (though not all) have suffered from a degree of unconscious blindness. While it might have been obvious that something was wrong, for a variety of reasons they have not seen it or have been unable to act on it. It is likely that many of the cognitive biases and other

influences mentioned in chapter 8 have been at play and that may be understandable in the circumstances. I believe there are other reasons and I explore some here.

21.13 When asked “*What one step would make a difference?*” a non-executive board member told me:

“The truth needs to come out. The NEDs were aware of it eighteen months ago. We have been working through the process of telling SG.” “...as a board we have missed a lot.” “There have been some big misses by this board. We have a lot of reflecting to do.”

21.14 A senior executive told me:

“That’s the other thing that worries me about the situation. There is so much that has come up to the surface that we’re not aware of. That is awful. It worries me more than anything else.”

21.15 A very senior figure commented:

“They (the Board) have been paralysed by fear of doing the wrong thing.”

21.16 A former non-executive director described the situation as seen by that person at that time (a view not held by all nor necessarily applicable now):

“Board operation prevented the CEO from being held to account in a forum where in depth examination of issues could be undertaken [of] evidence of institutionalised intimidation and its supporting committees were held in much the same way and allowed inappropriate behaviours between people. Intimidation was the norm.

... relations within the Board between executives and non-executives were confrontational and often made “personal” or at worst non-executives were deemed to be wasting the time of executives by their questions and/or requests. Non-executives received little or no support for their role. I coached informally several members or lay members about their role as they felt inadequate or foolish as a result of their treatment at the Board. The number of

36 Brown, J. and Walsh, S. (2018). Corporate Governance in NHS Highland.

resignations should have caused questions to be raised by government.”

“I raised issues discreetly with the Chair and within the Remuneration Committee under “our duty of care to our staff” but got nowhere.”

- 21.17 A central reason behind the resignation of at least one non-executive director was the lack of proper governance. To that person, the Board appeared peripheral and a rubber stamp, with decisions being taken by the chief executive and the Chair. Presentation of information to the Board was not conducive to effective and informed decision-making. Some board members played little part in discussions. It seemed that there was little opportunity for or encouragement of challenge. There was general concern about poor communication.
- 21.18 I understand that various non-executive directors have expressed concern about governance in recent years and the Brown and Polley reviews (referred to elsewhere) took place. One of the curiosities of the situation is that a number of non-executive directors have resigned but there seems to be a lack of transparency regarding the reasons for their doing so. It is arguable that both the Board (and, indeed, the Scottish Government) were, or should have been, sufficiently alerted by these developments alone to act more decisively at an earlier stage. It appears that resignation letters were not shared by the Scottish Government, even with the Chair. I understand that some board members feel that they did all they could. I sense that red lights should have been flashing by 2017 at the latest although some concerns about governance were apparently raised by Audit Scotland in 2015.
- 21.19 A director observed:
- “We have had at least three or four NEDs leave. I don’t know how many need to leave before someone wakes up to the fact we have a problem.” “They haven’t pulled their punches either. They wrote to the government and said the Chair cannot keep the CEO in check. We’ve had so many, a governance review. No trust in the CEO and no confidence in the chair. You’d think something would happen from that.”
- 21.20 Concerns were expressed by a number of respondents about the Chair’s ability to hold the chief executive fully to account. A now retired director expressed this concern about accountability:
- “My experience tells me that power rested with one individual in the organisation and they acted as the gatekeeper of opinion and advice to the Board and other senior officers. There was not the ability to safely challenge or express alternatives...In my opinion, the very necessary separation of powers held by the Executive (the chief executive), the Chairman, Non-Executives and Staff Director completely broke down... An organisation where there is responsibility without accountability results in turn in an extremely unstable organisation.”
- 21.21 This seems especially relevant to events in and around August 2017. While hindsight is a great thing, the concerns raised then were, I sense, not as well handled by the then Chair as they could have been. I acknowledge that he would be in a difficult position and that Scottish Government was also involved at that time. Decisive action at that stage to address concerns, amid board resignations and a difficult situation regarding radiology, might have made a big difference.
- 21.22 I believe that the Chair recognised that there was a problem in that people may have lacked confidence in the systems for raising their concerns and engaging in a conversation about their concerns directly with the Board. I acknowledge that external reviews have been commissioned and other steps taken to address the situation which has now arisen and that the Board is also awaiting this report.
- 21.23 While the question arises whether his relationship with the chief executive was sufficiently robust and frank, I acknowledge that the Chair was in a difficult position and would be trying his best in the circumstances in which he found himself. He has since resigned. However, in a public service with a budget of £800 million, new leadership should look seriously at all of these matters and the learning arising from what has occurred, especially in connection with holding to account. If this is done, it should be possible to assess and respond to allegations, such as those of bullying, more fully at an earlier stage.

Accountability and Competence

21.24 Overall, in trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, it seems reasonable to conclude that the Board has not functioned as well as it could. There appears not to have been a culture of sufficient openness and one which welcomes challenge.

21.25 One non-executive director told me:

“I think we need to change our approach to how people can raise things. Talking with the whistleblowers, they have tried to raise things for a while. So have NEDs. We didn’t know. As a board, we need to work on ourselves and how we lead. We have new members who we don’t know that well, so difficult to trust. Exec board colleagues, still don’t have that much contact with them outwith board meetings.”

21.26 I note that the Scottish Government published a guide for board members of public bodies in 2015. This summary on roles and responsibilities is helpful:

“The four main functions of the Board of a public body are: to ensure that the body delivers its functions in accordance with Ministers’ policies and priorities; to provide strategic leadership; to ensure financial stewardship; and to hold the chief executive and senior management team to account.”³⁷

21.27 NHSH has its own clear guidance about the role of the Board and its members, including non-executive members. It appears that the problem here is not lack of information but lack of implementation.

21.28 It is possible that concerns about the functioning of the Board went deeper. One former board member told me:

“Competence is another contributor. Some of the players were a level beyond their competence... The body was not competent enough to know what they wanted.”

21.29 I note that the fit and proper person regulation (FPPR) requirements³⁸ which came into force for all NHS trusts and foundation trusts in England in November 2014 require NHS trusts to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.

21.30 In order to meet compliance with these requirements, all NHS trusts must ensure they have robust processes in place to assess the suitability of directors at the point of recruitment and throughout their ongoing employment. They are also required to have effective arrangements in place to tackle issues should any concerns be raised about a director’s ongoing fitness and suitability to carry out any such role.

21.31 Although not applicable in Scotland, these illustrate what might be expected of a board functioning well and of an appointment and review system which is itself fit for purpose.

Governance Structure

21.32 None of this is helped by what seems like an extraordinary governance structure. As I believe Audit Scotland commented over three years ago, the governance model seems extensive and impenetrable to many. It does not seem conducive to open, transparent and effective operation. I confess that I found the maps of the governance structure complicated and very difficult to navigate. I found nobody who was able to explain to me how all the many and extensive committees operate in connection with each other. There appears to be no comprehensive organisational diagram or other presentation of the governance relationships. I understand that executive and non executive directors have raised this and been told that legislation or government guidance is needed for many aspects.

21.33 Incidentally, the same appears to apply to the multi-layered management structures. A very senior director manager was unable to describe this either and another commented on a lack of integration operationally.

37 The Scottish Government (2015). On Board: A Guide for Board Members of Public Bodies in Scotland. p.24.

38 www.nhsemployers.org. (2018). Fit and proper persons requirement for directors. [online] Available at <https://www.nhsemployers.org/your-workforce/recruit/employment-checks/criminal-record-check/fit-and-proper-persons-requirement-for-directors> [Accessed 18 Mar. 2019].

21.34 I have the impression that attempts have been made to examine and reform governance but progress seems to be slower than may be necessary. The Brown and Walsh report in May 2018³⁹ covered all of this in some detail. Again, there must be a simpler way of managing the organisation without, as one person suggested, tearing down the whole governance structure and starting again.

The Jan Polley Review

21.35 Simply by way of illustrating that there may be nothing new in much of what I comment on here, I note that the Jan Polley review which reported in February 2016 included the following recommendations:

“A deeper understanding of the respective roles of non-executive board members and executive board members in order to build confidence in and share appreciation of how they work as a team, adding greater value to each other;

A review of the remits of the governance committees to minimise duplication of papers and discussions and clarify the roles of and relationships between the Board and its committees;

A strengthening of the corporate governance support given to the board and its non-executive members in order to reinforce governance processes, including the training and development opportunities available to board members.”⁴⁰

Strategic Plan

21.36 I should add that, while generally outside my remit, the absence of a proper strategic plan with specific goals and timelines seems to be a contributor to the current sense of lack of direction. The report by John Brown made recommendations in this regard as it did on holding to account, roles and responsibilities and other matters referred to in this report. Executive Directors have pointed out that NHS Highland has a ‘NHS Highland Strategic Quality and Sustainability Plan’, which was approved by the Board in 2017. Work was apparently also

undertaken in 2018 on a simplified info-graphic summary, which was discussed with executive and non-executive directors but has not been finalised, due to changes in staff.

Board Meetings

21.37 In passing, I note one other issue which seems germane to the effective functioning of a board seeking to hold senior executives to account. That is the holding of board meetings in public.

“The other dynamic that is a constant... the theatre of the board meeting itself in public. What gets discussed in private versus public. There is a real issue - quite a tricky thing - to raise issues that need to be discussed at an open board meeting that will not impede the executives. The public nature is an ongoing problem. Not many people turn up, but it is webcast so in theory... and the press are there, in a small community. It’s in the paper the next day.”

21.38 I asked myself the question: how useful is subjecting health boards in this way to open public meetings and intense media scrutiny? On balance, does it assist or hinder? Does it fulfil an effective audit purpose? Might this be done differently? There must be an argument that the public nature of the meeting inhibits the kind of scrutiny which is essential. If board members are competent and have been transparently appointed, perhaps they should be trusted to get on with it, with specific open public fora once or twice a year.

Finally

21.39 This has been a lengthy chapter but effective governance is critical to the future of the organisation. As one senior clinician commented:

“Moving forward, the chief executive has left the organisation but there now needs to be a fundamental change in the relationships between clinicians and the corporate team, if the present situation is to improve. The individuals who have raised the issue did so in a manner that I do not support or condone. I can, however, see

39 Brown, J. and Walsh, S. (2018). Corporate Governance in NHS Highland.

40 Polley, J. (2016). NHS Highland Governance Review 2015-16. p2.

why they felt they had to do it in that way, having taken an issue to the CMO and attempted to bring the culture of Board officers to the attention of the Board.

The way that members of staff have been dealt with and the resignations of Non-Executive Directors of the Board certainly gave the strong impression that the clinical governance of the Board did not come up to the standards you would expect from a public institution. Whether the actions of the Board and the Executive team are labelled as bullying or simply poor management is less important than the need to move forward for the benefit of the service in general and the wellbeing of patients and staff alike.”

These words aptly sum up the need for a change of direction at board level.

Note

21.40 Board statement issued in October 2018, agreed by all board members present⁴¹:

“We all joined the Board of NHS Highland because we care very much about the NHS and the services we provide for the people of the Highlands. It feels like NHS Highland is being publicly torn apart, with little right of reply.

“For the sake of all of our staff and the people we serve we feel this cannot continue in this way. Our offer to meet the four clinicians remains open and we hope others will speak up and we urge that to happen as a matter of urgency.

“For the four doctors to make a public claim that ‘a thread of cruelty has purposefully been spun throughout NHS Highland’ simply cannot go unchallenged.

“We feel sure that everyone who cares about the NHS will share the view that our patients, staff and public deserve better and we are calling on everyone to make their voice heard.”

21.41 The statement went on to say:

“We recognise the utmost seriousness of the situation and are prepared to leave no stone unturned to get to the truth. There is clearly an issue of some sort which needs to be understood. We are of the firm opinion that it is surely in everyone’s interest for any allegations to be addressed as a matter of urgency.

“Therefore, we unanimously express our ongoing frustration that we are being denied any substance to the accusations and also that the opportunity to have a mature, responsible and respectful dialogue continues to stall.”

Board members heard from Dawne Bloodworth, NHS Highland’s interim director of HR, that all the internal evidence to date paints a very different picture from what is being publicly alleged.

She said: “There is no evidence that I have seen to date that indicates that the four doctors represent the views of all GPs and Consultants. Indeed some clinicians have raised concerns to this effect.

“In common with all parts of the NHS there are certainly pressures in the system and as a board we acknowledge that. Sadly we also know there are some incidents of bullying, past and present. We are unanimous as a board, however, that to claim there is a systemic culture of bullying is not a true representation of the facts and opinions that we are currently aware of including feedback from staff.”

She went on to stress: “That should not in any way, shape or form underplay any incidents of bullying. We have a duty of care to anyone who has been bullied and we are truly sorry that it can happen. We also have a duty or care to anyone accused of bullying to make sure they are also not unfairly treated.

“As a board we have mechanisms, policies and procedures in place to manage this. We have also invited external HR scrutiny to see what more we can do to bring the highest level of confidence possible.”

41 BBC News (2018). Claim 100 NHS Highland staff ‘bullied’. [online] Available at <https://www.bbc.co.uk/news/uk-scotland-highlands-islands-45952210> [Accessed 25 Mar. 2019].

She added: “I believe the action that we have taken so far has been immediate to actively encourage staff to express their concerns and views through a wide range of routes. We continue to welcome feed-back from staff who we know have a range of views. Somehow we need to encourage everyone to work together and in all good faith I really hope that something positive can come from this.”

22. Role of Non-Executive Directors (NEDs)

22.1 In trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, it seems important to address in some detail the role of the NEDs. In setting matters out as I do, I do not intend to be critical of individual NEDs who are well-motivated people trying to do their best in difficult circumstances. However, a number of matters have arisen about the way in which NEDs have functioned in NHS and I discuss these in this chapter.

Information

22.2 Firstly, as one NED put it *“it is vital for a NED to know what is going on – and wherever possible to see or hear independent views. There is a real danger of group-think”*. A number of NEDs at NHS tried to make a difference while others may have been simply intimidated or wholly frustrated. Access to key documents and other meeting information needs to be good. However, reporting and discussion seems to have been conducted in such a way as to reduce their active and appropriate participation. There has been no clear strategy to provide them with adequate information. They could not do their job effectively.

22.3 On lack of governance specifically, I was told by a former NED that

“there existed no system by which the Board could set a clear strategy for delivery. We never received costed options and alternative proposals on which to base decisions. So never were strategic decisions converted into clear delivery plans containing clear goals, milestones, risks etc by which the Board could direct a robust system of risk management and accountability and through which it could hold the CEO to account within a forum of mutual support and understanding.”

22.4 Another had said in his resignation letter:

“I am resigning as I feel that I cannot make a meaningful contribution to the outcomes from the Board. Too many strategic policy issues are taken, outwith the Board process, as being “operational”. I have requested, in vain, that

the NHS Board or a Committee discusses key issues including the impact of Brexit on our workforce, the new GP contract and its negative implications for remote rural GPs in the H&I, the consultant led Radiology Service, funding for the Voluntary Sector, the continuation of small rural residential Care Homes etc. There needs to be a much more forensic approach to financial scrutiny. We rarely receive an options appraisal on an issue, simply a recommendation. Constructive criticism is not welcomed.”

22.5 Another NED expressed the view that challenge or expressing a different point of view has not been particularly welcomed and rarely has it made any difference to an issue; there is an inability to carry out the role of holding the organisation to account without the information to do so; often they are receiving only reassurance rather than assurance, leading to ineffectiveness as a non-executive director.

22.6 On the theme of information to the Board, a very senior clinician observed:

“There was and, I think remains, no clear ability for clinical advice to get to the Board other than through the Executive Team... The Board did not and does not meet “rank and file” clinicians to inform themselves directly without the filter applied by the Executive team.”

This theme was repeated a number of times.

22.7 This diminishing of the input of NEDs is underscored by a senior executive director:

“In the private conversations in senior leadership teams, the NEDs would sometimes seem as nuisances that needed to be won round. Or people that didn’t really understand and we needed to manipulate them. I think references to some people, in their absence, could be quite dismissive.

There might be a criticism that they didn’t make that many decisions. A lot of stuff was airbrushed. Out of hours review was useless. If you look at the audit trail, board members feel that they haven’t all agreed to the final product. Decisions get made at the top. Decision making structure is opaque and labyrinthine, which

has developed over time. It's convenient to the management style...

I think if you look at the board papers, they are far too long and drowning the NEDs in information so that they were hard pressed to make a real decision. Need clear executive summaries, recommendations etc so the reader can assimilate the information properly."

22.8 I happened to see one set of Board papers from 2017. They were overwhelming. I cannot imagine what it must feel like to receive and try to digest these, far less ask intelligent questions. This is something which needs serious consideration to enable Board members to perform their function properly. The unnecessary use of jargon is an example of where barriers can be created, deliberately or inadvertently.

22.9 Overall, the sense that the Board (in the form of the non-executives) were disabled is summed up in these words from one observer:

"Everything to do with the Board was orchestrated. ...We would have dress rehearsals before the meeting. This is what will be said, this is what will be done. The Board weren't allowed to know exactly how bad it was."

Appointment and Training

22.10 The evidence suggests that the role, appointment, training and support of NEDs appears, in any event (whatever the theory), not adequate in practice to meet the needs of the board of a large publicly funded organisation with an £800 million budget. I note that some NEDs have asked for training in specific areas. I understand that developmental support for NEDs is a Scottish Government function.

22.11 I note that it appears that some NEDs may not be as clear or realistic about the extent and limits of their roles as they need to be. There may be some naivety about the role. There is need to pass on experience from outgoing to incoming NEDs. The lack of experience and knowledge of new appointees is a concern to a number of people with board experience. "*There is very little corporate memory,*" is how it was put. Consideration of an overhaul of how the Board is appointed, trained and sustained appears necessary.

22.12 The view has been expressed more generally that neither NEDs nor the Scottish Government fully understand the important role that NEDs should play. Be that as it may, Government guidance states: "*Public bodies allow the public sector to benefit from the skills, knowledge, expertise, experience, perspectives and commitment of the members who sit on their Boards and focus in depth on clear and specific functions and purposes.*"⁴²

22.13 Unless people with the necessary skills, knowledge, expertise and experience (and ability to ask the right questions in the right way while understanding financial, risk and other management issues) are appointed to NHS boards, there is a danger that governance will not be effective and national policies will not be implemented effectively. There may be a difficulty in finding people with the requisite competence and skills. If so, that should be faced up to, with clear criteria and honesty if they cannot be met. I am told that Board appointments have seemed to some to place too much power in too limited a selection process, leading to perceptions of favouritism.

22.14 I was interested in these comments about the need for external input:

"Within NHS Highland and more generally within NHS Scotland there is an introspective approach to organisational development and an 'internalisation' of responses to whistleblowing, bullying and harassment and grievances, and generally to governance. [x] advised me that the governance review framework he was using was developed by the NHS Board Chairs. This leads to 'group think' and behaviours. There would be benefit in establishing an external, independent source of advice for Boards and Board members on these and other governance issues. My experience is that NHS Scotland and particularly NHS Highland does not recognise the validity of advice and practice from private sector businesses to themselves, citing the NHS as too complex and different."

22.15 This was also said:

"Over recent years there has been an increase in appointment of Local Authority councillors and staff, and ex-politicians to Boards, particularly Chairs, which has introduced a more political way of working, with both a small and large 'p',

42 The Scottish Government (2015). On Board: A Guide for Board Members of Public Bodies in Scotland. p.2

and changed the dynamic of Boards. My view is that this has contributed to a dilution of the role of the NHS Board and compromised the role of the non-executive director.”

- 22.16 A concern was expressed that NEDs who are also councillors may be inclined to bring their own issues and agendas to meetings. I sense that this may not be confined to councillors.
- 22.17 I was also told that the imperative of inclusivity can lead to large boards, which seek to accommodate many interests, but that this may come with a cost to board effectiveness.
- 22.18 I did not explore the role of the Audit Committee but its effective functioning is clearly crucial.

Looking Ahead

- 22.19 One experienced NED offered this view which I record in full as a helpful guide for the future:
- “There is minimal investment in development of non-executives in the skills required for the role and the ‘training’ for board members is quite basic. Also NHS Highland did not utilize the checklist tools⁴³ for Board Members provided by the Auditor General in many of her reports.
- A more business-like approach is required. Improvements would be:
- Base recruitment of non-executives on their skills and abilities to do the job rather than their specific knowledge of sectors, issues, interests.
 - Clarify the role of the non-executive as a governance role, providing independent judgement on issues of strategy, performance and resources. As per the Cadbury Report, their independence brings a degree of objectivity to the Board’s deliberations and a valuable role in monitoring executive management.
 - Provide induction for executives and non-executives on their roles, the role of the Board, the Chair, Vice Chair and Committee Chairs.
 - Establish the role of the Senior Independent Director to act as a sounding board for the chair and an intermediary for other directors if they have concerns. They would also hold annual meetings, and other meetings as necessary, with non-executive directors, without the chair, to appraise the performance of the chair.

- Confirm and provide training for Committee Chairs on their role as well as how to chair meetings.
- Provide regular (at least annual) governance training for Boards framed in their specific environments to identify any issues, developments etc required and discuss solutions and improvements. Training to include such as what is assurance? How to look for assurance, what dimensions to consider in decision making.
- Record/codify/formalize Board conventions and procedures alongside Standing Orders (across NHS Scotland) and include in induction and training. Eg Board decision making re brokerage; Board members right to dissent, how it should be recorded.

All of these to be developed with external independent experts in governance.”

- 22.20 I have been made aware of some really helpful initiatives for NEDs in other NHS boards, such as Lothian, where there are well developed resources and an induction programme, alongside good support from executives and administrators, and structured shadowing with clinicians, with six board development sessions per year. There is a structure for sharing of concerns and a “buddying” system for new NEDs. I am sure NEDs in NHS SH would gain much from the support of, and the kind of initiatives available to, their colleagues elsewhere.

Remuneration

- 22.21 Finally, the rate of remuneration of a NED (£8,000 per annum) is, I understand, for a time commitment of one day per week. However, the actual time commitment (and responsibility) is considerably higher than this; I am told that “many will be responding to something on every day during the working week”. I understand that the Scottish Government is currently considering the remuneration of NEDs as part of a programme of work to review the system of corporate governance in NHS Scotland and do not comment further on this.

43 Auditor General (2018). NHS in Scotland 2018: Checklist for NHS non-executive directors. Supplement 1.

23. Senior Leadership

Concerns Expressed

- 23.1 In trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, I note that the senior leadership of NHSH has seemed to many with whom the review engaged, though not all, to have been characterised over some years by what has been variously described as an autocratic, intimidating, closed, suppressing, defensive and centralising style. It appears, at least to some, that challenge was not welcome.
- 23.2 It is said that there was pressure on senior management to conform even if individuals felt uneasy. Perhaps understandably, self-protection seems to have been the norm for some senior managers. People felt unsupported. I was told that attempts to change things failed and people lost jobs.
- 23.3 I was told this may have resulted in an unwillingness to speak frankly and that people felt helpless, trapped, unhappy and, at times, scared at work. I was told that power and control appear to have been concentrated in a very small group and exercised in a particular way, with limited sharing of information. I recall the words of Professor Charles Vincent, mentioned in an earlier chapter, summing up “culture” as meaning ““how we do things round here”, “here” being anything from a small group or team, to a whole organisation...”
- 23.4 Associated with this view, sadly, one of the more significant issues of concern brought to my attention has been how some respondents have viewed the apparent influence over a period of time of the recently departed chief executive. Given that departure, it is not useful to report in detail on the specific examples I was given from a variety of backgrounds in the organisation but it is important to seek to learn from this. Indeed, with the passage of time since my appointment and gathering of information, the organisation has to some extent already begun to move on. I am conscious of not wishing to impede that momentum.
- 23.5 I am also conscious that I have mentioned more than once in my report that one should

assume that people are trying their best in the circumstances in which they find themselves. I am also aware that I am reporting on views expressed which have not been tested forensically. I remind the reader of the caveats set out earlier in this report.

- 23.6 However, I feel I would not be fulfilling my remit if I do not mention this leadership issue, as acknowledgement to those who came forward and for those who told me of their experiences and who expressed the view that this cannot be allowed to happen again. That, I suggest, is the key point and I also cover aspects of this in my sections on governance and management.
- 23.7 A former non-executive director commented that:
- “I feel that unless one addresses the culture, it’ll all fall off again. I think the culture element is that the culture is set at the top. What they don’t tolerate/promote. Unless one changes those values, we will not change the way in which this organisation is run.”

Other Perspectives

- 23.8 It is important for me to acknowledge that the former chief executive feels that she has been unfairly treated and that the actions of others have been very damaging to her and the organisation and that she herself feels she was the subject of bullying. I also acknowledge the view that some of the issues raised in this report may have been evident before she came into post. One senior management representative said that they did “*not believe that the management culture at NHS Highland has been created by one person or that it emerged under the recent and current leadership*”.
- 23.9 I note the view of one board member:
- “I don’t think there is any way that [the chief executive] as one person can set a culture that applies to everyone. The culture is something that grows and develops itself.”

23.10 Another senior manager told me:

“I don’t think of it as possible or credible that one or two individuals of an organisation like the NHS could have that degree of influence. I don’t think so. Cannot pin the reputation of an organisation of this size on a very small number.”

23.11 A former senior manager noted:

“I believe the Leadership team has shown considerable strength and commitment in its drive to improve quality and safety. I understand that in taking forward such significant change, there will be some who remain unconvinced of the direction of travel and may even feel aggrieved by it. However I firmly believe that the organisation has followed due process in relation to any concerns raised.”

23.12 And a more nuanced view from a board member:

“The board is perceived as an omnipotent top of the pyramid, but it’s not like that. It’s much more collegiate. That’s really challenging to do. I think [the chief executive] has her faults, as we all do. I think she’s incredibly committed. She’s a driven person who can see a way forward and make change. Very focused on the needs of people, the political pressures, budget. Very complicated to deal with. I think that might lead to perceptions that she just drives ahead regardless and if you don’t agree you better get out of the way. There might be that type of perception/feeling.”

Inability to Speak Up

23.13 I reported at an earlier stage that a feature of the general situation in the organisation was unwillingness to speak up. It also seems that some people in senior management positions did not feel able to speak up, even collectively. I put this down to a perhaps understandable culture of learned behaviour – a degree of self-protection.

23.14 “Learned helplessness” is a recognised symptom of simply staying where you are when you have no control over your situation. It is important to note that it appears that those who sought to resist or challenge the situation as they perceived it felt side-lined, marginalised, undermined or intimidated.

“People in senior positions knew what was happening but there was nowhere to go.”

“I could see that senior managers disappeared or moved sideways. I would ask where they went. It

feels like it you’re not part of it... you’re either in or you’re out.”

“...if you rock the boat you are a marked man and you wouldn’t do it twice”

“who did I think would say no...? It would be career suicide.”

“Victims of bullying are often made to feel that they are the problem, or have a problem. I feared that I would be undermined.”

23.15 Many who were concerned at director and senior management level and themselves experienced bullying behaviour have left the organisation. I was also told that some people have been very damaged by the experience. Others, allegedly bullied, adopted bullying behaviour themselves. One senior manager who was herself the subject of specific allegations of bullying behaviour, reported that she had also experienced fairly horrific behaviour directed at her. The pressure to perform, conform and survive seems likely to have produced a vicious cycle. “*If the best way to manage is to yell and threaten that may percolate to all levels,*” as one put it.

23.16 I am aware that some now regret their inaction, experiencing what is described as bystander shame or guilt: “*I find that so sad because if we don’t care about people, we’re finished. Why didn’t I put my hand up?*” “*I thought I was the only one.*”

23.17 A person close to senior positions told me:

“I saw many bullies go unchallenged. I feel the culture of NHS highland supports bullying behaviour and treats it as normal and acceptable. The culture is toxic and is harmful to staff and I am sure this in turn is harmful to patients. I am ashamed I did not play a part in bringing this to a close.”

23.18 One said:

“I feel disgusted that bullying of this level can be allowed to go on when so many people at the top are aware of it.” Another described helplessness: “despite it being common knowledge no one helped.”

23.19 All of this, of course, reflects the themes highlighted by Dame Laura Cox and Sir Robert Francis in their reports referred to earlier. And, as NHS moves on to a new stage, this needs to be learned from and then left behind. I refer to my final chapters.

Leading by Example

23.20 The relationship between behaviour at a senior level and behaviour more generally was commented on by one senior manager:

“It’s contaminated through senior management this aggression that was never there before. It’s an aggression – a feeling of people don’t matter, results matter. It’s evidenced by the number of members of staff who have become patients. People talking about their fear and literally shaking when they have to have meetings ...”

23.21 Overall, in assessing what, if any, culture exists where allegations apparently cannot be raised or responded to locally, from what I have heard and with the important caveats already referred to, I understand why some have concluded that what was being experienced at the top of the organisation led to a situation in which identifying and addressing inappropriate behaviour was difficult.

23.22 In seeking to discern to what extent the way in which leaders behave influences an organisation, I note the Bowles report into NHS Lothian⁴⁴ at paragraph 3.2:

“Complex organisations have many sub-cultures, depending on a range of factors such as geography, sector, values and mission. In the NHS there will be very different cultures particularly in relation to healthcare professionals who have their own ethical standards and codes with which they need to comply. Nevertheless there will be an over-arching culture which is predominantly created and shaped by the Chief Executive and the senior leadership team.”

23.23 I note that Sir Robert Francis expressed the same view that *“culture starts at the top... and filters down through all levels of leadership and management to*

*the front line...”*⁴⁵ and that willingness to speak up is influenced *“not only by what is said by the leadership team, but also what they do and the signals they give.”*

23.24 The Bowles Report goes on:

“The role of leaders in setting or undermining avowed cultures

Leaders of organisations have a pivotal role in setting the tone and style of the over-arching organisational culture. From EMT downward through the management hierarchy, employees look to their managers to role model the espoused values of the organisation, and to guide them on the path to understanding and interpreting the culture so that they do things in the right way.

In any organisation where the behaviours and leadership styles of any of the leadership team are at odds with the avowed values of the organisation, it can cause a cultural disconnect, with layers of disaffection, poor engagement patterns and inappropriate behaviour throughout the workforce. The old adage... ‘Don’t do what I do, do what I say’... if in evidence and repeated throughout the management hierarchy can cause personal and organisational tension in terms of lost output, poor morale, stress, sickness absence and retention issues.”⁴⁶

23.25 From what I have been told, I have formed the view that this analysis is relevant in NHS also.

Learning?

23.26 Generally, for future appointments and to address these issues, it seems important to consider in general terms what drives leadership

44 David J Bowles & Associates Ltd (2012). Investigation into Management Culture in NHS Lothian.

45 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.1.4

46 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 3.3

behaviour. Some of it may be personal and personality-driven; indeed often fear will be a factor. It is possible for example that sub-optimal outcomes of a programme such as quality improvement, and the need to make it appear that everything is working well, could be an influence.

23.27 Reputation, fear of loss of face, or appearing not competent in a job may well play its part for so many under pressure in senior roles. A need to be (or at least to be seen to be) in control is another recognisable feature.

23.28 It must also be recognised that inappropriate behaviour can be attributable to a number of external factors including the pressure of the serious financial situation and fairly constant, and perhaps understandable, interventions from government. As a senior executive observed:
“The relationship with Scottish Government is one of command and control.”

23.29 A senior consultant put it this way:

“The bullying seems to start at the top with the SG giving CEs an impossible job. It is not just about the lack of money. We have too many hospitals in NHSH and yet the politicians have been unsupportive at attempts to rationalise and close hospitals that need to close. The problem has been that our local NHSH management has been insufficiently strong to challenge this, but I appreciate how difficult / impossible it might be to do so.”

23.30 It is a complex, multi-layered situation. While one can only speculate, and some of the factors outlined here may help to explain, the real value lies in seeking to ensure a different approach and outcome in the future.

23.31 The new chief executive will wish to take NHSH to a different place in terms of relationships and behaviours. I comment on this in my later chapters covering leadership and in my proposals.

23.32 As a senior director put it,

“We need new leadership and a new culture to be adopted. We’ll need a very capable CEO in terms of their people skills, their leadership. That’s critical. I think that we need to change how we engage with our staff (we haven’t done that properly or well).”

A Note of Caution

23.33 I am alert to one of the dangers I mentioned at the outset, that of scapegoating. In the comments above, I have tried to be respectful of the views expressed to me and to ensure that these are acknowledged. However, these words of a senior staff representative bear repetition:

“Scapegoating individuals will not resolve many issues. It is important for every employee to take personal responsibility for her/his own behaviour, to be the best version of her/himself, to be able to apologise if s/he has had a bad day which may have resulted in less than desired behaviour, for the apology to be accepted and for everyone to move on. It is important that employees feel safe to identify behaviours – their own and others - they would like to discuss and resolve in a positive, balanced and adult manner, to know that such a request is welcome and discussion is possible. The ability to self initiate the words ‘I’m sorry’ is powerful, especially when the person offering them is already aware that words will be accepted and respected. It brings greater peace of mind, trust and security. The worry of a grievance being lodged is stressful and can lead to ill health and time away from the workplace.

There are undoubtedly bullying behaviours evident within NHS Highland over a long period of time. HR practices and processes have often required challenge by members with our support. Rather than the responsibility of an individual employee, workplace cultures of bullying are an organisational wide issue and change requires an organisational intervention – it cannot be left to individual employees to challenge decisions and change the culture on their own. That said, every employee has responsibility to avoid it

as a chosen behaviour for the workplace, to challenge unfairness, bullying and harassment when it occurs and have this fairly resolved. It is important that when employees raise concerns that they are not ignored, unfairly removed from post, blamed for someone else's perception or told that the behaviour they are experiencing is not happening, the phenomenon known as gaslighting."

23.34 The challenge now is to create an environment in which these laudable aspirations can actually be met.

24. Role of Staff Representatives and Unions

Introduction

24.1 In trying to understand cultural issues, many people expressed their concerns to me about the role of trade unions and staff-side representation which appears to many employees to have failed adequately to represent the interests of employees of NHS in regard to bullying claims.

24.2 This narrative sums up views I have heard:

“With respect to the input of a trade union, x is a member of Unite. Her representative’s key advice throughout was that only by accepting redeployment could he guarantee that she would keep a job. He stated that his experience of NHS Highland was that the managers would gang up to ensure that she had no chance of winning her case. He may well have been correct in the last point, but it is a sad reflection of how a union should operate. It suggests that something is amiss within the checks and balances between union and management generally. At the outset, the same representative, having reviewed her evidence, had advised x that she had nothing to worry about. As noted previously, it is only now, with the involvement and support of GMB together with external influences, that x feels comfortable enough to take matters further within the organisation.”

The Partnership Model

24.3 The partnership arrangement for staff involvement in decision-making and the role of staffside representatives on the Board is a matter of concern to a number of those with whom the review engaged and appears not adequately to be addressing serious issues for employees in NHS.

24.4 This has raised questions about the role and effectiveness of the trade unions in the context of the partnership agreement model operated in the NHS in Scotland, which many have suggested is not appropriate or at least is not operating in NHS in the interests of the staff.

“The Staff Governance and partnership arrangements in NHS Scotland are probably now out of date. They have clearly failed staff in NHS Highland. Originally set up to provide a

constructive way of working between the Unions and Management, they may now be too cosy and unrepresentative. In NHS Highland the Staff Governance Committee was ineffective and its meetings were sterile. [For example] challenge about indicators of staff experience were turned into a positive presentation of engagement rather than a question about why people choose not to engage. The organisations around the table represented about 50% of staff.”

24.5 Observers contend that there is an inherent conflict in being a funded full-time employee representative and also an advocate for the staff side. This makes it difficult to challenge the Board and to retain appropriate independence and objectivity. It reduces the checks and balances. This can result in the employee director being perceived as ineffective or too close to management and unable to function in the interests of the employee side. At least, there is a blurring of boundaries. I suspect that the current staffside representative might concede that this could be possible.

24.6 I am sure that the current employee director is well motivated and does a huge amount in the full-time role as it is presently conceived. He works hard to function in the environment in which he operates and with which he is very familiar. However, he appears to be in serious danger of being sidelined and to have lost credibility by being associated directly with board and management actions which appear to have diminished the concerns about the allegations of bullying. His appointment alongside the Medical Director to chair a working group has tended, for some, to reinforce this perception.

The Role of the GMB

24.7 The GMB union has become involved in NHS following the transfer of adult social care to NHS from Highland Council. Their model and approach is perceived to be more confrontational and actively to use the more time consuming grievance procedures as a tool to help employees and challenge NHS. I am told that employees are going to GMB because they feel that other unions are not able to address

the situation adequately and many respondents reported that only GMB has really supported them, citing examples, as noted above, of failures by other unions.

“People wanted to speak up, but they couldn’t. They were afraid. So they would be willing to confidentially give their statement to GMB, a chance to be heard.”

- 24.8 Concern has been expressed that GMB, being outside the Partnership Agreement, have acted in ways which themselves are not acceptable and constitute intimidation. There are accusations of using bullying behaviour in emails, the press and meetings. I have had some fairly unpleasant behaviours described to me and ascribed to one or more GMB representatives. I cannot comment on the accuracy of these but it is again one of the ironies that those helping to expose what they see as bullying are perceived by some to exhibit similar behaviours.
- 24.9 I wholly understand why the GMB has taken the approach it has so far to seek to focus issues and raise awareness but I sense that, if the changes proposed following this review can be adopted, GMB will have much to contribute if they can find a way to engage fully with NHSH going forward. Providing information in response to requests to do so and engaging fully is ultimately likely to be helpful to their members in the longer term. As one informed observer said: *“I can’t help but think if the GMB would work with us we would achieve more than in the papers. It’s going to lead to polarisation.”*
- 24.10 The same applies of course to other staff representative bodies who all need to be very thoughtful about their role in supporting NHSH and its employees.

25. Human Resources Procedures, Policies, Processes and Related Issues

Introduction

- 25.1 The number of specific issues which were raised with the review covering what I would describe as “process” is enormous. I can only provide a summary here and expect that, as part of a new approach, matters like these will be taken up by others.
- 25.2 From what I have been told, there has been and continues to be serious delay in addressing many of the issues of significant concern to members of staff in NHS. This is often because of failures and delays in recording, reporting and investigating and in grievance and other procedures and policies for dealing with complaints and other concerns (including the inconsistent and inappropriate use of suspension and capability assessments, breaches of confidentiality and loss of impartiality). I have heard that this leads to polarisation, tension, stress, unhappiness, sickness and other detriment in individual departments. A key feature is said to be the lack of a willingness to follow process and properly investigate.
- 25.3 One respondent summarised matters in this way:
“I feel there was/is no confidence in the processes we have for dealing with issues such as bullying and harassment (nor the qualified people or appropriate training) and it will be an important part of your review to examine these and hopefully recommend improvements.”
- 25.4 While there is a lot of criticism of “HR”, that may be a catch-all which conflates management roles and the HR function and does not fully acknowledge the wide-ranging nature of the dysfunction across management generally. I acknowledge that the HR team’s morale has been affected by the allegations made and that there may be misunderstandings about the limits of the HR role. They tell me that they have also themselves been the subject of inappropriate behaviour on occasions.

- 25.5 I was impressed by the openness and candour of those I met from HR. In reality, it seems that Human Resources (and Occupational Health) have not, for a number of reasons, been able to cope with the enormity of the situation.

Resources

- 25.6 I note that there is a widely held (but not universal) view that resources within HR are not adequate (“*we end up firefighting*”), not least in the employment of a part-time HR director. It is fairly clear that such a role is not sufficient, as the present part-time Director of HR acknowledges. The view was also expressed that if HR could focus on preventative strategies, rather than simply handling a barrage of case work, they could be more proactive.
- 25.7 This view sums up what I heard from a number of respondents:
“...while I had good HR support for some aspects of the work, I do not think NHS Highland has anything like enough HR staff to provide the support needed to work through some of the very tortuous HR policies. This means that situations that can both cause and contribute to stress within departments are not dealt with in a timely manner. I’m thinking mainly of capability and attendance issues which can go on for several years without any resolution. This increases pressures on other members of staff.”
- 25.8 One respondent described the overarching issues as seen by that person:
- “Inexperienced HR personnel/advisors
 - Poor advice from HR
 - Lack of consistency
 - Not following guidance/PIN Policies etc.
 - Lack of moral/ethical compass
 - Difficult/complex issues filed on ‘too hard’ shelf”
- 25.9 It was suggested that HR difficulties may, in part, be a throwback to the inclusion of a large number of council employees (approximately

1500) when care services were transferred, especially as there were significant cultural differences between the two organisations. It seems unlikely that adequate HR resources were planned for at that time.

- 25.10 Much of this chapter takes the form of narratives of what I was told, which I feel speak for themselves. In a sense, it is the overall picture which emerges which merits consideration, demonstrating as it does extensive dissatisfaction with processes in NHS. I recall the remarks about NHS made by a full time union official, recorded at paragraph 16.42 above.

Lack of Implementation

- 25.11 It is said that policies are not implemented or interpreted consistently by managers, with serious results:
- “Furthermore, when my case was addressed by Senior Management the resultant actions, were not consistent with NHS Highland policies and were not based on any proper investigation of the case. NHS Highland has used policies, practices and threats to marginalise, isolate and bully in an attempt to pressure me into accepting a career ending change. My reputation and indeed personal confidence have been damaged as a result. The impact of the above has been traumatic adversely affecting my Health and Welfare with consequential impacts on my family generally.”
- 25.12 There is general concern about the application of policies and standards as these contributions show:
- “Throughout my experience in the last 3 years I have directly experienced breaches in the staff governance standard, breaches in NHS Highland policies, breaches in Health and Safety legislation and breaches in guidelines from ACAS in carrying out investigations. As evidenced by lack of adherence to policies, procedures and law it is clear that staff are unsupported, poorly trained, ill-informed and are effectively “making it up as they go along”.”
- “The NHS Highland Policy “Preventing & Dealing with Bullying & Harassment” states that “It is crucial that organisations treat seriously any form of intimidating behaviour”. From my own experience, my perception is that NHS Highland does not take such allegations seriously preferring to sweep the issue under the

carpet which in my view is questionable in terms of the Law, it certainly goes against Policy.

The “Dealing with Employee Grievances” policy clearly states that “employees are encouraged to raise grievances without fear of penalty or victimisation, and that NHS Highland has a clear commitment to operate in an open, consistent and fair manner with the aim of creating a no-blame culture”. Unfortunately, I believe I am being penalised. I have received no feedback from discussions that were supposed to take place between the Chief Officer & my line manager about her behaviour which leads me to believe my grievance is not being taken seriously, leave it long enough & it might go away.”

Other Specific Concerns

- 25.13 Specific concerns about the HR function were expressed by many respondents:
- “...after many weeks I was informed that [Senior HR] would be carrying out the review instead. After more delays [her] review came back not upheld and the recommendation of alternative employment for me was still the only conclusion and recommendation. I cannot get my head around why there were so many reviews carried out when the reviewers had no intention of investigating my case properly. Were they told not to? [she] advised in her report that she would be assisting me going forward in my redeployment and that she would arrange a meeting with another member of management. However I never did hear from [her] ever again and no such meeting was ever arranged.” I resigned from my post..., as it was clear that management were not going to fix or attempt to do anything to help my situation. I had been left with no job, thus no wages; my career has been destroyed by the negligence of NHS Highland Management. Someone has to be answerable to the destruction of my life.”
- “A couple of years ago a Give Respect/ Get Respect meeting held locally after a questionnaires being completed and returned by staff. This meeting was attended by an HR representative... and members of staff. Many members of staff spoke up about instances that had happened to them at..., the way they were treated or spoken to. This took a lot of courage for these woman to speak up, they decided to raise their issues as it seemed that NHS wanted to make changes and improve relationships

with staff. Consequently nothing has happened regarding issues raised, it has been swept under the carpet and some issues regarding ... management passed off as relating to another member of staff no longer at..."

"Overall she has lost faith in HR and management - feels they are underhand, all stick together and watch each other's backs, feels blocked at every turn, feels she has been lied to on occasion - the official escalation route has not worked"

"Disciplinary hearings: NHS are prosecutor, judge, jury, executor – not impartial"

"Senior managers are not trained to handle complaints"

"NHS does not have a robust or effective system for mediation and does not have enough experienced or unbiased staff to carry out investigations."

"Moreover, no member of Management or Personnel Department responded or held accountable for the handling of the process. [Senior HR] was not even challenged after he sent in error all the documents relating to my investigation to someone who had given evidence against me. The handling of my Investigation process was reviewed by a member of staff who was subordinate to the people involved. How would such a person be able to criticise his senior colleagues?"

25.14 The following remarks by another staff member capture many of the concerns about process:

- "NHS did not adhere to and showed poor knowledge of their own policies.
- Chose to use policies which suited the organisation rather than the victim to the detriment of fair process and unnecessarily (possibly deliberately) elongated time scales to the detriment of processes and resulting in the victim being timed out of other options.
- They did not allow the victims witnesses to be called or interviewed unless they were current employees of NHS – this seriously impacted on the victim's case.
- NHS did not apply reasonable care or common sense to look after the victim and ensure her safety in the work place.
- There was no named/confidential contact made available...
- The perpetrator effectively remained the manager of the victim and made decisions about her every day working etc. This allowed him to conduct a discrediting campaign, maximise her isolation and make her working environment intolerable.
- His manager was complicit with this and was at lengths to point out that the perpetrator's rights were to be upheld and as a manager his work was more important than the victim's.
- Grievances brought forward by the victim about this treatment were not progressed to completion.
- OH reports were not acted on and a crucial one was retained by HR and not shared with a new manager.
- The Perpetrator remains in the organisation, the victim has had to leave due to impossible working environment and the unwillingness of NHS to put in place robust measures to protect her.
- The same manager and HR person were assigned to both the perpetrator and the victim. The manager was his immediate line manager who he worked closely with.
- NHS used 'the pay out offer' just before the Tribunal which as they knew triggered the funding from the victim's union to be withdrawn thus effectively stopping the Tribunal and keeping knowledge of the assault out of public domain. This also stopped the opportunity for other victims to come forward.
- The internal investigation findings of 'not proven' changed at ETI response by NHS to not guilty and supporting the perpetrator. This without any further information from the victim.
- The process from making complaint to NHS, to the victim leaving the organisation, took 19 months.
- On leaving the organisation I sought to meet with [a very senior manager] to tell her of the problems with processes etc in the hope that the organisation could learn from my experience and no one else would have to go through the same experience as me.

- She did not acknowledge my several emails even though they were copied to her secretary.
- I was continually told by HR and managers that my case was unique, I cannot believe this is the case and feel it is more likely that others distrust the NHS processes and therefore do not report incidents.”

It is this general conclusion which reinforces so much of what I have heard from others. This needs to be addressed.

The Grievance Process

25.15 Many people have expressed frustration that their complaints are not dealt with adequately:

“The reason for adding my voice to my colleagues now is my dismay and frustration at NHS Highlands Bullying grievance process. Having plucked up the courage to go ahead, x was allowed to put in a counter-grievance against me, which incidentally was remarkably similar to the one x put in against one of my colleagues when x also raised a complaint. X’s grievance was treated to equal billing with mine and the whole process seemed to be aimed at causing the least amount of headache for HR and NHS management as possible. The sole aim seemed to be to get the 2 of us to be able to work together - not to look into my allegations of long-term bullying as I had hoped.”

25.16 That these are long standing issues is reflected in this commentary on “Lessons Learnt from NHS Highland Grievance Process” provided by an existing employee who experienced difficulties a few years ago:

- “The system for raising a grievance in theory should work, but it is flawed on every level. As I discovered even senior managers do not adhere to the process and timeframe, but the complainant is expected to.
- In its current format, it is biased in favour of management and personnel staff. Union representatives may well be acquainted with the various policies, but my experience showed them to be more inclined to keep in with managers and to belittle the nature of the grievance.
- My grievance while more than valid need never have reached a formal grievance process. There should be an independent reviewer to validate

whether a grievance should progress or just an apology given.

- Persons independent of the area in which the grievance is raised should deal with it. They should have no prior knowledge or involvement with the staff involved. I.e. the Line Manager of the friend of the Manager being investigated should not be the Investigating Manager for obvious reasons of possible bias.
- Personnel and Managers should be fully cognisant of policies and their content in order to apply them effectively and in the right context. It should also be made clear on every policy that it applies to every NHS employee regardless of roles, so that managers and personnel are not exempt.
- The so-called ‘No Blame Policy’ is the only policy that managers adopt for and between themselves. It does not actually exist on paper. I was told to my face by a group of managers that they would never ask another manager to apologise for their actions or the way they manage. Instead the organisation (a faceless concept) could apologise on their behalf, if necessary.
- The personnel people involved in the debacle were never brought to account for their incompetence in the way things were handled. They were rude, unprofessional and extremely unhelpful. This gives the impression they are untouchable and separate from the workforce.
- The grievance process is made to be difficult for the person who has the temerity to be raising a grievance. Why else would [Senior HR] try to dissuade by telling you how stressful it will be. It should not be a stressful process especially for a complainant raising concerns about the stress being caused to them, and more especially so if it is an issue of bullying and harassment.
- The person raising the grievance or any concerns for that matter should not be made to feel like a villain or that they are in the wrong. It should be recognised that to reach a grievance stage, it is a last resort, a corner into which the complainant has been pushed.
- The grievance process as it stands only serves to heighten the perception of ‘them and us. It shows that there is no parity between managers and staff, or between staff and personnel. It is a side-taking exercise that allows managers

to take cover behind the lines of the spurious and dubious implementation of policies by personnel staff and to some extent even Union representatives.

- There should be a system in place, a framework with options that allows any member of staff, be it a cleaner or a manager, to raise concerns in several ways, before it might ultimately end up a grievance. It needs to be a neutral, fair process, with absolutely no possibility of bias. In some ways there is a case to be argued for this to be run by a department independent of the organisation.
- My experience showed that in an organisation that purports to be representative of the gamut of the caring professions, it became instead a coldly, defensive, uncompassionate machine that eventually, after everything I'd had to go through, proffered what can only be termed as an automated 'apology from the organisation' a truly faceless concept.
- Finally, having been through the grievance process as the complainant, not only did I have to singularly defend and speak for myself, despite providing masses of written 'evidence' beforehand and having gone to a Stage 2, before my grievance was finally upheld. I have absolutely no doubt that my personal file will have me marked as 'trouble' and that's the price you pay for 'raising concerns or whistleblowing'."

- 25.17 Other concerns were expressed about a seemingly disjointed and impartial process where interviews of witnesses and "perpetrators" took place before any formally submitted complaint or allegation, with a perceived lack of independence by those conducting the investigation and failure to take account of independent evidence and other clinical concerns.

Delay

- 25.18 Passage of time and lengthy delay came up repeatedly in my discussions and in written responses, as these examples illustrate:

"... that whole process takes far too long. The effect of this is two or three-fold. You, as the complainant, have to have a difficult working relationship with your manager while it's being investigated. Sometimes the delay means that one or both the complainant and respondent

will go off on sick. Sometimes the investigation makes things more polarised. By the time the investigation concludes, it's too difficult to make it positive for either party, neither wants to work with each other. It's a corrosive process. It doesn't need to be systemic, you just need to multiply individual experiences to make a big problem."

"I would like to report that I put in a complaint regarding bullying and undermining behaviour regarding my clinical line manager in January of this year, and discussed the complaint with the service manager at that time. By late September when I had not heard anything further, I contacted members of the Board including the interim director of HR, board medical director and chair of the Board. Aside from an acknowledgement of my email from HR I heard nothing and after a further 5 weeks contacted the above individuals again in November. Again I received only an acknowledgement from HR. On both occasions the chair of the board has not responded at all. In frustration, I chose to write a separate email to the board medical director to express my distress and disillusionment at the situation. In response to this he advised me that on discussion with the director of HR it was acknowledged that my complaint had not been progressed, but at no point have I received any direct communication from HR to inform me of the status of my complaint. Since the external enquiry has been announced I have now received an invitation to an informal meeting with medical managers, but with no indication of process or progress. The behaviour I experienced was extremely distressing but the lack of any response over a 10 month period has left me completely disillusioned with my employer and considering leaving the specialty that I have trained in, in order to avoid further confrontation and distress."

"The processes took too long to happen - things dragged on for too long and by the time meetings were made between union/ employer and HR, details were forgotten and the energy to take it forward was lost. By the end, my union rep wanted me to take it further, but I had lost the will and just needed to get a salary again."

(For completeness, the Medical Director has advised that he took immediate action on receipt of the communication on both occasions.)

25.19 Another concern is a change in approach after much delay, as this contribution illustrates:

“A second meeting was then held on [date] where I was advised that NHS Highland had decided my formal grievance would now be dealt with by the alternative ‘bullying and harassment policy’. My grievance had been accepted since [10 months ago] and dealt with under the Grievance Policy. My [union] rep and I have formally objected to the abrupt and unnecessary change and are highlighting this to you as a further example of attempting to delay and intimidate me during the grievance process.”

25.20 It seems that there are a number of reasons for delays, not least the volume of case work and the impact of that, for example, on the availability of union representatives to handle these. Overall, however, for (at least) scores of people in NHS, the lapse in time is unacceptable and deeply affects relationships for all concerned.

Perceptions of Lack of Confidentiality and Bias

25.21 As we have seen already, lack of confidentiality and perceptions of bias are a repeated concern. Respondents reported that staff do not wish to raise formal concerns because of the damaging effect this will have on them both personally and professionally.

25.22 I was told of an instance where:

“... cases are heard by managers who are line managed by the very people (senior managers) the grievances are about. This seems fundamentally flawed and open to bias and inappropriate influence. I had similar issues with Union representation who was also a Board member and again feel this created a conflict of interest and influenced how the process was managed.”

Suspension, Capability and Redeployment

25.23 There is particular concern regarding the apparently peremptory, inappropriate and inconsistent use of suspension as a disciplinary

tool without full explanation and with long waiting times for information. The use and excessive length of suspensions can result in these becoming punitive in nature.

“This investigation turned into an unjustifiably long process. I was suspended from work and banned from entering any NHS Highland premises and told not to contact any member of staff, even those who were my friends. This process lasted for 2 years. I understand this practice of long-term suspension was a regular occurrence and staff often left in the process. Not only is this a cruel and unfair process it is also a complete waste of valuable skills and tax payers money. During this time not only was I deskilling, I was isolated in a rural area with my health and wellbeing suffering greatly.”

25.24 Similarly, concerns have been expressed about the (mis-) use of “capability” assessments – with no reasons given, long duration, and unsatisfactory outcomes.

“The whole process was treated more like punishment.”

“On a professional level, to be told that I was to be assessed through the capability procedures was devastating to me. The so called support plan was insulting in the extreme and had very little substance.”

25.25 I heard that Supported Improvement Plans should be used genuinely for improvement, not as “a device to get rid of people”.

25.26 I am told that the use of redeployment often fails to address the real issue:

“Then you get people who are redeployed, they don’t want it, but they are too scared to leave and lose the post.”

25.27 I am told that redeployment is also used as a threat. More tellingly:

“I was subjected to bullying and harassment by my team leader and two of my other nurse colleagues. There was a series of incidents; I was harassed and intimidated, sworn at, belittled on so many occasions. I was being set up to fail by my colleagues and team leader often...Management turned the whole situation around on me, as if I was the problem. I was encouraged not to raise a grievance but to follow the redeployment process and procedures. The reality of redeployment did not hit me at that time, as I was under so much stress and anxiety with everything that had been

happening over the time. Management were not interested in trying to rectify the situation and they only made my extremely difficult situation even more horrendous.”

- 25.28 On general governance issues there was a concern that management more often than not moved problems and people rather than addressing them. There is a concern that the alleged victim is often required to move, rather than the alleged bully. It is suggested that moving or suspending both the alleged bully and the alleged victim during investigation would be logical and fair and would put pressure on managers to get resolution within the time required by the regulations.
- 25.29 The use of temporary and short-term contracts is also viewed as intimidatory.
- 25.30 Concerns also related to the use of Partnership Information Network (PIN) policies. It is said that *“the NHS Scotland Pin Policy – Managing Employee Conduct – is not fit for purpose”*. I have heard claims that they can be misused as an intimidatory threat. I do not offer further views except to recommend that these are looked at afresh.

Diversity and Discrimination

- 25.31 I was told by a colleague that the picture painted is of a culture that is 30 years behind the times when it comes to diversity awareness. The view has been expressed that there is a strong need to improve this and bring the NHS culture into line with attitudes and practice in the rest of the UK.
- 25.32 Cultural and discrimination issues arise:
- “I’m left feeling victimised and discriminated by several NHS Raigmore staff for having a disability and doing my very best to remain in employment. I have never put anyone at risk as I know my own limitation and have friends that drive me home if required. The allegations are not a true reflection of my caring personality. NHS staff will pretend they care about you to obtain personal information then use it against you. It deeply upsets me that I have so many discrepancies and very sensitive information on my NHS personal file.”
- 25.33 One member of staff expressed this to me:
- “I’m left feeling victimised and discriminated by several NHS Raigmore staff for having a disability and doing my very best to remain in employment.”
- 25.34 One member of the portering staff described graphically the discrimination and disdain he experienced because of his accent and origins. He advised me that he was told it would be easier just to leave his job.
- 25.35 I have also been made aware by some respondents of significant and, for those involved, distressing instances of homophobia and racial discrimination.

Failure to Join Up Events

- 25.36 There is concern that the implications of the reporting of a number of comparable events, themes and patterns are not identified.
- “Not joining up the dots, lack of system to do so (eg number of similar cases, departures from one dept etc – why not analyse human resource loss like would do with physical resources eg scanners)”
- 25.37 As a former support manager told me:
- “One of my final points would be that the department had double digit staff turnover every year that I was there - if my memory is correct one year it was approximately 25%. I strongly believe that any department that has a double digit staff turnover rate should be investigated and managerial responses of ‘they decided they didn’t like it’, ‘too much like hard work’, etc should not be accepted at face value.”
- 25.38 I heard about a situation where there were at least three other reported cases against an individual in the previous five years and *“where no links have been made between these grievances, by HR or senior management, or if links are made there is no desire to do anything about it.”*
- 25.39 In another example, *“I was told by an Occupational Health doctor that this manager’s name was one he was familiar with when dealing with staff experiencing stress and depression; I asked why he hadn’t raised this, he claimed he had “no role” in intervening in such matters.”*
- 25.40 I am advised that steps were taken at board level to monitor trends relating to sickness absence and suspensions.

Occupational Health

- 25.41 There are concerns about the ineffectiveness of Occupational Health in collating and reporting on matters to do with bullying. I am told that *“Occupational health is drowning”*, often dealing with matters on the telephone when a proper interview would be required in order to assess the situation adequately, especially if mental health issues arise.

Loss of Earnings

- 25.42 I have been asked to note the continuing financial loss that some individuals have suffered and /or will suffer. For those staff who have been forced to leave or those who have had to retire early because, as one put it, *“they really couldn’t take any more”*, there is concern that they have lost or will lose out on pensions, wages, references and other benefits.
- 25.43 This is just one example of many given to me:
“One important point I wanted to make is the significant financial loss as a consequence of raising concerns regarding patient safety, and protocols/policy resulting in my ill health both mental and physical. The stress and anxiety and depression that led to a loss of earnings resulting in half pay, with the second episode of sickness pay being stopped after 4 months.”

Datix

- 25.44 Concerns were expressed that the use of this online reporting system is not as effective as it should be. This is beyond the scope of my report but I recommend a review so that employees not only understand how it works but can use it confidently and be confident in its results, especially when reporting incidents about the behaviour of colleagues in confidence.

iMatter Survey

- 25.45 I am advised that the ‘iMatter staff surveys’ seem to have superseded other forms of survey or staff consultation. However, it is said that because they are conducted for teams there is a feeling that any comments made are then traceable. I was told that these surveys are now viewed by some as *“I Don’t Matter”*. Generally, there *“have been various staff engagement exercises such as iMatters. These do not seem to pick up the feeling*

of many staff who I know have expressed concern with this management style. Nor do HR seem to tie these episodes together and take a closer look at the impact on staff. If they are aware, there is no reassurance to staff that things are being dealt with and that their wellbeing is being taken in to account.”

The Need for a Different Approach

- 25.46 A member of staff with personal experience discussed the need to find a different way of doing things:

“...generally the evidence is very difficult to obtain, and often is between 2 individuals with no witnesses. Most often even if no evidence is found or the complaint is withdrawn (which is very unusual) the relationships have broken down so far that staff cannot work together again and this means at least one of the staff is redeployed into another area. Staff can feel punished for having spoken up, as the whole process is very difficult. On the other side of things, I can very much appreciate the need for evidence to be present before formal action can be taken against staff who are behaving inappropriately. My own view is that the policy should more adequately support staff to raise and deal with issues at the informal stage, to prevent issues escalating. Managers should be properly trained to enable ‘difficult’ conversations with staff and to challenge inappropriate behaviours (without fear of being told they are bullying the staff by setting standards)”.

- 25.47 A senior staff member wrote to me in these terms:

“There needs to be better training for those dealing with grievance procedures, mediation and follow up when these processes are finished to ensure agreed changes are ongoing.

My hope is that processes in dealing with these issues are improved. There is better training for management who deal with these processes. The cases and picture gained through things like mediation are tied together and managers or other staff who do not behave professionally are given support to improve and the staff experiencing bullying are treated with respect and supported fully.”

HR Views

25.48 I am extremely grateful to senior members of the HR team for spending time with me and for providing me with their analysis following our meeting. I repeat this in full in Appendix 3 for three reasons: (a) it provides a useful acknowledgement of many of the points made above; (b) it provides a sense of balance from those within NHSH who have a far better understanding of many of these issues than I do; and (c) it provides a number of forward-looking proposals which deserve to be fully supported.

Confidentiality

25.49 I have been asked to note that there are significant constraints on the ability of an organisation to identify patterns of alleged bullying owing to the NHS policy of maintaining confidentiality in regard to individual cases. This could contribute to lack of knowledge at board and other levels.

26. Trauma and Mental Health

A Significant Issue?

26.1 It has become clear to me that mental health should be a major management issue for the NHS and NHSH in particular. I am not an expert in trauma but I have spoken to people who are. I am persuaded that a significant number of people employed in NHSH have suffered and some continue to suffer from significant mental health issues as a result of their experiences, many of which can be described as traumatic given their repetitive and intrusive nature in disruptive and damaging situations. Trauma appears to be a more common experience than might be thought. I am told that some employees have the symptoms of Post Traumatic Stress Disorder (PTSD). It is important to have the ability to diagnose and deal with PTSD appropriately.

26.2 As one former employee told me:

“A person with developing mental health illness is not well enough or confident to stand up for themselves...The long-term effects - like PTSD - should not be underestimated and has daily impact e.g. dealing with emails, phone, challenging conversations, sleep patterns. There was no neutral counsellor/ advocate to speak to early enough until the unions made themselves involved after nearly a year off sick. Discussion with colleagues only reinforced negative issues, and there was nowhere to take issues.”

26.3 One well informed member of staff advised me that, in his view:

“NHS Highland does not take PTSD seriously, as they would an overtly physical illness. They should ask why a person has developed this condition and act to mitigate distress. This applies even to Occupational Health, at senior staff level.”

26.4 He expressed concern that:

“When these people go to interview with a manager who will put them back to work in proximity to where they were abused, they won't be able to think and will be drawn back into the trauma memories. They will experience dissociation from the here and now, and will relive (for example) being trapped, with someone looming over them and shouting with an angry face. They may be silent, but that does not indicate acceptance. They are not participating. They won't remember what is said. They are unable to represent themselves.”

26.5 I am told there is thus an issue about by whom and how they are looked after. This requires a different approach to the standard investigation and advocacy in say a grievance setting.

26.6 Another well informed employee told me:

“The legacy effects of working in an emotionally unsafe system, and the culpability that can come from an uncomfortable awareness of having been involved and complicit in something inherently wrong, but where there was no voice, can be traumatic in itself. There will be advantages, if not a need, for people most affected, to have time and space make sense of, heal and recover even as the organisation moves ahead. If there were a way to achieve this, we might take the learning and wisdom into the future.”

26.7 More generally, this is a leadership issue. Trauma-informed organisations recognise that trauma is widespread in the lives of individuals, families and communities and that trauma can be perpetuated in organisational culture and practice. This may well be the situation for some of those affected in NHSH.

26.8 I note that the Scottish Government commissioned NHS Education for Scotland to develop a framework for Transforming Psychological Trauma⁴⁷. In that regard, I also note that:

“When an individual or a team struggles or cannot evidence insight and perspective on the impact of their distress or behaviour that can be traumatising to others, the wider system needs to step in and up. Senior leaders need to be able to actively visibly demonstrate competencies and teams around them have a duty to the wider organisation where a leader is known to be struggling.”

Confidentiality

26.9 I am told that the business process means that all administrative staff have access to mental health records and that this breaches confidentiality. There can be conflicts of interest for staff working in occupational health who are handling records and cases from departments where they have relatives.

47 NHS Education for Scotland (2017). Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce. NES in partnership with Scottish Government. [online]. Available at <https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainningframework.pdf>

27. Other Concerns about Behaviour

Introduction

- 27.1 Some specific concerns were raised in connection with a number of departments, disciplines and services. I raise these here, along with some commentary and observations about what may be needed. Again, I wish to reinforce that I have not tested these matters forensically but include them as they are indicative of what can be worked on to set NHSH on a different path in the future.

Concerns Regarding GPs

- 27.2 I was made aware of a number of difficulties in relationships between some GP practices and management/central services and concerns about how some GPs are perceived to behave. It seems that the relationship between many GPs, as independent contractors, and the organisation itself at senior management level and through support systems, is often rather strained. These comments capture the concerns expressed:

“Whilst the majority of GPs are excellent to work with, there are some that prove to be more challenging, disrespectful and on several occasions I find intimidating and passive aggressive. The only intimidation I have ever experienced has come from certain GPs.”

“What I do recognise and have experience of, both personally and directed towards people in my own team, is a culture of disrespect and intimidation from some GPs and some GP practice employed staff towards NHS managed service staff. I believe that some GPs have no recognition that the way they speak to and treat staff can be intimidating, threatening and bullying.”

“Some GPs appear to have no respect for the roles and professional responsibilities of other professions and have an attitude that, as GPs, they should be in a position to command and control what other professionals will and won't do and to dictate demands to us. This is far from the collaborative and multi-disciplinary approach to patient centred care that many of us strive to achieve. I have seen and heard many

examples where staff have been made to feel humiliate and belittled by GPs.”

“As well as individual GPs having no recognition that they behave in such a manner there is also no accountability for them to improve their behaviours. As independent contractors, the Dignity at Work Policy does not apply to them and, in any case, they do not recognise the concept of dignity at work. Until recently I would also say that there has been a reluctance in NHS Highland to recognise and to try and address some of these issues. When I/we have raised such incidents with managers, I perceive there has been an approach that, because it is GPs, there is little that can be done and that we just have to live with these unacceptable behaviours. I do not think this should be the case. When we have challenged individual GP's behaviour it often does improve in the short term but then reverts back.”

“Unless the culture amongst some GPs changes, I am very concerned that we see some very experienced and highly valued staff members leave, directly as a result of how they are being treated.”

- 27.3 The impact of this on some senior managers is reflected here:

“This behaviour has not been dealt with, not because there is a culture of bullying but because as an organisation (and as senior managers in this organisation) we are afraid to do anything that would upset these individuals or would make the situation worse. There is an imbalance of power in favour of those who display this behaviour (particularly when they are clinicians such as GPs and consultants) which also creates a climate of fear.”

- 27.4 A different perspective comes from one manager who understands the tensions:

“I still have tough conversations with GPs. One meeting where they were bordering on disrespectful. But for me, that's part of the process. They need to push the boundaries to get across their point. I can understand why people could believe there was a culture of bullying, I

personally don't think there is, but I could see why they feel that way."

- 27.5 On the other hand, I heard from a GP that he perceived an anti-GP ethos and felt picked on by management:

"They'll pick that up and infer you're a trouble maker if you keep challenging what they're trying to implement, like effectively withdrawing the district nursing practice in my area."

- 27.6 There is a perception about management interference, for example in prescribing practices, in order to reduce cost. Another GP expressed concerns about a bullying approach by NHS managers towards GPs. Yet another GP described experiences she has had which have left her *"feeling ever less valued and in tears (over years) despite a tremendous work ethic and a recognised loyalty to patients and their care."*
- 27.7 As ever, contradictions abound. Issues around the new GP contract and its impact in the Highlands add a further layer of complexity.
- 27.8 An astute observer posed this question:
 "When we work for an organisation like that health service, we care for one another and care for those in lead. There is a recognition that we must nurture each other to keep doing what we do. We do have a corporate sense of responsibility. I've spoken about subcultures. I don't always get that sense of corporate responsibility from general practice. It's the way that the service is set up, it's a microcosm focussing on their own enterprise in that area. GPs are good clinicians but... I wonder if the action of my four colleagues: is it about their lack of access to leadership and support? If we are better at interdisciplinary working and access to leadership and support services, would we have got to the position we are in?"
- 27.9 What is clearly needed is a new and open set of relationships with a new and collaborative approach to leadership and negotiation about use of limited resources. This will require people-centred skills and attitudes on all sides.

Nairn GP Practice

- 27.10 One GP practice, Nairn, featured significantly in this review. It is clear that there have been serious issues between Nairn and the Board

and managers for a number of years. I heard concerns expressed on both sides. However, again, the way of dealing with this is said to have been through implied or direct threats and intimidation. This is not sustainable.

- 27.11 Nairn is, I am told, innovative and different. It may not necessarily fit the expectations of some decision-makers. That issue could be faced up to directly and respectfully. I was encouraged to think that a quantitative analysis of clinical effectiveness would help to achieve an objective way forward.
- 27.12 In any event, urgent work seems to be needed to achieve a deep understanding and common ground between the Board and Managers and the practice. I believe that skilled independent mediation would offer a start.

Radiology

- 27.13 I was made aware of serious concerns regarding this important department. It has not been functioning as it should over the years. There have been tensions between senior radiologists and management and within the department.
- 27.14 There has been concern about locum provision and risk to radiology services, especially interventional. I was told of an apparent unwillingness on the part of the Board/chair/senior management to listen to concerns over a number of years. I was told that dealings with the senior management team and the Board have been frustrating and that the severe problems around recruitment of senior medical staff to Radiology have been essentially ignored until latterly. I also heard that this has fuelled discontent so far as Radiology is concerned.
- 27.15 However, it seems clear that there are many sides to this story and indeed I heard of real difficulties experienced by some senior clinicians who provided the interface between the service and management. Senior managers have also expressed concern about disruptive behaviour by some senior radiologists. *"The Radiologists never embraced change willingly or took a lead on this... The culture in the department was difficult with a huge amount of undermining and disrespectful behaviour on-going."*

- 27.16 This whole situation has been unhealthy and would benefit from an urgent rigorous independent assessment and review (and

possibly mediation) which takes account of all points of view and not only the strongest voices. Indeed, I would suggest an overall review of the future of Radiology to ensure confidence in the vital working relationships and decision-making the department needs to ensure the delivery of safe, effective and high-quality services to their patients in the Highlands. Could it be recalibrated and become a world-class centre of excellence?

- 27.17 Whatever the outcome, this could be an excellent example of where having an overall clinical strategy at Board level would be really constructive and beneficial for the future. And where deeper understanding of the real underlying issues from all perspectives might build a foundation for a more effectively functioning service.

Chaplaincy

- 27.18 I have been made aware, from a number of sources, of internal leadership issues, including allegations of bullying, connected with the chaplaincy service which, it is recognised by a number of people, does much good work and could do more in the counselling area. I am told that staff have sought to raise awareness over many years but feel that little has changed in managing concerns.
- 27.19 Again, this seems to exemplify what many employees of NHH are saying. As one observer put it: *“A more robust approach in dealing with concerns raised could have stamped this out 10 years ago.”*
- 27.20 I suggest that a review of the leadership of the chaplaincy function may be necessary.

Mental Health and Other Departments

- 27.21 I heard a number of concerns expressed about management in various areas of mental health including neurology, neuropsychology, psychology, psychotherapy and psychiatry, especially an apparent lack of respect for clinical judgment and needs: in one context, a consultant told me:

“Many acts of overt and covert attempts to destabilise and deconstruct the department, with direct impact upon individuals including myself; unprofessional and inaccurate, displaying a

fundamental lack of both knowledge about what we do, but also lack of concern about stating that we as a professional group are not cost effective.”

- 27.22 Another concern expressed was that a service lead for mental health banned the phrase “clinical governance”; *“however, clinical governance is the cornerstone to robust lines of accountability and appropriate practice. The Francis report clearly identified failings in clinical governance that led to multiple deaths and a very top down, blaming culture.”*
- 27.23 These views are replicated by others with concerns about intimidating behaviour, harassment, belittling of services, avoidance of key issues, failure to address bullying by a head of department over many years, inappropriate management, poor clinical governance, loss of staff and failure by the union to act appropriately.
- 27.24 I also mention paediatrics, orthopaedics, dentistry and maternity as areas where specific concerns about bullying have been raised. I cannot go into further detail in this report for reasons of confidentiality.

Belford Hospital, Fort William

- 27.25 I have the sense that a review at Belford would be useful. There are concerns about its isolated nature, burnout/longevity of senior staff, the relationship with other hospitals in NHH and some inappropriate behaviours. I suspect that these will be well known to senior management.

Argyll and Bute

- 27.26 A number of respondents came from Argyll and Bute (A&B). There is no doubt that the geographic spread of NHH creates unusual situations. It was put to me that *“A&B within the context of NHH, in many respects ‘manages its own smoke’, although there is clearly a corporate link with the ‘north’. A&B is a different place to ‘north’ NHH, as all secondary care referrals go to Glasgow, and so there is no ‘clinical link’ with ‘north’ NHH which includes Raigmore Hospital.”*
- 27.27 Initially it seemed that the circumstances in Argyll & Bute were such that many of the concerns in the north might not apply there. But, as evidence came in, similar concerns were

raised, especially about management behaviour and inconsistency, and inadequacy in training of managers, appointment and application of policies and systems.

27.28 In the time available, I was not able to conduct as full a review of Argyll & Bute as of the north Highlands. Thus, I fell into the position which is often the subject of criticism by those in the west and south, with justification, of not seeming to be as interested in that part of the organisation as elsewhere. I fully appreciate that there will be much more to learn.

27.29 However, I was concerned to hear from a number of sources about particular problems in some of the island communities and of a management culture located in Lochgilphead and Oban which seems to have created significant tensions and resulted in poor relations between managers and frontline staff.

27.30 This is one example:

“Thank you for listening to my concerns. When a working environment becomes toxic over a period of time, what is non acceptable behaviour becomes normal and suddenly it’s embedded. For staff on the frontline in Argyll and Bute defensive and intimidating behaviour is normal practice that we endure on a daily basis, it corrodes confidence and lowers morale but we keep on caring for people and their families. The calibre of frontline staff is immense and they are a credit. The solution to financial pressures is within them if senior management stop and listen properly and start to work with senior nurses and staff instead of treating us like the enemy. You save money by helping people to work more efficiently through workable IT and systems not by cutting nurses, services and beds.”

27.31 The key areas of concern were described by one respondent as:

- Intimidating behaviour individually and as a team by [certain senior managers]
- Aggressive body language and facial expressions.
- Making negative or derogatory comments.

- Changes in decision making leaving people on the back foot and ill prepared.
- Making decisions affecting individuals without consulting them and announcing them widely.

Other respondents described unacceptable treatment in a small community including ostracisation, victimisation, harassment, humiliation and rumour-spreading.

27.32 This observation summed up concerns: *“A culture of undermining, intimidating and pressurising operational managers has developed within the A&B HSCP.”* I am persuaded that a specific review of management practices in Argyll and Bute is necessary and, because the nature of some of the allegations implicate management at a very senior level, consideration should be given to this being conducted by someone from outside the area who is viewed as wholly independent. Consideration should also be given to greater integration with North Highlands.

27.33 I am aware that there is new director level leadership and I hope this will help in the process of resetting matters in this part of NHSH.

28. The Role of Scottish Government

Tension and Balance

- 28.1 I acknowledge that it must be hard to be an official in the Scottish Government trying to deliver all of the policies and targets of the government of the day and knowing, by implication or explicitly, that there are all sorts of issues at local as well as regional and national levels which are difficult to manage.
- 28.2 The tension of balancing possibly competing political, policy, financial and human needs must seem acute on a daily basis. The need to achieve particular goals must place real pressure on all concerned. The same, I suspect, will apply to a minister or a Cabinet Secretary.
- 28.3 There is also the tension between intervening and encouraging organisations and individuals to deal with issues themselves. Government is often accused of over-involvement. Yet, when things go wrong, it is held responsible. Judging when and how to intervene is not easy. I mention this as it may help to explain the Scottish Government's response to its own knowledge about events in NHS.

Awareness of Situation in NHS

- 28.4 Officials were made aware in autumn 2017 about concerns expressed by NHS non-executive directors. It seems likely that more active intervention at that time would have avoided such a public and arguably more damaging process now. Indeed, I am satisfied that senior people in Scottish Government were aware of the dysfunctioning situation with the Board and at senior leadership level for a considerable period of time prior to matters becoming more public in the autumn of 2017.
- 28.5 In particular, the resignation of a number of non-executive directors and other events and information provided to the Government over a period of time ought to have signalled the seriousness of matters and could have prompted more decisive action at an earlier stage. The question of whether the Scottish Government could and should have acted is for others to consider.

- 28.6 A few observations from senior people in NHS sum up what I have heard in this connection:

"The main point there, SG have known that there are things going on."

"We were told that "we're trying to deal with this internally" which gave me the clue that the Cab Sec wouldn't know".

"I can't feel the government in any of this. I don't know where they were, what role they were playing. They've almost been watching the board self-destruct. Watching to see whether we succeeded."

"I expected an exit-interview with government in which I could voice my concerns but this never happened. I subsequently attempted to raise my concerns with [a very senior official] on several occasions soon after leaving, prompted usually by another confidential call from a senior member of staff asking for my advice. I also offered to participate in the governance review conducted approx a year ago now.... but although given assurances by the civil servants that I would be contacted, I never was."

"Scottish Government was made aware of a number of the above issues and its action was to instigate a quiet 6 month review of Board governance rather than to take a more direct or more visible action."

"The overall message, yes I believe there was a serious problem. It related directly to the CEO. I believe that, for whatever reason, Chairs were afraid to do anything about it. There was also the dynamic of government civil service and politicians. I've had conversations with everyone including [senior civil servant] about it. The reaction from civil servants are "don't put it in an email please".

"I told him [senior Scottish Government official] my story and about the whistleblowing line being a waste of time. I told him there was a list of people to speak to them. I said if they can't speak to you, what should I tell them? He said, "tell them message received, loud and clear". But then nothing happened. So, SG was of no use."

Relationships

- 28.7 I have gained an impression that the Scottish Government is sometimes viewed as being less respectful and less coherent in its engagement with boards and their leaders than it may perceive from its perspective. Certainly, the same points about a collective and enabling approach to leadership which I mention in later chapters should also apply at the top of NHS Scotland.
- 28.8 There are no doubt lessons to be learned about when and how to act. Perhaps what is needed is the setting of clear benchmarks against which to assess whether, how and when to intervene. The Scottish Government is an essential part of the system. How it acts and reacts also impacts on those in NHS boards and executive positions in local areas. Now seems like a good time to review this relationship.

29. The Whistleblowers

Introduction

29.1 Some insight into the complex nature of bringing allegations about bullying and harassment to the fore in NHSH can be gleaned from a consideration of the actions of, and responses to, the whistleblowing event of September 2018.

29.2 On 26th September 2018, a letter to The Herald was published in these terms:

“The culture of bullying at NHS Highland must change

AS senior clinicians at NHS Highland, we wish to make clear our serious concerns around the long-standing bullying culture that exists within the health board where we work.

It is our belief that, for at least a decade, this practice of suppressing criticism, which emanates from the very top of the organisation, has led to a culture of fear and intimidation. This has had a serious detrimental effect on staff at all levels of NHS Highland, but equally importantly, has had an adverse effect on the quality of care we are able to provide for patients.

With the recent publication of a report on governance at NHS Highland, and with the departure of the chief executive announced and now imminent, we feel now is the time to speak out and ensure effective action can be taken.

Indeed these recent events have seen more and more clinicians share with us their concerns on the impact this culture has had on them, the organisation and ultimately patients. While the majority are still fearful of speaking about these publicly, there have now been discussions at various forums for clinicians and we feel that, on behalf of the whole clinical workforce, it is vital this bullying culture is exposed and finally now dealt with.

Anyone working in our NHS needs to feel supported and able to speak out on issues as serious as this. Yet at NHS Highland, our belief is that some staff have not been able to raise

concerns around bullying, or indeed some issues concerning patient care, due to the culture of bullying and fear that has pervaded across the organisation.

This is the moment that this has to change. We urgently need fresh leadership at NHS Highland to take the brave and extensive actions required to ensure NHS Highland is a safe positive place to work, based on a culture of openness, transparency, learning and honesty. That is the only way that we will be able to guarantee a safe environment, delivering high quality care for patients for the future.”

29.3 The letter was signed by Dr Eileen Anderson, Chair Area Medical Committee; Dr Lorien Cameron-Ross, Vice Chair, Area Medical Committee; Dr Jonathan Ball, Chair, (GP Sub Committee and Highland Local Medical Committee Chair) and Dr Iain Kennedy (Professional Secretary, GP Sub Committee & Medical Secretary Highland Local Medical Committee), c/o Riverside Medical Practice, Ness Walk, Inverness.

Context

29.4 Another doctor associated with the named whistleblowers explained:

“After much discussion, review and soul-searching, [we] felt we were left with no option but to make a public disclosure in the interests of patient and staff safety and to try and exert pressure on NHSH to take these allegations seriously.”

29.5 This was the culmination of a number of attempts to persuade the Board to take seriously allegations of a bullying culture using the committee structures which had, so far as the signatories were concerned, failed. To the whistleblowers, the Board and others in senior management seemed closed to suggestions that there were deep-seated problems.

29.6 Many people who do not recognise a bullying culture are understandably unhappy with the way in which matters became public (and the damage that has caused). However, I am

satisfied that those involved genuinely felt they had no option but to do so and that this was the only way to address matters, even with the costs which arose. That a number of senior professionals, from a variety of backgrounds and at considerable risk to themselves and their careers, came to that conclusion is itself an eloquent demonstration of how serious matters seemed to them to be and how inadequately it appeared to them that the Board was coping with the many concerns being expressed over a significant period of time.

29.7 As one whistleblower remarked:

“We have been accused of being troublesome malcontents. It would have been far easier to just continue doing the day job rather than highlighting the bullying culture but that would have been the wrong path to take.”

29.8 As this Report has made clear, many of the concerns expressed in the letter have a sound basis. Many others within NHS, with no association with the whistleblowers, have now come forward with their own stories. People are coming forward now because it appears possible to do so and they feel liberated because others are doing so. At the end of the day, my findings are not hugely influenced by the whistleblowers’ allegations; they were ultimately a catalyst for others to come forward.

Damaging Effect

29.9 It has to be recognised that the effect of the whistleblowers’ action is significant and, for many, damaging in its own way. Many people have been hurt and feel misrepresented and offended by what has appeared to them to be a brutal step. Individual reputations in a close community have been adversely affected. The assertion that there is an organisation-wide culture of bullying has been very distressing for those who do not have that experience and is perceived to be damaging reputationally and for patient confidence.

29.10 One respondent summed up the concerns of those shocked by the letter in this way:

“... we were deeply shocked to learn of allegations. We knew nothing about these concerns. There had been absolutely no forewarning that such a serious release was to be made to the press, at national level. You

will I hope have learned that this shock was widespread across essentially the entire senior clinical workforce.

29.11 It is said that the group’s decision to go to the press, the circumstances in which that decision was made, the “false claims” that the whistleblowers were speaking on “behalf of consultants and GPs”, and the subsequent “lurid, extreme and even sinister” allegations that were made (for example of “cruelty spun into the thread of NHS Highland” and the need for “deep cleansing”), caused offence, anger, distress and a profound sense of bewilderment.

29.12 A nursing manager told me:

“From a professional nursing and midwifery perspective, it has felt disappointing that our medical colleagues have chosen to go down this way. We work in the highlands and that is a small community and we uphold the organisation as that instils public confidence. The allegations in the press have been very challenging for staff who have to field questions from the public. We have been powerless against the allegations. The actions of our medics have been divisive.”

29.13 A member of the leadership team said: *“It has been designed to create maximum impact. Left us with zero reputation, no name. I find that upsetting. This is my organisation. This is my area. My people. I find it particularly offensive.”*

29.14 There seems little doubt that certain assertions were too broad and without the support claimed: in particular the expressions “on behalf of the whole clinical workforce” and “the culture of bullying and fear that has pervaded across the organisation” imply a universality that goes beyond what this report records. It also implies that all clinicians are victims whereas it is clear that some clinicians are also viewed as perpetrators. I recall Sir Robert Francis’ comments on the difficulty of making an organisation-wide assertion of bullying. And it appears that other aspects, such as the use of social media to wage a campaign, could have been conducted more thoughtfully and tactfully.

29.15 Regarding social media, one respondent expressed concern about *“a personal attack as opposed to a reasoned argument in regard to the topic matter, given this is a public platform seen by many and not the few.”* There has been real concern about the use of expressions already mentioned such as *“a thread of cruelty has*

purposefully been spun throughout NHS Highland”; “This thread of cruelty is now marbled into the culture of the organisation. It is so deeply ingrained that only deep cleansing will cure it.” As one observer said: “‘Deep cleansing’ is an appalling phrase and has incredibly revolting connotations in a historical context.”

- 29.16 I accept that the whistleblowers themselves did not anticipate the reaction which occurred and that they have themselves suffered distress also: “...whistleblowing has been... difficult, soul searching, time consuming and unpopular,” one commented. “It has been brutal and certain relationships are unlikely to recover.” “I have been cornered on regular basis,” said another. They are concerned about victimisation in the future.
- 29.17 All of this reinforces the need to establish a culture where this sort of action is not necessary and, if it is, where it can be done constructively and safely. Of course, none of this would have been necessary or would have developed as it did had the Board and management appeared to be open to a full exploration of the issues. As one whistleblower put it: “If they had said ‘this sounds terrible, what can we do?’ That’s all it would have taken. Or ‘Right, let’s work together and sort this.’”

Board and Management Reaction

- 29.18 It also appears that, as noted earlier, the initial response by some at board and management level to the whistleblowers’ actions was not appropriate and signalled lack of full understanding and insight at best. It was perhaps unfortunate that the response to the letter in some quarters appeared to be to try to undermine the individual whistleblowers rather than to address the issues.
- 29.19 Certainly, if the reaction by some in management and on the Board was to downplay the concerns because of how and by whom they were expressed, that seems to have been a misjudgement, as it distracted the Board and others from appreciating and acknowledging how serious these concerns were.
- 29.20 It has been put to me that the NHS Board publicity machinery moved to try to discredit and marginalise the signatories as well as deny the allegations, without any attempt to investigate them seriously. This observation sums up what some people have told me:
“Staffside Unions issued a statement saying they did not recognise a culture of bullying or have

an awareness of bullying in NHS. The Director of Occupational Health also issued a statement saying they were unaware of a bullying problem. ...No attempt was made to take the allegations seriously but rather all efforts were directed at discrediting and marginalising the whistleblowers. ...Instead of open minded listening given the potential for patient safety issues arising from the allegations of bullying, they chose to deny without evidence and attempt to undermine, discredit and marginalise the whistleblowers. Their actions and those of the Board have shown that being a whistle blower in NHS is unwanted and unprotected. Energies are directed at discrediting allegations and concerns rather than welcoming them and trying to genuinely understand the issues and work collaboratively with those raising them in order to correct matters and improve the service.”

- 29.21 Hopefully, with this experience and this report, NHS will be able to take steps to ensure that there would be a different approach in the future. I comment further on this below.

Concerns about the Whistleblowers’ Behaviour

- 29.22 In fairness and for balance, I am bound to record that there is some concern from a number of sources about the general behaviour of some of the whistleblowers. Social media activity can be unpleasant. A number of people say they have felt intimidated and bullied into conforming with the view that bullying has occurred.
“This has been a theme throughout this affair, where those who have raised allegations resent having them called allegations, resent the notion of other people having differing opinions about the situation.”
- 29.23 It goes further for some:
“What we have felt and seen since the allegations of a bullying culture were made... is that fear has pervaded the organisation. This is a fear of those instigating the allegations and fear of doing anything which might incite an adverse response from this group.”
- 29.24 In addition to these concerns about whistleblowing itself, one of the more difficult aspects of my review has been acknowledging that a number of respondents have commented on the manner of one or more of the whistleblowers more generally.

29.25 While it has been represented that this matter should not be mentioned in this report at all, I do so as it reinforces the complex, ambiguous and paradoxical nature of this situation. Ironically, this may be one of the reasons for some of the resistance the whistleblowers experienced. To be a whistleblower is not an easy thing. It does not seem right, however, that whistleblowing can provide automatic protection against allegations of inappropriate behaviour. In the future, it should not be necessary for whistleblowers to make themselves publicly known and this issue would not arise in this way.

29.26 Against this background, going forward, it seems essential to rebuild trust and confidence between and with some of the key people. This is a major and important task.

29.27 As one board member observed:

“... the one thing that worries me is the Board and the original 4. I worry about our relationship with those 4 doctors. Trying to renegotiate the primary care contract that has been agreed nationally and they all play a pivotal part. Somehow, we need to get back into the room with these people. I’m anxious about that. There’s no doubt we’ve lost our trust with each other.”

29.28 The whistleblowers may find it difficult but I believe that it will be important for them to show leadership in a new and open approach. They can demonstrate the change in behaviour which their initiative has sought. And those who have been angered by the whistleblowers’ approach will need to build bridges from their side of the story. There is no other way. There is a rebuilding job to be done. It needs to start with those who have enabled this to come to the fore. I suggest that mediation could provide a way to achieve this.

An Appropriate Whistleblowing Facility

29.29 According to the All Party Parliamentary Group on Whistleblowing, a “Whistleblower” is defined as “a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation that is either private or public.

These individuals are vulnerable to retaliation for their actions and whilst there are laws in place purposed to protect them, sometimes the laws are not adequate or effective in their practical application.”⁴⁸

29.30 One former consultant who resigned as a result of the way his concerns about patient care were dealt with told me that:

“NHS Highland was not willing to acknowledge that there had been shortcomings in the care provided to patients. They avoided addressing this issue by making a scapegoat of the whistleblower. Patients have been failed by NHS Highland by their unwillingness to investigate cases of neglect. The opportunity to improve services and prevent further instances of neglect has been lost. I feel that there needs to be a change in the way that managers of the organisation are held accountable for their behaviour towards patients and the staff of the organisation. Whistleblowers need to be able to raise concerns in the knowledge that they will be taken seriously, the concerns appropriately investigated and that they will not become the scapegoats. This will only happen if there is an independent body to which the concerns can be reported. It is not appropriate for Health Boards to investigate themselves.”

29.31 I cannot comment on the accuracy of the statement about neglect but sense that the general point about the inadequacy of whistleblowing protection is an important one. It seems that whistleblowing provision which covers only patient safety issues is also not sufficient.

29.32 I heard from a number of further sources that the existing system did not seem to be effective:

“Talking to the Whistleblowing champion didn’t help.” “First, I went to the Whistleblower. I said I wanted to discuss it. I was told “that’s not what we do”. The Whistleblower was in London. I said: “if you get lots of calls from one organisation, who do you report it to?” and he said “nobody”. He said they were a charity.”

48 APPG Whistleblowing. (n.d.). APPG Whistleblowing | Home. [online] Available at <https://www.appgwhistleblowing.co.uk/> [Accessed 22 Mar. 2019].

29.33 Others shared similar experiences:

“I whistleblow once and wouldn’t do it again. There’s a woman in NHSH who will not come and speak with you because she cannot bear to dig it up again. She was made to feel that her concerns were not valid. She’s an alcoholic now.”

29.34 I understand that a non-executive director has a whistleblowing champion role. My impression is that, despite that director’s efforts, this has not functioned as effectively as it needs to.

29.35 I address proposals for better provision for whistleblowing later in this report.



Ways Forward for NHSH: General Underpinning

30. Leadership: Creating a Collaborative, Compassionate Place of Work

Introduction

- 30.1 In this chapter, I explore some of the general theory underlying the leadership challenges and opportunities for NHSH as it looks ahead. In following chapters I discuss what this might mean in specific terms.
- 30.2 The following quotation, adapted from a recent speech⁴⁹ by the Prime Minister of New Zealand, Jacinda Ardern, sums up the way ahead.
- “...one priority will be to support the mental wellbeing of all employees.... From a purely economic perspective, there are clear benefits to supporting positive mental wellbeing, including enhanced productivity. From a kindness perspective, the modern age places huge stresses on all people, which affects their ability to live full, meaningful lives. Confronting this will make us a better [organisation]”.*
- 30.3 In summary as put by another observer:
- “Once staff become safe and are treated well, you will have a workforce that is happy. A happy workforce is a motivated and productive workforce.”*
- 30.4 One respondent to the review observed:
- “Your report acts as an urgent prompt/warning to help us redesign and reengineer NHS Highlands into a kind, compassionate, fair and caring organisation for both us and patients.”*
- 30.5 Others had similar views:
- “We need to care for the carers as we do for the patients.”*
- “We all need healing; it’s the nature of the human condition.”*
- “I hope that the outcome will encourage a thriving, happy, well led organisation which provides excellent patient care and looks after the people working within it.”*

A Better Way

- 30.6 History is full of examples of situations where focussing on the people who form the workforce has transformed an organisation. Research shows that when people do what they love, work feels more like play and they are more likely to keep going when the going gets tough. They end up being more productive and effective.
- 30.7 If leadership can be inspiring, visionary, energetic and attractive, people will deliver more. Perhaps this is especially true in public service, especially in the NHS, where people often act over and above the call of duty in order to serve. The converse is likely to be true if leadership is constraining, dictatorial and fear-based.
- 30.8 A recent example can be found in the fortunes of Manchester United Football Club. The writer, Matthew Syed, whose book *Black Box Thinking*⁵⁰ contrasts safety in the health service with the aviation industry, has pointed to the shift from fear-based and fear-inducing leadership, characterised by criticism, confrontation, blame and buckpassing, which impacted negatively on performance, to a joyful, supportive, liberating approach which has released players (the staff) to see things more widely (literally as well as metaphorically, as the brain responds differently), and to become more creative, responsible, and engaged. There is less fear and more interaction. More confidence and fun in what they do. Interestingly, the new (and, at the time of writing, interim) manager has also visited backroom staff and shown interest in how they support the playing staff.
- 30.9 I note in passing that, in the aviation industry, this is not just about a “no blame” culture; more it reflects a “just” culture, where the difference between what is acceptable and unacceptable is understood. This entails another shift in

49 Ardern, J. (2019). New Zealand hopes the world will follow its wellness-based policies. Financial Times. [online] Available at <https://www.ft.com/content/6b425632-18c1-11e9-b191-175523b59d1d> [Accessed 11 Mar. 2019].

50 Syed, M. (2016). *Black Box Thinking*. Hodder & Stoughton. I might add that recent events in the aviation industry may be an indicator of what happens when safety is compromised in the pursuit of financial performance.

mindset, moving from culpability and shame to acceptance of fallibility and vulnerability. This presents another useful challenge to NHS thinking.

Resetting the Organisation

30.10 In NHS, I believe that steps can be taken, both restorative and preventative, to reset the whole organisation and to promote an institution-wide healing and reconciliation initiative, supporting and liberating the workforce. This is likely to have a positive impact on patient care and outcomes too. Better staff relationships will lead to better clinical outcomes, especially when the tasks are complex and interdependent.

30.11 No doubt, this may take many months or even years. New thinking and fresh attitudes take time to embed. Changing habits requires conscious effort. As one respondent to the review observed, *“to turn round this liner, you need lots of people going in the same direction with confidence in those on the bridge – this will take time.”* Someone else suggested that the better analogy is with a flotilla of boats all heading in broadly the same direction. In any event, there is a transition stage to be undertaken. Another senior director told me:

“We need to work through, we will be working together for a long time. It’s going to take time. People have tried to sort our issues through one-off interventions. This is going to take years of counselling.”

30.12 Another manager told me:

“I think people, managers, NHS need to look at a way to work together rather than be in competition. Integrate properly. Add to that, the struggles I come across with the people I have professional responsibility for, I looked at a way to increase access. Managed to increase resources, but people need to work smarter. But there’s resistance there because they feel under attack. Management think they do communicate well, but I’m not sure they communicate effectively. They need to be more open with the struggles NHS is facing. Rather than coming up with immediate solutions, they need to work towards developing a shared vision and get people on board.”

Collaboration and Interdependence

30.13 To achieve this, there is an urgent need to collaborate and work together rather than to compete, based on a deeper and wider understanding of the shared interests that allow people to cooperate more effectively and efficiently to find solutions. No man, woman, doctor or manager is an island; there is a mutual interest in supporting each other. Interdependence is the watchword.

30.14 This has its own challenges, given the geography:

“[Management] didn’t come together very well in multiple sites. Now you have chief of medicines for various hospitals. It’s about achieving the balance of accountability and responsibility by site and also having the ability to work collaboratively and influence in the greater interest in the organisation in other sites. Joining these sites up without losing the individual strengths.”

30.15 It is likely that all of this will require an overall strategy which focusses on full engagement and openness, and the enhancement of effective working relationships throughout the organisation. This will help to build a culture of cooperation and respect which is founded on a deeper understanding of the differing roles and viewpoints of various groups such as clinicians and managers, to take an example. Inviting colleagues to participate in a rebuilding exercise will reap dividends. A coherent, integrated approach is necessary. Working in any one part in isolation will be challenging if the values are not shared by other parts of the chain.

30.16 As the consultants, The Phillips Kay Partnership, put it,

“To make sense of complex social systems requires many perspectives to be brought together. No one person or group could ever understand the whole environment. To release the collective intelligence in the system we must build strong and open relationships.”⁵¹

51 The Phillips Kay Partnership Ltd. (n.d.). [online] Available at <http://phillipskay.com/> [Accessed 11 Mar. 2019].

Process and Relationships

30.17 Put more broadly, I believe that this is an opportunity to encourage a different way of dealing with the inevitable stresses and strains of providing health services in the Highlands and to apply some new thinking, to the benefit of all concerned. It is, as Phillips Kay remind us, all about the how, the process, the journey: *“The process you use to get to the future is the future you get.”*

30.18 The key to survival as an organisation is cooperation. Arguably, in order to overcome the chronic nature of any dysfunctioning body, there needs to be a shift from paradigms which are power-based (resting on hierarchy and status, win/lose, operating by command, with an expectation of obedience) and/or rights-based (resting on bureaucracy, operating by control, with a high expectation of compliance) to one of mutual interests, with shared vision and openness, where power and decision-making is shared, and distributed, wisely and thoughtfully. What might that entail?

30.19 As Ken Cloke puts it in discussing the points made in the previous paragraph, we need to develop better attitudes, behaviours, processes and relationships with skills and capacities which help to reduce resistance, overcome impasse, build trust, encourage participation, value diversity and dissent, redress injustices, encourage feedback and evaluation, and which accept ambiguity and complexity. A tall order but it needs to be done for a complex organisation to thrive.

30.20 He explains:

*“If the content of the problem is successfully addressed and the relationship is constructive, but the process is ineffective and unfair; or if the content and process are successful and effective, but the relationship is competitive, adversarial and untrusting, chronic conflicts will arise that can prevent even the best solutions from being implemented. Yet nearly all of our focus in solving ... problems and making decisions is on the content, and comparatively little is devoted to improving either the processes or the relationships. This is often because of pressure to deliver, achieve results, under great pressure. Short term gains [but] with longer term losses.”*⁵²

30.21 He points out that: (a) the substance or content of the problem must be successfully identified, discussed, addressed and resolved; (b) the process for solving problems and making decisions must be inclusive, transparent, effective and fair; and (c) the relationship between the people who are impacted by the problem, or trying to solve it, or make decisions about it, must be respectful, constructive, trusting and collaborative.

30.22 Thus, as one senior NHS executive put it:

“All improvement begins with relationships. And by that I mean good, trusting and empathic relationships. Add reliable processes to this and as long as you are using the right measurement to steer your progress then improvement will happen.”

30.23 Another commented:

“I passionately believe that the people of the Highlands deserve a better health service and that this will only be achieved if we can foster better working relationships between clinical and operational staff and create a working environment where decisions can be made more promptly so that the standard of care is improved.”

30.24 Another put it succinctly, *“whatever change we seek to undertake, we are only as good as the relationships we are able, or capable of creating and sustaining.”*

30.25 If relationships are not strong, respectful and open, no amount of procedural changes or micro management will lead to the kind of cultural change that is required in NHS. The Scottish Government’s Collective Leadership initiative also reminds us that: *“We cannot make this kind of change by telling people to do it. We need a clear appreciation of the power and importance of relationships to enable our work.”*

52 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

Command and Control to Collective Leadership

30.26 This necessarily entails a move away from trying to control everything to a more distributed, multi-disciplinary or collective leadership and decision making. NHSH is probably too big and complex an organisation to control in any event but, in trying to do so, the trouble may have been that relationships have sometimes taken a back seat as one-off transactions seem a more efficient (or easier) way of operating. This turns out to be hugely inefficient and costly, however. A more holistic approach is needed, acknowledging complexity, ambiguity and uncertainty.

30.27 This also requires an approach to negotiating distribution of resources and addressing other potentially contentious issues which is based on interests rather than positions: the *Getting to Yes*⁵³ model. Ironically, perhaps, this helps to create more value. We are reminded that “[h]elping people create more value on their own represents one of the highest forms of respect.”⁵⁴

30.28 Many factors interact and conventional management approaches will need to give way to greater collaboration. In a sense, one is looking for a move from heroic leadership to post-heroic, as the jargon describes it. This is likely to apply both to senior management and to clinical leaders. Delegation and empowerment do not, however, mean abdication and senior leaders will still need to take appropriate responsibility. I note these words from the NHS Education Scotland Leadership Behaviour and Qualities Guidance Notes:

*“The model of ‘heroic leadership’ is no longer appropriate. What is required is ‘engaging leadership’: ‘a commitment to building shared visions with a range of different internal and external stakeholder...[which] exploits the diversity of perspectives and the wealth of experiences, strengths and potential that exists within the organisation, and with partners and other stakeholders’.”*⁵⁵

30.29 Peter Senge and others commented on the leadership style of Nelson Mandela:

*“Perhaps the most transcendent example of Mandela as a system leader was the Truth and Reconciliation Commission, a radical innovation in the emotional healing of the country that brought black and white South Africans together to confront the past and join in shaping the future. The simple idea that you could bring together those who had suffered profound losses with those whose actions led to those losses, to face one another, tell their truths, forgive, and move on, was not only a profound gesture of civilization but also a cauldron for creating collective leadership. Indeed, the process would have been impossible without the leadership of people like Bishop Desmond Tutu and former President F. W. de Klerk.”*⁵⁶

There are clear signals here for a different way to approach NHSH. Where are the Tutus and de Klerks?

Compassionate People-Centred Leadership

30.30 Such a pro-active approach requires resources and skill, of course. It needs an enabling culture from the top. Culture change needs to be owned by the leaders. That means leaders who are not afraid, who have high self-esteem and a great deal of humanity and compassion. Kindness is a critical component of the leadership which will be needed going forward. This is not some kind of passive, acquiescent, permissive approach but active engagement in building, encouraging and sustaining excellent personal and professional relationships.

30.31 As I mentioned in earlier in this report, and with reference to the NHS Highland Senior Manager and Executive cohort annual appraisal, humility, honesty, openness and self-awareness are all desirable characteristics. People-centred leadership in other words.

53 Fisher, R., Ury, W. and Patton, B. (2012). *Getting to Yes*. London: Random House Business.

54 Shook, J. (n.d.). Lean Quotes from John Shook to Inspire You and Your Team. [online] Lean.org. Available at <https://www.lean.org/LeanPost/Posting.cfm?LeanPostId=688> [Accessed 13 Mar. 2019].

55 NHS Scotland (2014). Guidance Notes for NHS Scotland Leadership Qualities Framework. [online] Available at: https://www.nes.scot.nhs.uk/media/3399300/scottish_leadership_qualities_framework_-_guidance_notes_july_2014_-_copy.pdf [Accessed 13 Mar. 2019].

56 Senge, P., Hamilton, H. and Kania, J. (2015). The Dawn of System Leadership. Stanford Social Innovation Review. [online] Available at https://ssir.org/articles/entry/the_dawn_of_system_leadership [Accessed 13 Mar. 2019].

30.32 This is a profoundly compassionate approach. And I believe that it was Bishop Tutu who said in his inimitable way:

“Compassion is not just feeling with someone, but seeking to change the situation. Frequently people think compassion and love are merely sentimental. No! They are very demanding. If you are going to be compassionate, be prepared for action!”

30.33 Commenting on this, a colleague observed:

“And you simply can’t be compassionate at the same time as being judgemental. When you judge you look down to get a clear view but when you feel compassion you are sitting beside someone looking at what they are looking at through their eyes with your arm round them - and you can’t be in those two different places/ mindsets at once.”

30.34 Research backs up the compassionate approach. The University of Edinburgh Global Compassion Initiative reports that:

“Mounting evidence from the new science of compassion demonstrates that it is key to: improving personal and organisational performance (in cooperation and productivity, resilience, employee commitment and retention), enhancing effectiveness (creativity and innovation, navigating change, collaboration, addressing conflict); supporting well-being (physical and mental health, engagement at work, and welfare); and building reputation (credibility).”⁵⁷

All of these are highly desirable outcomes for the new approach to leadership which NHSH has the opportunity to embrace.

30.35 The challenge for NHSH is to find the right kind of leaders. One senior consultant who regretted his own unwillingness to step forward told me:

“... we seem to have promoted within the organisation those who either have a thick skin or those who just don’t care. I feel sorry for the former group as they don’t seem to understand the qualities of leadership that are needed. We desperately need others to step forward. How

we encourage people with those skills to do so is unclear to me.”

This report is a call to action for people like this consultant.

Understanding and Complexity

30.36 I sense that an honest conversation is needed more generally in the NHS, and with the general public and employees, about realistic expectations and the perhaps inevitable tensions between clinical delivery and financial reality. Seeking real understanding is a key to all of this. How well do people really understand what the underlying issues are and where others are coming from? How can that be addressed?

30.37 As has been pointed out: *“If we assume too readily we can see things from others’ points of view we end up seeing them from merely a variation of our own.”⁵⁸* So we have to go further than simply stepping into another’s shoes to see what things look like: we need the competence to try to understand the context in which things are being seen by them.

30.38 That context is complex and multi-layered. I note the approach commended by the International Futures Forum (IFF):

“We follow the OECD definition that ‘competence in complexity’ is not an abstract achievement but “the ability to meet important challenges in life in a complex world...”⁵⁹

30.39 This resonates with the emerging work on systemic organisational constellations, drawn to my attention by my colleague Liz Rivers who assisted in the review:

“Systemic constellation is able to reveal embedded patterns that would otherwise be very challenging to understand and change, or simply impossible to access. Even if we intellectually recognise the patterns of negative behaviours and destructive relationships, it is in practice extremely difficult to transform these patterns. Through systemic constellations, we see the complex web of interconnection reaching into our

57 The University of Edinburgh. (2018). *Global Compassion Initiative*. [online] Available at <https://www.ed.ac.uk/global-health/global-compassion-initiative> [Accessed 20 Mar. 2019].

58 Baggini, J. (2018). *How the World Thinks: A Global History of Philosophy*. Granta Books.

59 Iffpraxis.com. (n.d.). Competence in Complexity. [online] Available at <http://www.iffpraxis.com/competence-in-complexity> [Accessed 11 Mar. 2019].

society, organisations and individual life. Experiencing this interconnectedness can have a powerful effect in our organisations and gives the possibility to transform unhealthy systems.”⁶⁰

30.40 I was struck by this comment about what is called “Eco-Leadership” which is *“very much the environment where we are concerned with emergent change, where we are no longer leading change in a traditional sense, but creating the leadership capacity under which we can handle ambivalence and uncertainty. In this situation, the leadership role is increasingly about interpretation and sense-making for the organisation.”⁶¹*

30.41 This may all make sense as an appropriate underpinning for a 21st century NHS and resonates again with the issues of complexity, ambiguity and uncertainty identified in the National Performance Framework referred to in chapter 4. And, of course, it fits in well with the Collective Leadership approach also promoted by the Scottish Government:

“Critical to working in this way is recognition that it is about “in here” as well as “out there” – we need to develop the skills and attributes to be able to work collectively within both the individual and groups for greatest impact on the system.”

60 Cohen, D. (n.d.). What are Constellations?. [online] Isca-network.org. Available at <http://isca-network.org/systemic-constellations/what-is-a-constellation> [Accessed 13 Mar. 2019].

61 Simonwestern.com. (n.d.). What is Eco-Leadership?. [online] Available at <http://www.simonwestern.com/leadership.asp.html> [Accessed 22 Mar. 2019].

31. Looking Ahead

Acknowledgement

- 31.1 It is against this theoretical backdrop that, as noted above, steps need to be taken urgently, both restorative and preventative, to reset the whole organisation.
- 31.2 As I have noted earlier, there is a desire among some for vindication and retribution. However, fault-finding and a culture of blame will not be a productive way forward. Wherever possible, NHSH will need to look forward constructively to the future and not dwell overmuch on guilt about the past.
- 31.3 Looking ahead, it will be necessary, however, to find ways to acknowledge the circumstances of the past, to recognise the impact on individuals, processes and services, to demonstrate acceptance of some personal responsibility, to show that lessons have been learned, to reassure staff and indeed the general public that there is a genuine willingness to grasp the need for change and that things will be different in the future, to rebuild confidence, and to move forward with greater competence in the years ahead.
- 31.4 Reassurance will be needed also for those who feel that their careers have been or may be affected merely by standing up for what they believe to be important. And also for those who have failed to match the expected standards of behaviour. It will be a difficult balance to strike.
- 31.5 As discussed earlier in this report, it seems likely that preservation of jobs and livelihoods has been very important at many levels and has driven behaviour both by those to whom bullying behaviour is attributed and by those who have felt bullied. The various factors which are unique to the area (and identified in chapter 16) suggest that real care is needed in supporting and nurturing inter-personal relationships in NHSH and identifying where these are weak.
- 31.6 Some grievances will still need to be addressed formally and steps should be taken expeditiously to address outstanding claims as part of a move to make a new start. This will require significant constructive engagement by the trade unions. This will only be relevant if the unions feel

that the management and Board have taken steps which fully and adequately address their members' concerns. I expand on this in my proposals in the following chapters.

- 31.7 Whether all of those who have participated in the events of recent years will be able or will wish to participate in such a rejuvenation is hard to know. The experience of humiliation, resentment, and anger that many people have experienced will not go away on their own and because people say they should. There is the familiar journey to be travelled from denial, through blame and on to acceptance.
- 31.8 A thoughtful and nuanced approach will be necessary. To what extent a truth and reconciliation approach is necessary requires to be worked out. There is a danger of moving too far too fast for some of those affected. And, as one respondent told me:

"I think the worst thing would be if your report says "we have some learning. We need to do things differently" in a wishy washy way."

Healing

- 31.9 It will be necessary in many cases to draw a line and move on and for many past grievances to be let go of. Individuals will need to decide whether and how they might do so. Adult conversations seem critical. Moving away from the victim/perpetrator paradigm is essential. Generosity of spirit will be necessary, even towards those viewed as perpetrators, who have often also been victims themselves. Bitterness will not assist healing. Freedom only comes with making the choice to move on. *"Resentment is like drinking poison and hoping the other person will die,"* as Nelson Mandela is reported to have once said. And to do this will require a lot of support and help.
- 31.10 One member of staff with experience in the mental health field said:

"I would observe/add that the legacy effects of working in an emotionally unsafe system, and the culpability that can come from an uncomfortable awareness of having been involved and complicit in something inherently wrong, but where there

was no voice, can be traumatic in itself. There will be advantages, if not a need, for people most affected, to have time and space to make sense of, heal and recover even as the organisation moves ahead. If there were a way to achieve this, we might take the learning and wisdom into the future.”

31.11 There may be some useful guidance in remembering that, as is often said, small changes may be all that is needed or possible but may themselves result in bigger changes in due course; the past cannot be changed and it may be most useful to concentrate on the present and the future; with the right support and encouragement, people often have the resources necessary to help themselves; in a sense, they are the experts in their own situations and can (re)build relationships one conversation at a time, if they have the necessary support and encouragement to do so.

31.12 There should be little doubt that many of the resources, ideas and skills needed to take the organisation forward exist already in NHS. These can be identified, released and facilitated. Existing good practices can be recognised and built on.

31.13 A member of staff addressed this in very specific terms:

“More than anything there needs to be a culture of support and value. This cannot be just created by a new initiative, but needs individual teams to start functioning as caring units, valuing each other and supporting each other. The expectation to work well beyond contracted hours needs to be changed, so that a work life balance can not only be achieved by staff, but be valued and used to promote the attractiveness of careers in health. It is so easy for health care staff to be coerced into working above and beyond, because if they don't patients will suffer and staff are by definition caring. The organisation needs to recognise that attention and resource must be put into supporting staff whether this is through addressing staffing levels and acknowledging that with current resources some services may be limited; or providing time for support such as the mentoring scheme for doctors (ideally for all staff), appraisal etc. It would be very encouraging to see the start of an open, honest and supportive culture within this organisation.”

31.14 Another senior NHS manager provided this summary:

“It is really sad that the pressure on NHS staff means that managers rarely have time, or skills or training to defuse tension and support their staff and so situations of frustration fester and result in unfortunate situations. What is so bizarre is that these personal attributes that make for good relationships exist - in spades - but are all directed towards the patient and there is nothing left for colleagues.”

31.15 In other words, as NHS looks forward, looking after the people who are looking after the people is central.

Resilience

31.16 In my research, I came across the example of the Lockerbie air crash and the effect that a profound shock to the system had on the public sector at the time: the local authorities rose to the occasion and developed ways of working together that held good in the future. It is said that shocks can test the resilience of a system and often enable it to come back stronger and more adaptive (not bounce back but bounce forward).

31.17 A crisis can create an opportunity to learn and build a better way forward. The system that will emerge on the other side of the crisis is shaped by those leaders who are able to harness the potential in the moment and galvanise others to act. This emphasises the opportunity now available to NHS to model a different way of behaving as an NHS organisation.

31.18 I also note this helpful reference to resilience in the context of health in the Annual Report of the Director of Public Health for NHS on Adverse Childhood Experiences, Resilience and Trauma Informed Care, in 2018, under the heading of a 'sense of coherence' as a route to resilience:

“[Aaron] Antonovsky concluded that a healthy outcome depended on an individual's 'sense of coherence' which was the ability to make sense of, and manage the external environment. Essentially, unless an individual can view the world as being manageable and meaningful, they will experience a state of chronic stress. The former Scottish Chief Medical Officer, Harry Burns, argued that public policy should seek to enhance this sense of being able to control one's life. He puts forward the view that if policy makers persist in defining a population by its deficiencies and problems,

then services will only ever be designed to fill gaps and fix issues, which leads to a further feeling of people as 'passive recipients of services, rather than active agents in their own lives.' The key, then, is to pay attention to the emotional, psychological and spiritual resources that allow people to build relationships and establish social networks, so that people have opportunities to find what is meaningful to them, in a way that fosters optimism and control.”⁶²

- 31.19 The emphasis on resilience, empowerment, building relationships and establishing thriving networks seems crucial to the future for the workforce in NHS.

Realism

- 31.20 Finally, one former director emphasises the need for realism:

“Realistic Medicine was introduced by the Chief Medical Officer for Scotland a few years ago and has gained great interest as a method of overhauling the clinical aspects of the health service. I have been suggesting Realistic Communication to be developed as a means of streamlining, and so making more effective, information dissemination at all levels. I would now add to that Realistic Management, as we need to be mindful of delegating realistic tasks ie not raising expectations of implementation with inadequate resources (especially time) which is effectively setting people up to fail and so brings about further disillusionment and disengagement.”

- 31.21 Finding ways to promote the kind of changes commended in this and the preceding chapter while realistically managing expectations will be one of the first challenges for the leadership.
- 31.22 On the other hand, there is no need to reinvent wheels, rather a need to make them work and move forward. I understand that the NHS Scotland Everyone Matters people strategy has some core and common values (care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork) which could readily underpin the kind

of strategy I am suggesting in NHS. As a keen observer commented: *“Much of what is suggested is already out there, alongside the good practice that is evident in other boards, which could help to shorten some of the journey time.”* What a useful point this is.

An Example to Others?

- 31.23 If the entire community of NHS can find a way to move forward from the experiences of the past several years, they might provide an example to others who will face similar challenges in adapting to a very different future. There is no choice but to face up to the need for change:

“The framework we use today may have been appropriate in earlier times, but it is no longer in touch with the complex challenges and demands of our time.”⁶³

Trust

- 31.24 I realised, when reviewing this report at a late stage, that I had not written much about trust. Everything in this and the next section of the report, however, is really about restoring trust. Without trust in the senior management, the board, managers, and each other, NHS will struggle to move forward. With trust, everything is possible. Trust takes a long time to build. It has to be earned and maintained. “Do as I do as well as do as I say” probably sums up well the need for integrity, consistency and example as foundation stones for a trusting community.

62 van Woerden, H. (2018). Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity. [online] p.38. Available at [https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_\(web-version\).pdf](https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf) [Accessed 20 Mar. 2019].

63 Scharmer, O. and Kaufer, K. (2013). Leading from the Emerging Future: From Ego-System to Eco-System Economies. Berrett-Koehler Publishers.

32. Dealing with Disagreement and Difficult Situations

Introduction

- 32.1 In NHS, as in many organisations, more attention should be paid to early intervention, when a difficulty or conflict is first identified. This is what is often known as preventative spend in reality. This could dramatically reduce the number of situations which escalate into full-blown bullying or harassment issues. Often, the presenting of such matters in a disciplinary or grievance context is merely symptomatic of deeper underlying concerns which are better dealt with in a non-binary or non-adversarial way.
- 32.2 I am told that many people accused of bullying behaviour are taken completely by surprise by the allegations, because nobody has raised concerns with them before. So often, relatively small incidents at the outset can escalate out of all proportion. Nipping matters in the bud is critical – and finding ways to do so is essential.
- 32.3 This can be addressed by education and training, by empowering those affected and bystanders to raise concerns early, and by introducing other different approaches which move away from adversarial or binary processes.

Dealing with Disagreement Generally

- 32.4 A wise observer of the NHS scene told me:
- “On complaints outcomes, I am increasingly drawn to moving away from the binary upheld/not upheld outcome of a complaint. However you dress this up, the experience of one party to a complaint on hearing the outcome is that they have ‘lost’ and the other is that they have ‘won’. My experience is that this can have a negative effect on future relationships from the point of view of both the complainant and the organisation (including the person complained about).
- And in relation to the impact of culture, it seems obvious to me that the way in which an organisation approaches and deals with its own internal disputes and disagreements must have a direct effect on how it deals with external concerns such as complaints. So I would argue that in order to improve complaints handling

about your services, you need first to improve the way in which you deal with internal disputes – by which I mean conflicts and grievances.

I believe strongly that conflict can be positive – as long as it is open, honest and respectful. So part of the work ... in future is to encourage organisations to change their internal culture by promoting the resolution of internal disputes through constructive discussions (which may be facilitated). This may mean moving away, wherever circumstances allow, from HR processes such as disciplinary and grievance investigations which can be experienced as destructive. We are not going to reduce the negative impact that being complained about can have unless we change our internal dispute resolution culture.”

Mediation

- 32.5 One way to enhance early management of difficult situations is to make more use of mediation and other facilitated conversations. As one union representative put it to me, mediation can be very useful; when a conflict is first identified, a mediated discussion can be extremely successful in preventing escalation and avoiding future conflict. It enables people to see one another’s points of view; to share their own perspectives and to have a good chance to explore all the issues in a balanced way which is not blame orientated. Because mediated outcomes are designed and agreed between the parties involved, there is increased ownership of the outcomes, and therefore higher likelihood of them being adhered to.
- 32.6 Many of the issues currently being addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, early intervention through mediation. The key is to encourage acknowledgement and recognition of adverse experiences, a more positive response, and ensure that staff feel their concerns are being appropriately handled, whatever the eventual outcome may be.

32.7 One respondent offered this view:

“Mediation in a well documented option for employees of NHS Highland as an alternative to moving straight to a first level grievance. However, it is not always selected as the way forward. This is especially the case when claims of bullying are against managers. It would be helpful to better understand the benefits of mediation as opposed to placing two or more people in adversarial proceedings where they blame and accuse each other of unreasonable behaviour and defend themselves against the same. These allegations often require lengthy and extensive investigation which often entrench positions and normally exacerbate problems in working relationships. We hope that one angle of your inquiry may be to recommend each employee of NHS Highland to take time to consider better ways of exploring and resolving conflict rather than seek to blame and punish colleagues through raising formal grievances.”

32.8 A staff representative said:

“We fully appreciate how difficult bullying and harassment cases can be for HR departments to deal with, but a change is due in the way concerns are investigated and how conflict issues are addressed. [Staff] advisers, who directly support members facing such difficulties, know that bullying and harassment complaints can take a long time to investigate and resolve. Often 6 months to a year in their experience, but even longer in some more complex cases. It is fairly common for ‘counter’ accusations to be raised against anyone who has raised their own concerns. This can all add up to a fairly torturous experience for all involved; prolonged investigations can drain people’s confidence, resolve, self-esteem and impact significantly on mental health and general wellbeing. There are often knock-on effects for other (uninvolved) colleagues in a department, who have to continue working in what can be a highly tense environment as a process is worked through.

We believe that there may often be better means for resolving issues, for example by processes like mediation. We strongly believe that mediation is not used or explored as an option often, or early, enough. Mediation has traditionally been seen by the NHS as an expensive luxury, but the potential savings to the NHS by dealing with conflict at an early stage can be considerable. Conflict can cost the NHS by way of lost working hours, staff demotivation and unease,

resignations, as well as financial and time resources spent on running formal processes.”

Scottish Government Initiative

32.9 I understand that, in 2016, the Scottish Government formed a Mediation Working Group. The aim was to develop an effective, alternative dispute resolution service as a shared resource for NHS Scotland employees, through engaging or establishing an “NHS Scotland Mediation Network”. The network aimed to coordinate NHS resources, and to support and develop NHS Scotland mediators. I understand that work on this project ended before real headway was made.

32.10 Many feel that this was a missed opportunity to place mediation at the centre of NHS dispute resolution, and that this may reflect a common reluctance to invest in a process that is known to be of considerable benefit. The opportunity should be taken to look again at an NHS Scotland-wide mediation network. Once again, the idea of preventative spend is surely a key factor in looking at a new approach.

32.11 One trained NHS mediator put it eloquently:

“We should reflect on the failure to translate the training as workplace mediators some of us had for the NHS as a whole in Scotland into activity that justified the investment. This was the most thorough and useful training I had in my last ten years as an employee and it was not a little frustrating that, once trained, the work place mediators were rarely used. I still do not know if this was a failure to match supply and demand or advertise the availability of (simple) mediation or if it all became bound up in HR processes and anyone who was a general manager was excluded from acting as a mediator – something that could have been sorted at the outset.”

Mediation in NHS

32.12 Therefore, it appears that the time has come to place mediation firmly at the centre of a preventative strategy in the NHS in Scotland. That could start in NHS. The process could be introduced in a layered fashion: a system of internal informal mediation would be available

to nip matters in the bud, with more formal internal and, where necessary, external provision available for matters which had escalated or were in danger of so doing.

- 32.13 The preservation of independence and perceived impartiality is crucial in any mediation provision. The use of HR professionals who have already been engaged in the investigation process should be avoided. To this end, a properly resourced mediation service, independent of HR, should be inaugurated using trained mediators throughout NHS.
- 32.14 This could also be shared across the public sector in Highland and the idea of a Highland Collaboration Hub has been mentioned, providing a resource for public sector bodies generally in the Highlands. This may be particularly useful given the geographic extent of NHS.
- 32.15 It is recognised that mediation does not always work and that maintaining appropriate training and standards is important. It was suggested that transparency would be more likely if the mediation and dispute processes were subject to random but frequent audit by an independent reviewer from outside the health board.

Hübl on group coherence and collective trauma it is noted that *“When strangers come together in a meeting place, some may arrive wearing social masks, protecting themselves from expectations and judgments, or presenting an image of themselves as how they want to be perceived.”*⁶⁵

- 32.19 Helping people to set aside the masks and face up to and move on from painful experiences will often require skilled intervention by skilled facilitators.
- 32.20 In a sense, the ideas in this chapter are steps to enable the organisation itself to become a community which is geared towards prevention rather than resolution, in which the staff as a whole are aware of, and wherever possible trained to look out for, each other and encouraged to evolve into a more compassionate, supportive culture.

Facilitation

- 32.16 To this, I would add, skilled facilitation. The Scottish Government’s Collective Leadership initiative makes the point that more generally there is *“a clear need for skilled facilitation and creation of the spaces to explore and have frank and honest conversations... long-term facilitation helps support and hold the space for change to emerge and become embedded.”*⁶⁴
- 32.17 I heartily endorse this approach and commend it for some of the work which is necessary in NHS.
- 32.18 Indeed, the importance of this becomes more apparent when one considers the collective impact of some of what has occurred. In the next sections, I recommend meetings and other ways to address these matters. However, this is not easy: in an article describing the work of Thomas

64 Collective Leadership (2019). Collective Leadership for Scotland: Year 1 Report. p.8.

65 Hübl, T. and Avritt, J. (2017). Thomas Hübl’s The Pocket Project: Facilitating the Integration of Collective Trauma – Kosmos Journal. [online] Kosmosjournal.org. Available at <https://www.kosmosjournal.org/article/thomas-hubls-the-pocket-project-facilitating-the-integration-of-collective-trauma/> [Accessed 11 Mar. 2019].



Ways Forward for NHSH: Specific Proposals

33. Specific Proposals: Leadership

Introduction

- 33.1 In this and following chapters, I set out proposals both for the present (restorative) and for the future (preventative), with one word of caution: if these are proceeded with in the same pressurised way that has characterised some activity in recent years, the result may be frustration and sub-optimal outcomes. This cannot simply be reactive problem-solving. A merely technical and transactional approach will risk simply repeating the errors of the past. As noted in previous chapters, this is as much about tone, attitude and relationships as it is about procedures.
- 33.2 This is a time for a measured, thoughtful and coherent strategy. As someone recently said, at a time of uncertainty and doubt: *“the winners will not necessarily be the ones that find an answer fast. They will be the ones that find the right questions.”* And those that take full responsibility for doing so.
- 33.3 Throughout these chapters, readers will wish to ask the crucial questions: *Where are the gaps? What is missing? What is not clear or is misunderstood? How can this be improved upon?*
- 33.4 What I suggest in the following chapters is only the beginning of such an approach and constitutes some of the possible component parts of such a strategy. There is a balance to be struck between moving towards the kind of radical cultural change which will help NHSH to thrive and the need for specific actions to be taken in the short and medium term.
- 33.5 There are a number of caveats: various other reports (including Gallanders, Polley and Brown, all mentioned in this report, together with others which have been commissioned) have already covered many of these (and other) points and most are useful and helpful. They should be a foundation to build upon; this report may merely supplement them.
- 33.6 I have not captured all of the points arising in previous chapters and readers will wish to refer back to earlier sections also. I have adopted

some proposals put to me by others which seem sensible and adapted others. All of these suggestions are therefore perhaps best viewed as guides.

- 33.7 There is a Quick Summary of Main Points and Proposals at the end of this section. While it is tempting to offer an order of priority for these, that is a task for NHSH to carry out in the manner I suggest in the following section.

Collaboration and Responsibility

- 33.8 As steps are taken to work out the appropriate way forward in collaboration with the NHSH community at large, it is worth remembering this maxim of The Phillips Kay Partnership:

“Strategy and policy designed remotely from the people who must deliver is never well implemented. It is better to design well a strategy with the people who must work with it, than to implement poorly a brilliantly thought out strategy that is developed elsewhere.”⁶⁶

- 33.9 Thus, the most crucial recommendation is for the new leadership to adopt the collaborative mindset set out in chapter 30 and take these ideas to the NHSH community at large and work with all the very able people there to build a new culture. Such a participative, collaborative approach to working out the way forward seems likely to be productive.

- 33.10 In conducting this review, I came across many able people (at all levels, many of whom are not “the usual suspects”) who would contribute hugely to the future of NHSH. Together, they could work through these ideas, suggestions and proposals and map out a great future for NHSH.

- 33.11 To this end, I commend a facilitated early gathering of a selected group of people who have responded to this review, to participate in a three-day retreat to consider this report, assess its proposals and plan the way ahead. I suggest that the Cabinet Secretary could attend on the final day.

66 The Phillips Kay Partnership Ltd. (n.d.). [online] Available at <http://phillipskay.com/> [Accessed 11 Mar. 2019].

- 33.12 It also occurs to me that a Priorities Task Force could identify and lead on five initiatives which are likely to make the biggest short-term difference.
- 33.13 I have pondered the appointment of an Associate Medical Director with specific responsibility for overseeing the short-term tasks as one way forward. That person, or the chief executive, could write to all staff and invite them to contact him or her with issues of concern and ideas of interest.
- 33.14 Thereafter, regular reviews with appropriate benchmarks to assess progress will be essential and a full review in one year's time would ensure accountability. This is an ongoing learning process, asking these questions throughout: What is working? Why? What hasn't worked? Why not? What could we do differently? How?
- 33.15 I am particularly aware of all of the material with which I have been provided. I estimate that I may have received well over one hundred individual pieces of confidential information that would be of specific use to the senior management of NHSH as they address the issues arising in this review. It would be really helpful if a way could be found for at least the most useful of that material to be utilised by the leadership going forward.
- 33.16 This might be done by again inviting people to contact the chief executive or an appointed senior person and provide in confidence the information which they have provided me. If helpful, I am happy to work with NHSH as they navigate their way through this difficult area.
- allegations made about bullying in NHSH and not fully to have understood their importance. I refer for example to my remarks about the response to the whistleblowers.
- 33.19 For NHSH to go forward positively, and given that it is essential that confidence and trust lie at the heart of all initiatives, it seems that real thought needs to be given by the new chief executive (and by the board) to the composition, chairing, remit and design of a group such as this. Again, a proper strategy rather than ad hoc reactions will reap dividends.

A Reset: People-Centred Leadership

- 33.20 Although there will be much focus on financial matters in the months ahead, as suggested in various parts of this report I suggest that making people the priority will ultimately produce the best outcomes. A new style of people-centred leadership will be crucial, with a more effective and competent management team and board, and a more compassionate, honest, courageous, humble, empowering culture, open to respectful challenge, communicative and accepting of the realities of operating in a very pressurised and financially challenging situation. Fear cannot be the driver. Effective relationships at all levels are key to the future.
- 33.21 The leadership team of executive directors and senior managers will greatly influence the future direction of travel and how NHSH is perceived both within and outwith. There seems no doubt that a resetting is needed both in senior management and at board level. There are too many, widely expressed and apparently valid, criticisms of some of those in senior management roles for it not to appear to be essential for changes to occur in order that a new way forward is seen to be both credible and competent – and for real confidence and trust to be restored. There are some very aware and insightful leaders in NHSH who have much to offer.
- 33.22 It has been suggested that some senior medical staff should revert back to clinical duties and undergo retraining before taking on further management roles. Certainly, ongoing training and support for the new leadership team should be provided in the months ahead.
- 33.23 I hope that the leadership of NHSH will consider some of the ideas discussed in my chapter on

Short-Life Working Group

- 33.17 In this connection, I have noted the role of a short-life working group to look at promoting a positive working culture across NHS Highland. It is proposed that this group “will seek to hear from people across the entire organisation and will aim to ensure that any concerns raised are heard and acted upon.”
- 33.18 While extremely worthy in itself, I am aware that the original composition of the group included people in whom I have heard, from a number of sources, there is a lack of confidence. This is for a number of reasons, including being perceived as having been sceptical about and resistant to the

Leadership. There should be much to be gained from taking time to engage actively with other NHS leaders in Scotland and with others in public sector leadership in Scotland through channels such as the Scottish Leaders Forum. Regular support and coaching for the leadership team is likely to be necessary going forward in what will be a crucial and challenging .

33.24 Leaders and others will also wish to reflect on and seek to align how things are done in NHSH with the National Performance Framework and its outcomes, including working to achieve the ambition that people employed by and associated with NHSH:

- *grow up loved, safe and respected so that they realise their full potential*
- *live in communities that are inclusive, empowered, resilient and safe*
- *are creative and their vibrant and diverse cultures are expressed and enjoyed widely*
- *are healthy and active*
- *respect, protect and fulfil human rights and live free from discrimination*
- *are open, connected and make a positive contribution.*

These will serve as useful benchmarks going forward.

The Chief Executive

33.25 Separately, as I have mentioned elsewhere, it seems essential for the new chief executive to exhibit an ability to engage with people at a personal level, to listen well and to seek to understand, to value contributions from all parts of the organisation and to be alive to the human effect of the inevitable tensions and constraints which funding limitations and other challenges bring. Going out and about and meeting people throughout the organisation at their places of work will make a huge difference. He will wish to be seen and recognised at all levels in the organisation (as will other senior managers).

33.26 He will need above all to build, and encourage the building of, relationships. A willingness to communicate openly and with clarity and frankness will be essential too. Ensuring the effectiveness of people-related systems and excellent communication across the organisation will be the key to ongoing healing.

33.27 This will also entail a thoughtful and open approach by the Scottish Government. The constructive interaction of Government with health boards and senior management is an inherent part of the system. Person-centred leadership ultimately comes from the very top. The availability of resources to encourage leadership development seems essential at this time.

33.28 The chief executive needs to be further supported as a leader. He will benefit from the support of like-minded and like-acting colleagues who can help lead by example and demonstrate real empathy, insight, self-awareness and vision in practice. He will need the support of an appropriately qualified Board chair who has a similar mindset. It is likely that the chief executive will benefit from high-level coaching and mentoring in this very important role.

Acknowledgement of NHSH Staff

33.29 While the chair of the Board issued a form of apology in late 2018 and the interim chief executive did much good work in his short stint by issuing supportive messages to staff, there is a real need for an authentic, meaningful acknowledgement and acceptance of how serious matters have been for many people in NHSH over a number of years, together with recognition of the impact on them of these circumstances and a reassurance that matters will be addressed now with rigour going forward. (I use the words acknowledgement, acceptance, recognition and reassurance deliberately, as each is a component in communicating how seriously matters are now being taken, along with the necessary engagement with staff and explanation to them of how things will be dealt with differently going forward.)

33.30 At the same time, there should be recognition of the impact on those who have not experienced adverse behaviour but who have been affected by the fact that the allegations themselves have been made. Healing can only occur if the different experiences are recognised and acknowledged.

33.31 *“If only they would say thank you”*, one staff member said to me. Although there will be much focus on financial matters in the months ahead, I have suggested that making people the priority will ultimately produce the best outcomes. As an indication of this, generally, people need to

be, and feel, thanked for doing a difficult job in difficult circumstances. And to be, and to feel, listened to when they have a concern or a problem. Ultimately, we all need to feel valued – and in a way which is genuine and authentic. Achieving this is one of the challenges facing leaders in NHS.

- 33.32 This would be a good moment to reinforce these messages in NHS and to celebrate all the good work which is being done. Simple, clear, consistent and regular messages to all staff should become the norm. I recall one very successful chief executive who would send an encouraging blog once per week to the staff. He was able to convey supportive messages to a widely dispersed workforce. They felt they knew him and that he cared. He did. He also invited suggestions for improvement from all members of staff. In NHS little things might make a big difference: such as an online “suggestion box”? Or a monthly open forum/drop-in session with the Medical Director?
- 33.33 Similarly, well thought through and transparent provision of information to the wider community, recognising the difficulties faced by NHS, should over time help to rebuild confidence. It is unlikely that this is a quick fix, more a longer-term strategy of openness and authenticity.
- 33.34 It is for consideration from whom these messages should come. However, it seems important that they come from the new chair and/or chief executive, unconnected with perceptions of inadequate responses in the past to allegations of bullying.

Civility

- 33.35 The need for civility and respect at all levels is one of the keys to moving forward. One consultant put it this way:
- “...irrespective of any inquiry we should all, immediately, be trying to reflect on how we behave with colleagues and staff generally to ensure we are all truly more sensitive and responsive to the needs of others and cognisant of the risks of not being so.”
- 33.36 Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation. Consideration

might be given to adopting something akin to the Commitment to Respectful Dialogue of Collaborative Scotland (see Appendix 4). The senior management team and the Board could lead the way.

Governance

- 33.37 I refer back to the chapter on Governance where a number of proposals are made.
- 33.38 The Board must be able to hold senior executives effectively to account, in the sense of supportively enabling and ensuring effective leadership rather than blaming or coercing. A review of governance structures, the committee network and culture will enable the kind of clear communication and taking of responsibility which this report commends. Allied to this, the Board will wish to oversee a review of the management structure also.
- 33.39 Review of board appointments, together with training and support for, and provision of appropriate information to, all non-executive directors is necessary, probably at Scottish Government as well as NHS levels.
- 33.40 Scottish Government may wish to review governance generally to ensure that candidates with the necessary skills, knowledge, expertise and experience are appointed to NHS and other NHS boards – and that the size of boards is commensurate with working effectively. Consideration of the appropriate mix of lay, patient and medical members will probably be useful. There is a need for deep understanding of what is necessary in the appointment and support of a non-executive director at all levels of government and the NHS.
- 33.41 Learning should be sought from other NHS and public sector boards in the short term. Recent independent recommendations to the Board, including by Audit Scotland and John Brown, have provided a starting point and need to be taken forward.
- 33.42 Specific external support should be offered to current non-executive directors who should be encouraged to continue to reflect on their position and role in handling matters going forward. I refer to the non-executive directors’ own recent consideration of matters including how they may appropriately engage and encourage feedback and flow of information.

33.43 In addition to matters already reflected in this report, I endorse their suggestions of (a) an independent person for the non-executive directors to go to if they have concerns that actions are not being addressed after raising these with the chair or chief executive, perhaps following the Senior Independent Director model from England and (b) regular assurance to the Board that there is a robust and working process available for anyone who wishes to raise concerns around bullying and safety.

33.44 Recognition should be given to the amount of time needed and devoted by non-executives generally. If possible, before new board appointments are made, consideration should be given to the specific areas of knowledge and skill which the present Board needs to oversee a budget of some £800 million.

33.45 A forward-looking strategic plan and a shared vision, linked to and taking account of the need for an effective people-centred approach and clinical and staff relationships in light of this review, is imperative.

33.46 Determining the strategic direction of NHS, including clinical strategy, will be important to bring clarity to decision making, implementation, monitoring and enabling NHS employees to understand why change needs to happen, what the purpose of the change is and how they can contribute to it. Full engagement of clinical staff seems paramount to the realisation of an effectively delivered clinical strategy.

33.47 Finally, the Board should take primary responsibility for ensuring that the issues raised in this report are implemented and progress maintained in the future and by showing the same constructive, respectful and compassionate approach which they should expect others to follow. They should keep these matters under review on a regular basis.

Clinical Engagement in the Contemporary NHS

33.48 Reassessment of the relationship between clinicians and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. Apparently, evidence from around the world shows that improved clinical outcomes follow greater clinician involvement in management. Thus, there should be reflection on the manner and benefits of clinical involvement in leadership. This may entail changes of attitude and behaviour for some as they move towards a more collaborative approach.

33.49 Clearer management structures, a better understanding of the needs and motivations of both management and medical staff and a positive approach to the greater good, will all benefit staff and patients alike. It has been suggested that adequate investment in administrative support and communication could enable clinical staff to feel a greater sense of ownership of decisions made by their organisation.

33.50 It has also been suggested that the apparently excellently conceived “Clinical Compact – The Highland Pledge”, subtitled “or how we will work better together” describing the relationship and obligations of clinicians to the organisation should be reviewed with a view to actual implementation. This is likely to raise issues of training. For example, clinicians may need training in negotiation and collaboration skills. It has been suggested that there may be scope for a Scottish NHS College.

33.51 A system for addressing urgently concerns/ complaints or differences of professional view will be valuable. The use of facilitation and mediation should be considered. The role played by an Associate Medical Director in this context could be critical.

33.52 Similarly, the relationship of GP practices to NHS needs review and a commitment to mutual understanding and respect. Honesty and clarity about priorities and resources is key, built on the foundation of much stronger relationships.

Trade Unions

33.53 The role of trade unions and staffside representation, including the partnership agreement, merits review in order to ensure really effective representation of employees' interests. The unions will wish to re-orientate their approach to NHSH to help assist in creating a supportive culture in which they can objectively identify and promote their members' interests.

33.54 While a non-adversarial approach, and constructively articulating members' interests, seems the only way to help members in the longer term, that will only work in a more rigorous and transparent overall environment. It seems essential that everyone works together to achieve that goal.

Argyll and Bute

33.55 By reason of its geographic and possibly other specific circumstances, as noted earlier, a separate review in and about the functioning of management in Argyll and Bute should be commenced, conducted by a person or persons from outside that area.

Patient Safety

33.56 In so far as staff have any specific concerns about patient safety, these should be referred to the chief executive or to a specified independent person if preferred.

34. Specific Proposals: Present Support

Individual Support

- 34.1 Support is needed for individual employees in NHS (at all levels), who have experienced inappropriate behaviour and who have suffered distress, harm and other loss. This should include providing safe spaces for many current and outstanding physical, emotional and psychological issues to be addressed fairly urgently.
- 34.2 This will include some people with whom I have met and others with whom there was not time to meet. Some responded to the review, others may not have spoken up at all. It is likely that there are quieter voices still to be heard. It is not enough to assume that, because people have not spoken out, there might not be a need to be pro-active now.
- 34.3 This support should be provided by facilitators who have a variety of skills, including trauma recognition, pastoral care and other counselling and complaint handling skills. The extent of this is not easy to measure and I acknowledge could take many months and will need to be well resourced. The number of those who may need help could be in the hundreds. A specific time limit should be set for completion of this task so that a sense of closure can be achieved.
- 34.4 A number of NHS employees have “bystander” guilt or shame. They now regret not acting when they could see things occurring which were inappropriate. These people may also need support and understanding as they work through the cycle of denial, blame, confusion, acceptance and moving on. Specific recognition of this experience may be an important step.
- 34.5 In all of these, clarity around purpose and objectives is essential in order to avoid creating unrealistic expectations.

Listening is Key

- 34.6 Linked to this, as noted above, there are a number of people who approached the review with whom there was not adequate time to meet. Some of these respondents may be satisfied that

the contents of this report address their concerns. However, others may still wish to be heard and offer views, whatever the rights and wrongs of what they have experienced or perceived.

- 34.7 A simple private listening exercise may be all that is required along the lines of the meetings I have already conducted in this review. This should be offered, again within a limited time period of say three months, if resources can be made available within that timescale.
- 34.8 For completeness, an invitation to participate in such an exercise should be extended to those employees who may not have received information about the review and to any others who may still wish to come forward. This needs to be well communicated and widely disseminated and, to manage expectations, there should be clarity at the outset about what the expected objectives, outputs and timescale are intended to be.
- 34.9 I am privy to a significant amount of information about specific instances of inappropriate behaviour in specific departments in NHS. The steps above should ensure that a mechanism is offered to those who have contacted me and still wish to take matters forward to be able to contact a confidential resource with these concerns.

Independent Process

- 34.10 It is likely that these initiatives will result in a need to address some specific complaints, disciplinary matters and grievances, many of which appear to remain outstanding and/or unresolved. The cooperation of the unions, especially the GMB, will be important in this. A strategy to resolve the many outstanding cases as speedily as possible should be devised, within a set timescale so that people and the organisation can move on.
- 34.11 It is for discussion whether this support should be provided on a basis independent of NHS. Certainly, as a number of issues pertain to the perceived inadequacy or lack of impartiality of internal support, it is likely that there will be much more confidence in external provision at least until NHS internal procedures are credible

and can meet this need and there is renewed confidence in governance and leadership. Indeed, I understand that NHSH HR department would welcome outside help from a dedicated team to help address current and outstanding individual cases.

Safe Spaces

- 34.12 Many of the issues currently being or which could potentially be addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, facilitated conversations and mediation. In all of this, thought should therefore be given to designing a process to engage a number of independent facilitators and mediators who could assist with the backlog.
- 34.13 Separately, there is a clear need for safe and independent spaces for people, including those characterised as “victim(s)” and “perpetrator(s)”, to be supported in trying to break the cycle of accusation and counter-accusation. I am mindful that providing support and compassion for those who have been viewed as perpetrators will be the most difficult aspect for many people; nevertheless, it will be necessary if healing is to occur. And, of course, these terms are not easy to apply and may be interchangeable in some contexts.
- 34.14 As part of this, steps should be taken, wherever possible, to rehabilitate, retrain and reintegrate staff who have been the subject of, or accused of, bullying. Where this is not possible, steps should be taken to make necessary staffing changes. Careful and wise oversight will be essential, especially in cases where there has been, or is, a diagnosis of trauma. Returning to a place where trauma has been experienced can, I am advised, be counter-productive. Trauma specialists should be asked to provide guidance.
- 34.15 To an extent, there is an element of truth and reconciliation and restorative justice in these proposals. This needs to be done for the longer-term health not just of NHSH but of individuals and communities.

Meetings and Workshops

- 34.16 Well facilitated meetings in local areas with specific groups may be useful as a way forward and to address current concerns. However, it is important to bear in mind that many issues arise within such groups. Thus, a mix of individual meetings and group sessions may be necessary. This would apply to specific departments and disciplines and to some geographic areas.
- 34.17 In particular, an initiative to identify, contact and support clinical departments and other practices and departments which have been particularly affected by inappropriate behaviours in recent times is necessary. In each case, steps should be taken to listen to all points of view, including the most junior staff, managers, clinicians and the quieter voices in a safe environment. A series of workshops and private meetings is likely to be the most effective combination for this.

Financial Matters

- 34.18 A number of people appear to have suffered some financial loss as a result of (alleged) inappropriate handling of their situations and are in financial difficulty as a result. Whether these claims are fully justified is beyond the scope of this report but many have a feeling of helplessness and hopelessness. Many feel let down by or inadequately supported by HR or other representatives, including on occasions trade unions and professional bodies. It is for consideration whether some form of independent review panel might be established for a limited period to bring closure for these individuals.

35. Specific Proposals: Training, Management and HR

Training in Better Conversations and Appropriate Behaviour

- 35.1 Longer term, a carefully designed ongoing comprehensive training programme addressing appropriate behaviour (including a well communicated, simple and clear definition of what constitutes bullying and harassment, together with diversity and discrimination awareness) could have a profound impact. This would help people throughout NHSH, from the grass roots up, to be more self-aware and to take responsibility themselves with confidence to manage differences, difficult situations and conversations with and for each other, in real time.
- 35.2 Such a programme, which could be multi- and inter-disciplinary, needs to be highly practical and interactive and not theoretical, properly structured and with regular review and reflection. An understanding of the aspects of human nature described in chapter 8 and of the cultural issues in NHS Highland referred to in chapter 16 above seems important in the design. Focus should be on the underlying causes of behaviour rather than merely on the symptoms and on finding proportionate responses.
- 35.3 In particular, all NHSH staff should be educated about the effects of bullying, on themselves and others, how to handle that and how to avoid entering the condition of “learned helplessness”. I suggest that having (or making clear the ready availability of) an informative NHS website on bullying is a useful first step but not a substitute for personal, practical training.
- 35.4 This could be a prototype more generally for public sector organisations in Scotland at a time when such allegations seem likely to increase. It would fit within the aspirations of the National Performance Framework. Paradoxically, it would probably lead to substantial financial savings owing to improved staff recruitment, morale and retention, in addition to improved quality and safety of care.

- 35.5 I recognise the resource implications, both financial and personnel. However, this is a major project, akin to building or funding a new capital resource. I suggest that such a perspective is brought to the costs of this initiative, again applying the principles of preventative spend.

Managers

- 35.6 I am struck by this formulation: “*The person you work for (your boss) is 90% of the employee experience*”⁶⁷. There is a need to rebuild confidence in and of managers. A programme of action learning, training, review, coaching and support is essential at all management levels, including for those preparing for recruitment, induction or promotion into management positions. This would cover people-handling, managing diversity and difference, handling and receiving complaints, effective communication and teamwork, giving feedback on performance, negotiation skills and multi-professional leadership development, especially for clinical leads and service managers.
- 35.7 Having the skills and resources to resolve difficult and sensitive situations without resorting to formal processes and being able to separate people from the problem, as well as the self-awareness and resources to accept concerns raised about one’s own practice, will be invaluable.
- 35.8 Viewing and training managers as “facilitators” of other staff would enable a different culture to be developed. Moving from performance targets to continuous learning with psychological safety seems important. A review of the recruitment and promotion process, to ensure that it is robust and objective, would complement these proposals.
- 35.9 This would sit within a framework of greater clarity about the roles and responsibilities of managers and identification of the support they require to equip them to be effective, with

67 LinkedIn.com. (2019). Your boss is 90% of the ‘Employee Experience’. Nothing else comes close. [online] Available at: <https://www.linkedin.com/pulse/your-boss-90-employee-experience-nothing-else-comes-jim-bohn-ph-d/> [Accessed 8 Apr. 2019].

a view to minimising any situations where poor management is perceived as bullying, and/or concerns are not addressed promptly at a local and informal level.

- 35.10 Mentoring and honest sharing of best practice and operating values across the organisation at all levels (and across Scotland?), with tolerance to discuss when things don't work and a willingness to learn from that, will be very valuable, along with freedom and safety to discuss what is acceptable and what is not acceptable behaviour.

Meetings and Relationships

- 35.11 Teamwork is so important in the NHS. Encouraging daily contact between managers and frontline staff seems important. Consideration and understanding of the particular cultural issues relating to NHS, referred to in this report, should form a part of this. Current best practices in NHS should be identified and replicated wherever possible. The ability to have conversations which feel more adult to adult is crucial to the future.
- 35.12 For example, the introduction and/or enhancement of well-facilitated team meetings on a regular basis, possibly across boundaries, with opportunities to express concerns, to brief and debrief safely, and review events and experiences in a supportive culture, could help greatly. Managers could be trained and encouraged to undertake and facilitate these.
- 35.13 Making sure that staff have adequate facilities and the opportunity to rest, reflect, meet and talk to colleagues away from immediate work pressures and patient-facing environments, will also create a more positive culture. Facilitated conversations over a cup of coffee can be very valuable. I understand that there is a policy of taking time to go for walks; this needs to be encouraged as acceptable and beneficial. In this context, I note the work of the Institute for Health Care Improvement on What Matters to You Conversations and Joy in Work.⁶⁸

- 35.14 It has also been suggested that there needs to be greater encouragement of social interaction with more of a feeling of a community spirit within Raigmore Hospital and elsewhere in NHS, with regular and organised local social functions focussed on the community of NHS.

- 35.15 Connected to this, it is suggested that there is value in small groups to build relationships, for support, intimacy and openness, and to build a sense of connection and belonging. It is hard to underestimate the value of well-hosted activities like these to help build supportive relationships where people feel secure and comfortable. There is a suggestion of appointing a trained "compassion champion" in each department to whom people could turn for support.

Mediation

- 35.16 Related to all of this, as discussed earlier in this report, more generally a new approach to handling internal issues should be adopted, to nip potential issues in the bud wherever possible. I refer to the chapter on mediation and other facilitated approaches.

Social Media Standards

- 35.17 It has been suggested that staff at all levels should sign up to NHS Highland or NHS Scotland standards of behaviour, including specific guidance on use of social media, which would be co-produced, with an expectation that everybody, including bystanders, could challenge whenever these standards are being breached, regardless of status or grade, and without fear of recrimination. I note the Commitment to Respectful Dialogue referred to earlier as a possible useful starting point.

Communication Generally

- 35.18 Excellent communication is essential at all levels in the organisation and becomes ever more important with increased organisational size and complexity. The age of electronic communication has resulted in a large increase in the volume of communications sent within and between organisations and has encouraged dissemination of information "to all", often

68 See "Useful Resources" Appendix

regardless of direct relevance. Ironically, the increased volume of information disseminated probably results in an inverse response to or digestion of the information.

- 35.19 A streamlined and realistic communication strategy should aim to direct material more effectively towards the necessary recipients and be graded in terms of the response required; other material can be posted on websites for interested parties to review.
- 35.20 More specifically targeted information will increase the actual impact of important messages and help to produce an informed workforce. Furthermore, by making this process more efficient, time will be saved which can be used for more necessary tasks. An effective communication strategy should ideally be led from the top levels of NHS and be consistent throughout.

Other HR Related Matters

- 35.21 There needs to be an organisation wide clarity about and understanding of the role of HR, and its limitations, and it and Occupational Health need full-time direction at the highest level. As noted above, resources may need to be deployed from other regions to assist in the short term but proper resourcing in NHS itself seems essential, including the appointment of a full-time HR Director.
- 35.22 All HR and other policies and procedures should be reviewed, updated and simplified, in the context of national reviews – and properly publicised. Systems for accurate and robust recording of complaints about alleged bullying and harassment should be maintained so that understanding of the extent, nature and distribution of bullying and harassment in the organisation is improved.
- 35.23 Work begun by HR in this regard needs to be supported and resourced. I refer back to the proposals from HR in an earlier chapter (and included in full in Appendix 3) and to my own observations in that chapter.
- 35.24 I note that policies and procedures already exist which purport to deliver many of the goals to

which everyone aspires. Again, the apparent gulf between what is written down and what actually happens in practice needs to be addressed. It would be good to make this exercise a collaborative one in which employees and unions feel part of the process. Above all, processes must be experienced as being fair in practice, whatever the outcomes.

- 35.25 I am also told that the national PIN policy needs revision or perhaps to be better understood and implemented. Consideration needs to be given to the operation of the Datix system and the iMatters recording function so that they can be used safely and with confidence. Training in these matters should be clear and consistent.
- 35.26 The use of suspension should be reviewed and utilised only in exceptional and clear circumstances and for as short a period as possible.
- 35.27 In any event, as a last resort, grievance and other formal procedures, when used, must be redesigned to be speedy, transparent and fair to all. Inconsistencies in treatment between staff and lengthy delays must be avoided wherever possible.
- 35.28 Where two people (or more) separately raise issues which are related, the links need to be made and appropriate steps taken. When there is a pattern of high staff turnover, sickness or frequent themes identified, this should be identified and the chief executive informed.
- 35.29 I commend the recommendations in the Francis Report on “Good Practice – Promoting a no bullying culture”.⁶⁹

Mental Health Issues

- 35.30 In suggesting that all NHS staff should be educated about the effects of bullying, reference has been made to the trauma model, the Adverse Childhood Experiences study and how people can address unprocessed trauma leading to consequences for the alleged victim and to themselves.

69 Francis, R. (2013). *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS*. p 109.

- 35.31 Generally, awareness of the potentially adverse impact of a return to the workplace in which bullying or other inappropriate behaviour has allegedly occurred should result in outcomes in which people feel protected from anyone who has allegedly bullied or harassed them.
- 35.32 Consideration should be given to a requirement that the Occupational Health department should ensure that those who appear traumatised are accurately assessed by a properly trained therapist or clinical trauma specialist or consultant within a short period and offered treatment. That assessment must be part of any investigation process. There needs to be a funded fast-track service, given the long wait times for routine psychiatry and psychology services. Mental health supervision is essential.
- 35.33 It has been suggested that a peer supporter (“compassion champion”, mentioned earlier) or “mental health first aider” could be appointed at every layer of the organisation, educated to look for signs of stress and in the trauma model, able to raise concerns and to activate a process to help someone who is experiencing difficulties. There should be a link with the health and wellbeing committee. A staff member trained to a high degree in trauma should be a member of the health and wellbeing committee.
- 35.34 On the matter of confidentiality, mental health records should be completely segregated from main occupational health records and removed from the E-epos programme. Staff with relatives working in the department should declare any conflict.
- 35.35 Generally, the adequacy of counselling and other psychological support should be reviewed.

Bullying Generally

- 35.36 I am told that BMA Scotland (and the wider BMA) has recently started work to address bullying and harassment issues, and the wider workplace culture in the NHS. Many organisations with an interest in the NHS have also been addressing these issues. For example, I understand that the academies, royal colleges, GMC, and other boards in NHS Scotland itself are all looking at this subject, but possibly independently and in their own ways.
- 35.37 Efforts to create a more joined-up, cohesive approach to address these issues would seem useful. An honest conversation among all the stake-holders, reflecting on causes as well as symptoms, is likely to reap dividends for NHS and other NHS boards.

36. Freedom and Safety to Speak Up

Discussion

- 36.1 While one would hope that the steps above would minimise the need, and that “whistleblowing” would be very much a last resort, further steps should be taken to provide a properly functioning, clear, safe and respected wholly independent and confidential whistleblowing or, more helpfully, “speaking up” mechanism, which presently does not seem to exist.
- 36.2 All staff should be aware of how to use this and in what circumstances its use is relevant, so that individuals with concerns are able to express these confidently in the future.
- 36.3 The expressing of serious concerns needs to be viewed as a good thing and acted on in a culture that is both supportive and safe. This must apply to concerns about staffing issues in addition to patient safety, realising that they are of course intimately linked. It is for consideration to what extent these matters can be addressed by internal provision and in what circumstances wholly external provision is essential.
- 36.4 Perhaps an internal safety valve (such as a dedicated confidential email address and telephone hotline), is necessary, with external provision if the internal function is not sufficient. Endorsement, oversight and support of, and tangible commitment to, the process from the highest board and management levels will build confidence.
- 36.5 In this context, provision of an independent, confidential, trained “guardian” or guardians seems essential both for those who experience and wish to report inappropriate behaviour

and for those against whom such behaviour is alleged, and who feel that there is no other available resource. Such a facility could also be used to enable the current whistleblowers to address their concerns about future victimisation.

- 36.6 Such a person would address serious concerns and complaints and independently investigate and act on them, within a time scale. Appropriate feedback is important. Any actions should be anonymised and published.
- 36.7 I understand that the Scottish Public Services Ombudsman has worked closely with the Scottish Government as they develop plans for introducing the Independent National Whistleblowing Officer and on proposals for a National Whistleblowing Standard. It is to be hoped that the Scottish Government will move swiftly to implement a really effective mechanism.

The Francis Report

- 36.8 The content and recommendations in the Francis Report on “Freedom to Speak Up” provide a rich resource. Time should be spent considering and implementing recommendations in that report which are likely to be equally applicable to Scotland. Sir Robert refers to the Parliamentary and Health Service Ombudsman’s (PHSO) vision for raising concerns in the NHS and provides an adaptation of a PHSO diagram to apply to staff raising concerns⁷⁰. I commend it.

70 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. para 4.18

- 36.9 I note the presence of Freedom to Speak Up Guardians in the NHS in England⁷¹. I understand that, in one English trust, the FTSU guardians (as they are called) promote confidential disclosure of any issues and have open access to the Board and the executive in order to resolve concerns and issues as early as possible.
- 36.10 I am told that most issues can be resolved locally as misunderstandings, which would accord with adopting a preventative or “safety valve” approach in NHS, and indeed underscores the utility of an early intervention mediation resource.
- 36.11 I note that Sir Robert Francis says he “gave serious consideration to recommending that the term ‘whistleblower’ should be dropped, and some other term used instead.”⁷² Although he still had reservations about the term, he had been persuaded that it is now so widely used, and in so many different contexts, that this would probably not succeed. Instead, there should be a focus on giving it a more positive image.
- 36.12 I support his suggestion that the measures recommended in his report will do much to promote the acceptance of ‘whistleblowing’ as normal and positive behaviour in healthcare. This seems a sensible approach for NHS to adopt.

71 Care Quality Commission. (2019). Freedom to Speak Up. [online] Available at <https://www.cqc.org.uk/national-guardians-office/content/national-guardians-office> [Accessed 20 Mar. 2019].

72 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. para 5.3.24

37. Quick Summary of Main Points and Proposals

(See paragraph 33.7)

- Collective, collaborative, cooperative culture and leadership
- Compassion, kindness, relationships and people at the heart of NHS
- Acceptance of uncertainty, complexity and ambiguity
- Acknowledgement of past, willingness to look forward
- Use best practice and current excellent resources wherever possible
- Deal with disagreements and difficulties early and promote civility
- Mediation and facilitation have important roles to play
- Measured, thoughtful and coherent strategy needed to take matters forward
- Build on earlier reports
- Seek to align how things are done in NHS with the National Performance Framework and its outcomes
- Reset senior management – openness and communication are key
- Engage with other public sector leaders
- Chief executive to lead by example, supported by able senior managers and the Board Chair
- Engagement with staff at all levels, recognising impact of the past and recent events and acknowledging the commitment shown at all levels
- Scottish Government to demonstrate and support people-centred leadership
- Board to exercise governance function well; review governance structures
- Non-executive board members to be well trained and supported
- Board strategic vision needed
- Ensure clinical engagement and effective relationships with managers
- Enhance relationships with GPs
- Role of trade unions and staff representation to be reviewed
- Review management and other arrangements in Argyll and Bute
- Ensure support available, including listening, for those who have experienced inappropriate behaviour
- Consider strategy for meetings, safe spaces and other forums to address issues and build relationships
- Instigate programme of training for staff and managers
- Adopt social media and communication standards so that simple, clear, consistent and regular messages to all staff become the norm
- Support and develop HR-related strategies to deal with issues adequately
- Recognise importance of mental health
- Introduce effective “speaking up” / “whistleblowing” facilities
- Convene a three-day retreat to consider this report, assess its proposals and plan the way ahead
- Regular reviews with appropriate benchmarks to assess progress

38. Final Thoughts

As you finish reading this report, look again at the questions on page 3.

Reflect on them.

What is your reaction to the report?

Shock? Anger? Resistance? Acceptance? Relief?

What does your reaction tell you?

What needs to happen now? For you? For others?

For those who have been affected, how will NHS move from fear to safety, from anger to compassion, from blame to kindness, from shame to dignity?

It can be done.



Appendices

Appendix 1 Useful Resources

- AI.1 I have referred to a number of resources in this report. More generally, my attention was drawn to these further potentially helpful resources which I mention for such value as they may have.
- AI.2 The work of Project Lift which “encourages a new style of leadership to rise from the complexity”, with leaders “who believe that success does come through putting people at the heart of everything we do. Leaders not focused on being heroes, or being saviours, but being true collaborators – who know that working collectively, collaboratively – genuinely together – is a powerful force for future success.”
- <https://www.projectlift.scot/>
- AI.3 The handbook entitled “The Duty of Care of Healthcare Professionals” by Roger Kline with Shazia Khan: published following the Mid Staffs Inquiry, “This practical handbook advises staff at every level about how, collectively and individually, to handle pressures that compromise good care standards. Underpinned by an understanding of the law, and with links to additional information and resources, it is designed to help staff uphold standards of ethical behaviour and professional accountability, and their duty of care to patients, when they feel these may be in danger of being undermined by other pressures”.
- http://www.publicworld.org/files/Duty_of_Care_handbook_April_2013.pdf
- AI.4 The Being Complained About Guidelines, which were recently published by Glasgow University School of Law, for organisations to help them avoid the potentially negative effects of complaints and support employees who have been complained about.
- <https://www.gla.ac.uk/schools/law/research/groups/lawreform/beingcomplainedabout/#d.en.636617>
- AI.5 The Healthcare Improvement Studies Institute work on “improving the employee voice about transgressive or disruptive behaviour”: “Even where reporting mechanisms are in place, employees can still be reluctant to report disruptive behaviour because they fear the consequences or don’t think their organisation will respond appropriately. In the case of one American academic medical centre, that reluctance meant transgressive behaviours by “untouchables” went on unchallenged and contributed to a culture of fear. The organisation had multiple mechanisms to report incidents, but not everyone in the organisation knew how to raise concerns, and some systems were slow and complicated to use. To address the problem, the organisation launched an initiative to improve how it responded to reports of disruptive behaviour.”
- <https://www.thisinstitute.cam.ac.uk/research-articles/improving-employee-voice-transgressive-disruptive-behaviour-case-study/>
- AI.6 The work of Amy Edmondson on Teaming, in a health care context:
- <https://hbr.org/2015/12/the-kinds-of-teams-health-care-needs>
- AI.7 The work of the King’s Fund and Professor Michael West, whose areas of research interest are team and organisational innovation and effectiveness, particularly in relation to the organisation of health services.
- <https://www.kingsfund.org.uk/about-us/whos-who/michael-west>
- AI.8 The work of the Carnegie Trust on Kindness and Compassion in public policy:
- <https://www.carnegieuktrust.org.uk/project/kinder-communities/>
- AI.9 The work on trauma undertaken in Oregon: and Missouri:
- <https://traumainformedoregon.org/standards-practice-trauma-informed-care/>
- <https://dmh.mo.gov/trauma/docs/HRPolicyGuidance32017.pdf>

- AI.10 The Institute for Health Care Improvement (IHI) has a number of resources including those designed to help provide psychologically safe learning environments – linking safe environments to improved patient safety:
- <http://www.ihl.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx>
- AI.11 The Institute for Health Care Improvement document “What Matters to You?” Conversation Guide for Improving Joy in Work, which includes preparing for the “What matters to you?” conversations. These are rich, learning conversations — not intended to communicate information, but rather to listen and learn. Leaders and colleagues should recognise this is a different approach than the usual “I tell you what isn’t working and you fix it” approach. The guide helps leaders get started quickly with conducting effective “What matters to you?” conversations, learning as they go, and resolving issues that arise from such conversations. Builds on the IHI White Paper: Framework for Improving Joy in Work.
- <http://www.ihl.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx>
- AI.12 The Whistleblowing Guide: Speak-up Arrangements, Challenges and Best Practices apparently offers “conceptual clarification about ... key issues, including a focus on internal and external speak-up procedures, organisational response and communication, impartiality and trust.”
- <https://www.wiley.com/en-gb/The+Whistleblowing+Guide:+Speak+up+Arrangements,+Challenges+and+Best+Practices-p-9781119360759>
- AI.13 The following websites were mentioned in the context of whistleblowing initiatives:
- <http://www.workinconfidence.com/speakinconfidence/>
 - <https://www.whistleblower.org/resources/>
 - <https://healthyworkforceinstitute.com/>
- AI.14 Engaging Transformational Leadership & impact on organisational performance, staff wellbeing and patient outcomes:
- <https://www.emeraldinsight.com/doi/full/10.1108/14777260810916560>
- AI.15 The Impact of Engaging Leadership on Performance, Attitudes to Work and Wellbeing at Work: A Longitudinal Study. 2012 Beverly Alimo-Metcalfe (University of Bradford School of Management, Bradford, UK and Real World Group, Leeds, UK) et al;
- <https://www.hsj.co.uk/leadership/transforming-leadership-culture-after-francis/5057102.article>
 - <https://www.kingsfund.org.uk/audio-video/beverly-alimo-metcalfe-engaging-boards>
- AI.16 Drama Triangle: adopting and relinquishing the tendency to fall into roles of victim, persecutor and rescuer:
- http://www.widgetlibrary.knowledge.scot.nhs.uk/media/WidgetFiles/1011649/DramaTriangleArticleE-PrintFeb05Burgess_99-114.pdf
 - <https://www.leicspart.nhs.uk/Library/TransactionalAnalysisforLPT2018HandoutforGroup.pdf>
- AI.17 Relationship between leadership, staff experience and patient outcomes:
- <https://www.nhsemployers.org/-/media/Employers/Publications/Research-report-Staff-experience-and-patient-outcome>
 - https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf

Appendix 2 Excerpts from the Gallanders' Report

A2.1 I refer to this appendix in chapter 12 at paragraph 12.33. It contains much which is useful and, I think, consistent with the contents of this report.

A2.2 The report noted that “The NHS Highland Preventing and Dealing with Bullying and Harassment Policy is based on an NHS Scotland PIN policy” and went on:

- “53. The policy is very comprehensive and written in the formal style which is fairly conventional in employment policy documents of this type.
54. The policy is in line with the ACAS Guide on Bullying and Harassment and contains the components of good practice which would be expected, such as;
- Definitions and examples of bullying and harassment
 - An informal stage aimed at early resolution of issues
 - Access to confidential advice and other support such as mediation through HR contacts
 - Formal investigation stage
 - Right for review of outcome by the complainant
 - Potential for management referral of employee or alleged bully / harasser to Occupational Health for support / counselling.”
- 56 It has been acknowledged to me anecdotally that the policy approach is something of an unattractive and blunt instrument in addressing very sensitive, nuanced issues affecting people who may be feeling demotivated, vulnerable or isolated. Larger organisations in particular face this type of difficulty.
57. It is a commonly expressed view that once an issue of alleged bullying and harassment is positioned within a formal process of investigation, the already damaged relationship is extremely difficult to recover.
58. A formal policy is desirable to manage cases of potential misconduct and formal action may be required and the policy is fit for purpose in this respect. There appears scope however making it more accessible, particularly in simplifying language, presentation and volume.
59. In addition, it would be useful to explore the use of face to face interventions and confidential access to an independent trusted professional resource such as self-referred counselling support and mediation. This may help offer an alternative to recourse to the formal policy.

CONSIDERATION OF NEXT STEPS:

61. Today's workforces will no longer tolerate, to the same extent as their predecessors, bad behaviour which may stop short of what would be traditionally categorised as bullying. Substantial research evidence is emerging on incivility, which manifests as low level negative behaviours such as rudeness, disregard for others, or treating others with disrespect. These behaviours are seen as contributing to the creation of cultures that tacitly accept bullying and, as such, need to be addressed. This may be partly behind the growing perception of the existence of bullying behaviour across organisations.
62. Traditional approaches based on policy documents, prescribed procedures and the injection of support for employees within the procedural framework are not working in the way that was envisaged when they were established. This is recognised by ACAS who were the authors of the best practice guide on Bullying and Harassment at Work upon which most workplace bullying policies are based.

63. Solutions are increasingly being seen as workplace climate or culture focused with a greater emphasis on issues such as people management skills and emotional intelligence in managers. This is referenced in the ACAS Policy Discussion Paper – “Seeking better solutions: tackling bullying and ill-treatment in Britain’s workplaces”.
64. Particular challenges exist in workplaces, such as the NHS specifically and public sector more widely, where there are pressures relating to customer / patient expectations, demographic pressures and finite resources. The recent BMA Survey, “Caring, Supportive, Collaborative”, demonstrated significant concerns among doctors regarding, amongst other things, inadequate resources, fear of making errors, workload pressures, and problems with bullying, harassment and undermining.
65. ...
66. In terms of good practice elsewhere, there are also examples which can be learned from.
67. London Ambulance Service (LAS) was placed in special measures in 2015 and concerns were raised about bullying and harassment. A number of measures were taken to address the problem including the nomination of a non-Executive Director sponsor, the appointment of a bullying and harassment specialist who provided training and workshops and engaged teams in dialogue around tackling bullying and culture. There have been tangible improvements in the number of staff recommending LAS as a place to work as well as sickness and turnover statistics.
68. Arising from the Mid Staffs Scandal public enquiry, “Freedom To Speak Up” originated in NHS England as a means by which concerns regarding patient safety could be raised and escalated. Bullying and harassment is one dimension of this. FTSU “Guardians” have been appointed in a number of NHS providers as a safe point of contact for concerns to be raised. Appointees have generally been clinicians who carry out the role in addition to their day job. Networks of Guardians are now in place and they are well established as an important and trusted resource for staff.
69. A “Fair Treatment at Work” initiative was implemented by Fife Council which saw two Fair Treatment Advisers appointed on a full-time basis within the HR team at a time when grievance rates were high, bullying was emerging as an issue which the trade unions were increasingly highlighting and sickness absence was above the local government average. Their role was partly educational, involving visiting management teams, trade union meetings and staff groups and partly operational, entailing coordinating investigations and producing management reports. This was part of a wider employee care programme and was credited with improvements in performance in employee relations indicators.
70. The instances where organisations can claim some success in tackling bullying and harassment generally have issues of culture and employee engagement at their heart.”

Appendix 3 Views from HR

A3.1 I refer to this Appendix in chapter 25 at paragraph 25.48.

Bullying and Harassment in NHS Highland

- A3.2 There are pockets where bullying and harassment occurs (like in any organisation, particularly big and highly structured and complex ones)
- A3.3 Although a number of bullying and harassment complaints have been raised when looking into it (for a certain period) not one had gone to a hearing, usually due to finding of no evidence but instead pointing out relationship issues; however, by the time the investigation has been completed the relationship is often definitely destroyed and redeployment is usually required (although this is then usually left to the manager to deal with)
- A3.4 Where investigations are carried out these tend to take a long time and have a huge negative impact on the complainant as well as everyone involved in the process often leading to relationship breakdowns and a need for redeployment (often the complainant) à if there is a need to move somebody out of a team does that not mean there is something seriously wrong?
- A3.5 Complaints are not being dealt with consistently (e.g. consultants not easy to recruit or in other areas he/she has always behaved like that are common arguments; particularly differently dealt with in remote/rural areas)
- A3.6 Raising a bullying and harassment complaint is difficult because of tendency to immediately consider the complainant as the difficult party, managers not supporting the complainant through the process, closing ranks, tendency to remove complainant rather than alleged bully away from the workplace leading to “card being marked” and fear of repercussions after the process has ended

A3.7 HR team members have been exposed to inappropriate intimidating behaviours from union representatives during meetings when supporting managers, and generally partnership working has been damaged and is not working that well

A3.8 Senior managers from across the organisation showing aggressive and intimidating behaviours towards HR (blaming for shortcomings that in our view sit within their area of responsibility) potentially indicating that the organisation is unclear about the role of HR; managers also using HR to “sound off” which can be perceived as aggressive and intimidating

A3.9 There are instances when employees appear to bully upwards and this should be taken as seriously as any other incident of alleged bullying and harassment

Bullying and Harassment Policy and Procedure

- A3.10 No consistent clarity on what constitutes bullying and harassment and what is and is not inappropriate behaviour in the workplace
- A3.11 Employees should have a responsibility for challenging behaviours that they consider to be inappropriate/of a bullying nature; a need to make it easier for employees to do that by offering a variety of options how they can do that (e.g. speak directly to the person, ask a colleague or the manager of the person to speak to them, confidential contacts across the organisation could assist, union rep, etc.)
- A3.12 The informal stage of this policy should be strengthened to allow for more immediate and targeted intervention before we venture into lengthy and often damaging investigations
- A3.13 Definition available in the policy, however, particularly bullying is about how an individual perceives another’s behaviour and it is therefore very difficult to establish whether bullying has in fact occurred. That may lead to focussing too much on proving bullying or not, although focus should be on repairing the relationship and ensuring behaviours are appropriate.

- A3.14 Managers do not feel that the policy supports them when dealing with people management and it's too easy to call out bullying
- A3.15 Policy is too long and structure not assisting with easy application and not helpful to managers despite it saying all the right things, e.g. in appendix 2 (5 pages long and at the end of the policy) mentions what is appropriate for a manager to do when managing people
- A3.16 Bullying and harassment procedure not robust enough to make it safe to raise complaints and review process often a tick box exercise biased against complainants (closing ranks and being dismissive); the review offered under the policy should be a robust and transparent appeal process and not just a desk top exercise (as it's often done); we have seen an increase in grievances for b&h issues as this is seen as a more transparent and robust process.
- A3.17 Too easy to call out bullying with no consideration whether this is because of reasonable management having put pressure on the employee or even malicious complaints; even if complaint not malicious or vexatious employee should be clear what is reasonable management; Induction and regular appraisals.

People Management

- A3.18 Behaviours/performance are not being challenged or not immediately being challenged (leading to a future manager being challenged over them finally managing a team/ individual)
- A3.19 There is a nervousness around dealing with behaviours and general reluctance to pick up issues early (considered difficult conversations that managers either don't want to have or because they don't like it/see as a risk to their relationships or they may not feel equipped/confident to do)
- A3.20 When concerns are raised there appears to be a bit of a panic reaction and too much time is taken over what to do next, incl. copying in too many people when trying to get guidance which in turn breaches confidentiality
- A3.21 We consider ourselves as a people focussed organisation (see HQA) but it appears to all be about the patients and not about the people in the organisation supporting the delivery of our services and the patient focus, i.e. employees

Management Capability

- A3.22 Managers not confident to have courageous/difficult conversations and are therefore unable to deal with bullying and harassment complaints effectively
- A3.23 Mediation intervention either considered too late or often used to allow a manager not to have to deal with staff relationships (offload management responsibility); needs strong criteria around referral to mediation service and managers to develop facilitation skills to ensure they feel confident in holding facilitated meetings
- A3.24 People management and any complications around this are seen as HR issues, e.g. complaint from unions against HR and not against managers; comments from staff geared towards HR (Facebook); this appears to suggest the role of manager is unclear across the organisation (and therefore the role of HR needs clarification as well)
- A3.25 No repercussion for being a "bad manager"; no accountability at management level and generally performance management non-existent, specifically at Band 7 and above
- A3.26 Is "financial bullying" leading to ineffective prioritisation of people management?
- A3.27 Exclusive focus on measures (compliance) set by Scottish Government may have led to us forgetting about other measures we should keep an eye on as a good employer
- A3.28 Has job design actually considered people management or was it just added without consideration of ensuring this is deliverable as part of the overall job of a manager?

Improvement Ideas

- A3.29 Leadership development with focus on defining positive behaviours, raising self awareness and leading by example with senior management requiring to demonstrate positive behaviours and employees understanding that everyone has a leadership role – must include board members

- A3.30 Introduce culture which ensures it is safe to call out inappropriate behaviours (at all levels) – developing confidence and trust amongst staff to do this through training and development/use of iMatter (ensuring iMatter does not become iDon'tMatter)
- A3.31 Introduction of effective management development programme, including for those preparing for promotion into manager positions
- A3.32 Review recruitment approach into manager positions to ensure that those who are appointed into manager positions do have people management skills as well as the required technical skills
- A3.33 Introduce a much improved and much more supportive approach to bullying and harassment with regards to both, the complainant and the alleged bully – through improved communication and support throughout by management (not left to HR or so called contact officers within HR)
- A3.34 Improve policy and procedures and ensure robust management training on new policy –in line with what has been mentioned above and ensuring clarity of the manager's responsibilities within the process
- A3.35 Policy: ensure employees who have raised concerns as well as those who have been accused (suspended or not) are well supported throughout; build in a robust and transparent appeal process; ensure open and honest feedback is given to all where complaint is not going forward to a hearing; build in debrief and team building where case was considered at a hearing (consider external input); build in robust return to work process for complainants and suspended employees; outcome communicated just by letter to both the complainant and the alleged bully is common but not adequate; should we not share the report to ensure openness and transparency?
- A3.36 Introduce confidential “guardians” for employees to turn to when they first experience problems and that they can speak to during ongoing processes; also for supporting alleged bullies during process
- A3.37 Need a strategic approach to people management with a link to overall organisation's strategy which features an element of “striving for excellence and continuous improvement” not just in relation to clinical/patient service delivery.”

Appendix 4 Respectful Dialogue and Civility

A4.1 I refer to this at paragraphs 33.36 and 35.17.

Commitment to Respectful Dialogue

A4.2 This, from Collaborative Scotland (www.collaborativescotland.org), is a useful set of ideas (of which I am the author) which capture some of what may have been missing in NHS Scotland in recent years. Perhaps everyone could commit to this:

A4.3 “We acknowledge that how we engage with each other is just as important as any outcome. We believe that it is in the interests of a flourishing health service in the Highlands of Scotland and our own communities that we treat each other with civility and dignity. Therefore, we undertake to do our best, and to encourage others to do their best, to:

- Show respect and courtesy towards all colleagues, whatever views they hold;
- Listen carefully to all points of view and seek fully to understand what concerns and motivates those with differing views from our own;
- Acknowledge that there are many differing, deeply held and valid points of view;
- Use language carefully and avoid personal or other remarks which might cause unnecessary offence;
- Ask questions for clarification when we do not understand what others are saying or proposing;
- Express our own views clearly and honestly with transparency about our motives and our interests;
- Respond to questions asked of us with clarity and openness and, whenever we can, with credible information;
- Look for common ground and shared interests at all times.”

A4.4 I note also and commend the work of healthcare professionals in Civility Saves Lives: <https://www.civilitysaveslives.com/>

“Civil work environments matter because they reduce errors, reduce stress and foster excellence.

Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice.

Civility between team members creates that sense of safety and is a key ingredient of great teams. Incivility robs teams of their potential.”

Appendix 5 Acronyms

A & B	Argyll and Bute
CE	Chief Executive
FPPR	Fit and Proper Person Requirements
FTSU	Freedom to Speak Up
GP	General Practitioner
HQA	Highland Quality Approach
HR	Human Resources
IFF	International Futures Forum
IHI	Institute for Health Care Improvement
LAS	London Ambulance Service
NEDs	Non-Executive Directors
NHS	National Health Service
NHSH	NHS Highland
NPF	National Performance Framework
OECD	Organisation for Economic Co-operation and Development
PHSO	Parliamentary and Health Service Ombudsman
PIN	Partnership Information Network
PTSD	Post Traumatic Stress Disorder
SG	Scottish Government



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This publication is available at www.gov.scot

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-776-0 (web only)

Published by The Scottish Government, May 2019

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS576650 (05/19)

Integration Joint Board

Item : 5.1

Date of Meeting: 29 May 2019

Title of Report: Visible Changes Improvement Plan Update

Presented by: Joanna MacDonald

The Integration Joint Board is asked to:

- **Note** progress of the Visible Changes Improvement plan.
- **Approve** proposed review in August 2019.

1. EXECUTIVE SUMMARY

- 1.1 The Visible Changes Improvement Plan was developed with the IJB and its content approved on 1 August 2018. The plan was put in place in response to a range of feedback and issues from staff, community and political feedback pertaining to service change and transformation across health and social care services within Argyll & Bute Health & Social Care Partnership.
- 1.2 A summary of progress is provided and a further development session to review the plan for the forthcoming 12 months is proposed.

2. INTRODUCTION

- 2.1 The IJB have responsibility for assuring high quality, safe and sustainable models of care delivery within the available resources. While there remain significant challenges, which are not uncommon nationally, there are also opportunities to innovate. This is based on maximising the skills available in a rural setting with a model tailored to Argyll & Bute.
- 2.2 In response to feedback the improvement plan detailed a range of improvement work and support from partners required to implement visible changes to local arrangements.
- 2.3 The IJB have approved a balanced budget for 2019-20 which further takes cognisance of the resources available and the need for continuous improvement and innovation for service delivery. The detail of the report highlights performance against the 2018-

2019 plan and seeks commitment from the IJB to review and plan for 2019-2020 plan in line with the Strategic Plan and approved policy proposals.

3. DETAIL OF REPORT

3.1 The plan aimed to deliver visible improvement activity under 5 key areas:

1. Ensure the areas of service change aimed at delivering the objectives of the IJB Strategic Plan are understood by the partner organisations, NHS Highland and Argyll and Bute Council, and that support is aligned to priority areas with the aim of achieving shared success.
2. The IJB to undertake self-evaluation activity aimed at identifying areas to inform a programme of improvement work which will assure effective governance and leadership to transform health and social care services in Argyll and Bute.
3. Review and refocus communication and engagement strategy to improve understanding by communities and all staff of the case for change across health and social care services and provide opportunities for community feedback to influence the change.
4. Ensure consistent communication of the case for change across the HSCP and leadership capacity
5. To develop a shared culture and identity across the HSCP, underpinned by a model of collective leadership.
6. To provide an opportunity for local MSPs and MPs to be regularly briefed about areas of service change.

3.2 The plan can be reviewed in detail in appendix 1. Items are coded green where complete but may still be subject to ongoing review to ensure activity is embedded or Amber where work is ongoing.

3.3 Under the first aim collaborative leadership has developed and greater potential has been identified in joint planning. Four out of the six items in section 1 are still ongoing including the Review of the Scheme of Integration. Service and Infrastructure are still identified as being scoped for a completion date although significant progress has been made especially within IT infrastructure and alignment of corporate services. This has been reported at IJB separately.

3.4 The second aim has moved significantly improving the communication between IJB members and senior officers. Progress has been made but still outstanding are the development programme for IJB members including shadowing opportunities and a complete development session programme for the IJB meetings which forecasts key business areas.

3.5 The third aim has seen the development of a new engagement strategy and communications strategy completing the Health & Social Care Partnership's corporate approach. This was a key area and both

strategies have been approved at the IJB. The HSCP Is currently recruiting to the new Locality Planning Group Structure.

- 3.6 The contribution of the delivery of the Values framework supports outstanding actions and this will require to be evaluated to confirm completion.
- 3.7 The fourth aim links to ongoing work with the proposed restructure of management and the ongoing work with NHS Greater Glasgow & Clyde. Each of these is rated at Amber with a revised timescale or ongoing review process.
- 3.8 The fifth aim is partially complete with the Senior Leadership Team identifying structures to enable better leadership and management practice, the opportunity to support staff and communication to inform best practice.
- 3.9 The values framework is currently being deployed across the HSCP and again this will be subject to ongoing evaluation to ensure that the activity permeates throughout the organisation.
- 3.10 The Grip and Control initiative has supported the visibility and accessibility of senior managers providing a deeper understanding of daily challenges and the complexity of the operational role and how that can be met through strategic planning.
- 3.11 The management restructure is ongoing to ensure the best structure is in place to deliver in an increasingly challenging environment, this is reported separately to IJB and follows the prescribed governance.
- 3.12 While the sixth aim is deemed to be achieved it will require ongoing monitoring to ensure consistency and effectiveness.

4. RELEVANT DATA AND INDICATORS

The Visible Changes Improvement Plan has given prominence and key tasks which also pertain to core areas of IJB business touching on the continued progress of integration, ongoing staff and IJB governance, Infrastructure and co-location, engagement assurance and communications. Each of these elements is reported on a regular standing basis at the IJB and highlights the relevant data and indicators measured.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

This is aligned with the strategic priorities.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

No direct financial impact from the plan.

6.2 Staff Governance

Direct impact on staff governance in ensuring better communications and best practice.

6.3 Clinical Governance

No direct impact on clinical governance.

7. EQUALITY & DIVERSITY IMPLICATIONS

Aligned with the development of good practice, no implications for reduction in the quality of practice or service delivery.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

No impact.

9. RISK ASSESSMENT

Impact of not delivering the plan noted in the Strategic Risk Register.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

No public involvement in the production of this paper.

11. CONCLUSIONS

The Visible Changes Improvement Plan has delivered some key changes notably in progressing themes of engagement, communication and focussing the business of the IJB.

There remains a more focussed approach to be taken on delivering further integration and the structures to support this, also in ensuring that change is embedded and there is further engagement in continuous improvement.

The request is to review and maintain this planning tool for short term visible changes on an annual basis.

12. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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Appendix 1

	Actions Required	Lead	Original Timeframe	Revised timeframe	Partner Support Required	Progress	Status
1	Aim: Ensure the areas of service change aimed at delivering the objectives of the IJB Strategic Plan are understood by the partner organisations, NHS Highland and Argyll and Bute Council, and that support is aligned to priority areas with the aim of achieving shared success.						
1a	Collaborative Leadership meetings held regularly	CEOs of NHS Highland and Argyll & Bute Council, CO of IJB	Ongoing	complete	Health Board and Local Authority senior leadership, with a focus on supporting service change.	COMPLETED. Meeting held 16.5.18 and calendar of quarterly meetings now finalised.	Green
1b	Corporate Service redesign and realignment	Head of Strategic Planning and Exec Director for Customer Services	Scoping extended January 2019	Aug-19	Support from Health Board and Local Authority to scope potential areas of redesign and realignment of corporate services across organisations.	Local Authority and HSCP Transformation Boards established: work progressing across catering and co-location, further opportunities to be identified	Amber
1c	Integration Scheme review	Short Life Working Group (SLWG) to be established to lead work.	Feb 2019- review process to be started	Jun-20	SG Integration team support to facilitate/ support review process.	SLWG to be chaired by the Council's Exec Director for Customer Services.	Amber
1d	Scope, facilitate and support a review of IT systems and processes	Head of Strategic Planning, Head of Customer and Support Services, CO.	Once scope agreed, timeframe to be agreed	scoping	IT colleagues across Health Board, Local Authority and HSCP to agree the scope and undertake a review	Skype for Business integrated comms business case in development - potential pilot site LIH, Oban	Amber
1e	Workforce transition process (new roles required to deliver new service models)	Head of People and Change	Revised to July 2019	Jul-19	HR and Finance colleagues from Health Board and Local Authority Issues identified by SLWG to be fed into groups supporting national health and social care workforce planning	Meeting held 28th August chaired by NHS Deputy Director of HR- high level discussion re key principles. We will now explore opportunities for Redeployment across HSCP	Amber
1f	Asset mapping across localities	Heads of Service and Head of Strategic Planning	March 2019 to complete review of asset mapping	complete	Health Board, Local Authority and HSCP officers to review previous asset mapping undertaken as part of CPP work plan, identifying opportunities to further reduce footprint.	Council commissioning team to support review process	Amber

2	Aim: The IJB to undertake self evaluation activity aimed at identifying areas to inform a programme of improvement work which will assure effective governance and leadership to transform health and social care services in Argyll and Bute.						
2a	Initial induction of new IJB members.	CO	May-18	complete		COMPLETED: 15.5.18	Green
2b	Development session with IJB to discuss and inform Visible Changes IJB draft improvement plan and identify next steps	CO	May-18	complete		COMPLETED : Updated Improvement Plan to IJB 1.8.18	Green
2c	Development Programme for IJB, informed by a self evaluation process to be developed	CO, Head of People and Change	August 2018	May-19	Areas which would benefit from input from Local Government Improvement Service and Integration Team of SG to be discussed and agreed by IJB.	Improvement Service self assessment questionnaire distributed. Action planning 4.10.18. Initial Development topics agreed but Programme needs to be established for whole of 2019.	Amber
2d	Review frequency and format of meetings between members of the IJB and Chair and vice Chair	CO, Chair and vice-Chair	July/Aug 2018	Complete		Dates being identified for a Senior Members/Officers Group (SMDG) to enable early discussion between the IJB and members of SLT re policy development	Green
2e	Shadowing opportunities for all IJB members including IJB Chair, vice Chair, CO	CO, Chair and vice-Chair	July/Aug 2018	Review for IJB interest and availability	Integration team of SG to identify Partnerships facing similar challenges to maximise potential for shared learning	CO discussing arrangements with SG Integration Team	Amber
2f	Induction and support programme for service user and carer reps on statutory groups to be developed (IJB, Strategic Planning Group, Locality Planning Groups)	Engagement Team	Jun-19	on track		Induction materials pending completion Nomination process for new community members and carers is in progress and will be completed by the end of May	Amber
2g	As part of IJB development programme, invitations to be extended to colleagues from other areas to come and share areas of good practice	CO, Chair and vice Chair	Nov-18	Ongoing		Programme to be developed	Amber
2h	Support IJB members to operate strategically and undertake an ambassadorial role	CO	Oct 2018	Ongoing		IJB Development Programme to be informed by self assessment process	Amber
2i	Regular meetings between senior officers and IJB to ensure appropriate information available to inform IJB decision making.	CO, Chair and vice Chair	Aug-18	Complete		Dates being identified for a Senior Members/Officers Group meetings	Green
2j	Seminar/ Development sessions to be organised prior to significant areas of work, with opportunities for informal networking of IJB members optimised	CO	Sept/Oct 2018	In development		In development	Green

3	Aim: Review and refocus communication and engagement strategy to improve understanding by communities and all staff of the case for change across health and social care services and provide opportunities for community feedback to influence the change.						
3a	Revised communications and engagement plan to be developed based on Transforming Together message	Head of Service Strategic Planning and Associate Director of Public Health		Complete	Joint support and leadership across the Health Board, Council and IJB to ensure consistent messaging and collective responsibility.	Engagement Framework updated (April 2019) to reflect all the milestones achieved. This document will be presented to the IJB in May 2019.	Green
	Proactive communications and engagement with communities, which describes case for change and positive achievements					SG Integration Team to attend IJB. Date still to be identified	
3b	Information re Transforming Together programme to be shared with all staff and communities, linked to the review of the Strategic Plan and budget consultation process	Head of Service Strategic Planning, Associate Director of Public Health, Chief Financial Officer	June- Oct 2018	Complete		An Engagement Specification has been shared with the Transformation Board and Workstream Leads. An Engagement Specification is required to be completed for exh transformation change.	Green
3c	Support for Locality Planning Groups	Head of Service Strategic Planning and Associate Director of Public Health	end Jun 2018	Complete	SG identify and share areas of good practice from other Partnerships	9 LPGs formally dissolved and the new 4 LPG arrangements are being implemented. Nomination process underway for revised membership.	Green
3d	Proactive communication across all stakeholders following IJB decision making at meetings	Associate Director of Public Health	Aug 2018	Complete		Communication Framework approved by the IJB in March 2019. A performance framework is being developed to measure progress.	Green
3e	Focussed work with clinicians and social work staff so that they can engage effectively with communities re the case for change	Heads of Service and Associate Director of Public Health.	Sep-18	Complete		Engagement Framework and associated tools will be shared with all HSCP services following IJB May 2019.	Green
3f	Locality based work with all staff groups which clarifies the governance and decision making processes	Heads of Service and Head of People and Change-	scoping	set evaluation period			Amber
3g	Proactive messaging from the IJB to address any perceived division between health and council staff groups within the HSCP	Associate Director of Public Health and Head of People and Change.	Aug-Sept 2018	Complete		Communication pathways are outlined in the approved Communication Framework	Amber

4	Aim: Ensure consistent communication of the case for change across the HSCP and leadership capacity aligned to priority areas for change.						
4a	Strategic Management Team structure to be strengthened	Chief Officer with SLT members	Oct-18	Jul-19		Management Structure completed by May 2019 (IJB for note) Job Descriptions undergoing revision and evaluation process- anticipate advertising vacancies March-June 2019	Amber
4b	Exec Sponsors for workstreams within Transforming Together programme to develop Strategy/Policy documents which will underpin the changes going forward Support from the Improvement Service and HIS to enhance capacity and capability.	Head of Strategic Planning, Assoc Director of Public Health	Oct 2018	Complete	Integration team of SG provide contacts to share examples of good practice	Project Managers in post, Executive Sponsors identified, Transformation Board established Strategy Document outlining key principles of each area of service change to IJB in November HIS support for developing alternative housing models progressing Improvement Service issued self assessment survey. Action planning meeting 4.10.18	Green
4c	Prioritise internal benchmarking analysis of areas/trends in pay and non-pay expenditure for SMT to support focussed performance management.	Chief Finance Officer	Jul-18	Superseded by Grip & Control Initiative, Update to be presented at August IJB	Support from Health Board and Local Authority to progress alignment of the finance teams and integrated financial reporting Integration Team of SG to facilitate work with CFOs, including Argyll and Bute, to identify the potential to realise shift in resource from large acute settings to local community settings.	Management structure paper approved at IJB 1.8.18. Potential for shared management arrangements over finance teams to be explored [Reference proposal for May 2019 IJB] Links with 4d below	Amber
4d	Continue to focus on delivering Commissioning Intentions notified to NHS GG&C, with resulting reduction in value of Service Level Agreement (SLA) Re-negotiate terms of SLA to reflect IJB requirements and ensure timely agreement of payment value.	Head of Service Strategic Planning, Chief Finance Officer	2019 pending negotiation	on Track on Track	Support from Integration Team of SG to review the costing model between NHS Board delivering services and Board of patient's residence Review of how costing model influences commissioning intentions and resulting resource release.	Meeting between CO and GG&C colleagues being arranged to assess impact of commissioning intentions to value of SLA. Cross boundary flow model shared with SG colleagues	Amber Green
4e	Focus of all managers in HSCP on budget to enable services to operate within budget while addressing increasing demand	Chief Finance officer	Jun-18	Reviewed Monthly	Support from NHS and Council finance teams -to monitor progress and identify variance from plans. Close scrutiny and monitoring of trajectory of savings to allow corrective action to be taken.	Sessions held across the HSCP to focus efforts and ensure consistency of approach. Monthly Budget reporting and forward planning put in place, reporting through Budget challenge process ongoing Integrated financial reporting project plan to be taken forward, with trajectory re monthly reduction in spend identified Managers have led sessions with local teams with consistent messages	Amber

5	Aim: To develop a shared culture and identity across the HSCP, underpinned by a model of collective leadership.						
5a	Enhanced leadership visibility of SLT	Head of People and Change-	June 2018.	Jun-19		Start the Year sessions undertaken April/May 2018. Feedback to be issued with structured approach to increasing visibility and engagement of SLT. Approach for 2019 to be agreed with CO	Amber
	To be further cascaded by local managers engaging with their teams						
5b	SLT to identify different ways of working to ensure effective delivery of Transforming Together programme.	CO	May-18	Complete		COMPLETED. Range of actions identified including: establishing an adult services management team across Argyll and Bute, team development to be facilitated through action learning.	Green
5c	Develop programme of two way communication with managers across the organisation	Heads of Service, Lead Nurse, Head of People and Change	Jun-18	Delivered and for review	Organisational development resource from Health Board and Local Authority to support programme development.	Session with LMs and LAMs held June. Feedback will inform proposed management redesign, communication structures and any future development programme by Oct 2018.	Amber
5d	Refresh shared values of the HSCP and embed within processes of the organisation.	Head of People and Change	Aug-18	Sep-19		Refreshed values and behaviour framework approved by IJB 18.18. Embedding approach approved by IJB March 2019, Project Plan now drafted.	Green
5e	HSCP branding to facilitate staff having shared sense of identity and belonging	Associate Director Public Health	Sept/Oct 2018	Oct-19	Branding and identity development will require support from Health Board and Council.	Branding and templates being introduced on a phased basis	Green
6	Aim: to provide an opportunity for local MSPs and MPs to be regularly briefed about areas of service change and factors impacting on care delivery across Argyll and Bute, along with issues highlighted to them by constituents						
6a	Regular formal communication and briefings with A&B political representatives by CO, Chair and vice-Chair	CO	June onwards	Reviewed Monthly	Integration Team of SG to provide initial support for meetings with MSPs - held in Edinburgh to facilitate attendance	CO to discuss arrangements with SG Integration Team.	Green

Integrated Joint Board

Agenda item: 5.2 (i)

Date of Meeting: 29 May 2019

Title of Report: Budget Monitoring for the Year ended 31 March 2019

Presented by: Kirsty Flanagan, Interim Chief Financial Officer

The Integrated Joint Board is asked to:

- Note the financial position of the Health and Social Care Partnership as at the end of financial year 2018-19.
- Note the repayments arrangements for the overspend.
- Approve the earmarked reserve for Technology Enable Services amounting to £117,100 and the earmarked reserve in relation to the Primary Care Investment Fund of £207,684.
- Instruct the Chief Officer to bring back further information on the negotiations within NHS GG&C for Board approval.

1. EXECUTIVE SUMMARY

- 1.1 This report provides information on the financial position of the Health and Social Care Partnership as at the end of financial year 2018-19.
- 1.2 The final year end position is an overspend of £6.681m, made up of an overspend of £3.554m for Health related services and £3.127m for Social Work related services.
- 1.3 This final position is a deterioration of £2.563m since the February position. The most significant area of deterioration relates to the charges from NHS Greater Glasgow and Clyde (GG&C). There was £1.2m of SLA charges in dispute that had previously been reported to the IJB and also a further £0.654m of charges by NHS GG&C after 31 March for services deemed by them to be exceptional charges outwith the main SLA.
- 1.4 There is detail on the 16 significant budget overspends (>£0.100m) amounting to £5.403m within Health relates services. There were budget underspends that helped to contain the overspend to £3.554m.

- 1.5 There is detail on the 9 significant budget overspends (£>0.100m) amounting to £3.845m within Social Work related services. There were underspends that helped contain the overspend to £3.127m.
- 1.6 NHS Highland have received brokerage from the Scottish Government, that doesn't require to be repaid, and covers the overspend in 2017-18 and 2018-19 for Health related services. The overspend on Social Work related services does require to be repaid to Argyll and Bute Council and repayment arrangements are in place for both the 2017-18 and 2018-19 overspends over financial years 2019-20 to 2022-23.
- 1.7 It is of vital importance that the budget monitoring process for 2019-20 is robust and when an activity deviates from plan/budget that budget managers are held to account and corrective action is taken immediately to minimise any future overspends. It is also really important that the delivery of savings options agreed for 2019-20 are closely monitored.
- 1.8 Two new earmarked reserves have been created at the end of 2018-19 within NHS Highland.
- Funding received for Technology Enabled Services that has not been fully spent in 2018-19 due to delays in the project. There is an underspend of £117,100 to be earmarked.
 - Funding received for Primary Care Investment Fund that has not been fully spent in 2018-19 of £207,684.

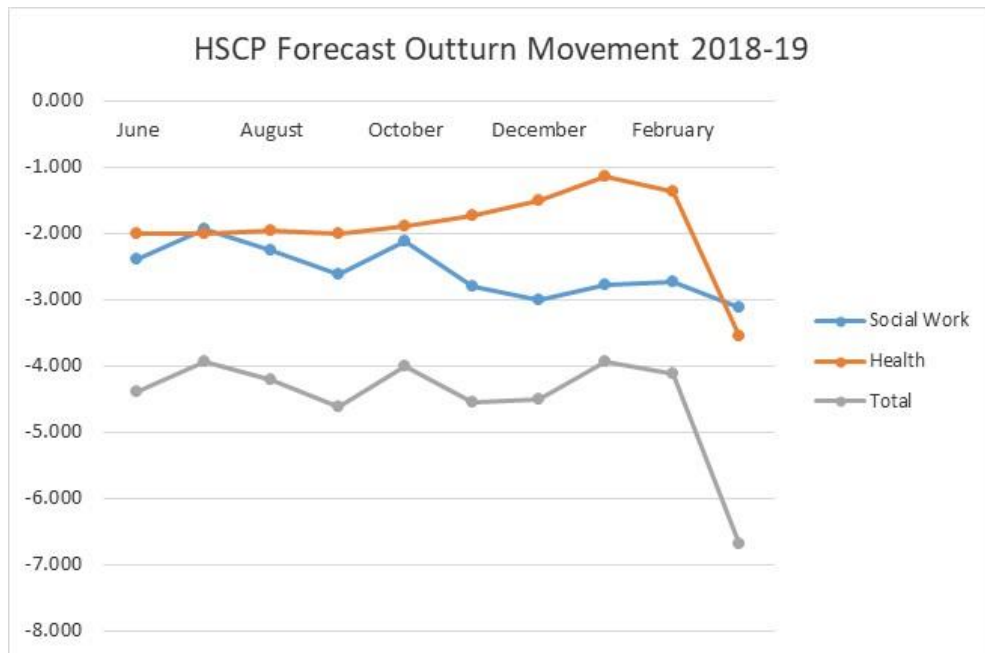
2. INTRODUCTION

- 2.1 This report provides information on the financial position of the Health and Social Care Partnership as at the end of financial year 2018-19.

3. DETAIL OF REPORT

3.1 Summary of Final Outturn Position

- 3.1.1 The forecast outturn position as at the end of February, reported verbally to the IJB on 27 March 2019, was a forecast overspend of £4.118m, made up of an overspend of £1.376m for Health related services and £2.742m for Social Work related services.
- 3.1.2 The final year end position is an overspend of £6.681m, made up of an overspend of £3.554m for Health related services and £3.127m for Social Work related services. This final position is a deterioration of £2.563m since the February position.
- 3.1.3 The chart below shows the forecast outturn movement and the finalised position during 2018-19.



- 3.1.4 The most significant area of deterioration in the outturn position is in relation to charges from Greater Glasgow and Clyde. It was previously reported to the IJB that there was a risk that the outturn could increase by £1.2m due to a dispute over the value of the SLA agreement. At the end of financial year 2018-19 the dispute remained unresolved. With intervention from the Scottish Government it was agreed that the brokerage given to NHS Highland would cover the disputed costs for 2018-19 and that there would be collaborative work with other IJBs who have an SLA with GG&C on a new funding model for 2019-20 onwards. We have been clear that if activity levels for 2019-20 do not increase from the 2018-19 levels, then we will not pay more than our 2018-19 SLA offer plus inflation. This remains a significant financial risk for the IJB.
- 3.1.5 The further significant area of deterioration in the outturn position was in respect of further charges amounting to £0.654m being made by NHS GG&C after 31 March for services deemed by them to be exceptional charges outwith the main SLA.
- 3.1.6 There were a number of other small areas of deterioration that gave rise to the final outturn.

3.2 Health Related Services Overspend

- 3.2.1 The paragraphs that follow provide some detail on the significant budget overspends (> £0.100m) within the Health related services. In total there are 16 significant budget overspends detailed amounting to £5.403m. These overspends are greater than the outturn position for Health and this is due to budget underspends helping to contain the overall overspend to £3.554m.
- 3.2.2 NHS Greater Glasgow & Clyde patients' services SLA – £1.091m
Relates mainly to increased charges from NHS GG&C for mental health services. In previous years, charges were estimated. For 2018-19, GG&C increased the charge significantly based on actual patient activity.

- 3.2.3 NHS GG&C exceptional charges outwith the main SLA - £0.874m
- Increased use of oncology drugs - £319k
 - Autograft and transplant readmissions - £284k
 - Rheumatology & cystic fibrosis drugs - £130k
 - CPAP -sleep related breathing disorder medical devices - £84k
 - EBUS - diagnostic test for lymph node disorders - £57k.
- 3.2.4 Psychiatric medical services - £0.518m (36% overspent)
Mainly due to locum cover for consultant, specialty doctor and specialty registrar vacancies.
- 3.2.5 Mull GP services - £0.441m (56% overspent)
Mainly due to ongoing use of GP locums to cover several vacancies.
- 3.2.6 Lorn & Islands Hospital Day Bed Unit - £0.364m
Increased use of oncology drugs, specifically recently approved chemotherapy and immunotherapy drugs including; Lenalidomide, Olaparib, Palbociclib, Pembrolizumab and Cabazitaxel.
- 3.2.7 Patient referrals to private sector providers - £0.310m
Increased referrals to private sector providers for eating disorders and post traumatic stress disorder - Huntercombe £211k and The Priory £99k.
- 3.2.8 Lorn & Islands Hospital Laboratory - £0.281m
- Pay costs overspent by £110k due to use of agency staff to cover several vacancies.
 - Biochemistry Managed Service Contract - increase in reagent costs £90k
 - Haematology - external tests and blood costs from SNBTS £36k
 - Higher than expected charge from Raigmore for provision of microbiology services £25k
- 3.2.9 Lorn & Islands Hospital ward nursing - £0.274m
Mainly the use of bank and agency staff in wards B and I.
- 3.2.10 NHS Services commissioned outwith Scotland - £0.212m
- Single patient admission to the Walton Centre, Liverpool - £133k
 - Single patient admission to hospital in Manchester in February 2019 (notification received on 18 April 2019) - £79k.
- 3.2.11 Helensburgh [Dr McLachlan Practice] GP Prescribing - £0.184m (11% overspent).
- 3.2.12 Helensburgh [Millig Practice] GP Prescribing - £0.183m(10% overspent).
A further report is being prepared by the Lead Pharmacist in relation to prescribing.
- 3.2.13 Lorn and Islands Hospital medical services - £0.164m
- Excess cost of retaining a retired consultant in addition to the approved medical staffing establishment £107k

- Vacant posts covered by agency junior doctors and associated loss of NES income £55k.
- 3.2.14 Flu vaccines - £0.152m
Unfunded costs of flu vaccines issued to GP practices. There was an expectation that these costs would be, at least, partially funded by SGHD. However, no additional funding was received.
- 3.2.15 Services commissioned from other Scottish Health Boards - £0.152m
- NHS Lothian additional cardiac activity - £83k
 - NHS Tayside adolescent mental health service referral following closure of Huntercombe - £69k.
- 3.2.16 Argyll and Bute Hospital Rates - £0.102m
Removal of rates relief (accrued and being appealed).
- 3.2.17 GP practice locums to cover ill health absence - £0.101m
For Lochgilphead and Dunoon practices.

3.3 Council Related Services

- 3.3.1 The paragraphs that follow provide some detail on the significant budget overspends (> £0.100m) within the Social Work related services. In total there are 9 significant budget overspends detailed amounting to £3.845m. These overspends are greater than the outturn position for Social Work and this is due to budget underspends helping to contain the overall overspend to £3.127m.
- 3.3.2 The largest overspend in Social Work was the closing balance against unidentified savings of £1.473m. The opening balance for the year had been £2.345m, which was included as a balancing entry in the 2018-19 budget agreed by the IJB in March 2018 – there was an offset of circa £0.700m on the health accounts producing a net shortfall across the Partnership of £1.6m. The initial balance had been reduced through the completion of a budget challenge exercise during the year but further savings were not developed to reduce or eliminate this balance.
- 3.3.3 A further overspend arose due to slippage on the delivery of agreed savings. Overall, there were 7 savings options totalling more than £0.100m which were not delivered which produced an overall overspend of £2.004m. These savings related to:

Description	Undelivered Saving £000
Learning Disability – Supported Living Services	582
Older People Services – Redesign of area teams and day services and contract management.	545
Central Services - Administration and catering service reviews.	225
Looked After Children – External Residential Placements	200
Learning Disability – Residential Placements	194
Children and Families – Management Team Review	150
Older People – Internal Residential Care	109
Total	2,004

3.3.4 There was a further overspend of £0.253m arising from slippage on the delivery of a further 6 savings options which were for less than £0.100m. The overall overspend arising from the unidentified savings balance and slippage on the delivery of identified and agreed savings totalled £3.730m.

3.3.5 The homecare budget was overspent by £0.115m due to a combination of demand pressures across the service and overspends on sickness, overtime and travel costs within the internal home care services operated by the Partnership.

3.3.6 The above balances were partially offset by underspends across the service, the most significant of which are listed below:

Description	Underspend £000
Older People – External Care Home Placements	418
Higher than budgeted savings arising from vacant posts	219
Older People – Progressive Care Centres	182
Total	819

3.4 Repayment of Additional Funding from Partners

3.4.1 NHS Highland have received brokerage from the Scottish Government that covers the overspend in 2017-18 and 2018-19 for NHS Highland. This includes the Health related services within the Health and Social Care Partnership. The brokerage is not required to be repaid and therefore the overspend on Health related services for these years has effectively been written off.

3.4.2 The Council had agreed a repayment plan related to the 2017-18 overspend on social work services and due to the forecast outturn position within 2018-19 the Council, at its meeting on 21 February 2019, agreed to defer the pay-back of the 2017-18 overspend by one year and repayments are now required over 2019-20 and 2020-21.

3.4.3 A report was considered at the Council's Policy and Resources Committee on 16 May 2019 in respect of the repayment arrangements for the 2018-19

overspend and it was agreed that this be repaid over a period of three years commencing in 2020-21 with repayments weighted across the three years.

3.4.4 The total repayments to the Council are summarised in the table below.

Financial Year	Repayment 2017-18 Overspend £000	Repayment 2018-19 Overspend £000	Total Repayment £000
2019-20	100	0	100
2020-21	300	800	1,100
2021-22	755	1,000	1,755
2022-23	0	1,327	1,327
Total	1,155	3,127	4,282

3.5 Budget Monitoring 2019-20

3.5.1 The IJB agreed a balanced budget for 2019-20 at their meeting on 27 March 2019. Any savings options previously agreed that are considered to be undeliverable have been removed from the savings plan. Management/operational savings of £5.058m were agreed, many of which are right-sizing of the budget and are therefore easily delivered and policy savings options of £1.736m were agreed.

3.5.2 Whilst there is a balanced budget, there remains significant risks in delivering the service within budget in 2019-20. Many of the budget overspends within the health related services are continuations of overspends experienced in 2017-18 and 2018-19 (and in some cases for years before). There is a risk that they continue into 2019-20 until corrective action is taken.

3.5.3 It is of vital importance that the budget monitoring process for 2019-20 is robust and when an activity deviates from plan/budget that budget managers are held to account and corrective action is taken immediately to minimise any future overspends. It is also really important that the delivery of savings options agreed for 2019-20 are closely monitored.

3.5.4 The most significant risk for the 2019-20 position is the contract with NHS Greater Glasgow and Clyde (GG&C) that is currently in dispute. With intervention from the Scottish Government it was agreed that the brokerage given to NHS Highland would cover the disputed costs for 2018-19 and that there would be collaborative work with other Health Boards who have an SLA with GG&C on a new funding model for 2019-20 onwards and the Chief Officer is leading on this negotiation. We have been clear that if activity levels for 2019-20 do not increase from the 2018-19 levels, then we will not pay more than our 2018-19 SLA offer plus inflation. Further information on the ongoing negotiations will be brought back to the Board for approval. This remains a significant financial risk for the IJB.

3.6.1 Reserves

3.6.1 The Scheme of Integration states that "Argyll and Bute Integration Joint Board may retain any underspend to build up its own reserves and the

Chief Financial Officer will develop a reserves policy for Argyll and Bute Integration Joint Board". The IJB approved a reserves policy in March 2017, this outlines the governance for creating and holding reserves for the IJB.

- 3.6.2 One of the reasons the IJB should seek to hold reserves is to build up a contingency to cushion the impact of unexpected events or emergencies. The Reserves Policy suggests a prudent level of general reserve be set at 2% of the IJB net revenue budget, this would equate to around £5.5m. The 2% is in line with the position taken by a number of Integration Joint Boards facing similar strategic, operational and financial risks as Argyll and Bute and is also in line with the Council reserves policy. Currently this target is aspirational and should be viewed as an optimum level of reserves to be built up over time, recognising the tensions between prudent financial planning and budgetary constraints.
- 3.6.3 The IJB started the 2018-19 financial year with a reserves balance of £0.104m, noted as follows, which was fully drawn down during 2018-19.
- Mental Health Fund - £0.031m
 - Primary Care Transformation Fund - £0.045m
 - Contingency - £0.028m.
- 3.6.4 Two new earmarked reserves have been created at the end of 2018-19 within NHS Highland.
- Funding received for Technology Enabled Services that has not been fully spend in 2018-19 due to delays in the project. There is an underspend of £117,100 to be earmarked.
 - Funding received for Primary Care Investment Fund that has not been fully spend in 2018-19 of £207,684.

4. RELEVANT DATA AND INDICATORS

- 4.1 Information is derived from the financial systems of NHS Highland and Argyll and Bute Council.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

- 5.1 The Integrated Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. This needs to be considered when options are developed to balance the budget.

6. GOVERNANCE IMPLICATIONS

- 6.1 Financial Impact – The final year end position is an overspend of £6.681m, made up of an overspend of £3.554m for Health related services and £3.127m for Social Work related services. Funding from the partner organisations is required to fund the overspend.
- 6.2 Staff Governance – None
- 6.3 Clinical Governance - None

7. EQUALITY AND DIVERSITY IMPLICATIONS

7.1 None.

8. RISK ASSESSMENT

8.1 It has been reported throughout the year that there was a risk to not achieving financial balance in 2018-19.

9. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

9.1 None.

10. CONCLUSIONS

10.1 This report provides information on the financial position of the Health and Social Care Partnership budget as at the end of financial year 2018-19. The final year end position is an overspend of £6.681m, made up of an overspend of £3.554m for Health related services and £3.127m for Social Work related services.

10.2 NHS Highland have received brokerage from the Scottish Government that covers the overspend in 2017-18 and 2018-1, this includes the Health related services within the Health and Social Care Partnership and doesn't require to be repaid. The overspend on Social Work related services does require to be repaid to Argyll and Bute Council and repayment arrangements are in place for both the 2017-18 and 2018-19 overspends over financial years 2019-20 to 2022-23.

11. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 – Final Outturn for 2018-19 as at 31 March 2019

REVENUE BUDGET MONITORING SUMMARY - AS AT 31 MARCH 2019

FINAL POSITION FOR 2018-19

Reporting Criteria: +/- £50k or +/- 10%

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	839	(232)	(1,071)	461.6%	The variance is a combination of the unidentified savings total, slippage on identified efficiency savings and higher than expected bad debt provision charge partially offset by additional vacancy savings, slippage on the Community Services Investment Fund expenditure and the recognition that additional funding provided for superannuation costs related to auto-enrolment were not required.
Service Development	385	383	(2)	-0.5%	Outwith reporting criteria.
Looked After Children	7,506	6,859	(647)	-9.4%	Overspend arises mainly due to the high cost of meeting demand for expensive external care home placements and slippage on efficiency savings designed to reduce this cost as well as on legal costs within the Adoption service and agency staffing costs within the CARO service. These were partially offset by underspends on the foster care, supporting young people leaving care and children's houses budgets.
Child Protection	3,218	3,285	67	2.0%	Underspend arises due to lower than expected demand/spend on contact and welfare services.
Children with a Disability	802	848	46	5.4%	Outwith reporting criteria.
Criminal Justice	(35)	100	135	135.0%	Underspend arises mainly due to vacant posts and lower than budgeted spend on external services - spend is less than the specific grant payment for the year.
Children and Families Central Management Costs	2,421	2,415	(6)	-0.2%	Outwith reporting criteria.
Older People	29,367	29,462	95	0.3%	Underspend arises mainly due to lower than budgeted demand for care home placements and lower than budgeted spend on progressive care partially offset by overspends on homecare, residential units and from slippage on the delivery of agreed savings.
Physical Disability	1,880	1,316	(564)	-42.9%	Overspend arises mainly due to higher than budgeted demand as well as slippage on the delivery of efficiency savings for supported living services, higher demand for residential care placements and the purchase of equipment by the Integrated Equipment Store.
Learning Disability	10,874	9,446	(1,428)	-15.1%	Overspend arises due to a combination of higher than budgeted demand for supported living and care home services and slippage on savings developed to reduce both of these commitments partially offset by underspends in assessment and care management, respite and resource/day centres.

REVENUE BUDGET MONITORING SUMMARY - AS AT 31 MARCH 2019

FINAL POSITION FOR 2018-19

Reporting Criteria: +/- £50k or +/- 10%

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
Mental Health	1,624	1,901	277	14.6%	Underspend reflects demand for supported living services and residential placements and staffing underspends on the assessment and care management and area community support teams.
Adult Services Central Management Costs	463	434	(29)	-6.7%	Outwith reporting criteria.
COUNCIL SERVICES TOTAL	59,344	56,217	(3,127)	-5.6%	

REVENUE BUDGET MONITORING SUMMARY - AS AT 31 MARCH 2019

FINAL POSITION FOR 2018-19

Reporting Criteria: +/- £50k or +/- 10%

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
HEALTH SERVICES:					
Adult Services - West	53,232	50,776	(2,456)	-4.8%	Savings not being achieved and several budget overspends, including; Psychiatric medical services - locums, LIH Day Bed Unit - oncology drugs, Mull Medical Group - GP locums, LIH wards - agency nurses, LIH Laboratory - agency staffing and non pay costs, GP prescribing - Lochgilphead Medical Practice, LIH medical staffing, Flu vaccine costs
Adult Services - East	29,125	28,532	(593)	-2.1%	Savings not being achieved and budget overspends on GP prescribing; Millig Practice, Helensburgh & McLachlan Practice, Helensburgh
Children & Families Services	6,201	6,656	455	6.8%	Mainly due to vacancies
Commissioned Services - NHS GG&C	64,370	61,391	(2,979)	-4.9%	Savings not being achieved and increased charges for; mental health in-patient services, oncology drugs and other high cost services not included within the main patients services SLA
Commissioned Services - Other	4,230	3,653	(577)	-15.8%	Increased referrals to Huntercombe and the Priory and two high cost patient admissions to hospitals in England
General Medical Services	16,723	16,674	(49)	-0.3%	Outwith reporting criteria.
Community and Salaried Dental Services	3,540	3,923	383	9.8%	Mainly due to vacancies
Other Primary Care Services	8,806	8,806	0	0.0%	Outwith reporting criteria.
Public Health	1,714	2,018	304	15.1%	Vacancies and slippage on in year allocations
Management and Corporate Services	4,905	5,210	305	5.9%	Mainly due to vacancies
Health Board Provided Services	2,206	2,206	0	0.0%	Outwith reporting criteria.
Depreciation	2,441	2,524	83	3.3%	Capital underinvestment
Estates	5,538	5,099	(439)	-8.6%	Savings not being achieved and Argyll & Bute Hospital - rates
Budget Reserves	0	2,009	2,009	100.0%	Slippage and uncommitted budget reserves
HEALTH SERVICES TOTAL	203,031	199,477	(3,554)	-1.8%	
GRAND TOTAL	262,375	255,694	(6,681)	-2.6%	

Integration Joint Board

Agenda item: 5.2 (ii)

Date of Meeting: 29 May 2019

Title of Report: Budget Outlook 2020-21 to 2022-23

Presented by: Kirsty Flanagan, Interim Chief Financial Officer

The Integration Joint Board is asked to:

- Consider the current estimated budget outlook report for the period 2020-21 to 2022-23.

1. EXECUTIVE SUMMARY

- 1.1 This report summarises the budget outlook covering the period 2020-21 to 2022-23 taking into consideration the budget decisions taken at the Integrated Joint Board (IJB) on 27 March 2019. This is the first outlook of the financial year and is predominantly a roll forward of assumptions used as part of the 2019-20 budget process and extends the budget outlook to 2022-23. The assumptions will be updated and refined as the year progresses.
- 1.2 The funding from NHS Highland in 2019-20 included an uplift of 2.5%. The budget was set for 1 year only. The future estimates have been based on a 1.5% uplift for worst case, 2.5% best case and 2.0% mid-range.
- 1.3 When the Council agreed the funding allocation to the Health and Social Care Partnership for 2019-20 it also agreed indicative allocations for 2020-21 and 2021-22 subject to the level of Scottish funding and the Council's overall financial position in future years. The indicative allocation was based on current year less 1%. The mid-range scenario is based on a reduction of 1%, reflecting the indicative allocations agreed at the Council. This 1% reduction has been extended out to year 3 in the outlook. The best case scenario assumes a flat cash position and the worst case scenario assumes a reduction of 2% equal to the Council's mid-range assumption on the Scottish Government funding reduction.
- 1.4 The base budget for 2020-21 is the budget approved in 2019-20 adjusted for the resource transfer uplift that is directly passed to Social Work.
- 1.5 The changes to the employee costs are in respect of the pay award and also incremental progression. Pay awards have now been agreed for both NHS

and Council staff up to and including 2020-21. For future years, the current level of pay award is reflected within the mid-range scenario.

- 1.6 For non-pay inflation, only unavoidable/inescapable inflation has been built into the budget outlook across all three scenarios. The non-pay inflation is in respect of:
- Prescribing
 - Hospital Drugs
 - Main Greater Glasgow and Clyde SLA
 - Other SLAs
 - Energy Costs
 - Catering Purchases
 - National Care Home Contract
 - NHS Staffing Recharges to Social Work
 - Purchase and Maintenance of Equipment
 - Specific RPI Increases, for example, Audit Fee.
 - Scottish Living Wage
- 1.7 There are a number of cost and demand pressures built into each scenario:
- Lorn and the Isles Hospital Laboratory
 - GP Out of Hours Services
 - Other NSD Developments
 - Oncology Drugs Demand
 - Bute Dialysis
 - Microsoft Licence Agreement
 - Older People Growth
 - Care Services for Younger Adults
 - National Care Home Contract
 - Throughcare
- 1.8 In addition to the identified cost and demand pressures an allowance for unidentified cost and demand pressures has been included between £0.500m (best case) and £1.500m (worst case) with a mid-range of £1.000m per annum.
- 1.9 The Board agreed to reset the previously agreed Quality and Finance Plan at its meeting on 30 January 2019. There are three savings where additional savings are expected in 2020-21 amounting to £0.139m.
- 1.10 A number of management/operational and policy savings options for 2019-20 to 2021-22 were agreed at the IJB on 27 March 2019. These are now factored into the budget outlook based on the planning profile of savings.
- 1.11 In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over the three year period 2020-21 to 2022-23 is £18.074m with a gap of £6.403m in 2020-21.
- 1.12 In contrast, the budget gap in the best case scenario over the three years is £7.582m with a gap of £2.835m in 2020-21 and in the worst case scenario, the budget gap over the three years is £28.830m with a gap of £9.948m in 2020-21. A summary of all three scenarios is included within Appendix 1.

2. INTRODUCTION

- 2.1 This report summarises the budget outlook covering the period 2020-21 to 2022-23 taking into consideration the budget decisions taken at the Integrated Joint Board (IJB) on 27 March 2019. This is the first outlook of the financial year and is predominantly a roll forward of assumptions used as part of the 2019-20 budget process and extends the budget outlook to 2022-23. The assumptions will be updated and refined as the year progresses.
- 2.2 The budget outlook has been prepared using three different scenarios, best case, worst case and mid-range. Relatively small variations in assumptions can lead to fairly significant changes in the outcome. In the paragraphs that follow, the mid-range outlook is shown, however, all three scenarios are detailed within Appendix 1.

3. DETAIL OF REPORT

3.1 Funding Estimates

NHS Highland

- 3.1.1 The funding from NHS Highland in 2019-20 included an uplift of 2.5%. The budget was set for 1 year only. The future estimates have been based on a 1.5% uplift for worst case, 2.5% best case and 2.0% mid-range.
- 3.1.2 An NHS Circular from the Scottish Public Pensions Agency was issued on 7 February 2019, followed up by a letter from the Scottish Government on 12 February 2019 in respect of the changes to employer pension contributions. UK Treasury has confirmed that the planned increase (from 14.9% to 20.9%) to public service pension schemes' employer contribution rates would go ahead from 1 April 2019. The UK Government has committed to provide funding to fully cover the increased pension costs for the NHS and the final funding arrangements were expected to be confirmed at the UK Spring Statement on 13 March 2019, however, this didn't happen. The increase has taken effect from 1 April 2019 and the Scottish Government is continuing to engage with HMT on the funding and will provide an update to Health Boards as soon as the necessary clarity is obtained from the UK Government. At this stage, I have assumed that funding will be received that will cover the full year cost of approximately £5.0m: £2.7m of direct payroll costs and a further £2.3m of pass through costs for SLAs with other Health Boards and contracts with GP practices (all included within the base budget). There remains a risk that the funding passed through to Health Boards and onto Health and Social Care Partnerships is not sufficient to fully meet the cost.
- 3.1.3 The table below outlines the updated estimated funding from NHS Highland over the next three years within the mid-range scenario.

	2020-21 £000	2021-22 £000	2022-23 £000
Baseline funding	170,951	170,951	170,951
Baseline funding uplift	3,419	6,906	10,463
Other Recurring Funding	30,327	30,327	30,327
Resource Transfer baseline	11,556	11,556	11,556
Resource Transfer uplift	231	467	707
Pensions Increase	5,000	5,000	5,000
Total Funding NHS	221,484	225,207	229,004

Argyll and Bute Council

- 3.1.4 When the Council agreed the funding allocation to the Health and Social Care Partnership for 2019-20 it also agreed indicative allocations for 2020-21 and 2021-22 subject to the level of Scottish funding and the Council's overall financial position in future years. The indicative allocation was based on current year less 1%.
- 3.1.5 The Head of Strategic Finance for the Council has presented the Council's Budget Outlook for the next three years and this report mirrors the scenarios that the Council has included.
- 3.1.6 The mid-range scenario is based on a reduction of 1%, reflecting the indicative allocations agreed at the Council. This 1% reduction has been extended out to year 3 in the outlook. The best case scenario assumes a flat cash position and the worst case scenario assumes a reduction of 2% equal to the Council's mid-range assumption on the Scottish Government funding reduction.
- 3.1.7 The Council agreed to defer the pay-back of the 2017-18 overspend by one year and repayments are required over 2019-20 to 2021-22. A report was considered at the Council's Policy and Resources Committee on 16 May 2019 in respect of the repayment arrangements for the 2018-19 overspend and it was agreed that this be repaid over a period of three years commencing in 2020-21 with repayments weighted across the three as follows:
- 2020-21 - £0.800m
 - 2021-22 - £1.000m
 - 2022-23 - £1.327m.
- 3.1.8 The table below outlines the estimated funding from Argyll and Bute Council within the mid-range scenario, taking into consideration the repayment of the overspends.

	2020-21 £000	2021-22 £000	2022-23 £000
Funding 2019-20	58,814	58,814	58,814
1% Reduction	(588)	(1,170)	(1,746)
Estimated Funding	58,226	57,644	57,068
Less 2017-18 overspend repayment	(300)	(755)	

Less 2018-19 overspend repayment	(800)	(1,000)	(1,327)
Net Payment from Council	57,126	55,889	55,741

3.1.9 The table below summarises the total estimated funding over the next three years within the mid-range scenario.

	2020-21 £000	2021-22 £000	2022-23 £000
Funding NHS	221,484	225,207	229,004
Funding A&B Council	57,126	55,889	55,741
Total Funding	278,610	281,096	284,745

3.2 Base Budget

3.2.1 The starting point for the 2020-21 budget is the approved budget for 2019-20 as agreed at the IJB meeting on 27 March 2019. This budget includes the estimated additional costs for public sector pensions, £5.0m that is matched by funding. The base budget is adjusted for the estimated resource transfer estimated uplift and this is directly passed to Social Work.

3.2.2 The table below summarises the base budget in the mid-range scenario.

	2020-21 £000	2021-22 £000	2022-23 £000
Base Budget	276,327	276,327	276,327
Resource Transfer Uplift	231	467	707
Base Budget	276,558	276,794	277,034

3.3 Employee Cost Increases

3.3.1 The changes to the employee costs are noted in the paragraphs that follow.

3.3.2 For Health staff, a 3 year pay deal has already been agreed for 2018-19 to 2020-21 at 3% each year. For 2021-22 and 2022-23, it has been assumed that the 3% will continue within the best case and mid-range scenarios, with a 3.5% increase in the worst case scenario.

3.3.3 For Social Work staff, an agreement has been reached on the pay award and the increase in 2019-20 and 2020-21 is 3%. For 2021-22, the best case scenario assumes the public sector pay commitment which averages around 2.7%, the worst case scenario assumes a 3.5% increase (similar to the 2018-19 offer) and the mid-range scenario assumes a 3% increase.

3.3.4 The cost of employee increments for 2019-20 was £0.200m for Health staff and £0.091m for Social Work staff. There remains a fairly regular turnover of staff within posts and when this happens the cost of increments can, in some cases, be absorbed by the budget provision for the previous post holder, who may have been at the top of the spinal column point for the grade. This is accounted for as part of the employee base adjustment.

3.3.5 In terms of the budget outlook it has been assumed that for the best case scenario the cost of increments will be absorbed within any base

adjustment, for the worst case, the cost of increments will be the same as 2019-20 and the mid-range is between the two.

- 3.3.6 The increases to the employee budgets estimated over the next three years within the mid-range scenario are summarised in the table below.

	2020-21 £000	2021-22 £000	2022-23 £000
Health pay award	1,750	3,553	5,408
Health pay increments	100	200	300
Social Work pay award	970	1,940	2,910
Social Work pay increments	46	92	138
Total Employee Cost Changes	2,866	5,785	8,756

3.4 Non-pay Inflation

- 3.4.1 Non-pay inflation was included within the budget in 2019-20 only where it was deemed to be unavoidable or inescapable. Due to the financial pressures facing the Health and Social Care Partnership this is the basis of the inflation estimates in all three scenarios.
- 3.4.2 The non-pay inflation estimates will be reviewed during 2019-20 and updated throughout the year.
- 3.4.3 The table below summaries the updated non-pay inflation estimated over the next three years within the mid-range scenario. Further information is included within Appendix 2.

	2020-21 £000	2021-22 £000	2022-23 £000
<i>Health:</i>			
Prescribing	500	1,000	1,500
Hospital Drugs	75	154	237
Main GG&C SLA	1,340	2,714	4,122
Other SLAs	282	571	867
Energy Costs	78	160	244
<i>Social Work:</i>			
Catering Purchases	18	36	54
National Care Home Contract	5	10	15
NHS Staffing Recharges	57	114	171
Purchase and Maintenance of Equipment	7	14	21
RPI Essential increases	39	78	117
Scottish Living Wage	1,039	1,964	2,946
Total Non-Pay Inflation	3,440	6,815	10,294

3.5 Cost and Demand Pressures

- 3.5.1 There are a number of cost and demand pressures already identified and reported as part of the budget agreed on 27 March 2019. The estimates have been reviewed and updated. A further cost pressures has been

included in relation to Microsoft Enterprise Agreement for Windows 10 within Health related services.

3.5.2 When creating a budget outlook beyond one year, there is a risk that unknown cost and demand pressures will emerge that have not been included within the outlook. An allowance of £0.500m per annum is included within the best case scenario, £1.000m per annum in the mid-range and £1.500m per annum in the worst case scenario.

3.5.3 The table below summaries the updated cost and demand pressures estimated over the next three years within the mid-range scenario. Further information is included within Appendix 3.

	2020-21 £000	2021-22 £000	2022-23 £000
Health:			
Pharmacy Homecare Services (Chrohn's Disease)	100	200	200
Out of Hours GPs	200	200	200
Other NSD developments	50	100	150
Oncology Drugs demand	450	900	1,350
Bute Dialysis	90	90	90
Microsoft Licence Fees	55	55	55
Social Work:			
Older People Growth	320	645	975
Care Services for Younger Adults	181	359	540
National Care Home Contract	308	625	952
Throughcare (previously included as Continuing Care)	232	406	580
Allowance for Unknown Cost and Demand Pressures	1,000	2,000	3,000
Total Cost and Demand Pressures	2,986	5,580	8,092

3.6 Savings Measures Already Approved

3.6.1 The Board agreed to reset the previously agreed Quality and Finance Plan at its meeting on 30 January 2019. There are three savings where additional savings are expected in 2020-21 as follows:

- Ref 1819-5 - Closure of Aros – additional £0.020m
- Ref 1819-18 - Review provision of HSCP care homes – £0.099m
- Ref 1819-32 - Catering and Cleaning Review – additional £0.020m.

3.6.2 A number of management/operational and policy savings options for 2019-20 to 2021-22 were agreed at the IJB on 27 March 2019. These are now factored into the budget outlook based on the planning profile of savings.

3.7 Updated Budget Outlook

3.7.1 The updated budget outlook for the mid-range scenario, taking into consideration all the factors noted within this report, is summarised in the table below.

	2020-21 £000	2021-22 £000	2022-23 £000
Base Budget	276,558	276,794	277,034
Employee Cost Changes	2,866	5,785	8,756
Non-Pay Inflation	3,440	6,815	10,294
Cost and Demand Pressures	2,986	5,580	8,092
Q&F Plan Savings	(139)	(139)	(139)
Management/Operational Savings agreed March 2019	(500)	(1,020)	(1,020)
Policy Savings agreed March 2019	(198)	(198)	(198)
Total Estimated Expenditure	285,013	293,617	302,819
Estimated Funding	278,610	281,096	284,745
Estimated Budget Surplus / (Gap) Cumulative	(6,403)	(12,521)	(18,074)
Estimated Budget Surplus / (Gap) In Year	(6,403)	(6,118)	(5,553)

3.7.2 In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over the three year period 2020-21 to 2022-23 is £18.074m with a gap of £6.403m in 2020-21.

3.7.3 In contrast, the budget gap in the best case scenario over the three years is £7.582m with a gap of £2.835m in 2020-21 and in the worst case scenario, the budget gap over the three years is £28.830m with a gap of £9.948m in 2020-21. A summary of all three scenarios is included within Appendix 1.

3.7.4 The changes from the previous anticipated outlook to 2021-22 (as noted at the IJB meeting on 27 March 2019) are summarised in the table below:

	2020-21 £000	2021-22 £000
Previous Reported Budget Gap (mid-range)	(6,287)	(13,065)
Change to NHS Funding estimates due to change in mid-range scenario assumption from 1.5% to 2% and other updates to funding figure	1,068	1,946
Council Funding – small change to 1% reduction figure	(4)	(8)
Council Funding – pay back of 2018-19 overspend	(800)	(1,000)
Change to Base Budget linked to Resource Transfer Uplift (NHS Funding changed mid-	(58)	(118)

range scenario from 1.5% to 2%)		
Change to Employee Cost Change Estimates	228	492
Minor change to Non-Pay Inflation	2	0
Change to Cost and Demand Pressures	(44)	240
Change to Allowance for Unknown Cost and Demand Pressures	(500)	(1,000)
Q&F Plan Update	(8)	(8)
Revised Budget Gap (mid-range)	(6,403)	(12,521)

4. RELEVANT DATA AND INDICATORS

- 4.1 The budget outlook is based on a number of assumptions, using a best, worse and mid-range scenario. These assumptions will be regularly reviewed and updated as appropriate.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

- 5.1 The Integrated Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. This needs to be considered when options are developed to balance the budget.

6. GOVERNANCE IMPLICATIONS

- 6.1 Financial Impact – There is a significant budget gap for future years that requires to be addressed.
- 6.2 Staff Governance – None directly from this report but there is a strong link between HR and delivering financial balance.
- 6.3 Clinical Governance - None

7. EQUALITY AND DIVERSITY IMPLICATIONS

- 7.1 None directly from this report but any proposals to address the estimated budget gap will need to consider equalities.

8. RISK ASSESSMENT

- 8.1 There is a risk that sufficient proposals are not approved in order to balance the budget in future years. Any proposals will need to consider risk.

9. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

9.1 None directly from this report but any proposals to address the estimated budget gap will need to take into consideration local stakeholder and community engagement.

10. CONCLUSIONS

10.1 A budget outlook covering the period 2020-21 and 2022-23 has been prepared. In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over the three year period 2020-21 to 2022-23 is £18.074m with a gap of £6.403m in 2020-21. The assumptions will be updated and refined as the year progresses.

11. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 – Budget Outlook Best, Worst and Mid-Range Scenarios

Appendix 2 – Non-Pay Inflation

Appendix 3 – Cost and Demand Pressures

	Best Case Scenario			Mid-Range Scenario			Worst Case Scenario		
	2020-21	2021-22	2022-23	2020-21	2021-22	2022-23	2020-21	2021-22	2022-23
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Base Budget:									
Base Budget	276,327	276,327	276,327	276,327	276,327	276,327	276,327	276,327	276,327
Base Budget Adjustments	289	585	889	231	467	707	173	349	528
Revised Base Budget	276,616	276,912	277,216	276,558	276,794	277,034	276,500	276,676	276,855
Employee Cost Changes:									
Pay Award	2,720	5,396	8,124	2,720	5,493	8,318	2,720	5,663	8,668
Pay Increments	0	0	0	146	292	438	291	582	873
Total Employee Cost Changes	2,720	5,396	8,124	2,866	5,785	8,756	3,011	6,245	9,541
Non-Pay Inflation:									
<i>Health:</i>									
Prescribing	400	800	1,200	500	1,000	1,500	600	1,200	1,800
Hospital Drugs	45	92	142	75	154	237	105	216	332
Main GG&C SLA	1,072	2,171	3,298	1,340	2,714	4,122	1,608	3,257	4,946
Other SLAs (GPs, GG&C, other HBs, service inputs)	226	457	694	282	571	867	338	685	1,040
Energy	59	120	183	78	160	244	98	200	305
<i>Social Work:</i>									
Catering Purchases	18	36	54	18	36	54	18	36	54
National Care Home Contract	3	6	9	5	10	15	8	16	24
NHS Staffing Recharges	57	114	171	57	114	171	57	114	171
Purchase and Maintenance of Equipment	5	10	15	7	14	21	8	16	24
specific RPI Increases	31	62	93	39	78	117	46	92	138
Scottish Living Wage	1,039	1,964	2,946	1,039	1,964	2,946	1,039	1,964	2,946
Total Non-Pay Inflation	2,955	5,832	8,805	3,440	6,815	10,294	3,925	7,796	11,780
Cost and Demand Pressures:									
<i>Health:</i>									
LIH Laboratory	100	200	300	100	200	200	100	200	300
Out of Hours - GPs option out of hours	0	0	0	200	200	200	400	400	400
Other NSD developments	50	100	150	50	100	150	50	100	150
Oncology Drugs Demand	350	700	1,050	450	900	1,350	550	1,100	1,650
Bute Dialysis	90	90	90	90	90	90	90	90	90
Microsoft Licence Fees	55	55	55	55	55	55	55	55	55
<i>Council:</i>									
Older People Growth	0	0	0	320	645	975	641	1,302	1,983
Care Services for Younger Adults	0	0	0	181	359	540	362	718	1,080
National Care Home Contract	231	469	714	308	625	952	385	782	1,190
Throughcare	116	203	290	232	406	580	325	568	812
Allowance for Unknown Cost and Demand Pressures	500	1,000	1,500	1,000	2,000	3,000	1,500	3,000	4,500
Total Cost and Demand Pressures	1,492	2,817	4,149	2,986	5,580	8,092	4,458	8,315	12,210
Savings Previously Agreed:									
Quality and Finance Plan Savings	(139)	(139)	(139)	(139)	(139)	(139)	(139)	(139)	(139)
Management/Operational Savings - Agreed March 2019	(500)	(1,020)	(1,020)	(500)	(1,020)	(1,020)	(500)	(1,020)	(1,020)
Policy Savings - Agreed March 2019	(198)	(198)	(198)	(198)	(198)	(198)	(198)	(198)	(198)
Total Savings	(837)	(1,357)	(1,357)	(837)	(1,357)	(1,357)	(837)	(1,357)	(1,357)

**BUDGET OUTLOOK 2020-21 TO 2022-23
INTEGRATED JOINT BOARD - 29 MAY 2019**

APPENDIX 1

	Best Case Scenario			Mid-Range Scenario			Worst Case Scenario		
	2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000
Total Estimated Expenditure	282,946	289,600	296,937	285,013	293,617	302,819	287,057	297,675	309,029
Funding:									
NHS	222,397	227,074	231,868	221,484	225,207	229,004	220,571	223,350	226,171
Council	57,714	57,059	57,487	57,126	55,889	55,741	56,538	54,730	54,028
Total Funding	280,111	284,133	289,355	278,610	281,096	284,745	277,109	278,080	280,199
Budget Surplus / (Gap) Cumulative	(2,835)	(5,467)	(7,582)	(6,403)	(12,521)	(18,074)	(9,948)	(19,595)	(28,830)
Budget Surplus / (Gap) In Year	(2,835)	(2,632)	(2,115)	(6,403)	(6,118)	(5,553)	(9,948)	(9,647)	(9,235)

<i>Partner Bodies Split:</i>									
Health	721	1,211	1,219	(1,257)	(2,597)	(4,366)	(3,236)	(6,403)	(10,149)
Social Work	(3,556)	(6,678)	(8,801)	(5,146)	(9,924)	(13,708)	(6,712)	(13,192)	(18,681)
Budget Surplus / (Gap) Cumulative	(2,835)	(5,467)	(7,582)	(6,403)	(12,521)	(18,074)	(9,948)	(19,595)	(28,830)
Budget Surplus / (Gap) In Year	(2,835)	(2,632)	(2,115)	(6,403)	(6,118)	(5,553)	(9,948)	(9,647)	(9,235)

**HEALTH AND SOCIAL CARE PARTNERSHIP
NON-PAY INFLATION FOR BUDGET OUTLOOK 29 MAY 2019**

APPENDIX 2

Health or Social Work	Inflation Assumption	Best Case			Mid Range			Worst Case		
		2020-21 £000	2021-22 £000	2022-23 £001	2020-21 £000	2021-22 £000	2022-23 £001	2020-21 £000	2021-22 £000	2022-23 £001
Health	Prescribing - estimated cost growth between £400k and £600k per annum, mid-range £500k.	400	800	1,200	500	1,000	1,500	600	1,200	1,800
Health	Hospital Drugs - estimated cost growth between 3%-7%, mid-range 5%	45	92	142	75	154	237	105	216	332
Health	Main GG&C SLA - information regarding SG uplifts for 2019-20 indicate that 2.5% uplift is likely. Best Case assumes 2%, worst case 3%, mid range 2.5%.	1,072	2,171	3,298	1,340	2,714	4,122	1,608	3,257	4,946
Health	Other SLAs (GPs, GG&C, other HBs, service inputs) - information regarding SG uplifts for 2019/20 indicate that 2.5% uplift is likely. Best Case assumes 2%, worst case 3%, mid range 2.5%.	226	457	694	282	571	867	338	685	1,040
Health	Energy - estimated cost growth 4%, reference to RPI for energy costs. Best Case 3%, worst case 5%, mid-range 4%.	59	120	183	78	160	244	98	200	305
Social Work	Catering Purchases - reflects the expected increase in the unavoidable food costs associated with the provision of meals at the partnership's care homes, children's houses, hostels and progressive care centres.	18	36	54	18	36	54	18	36	54
Social Work	National Care Home Contract - reflects the estimated impact on the cost of replacement care arising from the annual review of the rates set out in the National Care Home Contract.	3	6	9	5	10	15	8	16	24
Social Work	NHS Staffing Recharges - reflects the estimated impact on Social Work of increased charges for services provided by NHS staff arising from annual pay increments and inflation.	57	114	171	57	114	171	57	114	171
Social Work	Purchase and Maintenance of Equipment - reflects the estimated impact of inflation on the purchase and maintenance costs of aids and equipment provided by the Integrated Equipment Store to support discharge from hospital and help people continue to live at home for longer.	5	10	15	7	14	21	8	16	24
Social Work	General RPI Increases - reflects the estimated impact of inflation on a range of unavoidable costs including the IJB annual audit fee from Audit Scotland as well on care and support costs for carers.	31	62	93	39	78	117	46	92	138
Social Work	Scottish Living Wage - reflects the estimated cost of maintaining the IJB's commitment that all adult social care staff employed by external providers or service users are paid at least the Scottish Living Wage. The estimate takes account of annual inflationary uplifts in the funding provided by the Scottish Government, routed via NHS Highland, to fund the national commitment to the Scottish Living Wage.	1,039	1,964	2,946	1,039	1,964	2,946	1,039	1,964	2,946
TOTAL NON-PAY INFLATION		2,955	5,832	8,805	3,440	6,815	10,294	3,925	7,796	11,780

HEALTH AND SOCIAL CARE PARTNERSHIP

APPENDIX 3

COST AND DEMAND PRESSURES FOR BUDGET OUTLOOK 29 MAY 2019

Health or Social Care	Service	Cost/Demand Pressure	Best Case			Mid Range			Worst Case		
			2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000
Health	GGC Homecare Pharmacy Services	Pharmacy Homecare Services (Crohn's disease): Scottish Medicine Consortium have approved new drug treatments which are prescribed by hospital consultants for dermatology and Crohn's patients. This has led to increased numbers of patients receiving ongoing treatments. Historical analysis of patient numbers and treatments indicates an increasing demand in future years.	100	200	300	100	200	200	100	200	300
Health	Adult Services	Out of Hours GP: Impact of GPs opting out of "Out of Hours" service. Cost pressure of £100k provided for Jura in 2019-20. Mull £200k, Coll £100k and Colonsay £100k. Best case is based on no additional cost, mid-range based on Coll and Colonsay in 2020-21 and Mull in 2021-22. Worst case is based on Coll, Colonsay and Mull in 2020-21.	0	0	0	200	200	200	400	400	400
Health	All Services	Other NSD developments - NHS Board Chief Executives Group approve a number of services to be provided on a national basis each year. Contributions are based on NRAC shares.	50	100	150	50	100	150	50	100	150
Health	Services commissioned from GG&C and Adult Services West (LIH)	Oncology drugs demand, assumed to be between £350k and £550k, mid-range £450k - SMC new drug approvals for treatment of a range of cancers including urological, haematological, breast & lung	350	700	1,050	450	900	1,350	550	1,100	1,650
Health	All Services	Plans are being developed for a renal dialysis unit on Bute. This will save patients travelling to Greenock three times a week for dialysis. Start up costs will be met from charitable donations and fundraising. Recurring costs of £90k per annum will require to be met by the HSCP.	90	90	90	90	90	90	90	90	90
Health	All Services	In response to the Cyber-attack on NHS systems in 2017, the Scottish Government has provided funding to purchase hardware to support the installation of windows 10 in the NHS in Scotland, however NHS Boards have to fund the enterprise agreement (EA) with Microsoft for windows 10. This is a recurring annual cost of £55k.	55	55	55	55	55	55	55	55	55
Adult Care	Adult Care	The number of older people is increasing and older people are living longer with significant health and support needs and significant expectations of the support they are entitled to receive. Demand pressure estimates 3% growth in homecare and care home placements, this increase is supported by the growth in clients and care requirements over a number of years although in some areas the service capacity is being fully utilised and service expansion is proving difficult. The best case recognises the current capacity limits, the mid-range reflects 1.5% growth and the worst case reflects 3% growth. For 2019-20 this was absorbed within existing resources by changing the assessment and service provision processes.	0	0	0	320	645	975	641	1,302	1,983

HEALTH AND SOCIAL CARE PARTNERSHIP

APPENDIX 3

COST AND DEMAND PRESSURES FOR BUDGET OUTLOOK 29 MAY 2019

Health or Social Care	Service	Cost/Demand Pressure	Best Case			Mid Range			Worst Case		
			2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000	2020-21 £000	2021-22 £000	2022-23 £000
Adult Services	Adult Services	There has been continuing increase in demand for care and support services for profoundly disabled younger adults (ie under 65) whose parents have historically provided care but are no longer able to. The best case assumes new demand will be met from attrition or reductions in existing services, the mid-range reflects demand of 1.5% and the worst case reflects demand of 3%.	0	0	0	181	359	540	362	718	1,080
Adult Services	Adult Services	National Care Home Contract: Contract rates are negotiated on an annual basis with representatives of the Scottish care home sector by Scotland Excel. The best case scenario figures provided are based on an annual increase of 3% (in-line with the 2019/20 increase in the Scottish Living Wage rounded to the nearest whole number), the mid range reflects an increase of 4% and the worst case 5%. For 2019-20, this pressure was absorbed within the current underspend in this area.	231	469	714	308	625	952	385	782	1,190
Children and Families	Children and Families	Estimated cost of Throughcare Services for Young Adults leaving Continuing Care Services as they reach 21 from 1 April 2020 onwards. Children and Families will continue to have a responsibility up to the day before the affected Young Adults turn 26, should the Young Adults choose to continue to receive support. The cost pressure is based on the trend in expenditure on continuing care over the period 2014-15 to 2018-19. The mid-range assumes 5% demand, best case 2.5% and worst case 7.5%.	116	203	290	232	406	580	325	568	812
All Services	All Services	Provision for Unknown Cost and Demand Pressures	500	1,000	1,500	1,000	2,000	3,000	2,000	4,000	6,000
Total	Total		1,492	2,817	4,149	2,986	5,580	8,092	4,958	9,315	13,710

Integration Joint Board

Agenda item: 5.3

Date of Meeting: 29 May 2019

Title of Report: Staff Governance Report

Presented by: Sandy Wilkie, Head of People & Change (HSCP)
Jane Fowler, Head of Customer Services (A&BC)

The Integration Joint Board/Committee is asked to:

- Note the content of this quarterly report on the staff governance performance in the HSCP.
- Note a paper will be brought to the IJB in August 2019 regarding absence and return to work data.

1. EXECUTIVE SUMMARY

1.1 Staff Governance is defined as “A system of corporate accountability for the fair and effective management of all staff.”¹ The Standard requires all NHS Boards to demonstrate that staff are:

- Well Informed;
- Appropriately Trained and Developed;
- Involved in Decisions;
- Treated Fairly and Consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

1.2 In the context of health & social integration, we also consider the following:

- adopt best practice from both employers
- ensure compliance with terms and conditions and employing policies
- Identify any service change implications for the workforce and compliance with the above.

1.3 This paper sets out current key issues and supporting performance data for staff governance in the Health & Social Care Partnership, with NHS Highland and Argyll & Bute Council are the employing bodies.

¹ NHS Scotland Staff Governance Standard, 4th Edition, Published 2012.

- 1.4 Further to the outstanding action request from the IJB on the following:
1. The levels of absence and a consolidation of the data to advise on causes and trends.
 2. Data on return to work interviews.
 3. iMatter update and the steps taken as an outcome of the external evaluation.
 4. Clarity on employee relations cases.
- 1.5 Points 3 & 4 are addressed in this paper with points 1 & 2 being brought back to the IJB in August 2019 due to the challenge in consolidating the required data.

2. INTRODUCTION

2.1 This report provides an overview of the staff governance issues identified above as raised and discussed at the Strategic Leadership Team and Joint Partnership Forum. This report will be presented to the IJB on a quarterly basis. This report includes updates on:

- Progress under the 5 Staff Governance themes
- Additional Integration work
- Spotlight on Staff Wellbeing
- Supporting Performance Data
 - Recruitment & Redeployment activity
 - Fixed Term Contracts
 - Employee Relations Case
- Work planned over the next 3 months

2.2 The data represents Quarter 4 (Jan-Mar 2019) unless otherwise stated.

3. PROGRESS UNDER THE 5 STAFF GOVERNANCE THEMES

3.1 Well Informed

Over the last few months, a new number of communication channels to HSCP staff have been developed. These include a NHS Highland CEO weekly email, our Chief Officers weekly update, a new monthly NHSH Team Brief and occasional People & Change and Council HR/OD newsletters. Cascades of key information also take place in huddles and Service/Locality team meetings.

A new HSCP Staff Newsletter was also piloted in Autumn 2018 and is under review. Some update communications have been provided by the Transformation Board project steering groups. The Council's Intranet and the NHS intranet are also used as key communication tools for staff, however not all staff have daily access to the Intranet or email, so local arrangements are made where possible to provide printed copies of key materials on noticeboards.

3.2 Appropriately Trained & Developed

There has been a renewed focus on ensuring HSCP staff are participating in appraisal & development conversations under our new TURAS and PRD systems. These conversations together with regular 1:1 meetings with individual staff, will allow training needs to be identified.

Compliance in Statutory/Mandatory training for NHS staff is being monitored through our local Accountability Wall. The current 'Grip & Control' measures are reducing the amount of travel and accommodation approved, so staff will be attending fewer external training events or conferences just now.

Outcomes from PRD/TURAS, along with workforce planning information, will inform training plans for the 2019/20 year. This will include prioritisation by the Council's Social Work Training Board of training investments such as social work degree students, SVQs in social care and apprenticeships/foundation apprenticeships.

3.3 Involved in Decisions

The Transformation Board has a number of Steering Groups and Short-Life Working Groups (SLWG) that give the opportunity for managers and staff-side colleagues to be part of service redesign work.

We also remain committed to using the A&B HSCP Partnership Forum, Staff Liaison Group and Organisational Change Group as formal occasions where decisions on organisational change can be taken in partnership.

3.4 Treated Fairly and Consistently

Our HSCP Shared Values framework 'CIRCLE' promotes INTEGRITY and RESPECT as two of our Six Values. The practices associated with these Values uphold this Staff Governance theme.

Actions arising from the Sturrock Review of NHS Highland will be reported to the IJB implemented as appropriate within our HSCP.

3.5 Provided with a continuously improving and safe working environment.

We have a co-location programme for corporate services and other administration / clinical support / social work functions over the next few months. These include the closure of Aros and the move of NHS staff to Kilmory/Whitegates (target dates mid-June & early-July) and a more complex co-location of NHS and Social Work staff across 3-4 buildings in Oban (end-August).

These moves will provide better opportunities for integrated working and improve communication between related teams.

4. ADDITIONAL INTEGRATION WORK

4.1 Workforce Planning

The first HSCP Workforce Plan for 2018/19 was developed focusing primarily on Adult Services. The final version was approved at the August IJB.

The Plan includes actions to improve the process of workforce planning as well as actions to bridge the gap. Service specific integrated workforce plans are now being developed as part of a programme of joint working between HSCP and Council OD teams. This is critical to supporting both service redesigns as they are progressed for the areas reporting to the Transformation Board and the serious challenges of recruitment to some posts.

The next HSCP Workforce Plan will include information about all services and encompass more detail about the role of the third-sector, voluntary organisations, community networks and other commissioned providers who support the HSCP. This will align with the HSCPs refreshed 3 year Strategic plan for 2019 to 2022.

Consideration has been given as to how best to take this forward, clarity and confirmation of governance and approach is still needed. In the meantime, consultation with staff & managers in our Localities, and with our third/voluntary sector colleagues is commencing this month. There are ongoing developments at national level which inform the development of our next plan. The National Health and Social Care Integrated Workforce Plan was expected earlier in the year but we understand it is due to be published soon

We will bring our refreshed HSCP Workforce Plan 2019-2022 to IJB for approval in early October 2019.

4.2 HSCP Management restructure

Work has been undertaken in March/April/May by our Chief Officer to define a new Senior Leadership Team structure to enable delivery of our HSCP Strategic Plan and meet our current financial challenges. A separate paper detailing the proposals and progress are covered elsewhere on the IJB agenda today.

4.3 Integration of corporate functions

As part of the management restructure, we are proposing to move to a shared services arrangement with Argyll & Bute Council for a number of HSCP corporate functions as highlighted in the strategic plan; this will give us closer integrated working, help with joint reporting and provide

opportunities for efficiencies over time. Co-location of Aros based staff to Kilmory will be an enabling factor. The services delivered by these operational functions will be defined and agreed in an SLA with the HSCP.

It is anticipated that these arrangements will be in progressed by 1st August 2019, subject to consultation through the appropriate channels.

4.4 HSCP Values & Culture

Following approval of the paper at the March IJB, a project plan has been created. However timescales may now be affected by the need to respond to the Sturrock Review.

A further update will be given at the next IJB meeting in August 2019.

4.5 Staff Experience

Our participation in the third wave of the national iMatter survey is underway. This measures the overall level of engagement within teams & organisations, based upon the 5 Staff Governance themes. The first two iMatter waves helped us to understand some areas for improvement:

- **I am confident performance is managed well within my organisation**
- **I have confidence and trust in senior managers responsible for the wider organisation**
- **I feel senior managers responsible for the wider organisation are sufficiently visible**
- **I feel involved in decisions relating to my organisation**

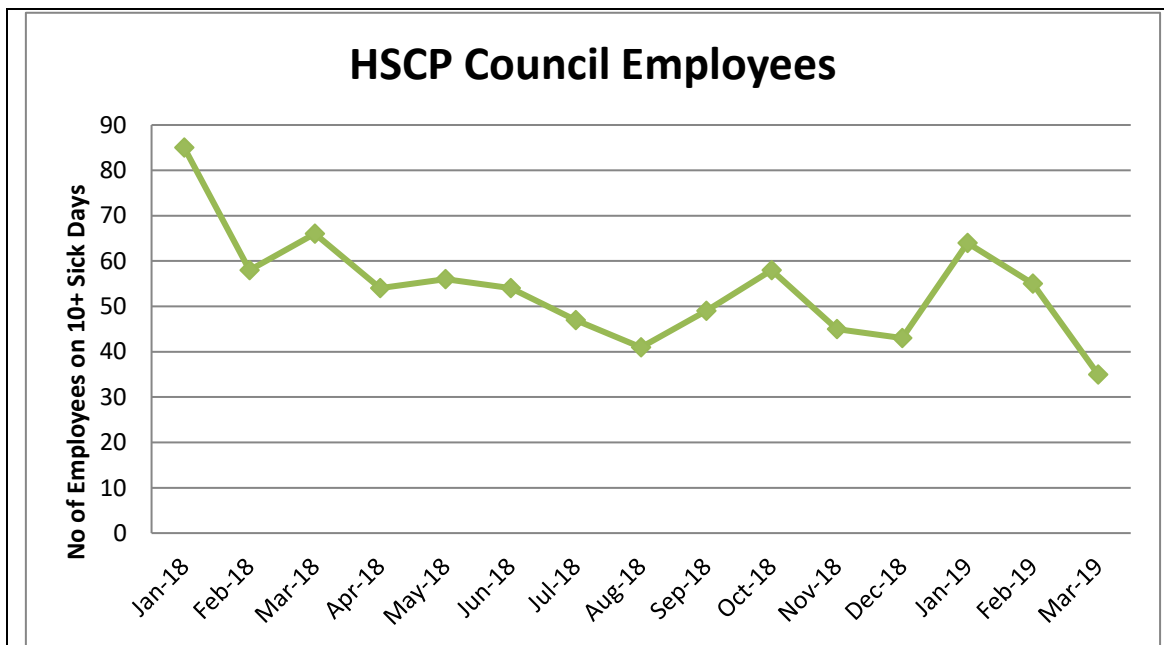
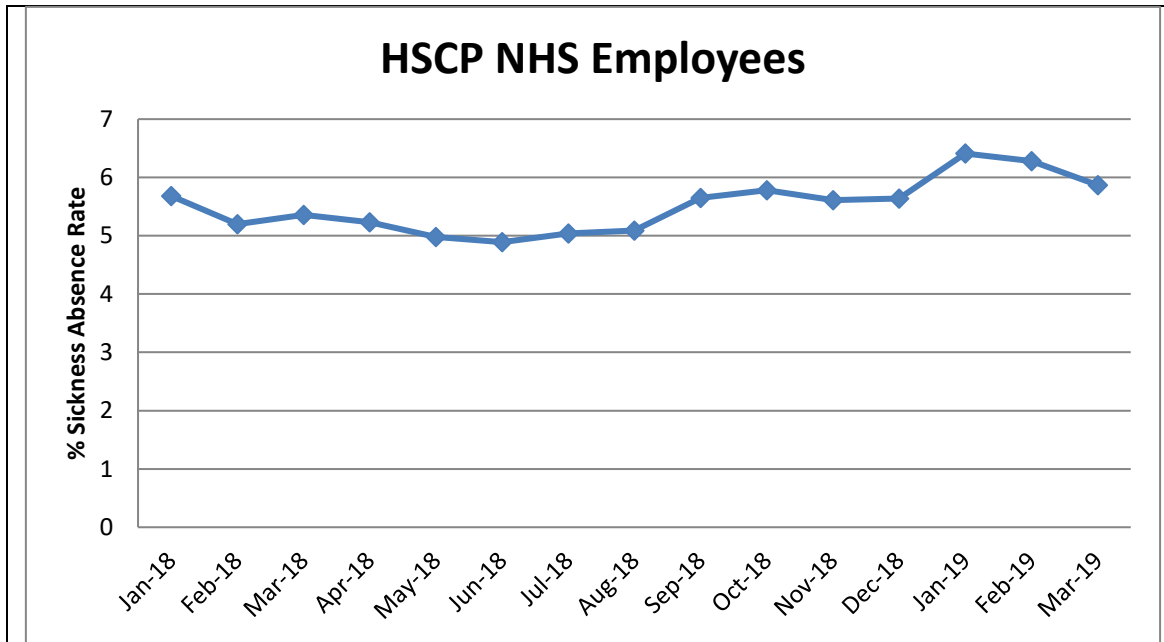
For Wave 3, we will be encouraging all managers to promote participation in iMatters and undertake local action planning follow through. Early evidence from waves 1&2 suggest the teams that create and implement an action plan, see a corresponding improvement in engagement. Keeping engagement levels up at times of organisational and service change is really important, else productivity suffers and staff retention could become an issue.

The remaining timeline for Wave 3 is as follows:

- **27th May - 17th June** - Questionnaire runs for three weeks - Managers encourage participation
- **1st July** - Reports issued to teams (if 100% response rate for team of 4 or less, 60% response rate for team of 5 or more). Teams review report and identify opportunities for improvement action
- **23rd September** - 12 week deadline - Action plans are a key output contributing to improved staff experience

5. SPOTLIGHT ON STAFF WELLBEING

5.1 In our Q3 Staff Governance Report, we focused on sickness absence levels within the HSCP and some of the potential Maximising Attendance strategies to get our staff back to work more quickly. Investing in improved staff health & wellbeing is also another strategy to prevent illness happening in the first place. Some helpful context is provided by looking at the sickness absence trend over the last 12 months or so:



5.2 This shows a rise (year on year)² for our NHS employees going into Q4, with all our monthly %'s above the NHS Scotland national target of 4.0%. We see an improving trend for social work & social care staff down from a high in January 2018. The Grip and Control focus has been applied to

² Ave Sickness Absence rates are 5.41% (Q4, 2018) and 6.19% (Q4, 2019)

Council absence statistics with a regular, weekly very detailed review of the individual absence cases between HR and Heads of Service.

5.3 Following a HSCP-wide Staff Wellbeing Survey in Spring 2018, a Staff Health & Wellbeing group was established to review the data and propose some positive interventions. An initial paper was presented to SLT in Autumn 2018, with a follow-up paper going to SLT this month to agree actions that will be taken forward.

5.4 One of the initial recommendations was to arrange workshops focusing on building resilience and stress awareness. Sessions were held in Dunoon, Lochgilphead and Oban in November 2018 with nearly 60 staff attending. Further dates were arranged for Campbeltown, Helensburgh, Islay and Bute in January/February with another 60 staff attending, the Bute one is still to be held as it needed to be rearranged. One of the exercises undertaken by staff attending the workshops was to write down what the HSCP could do to help build employee resilience. The themes from these comments are being used to inform the recommendations.

5.5 A visual summary was prepared to enable easier understanding of the Survey results. The results are displayed using the four headings below which emerged as themes. The draft Health and Wellbeing recommendations were developed by the group based on the survey results plus other information such as iMatter results. These are arranged under the four headings and the finalised recommendations will inform the Action plan, some are short, medium and long term:

- **Flourish and Move more**
- **Healthy Workplace**
- **Connections - communication and social**
- **Support – targeted interventions**

5.6 We believe that both Maximising Attendance, through the application of the relevant policies, and a preventative approach to improving staff health and wellbeing are necessary as a twin-track approach to bring sickness absence levels down. There are benefits of improving the health and wellbeing of staff to the organisations, employee and service users.

5.7 An update on the final Maximising Attendance and Health & Wellbeing recommendations agreed, together with how the impact of these will be monitored, will be provided in the next Staff Governance Report (August 2019).

6. SUPPORTING PERFORMANCE DATA

6.1 Recruitment & Redeployment activity

Data for both NHS and Council Social Work activity is shown in Appendix 1.

Attracting and retaining suitable applicants predominantly within nursing, social work and some AHP roles remains challenging across all areas particularly OLI at present. The Communications Team continues to uploading and sharing posts and information relating jobs throughout the UK to relevant groups and contacts on social media. Further work requires to be done to highlight health posts via ABPlace2B online site.

There are now 29 staff on the NHS primary redeployment register (a decrease of 2) and 29 on the secondary register (a decrease of 1). Matching this quarter has enabled a few staff to be placed in new roles. No Social Work staff are currently on the redeployment register.

6.2 Fixed Term Contracts

Combined data for NHS and Council Social Work is shown in Appendix 2.

The number of Fixed Term Contracts within the NHS staff group continues to be higher than normal. This is predominately due to a bar we placed on permanent recruitment to administration & clinical support roles while the Admin Review transformation project theme was progressing; we did not wish to build in obsolescence into our admin structures when services were changing. This bar has now been lifted so we anticipate that FTCs will drop to the normal 30-40 range during the next two quarters.

There continues to be approximately 10% of all Council Social Work/Care employees in temporary or fixed term posts. This can be as a result of temporary cover for absence or other leave such as maternity/paternity or can be as part of a management approach to minimising the impact of service redesign. The number of fixed term contracts have significantly increased as a result of current redesign work. This is not ideal and brings its own challenges but this is deemed best practice given the financial challenges the IJB face in the short to medium term.

As redesign of services are completed then the number of staff on FTCs will reduce. It is important to recognise the importance of ongoing communication with staff in temporary posts regarding future planning, as uncertainty can lead to unnecessary stress and the potential for absence.

There are automated alert systems in place for managers and employees regarding Council temporary contracts, giving notice of the forthcoming ending of a contract and requiring action to extend it. This serves as a reminder to managers to keep employees informed of changes.

6.3 Employee Relations Cases

Data for both NHS and Council Social Work activity is shown in Appendix 3.

Argyll & Bute HSCP is committed to managing employees with fairness and consistency. If a concern arises in relation to an employee's conduct, the approach is a preference to deal with this through informal action initially. However, where such informal action is inappropriate or does not lead to the required improvement, managers will normally undertake an investigation under the terms of the appropriate Disciplinary Procedures

The number of ER cases within the NHS staff group is now half of what it was back in July 2018. Support by our HR Business Partners & HR Advisers has enabled a number of investigations to be concluded and resolved. Thanks are due to our service/line managers for helping the situation to improve.

In the Council, the Employee Relations Team carries out all disciplinary investigations, but managers are responsible for investigating grievances. This has resulted in a significant improvement in the time to reach a conclusion.

7. WORK PLANNED FOR THE NEXT 3 MONTHS

- All HSCP staff will be invited to participate in iMatter wave 3 which launches on 27th May. This will give teams the opportunity to give feedback on their staff experience and participate to team action planning using the results
- Agreement and implementation of Maximising Attendance and Staff Health & Wellbeing recommendations to reduce levels of HSCP sickness absence
- Subject to our need to respond to the Sturrock Review, make headway with our Culture & Values work to ensure supportive relationships & behaviours become embedded during a period of organisational change
- Finalisation and implementation of new OD and HR structures to support HSCP managers going forward under a revised Senior Leadership Team
- Our next 'Spotlight On' feature for the August IJB Staff Governance Report will be on the uptake of Appraisal conversations as evidenced through TURAS and PRDs; this was a topic we promised the IJB an update after June 2019.

8. CONTRIBUTION TO STRATEGIC PRIORITIES

The staff governance paper sets out the issues relating to our people that support or have an effect on the delivery of the HSCP strategic priorities.

9. GOVERNANCE IMPLICATIONS

9.1 Financial Impact

A reduction in sickness absence will help us save costs.

9.2 Staff Governance

This is the Staff Governance Report which provides an overview of all work that contributes against this theme.

9.3 Clinical Governance

None.

10. EQUALITY & DIVERSITY IMPLICATIONS

Our CIRCLE framework includes '**Respect**' and '**Integrity**'. Our Shared Values & Practices apply to all HSCP staff employed by NHS Highland and A&B Council.

Other Equality & Diversity issues are picked up within the NHS People & Change and Council HR & OD teams as appropriate when policies and strategies are developed.

11. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Nothing to note, this paper complies with general GDPR guidance as all data presented is summarised and anonymised.

12. RISK ASSESSMENT

Risks are considered low. Positive work around the Staff Governance standard will enhance the workplace experience for all HSCP employees. There are individual HR risks already identified on the Risk Register.

13. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Not applicable.

14. CONCLUSIONS

It is recommended that the Integration Joint Board/committee:

- Note and accept this quarterly Staff Governance update
- Take the opportunity to ask any questions on people issues that may be of interest or concern
- Provide support for our overall direction of travel, including future topics that they would like further information on

15. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name: **Sandy Wilkie, Head of People & Change**

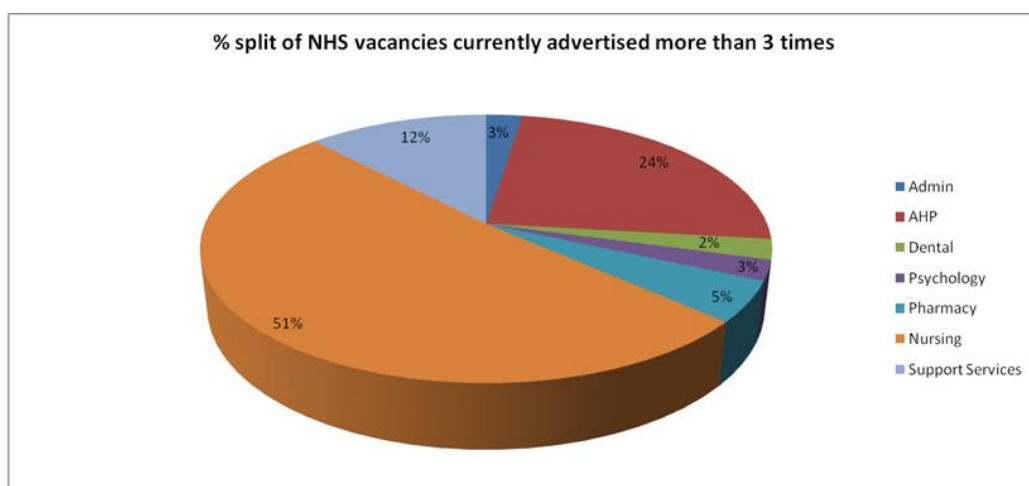
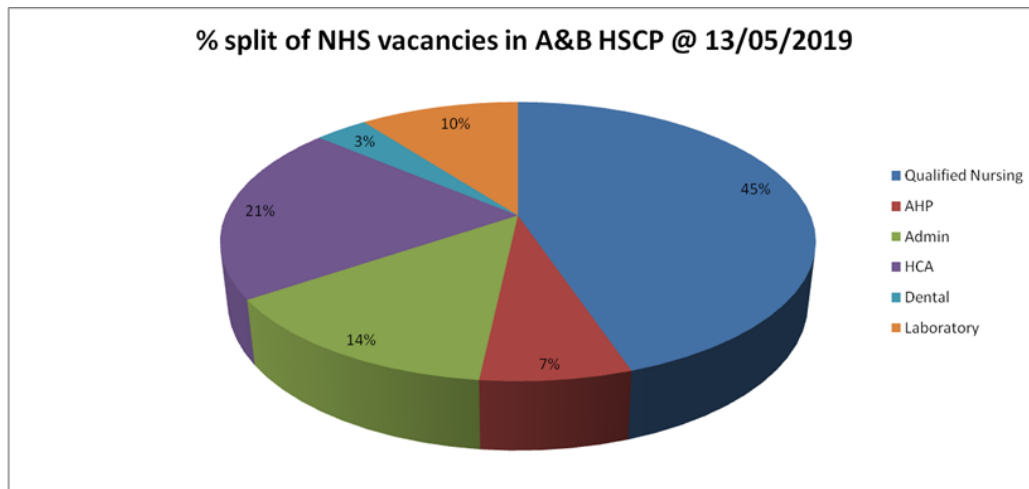
With input supplied by Jane Fowler/Jo McDill (Council HR), Fiona Sharples and Charlie Gibson (NHS People & Change).

Email: sandy.wilkie@nhs.net

Appendix 1 – Recruitment & Redeployment Activity (Q4)

NHS Vacancies

	January		February		March	
	New	Re-Ad	New	Re-Ad	New	Re-Ad
Adult Services EAST	7	4	9	2	15	0
Adult Services WEST	8	12	11	9	18	15
Children & Families	5	3	0	3	0	0
Corporate Services	1	0	1	0	1	1
Totals	21	19	21	14	34	16
	40		35		50	



Average Time to Recruit Successful NHS Appointees in last 6 months (figures based between date recruitment file opened to start date of employees):

- Internal appointments – 13.5 weeks (there have some recent internal posts that have delayed start dates due to service delivery reasons)
- External appointments – 12.5 weeks

Council Social Work/Care vacancies

For the month of **January 2019**, there were **16 (7 x Temp, 9 x Perm)** internal job adverts for HSCP Council Posts, and **24 (11 x Temp, 13 x Perm)** external job adverts.

For the month of **February 2019**, there were **18 (8 x Temp, 10 x Perm)** internal job adverts for HSCP Council Posts, and **27 (13 x Temp, 14 x Perm)** external job adverts.

For the month of **March 2019**, there were **12 (8 x Temp, 4 x Perm)** internal job adverts for HSCP Council Posts, and **10 (6 x Temp, 4 x Perm)** external job adverts.

NHS Redeployment

Primary Register

NHS Employees	Jan	Feb	Mar
A&B Adult Services – East Total	9	9	10
A&B Adult Services – West Total	19	19	16
A&B Children & Families Total	0	0	0
Corporate Services Total	3	3	3
Totals	31	31	29

Current month:

- **Adult East** : 2 x Band 7-1.07wte, 1 x Band 5-0.50wte, 1 x Band 2-0.43wte, 6 x Band 1-1.23wte
- **Adult West** : 2 x Band 7-2.00wte, 4 x Band 4-3.40wte, 1x Band 3-1.00wte, 8x Band 2-6.68wte 1x Band 1-0.54wte
- **Corporate Services** : 3 x Band 4-1.29wte

Appendix 2 – Fixed Term Contracts (Q4)

NHS & Council Social Work/Care Fixed Term Contracts

Employees on T/FT contracts	January 2019	February 2019	March 2019
Adult Care West (ABC)	43	44	44
Adult Care West (NHS)	21	25	24
Adult Care East (ABC)	34	34	34
Adult Care East (NHS)	22	20	23
Children and Families and CJ (ABC)	23	26	28
Children and Families and CJ (NHS)	4	4	2
Strategic Planning and Performance (ABC)	0	0	0
Corporate Services (NHS)	8	4	2
OVERALL TOTAL	155	157	157

Appendix 3 – Employee Relations Cases (Q4)

NHS ER cases

	Jan	Feb	Mar
Grievance Total	5	3	1
A&B Adult Services - West	4	2	1
A&B Adult Services - East	1	1	0
A&B Children & Families	0	0	0
A&B Corporate	0	0	0
Conduct Total	3	3	4
A&B Adult Services - West	3	3	3
A&B Adult Services - East	0	0	1
A&B Children & Families	0	0	0
A&B Corporate	0	0	0
Capability Total	3	3	3
A&B Adult Services - West	1	1	0
A&B Adult Services - East	2	2	3
A&B Children & Families	0	0	0
A&B Corporate	0	0	0
Bullying & Harassment Total	1	1	1
A&B Adult Services - West	1	1	1
A&B Adult Services - East	0	0	0
A&B Children & Families	0	0	0
A&B Corporate	0	0	0
Totals	12	10	9

Council Social Work/Care ER cases

	January 2019		February 2019		March 2019	
	Disc	Grievance	Disc	Grievances	Disc	Grievances
Adult Care W (ABC)		1				1
Adult Care E (ABC)						
C&F & CJ (ABC)	3		3		3	
Strat P&P (ABC)						
Total	3	1	3	-	3	1

Integration Joint Board

Agenda item: 5.4

Date of Meeting: 29 May 2019

Title of Report: HSCP Management Structure

Presented by: Joanna Macdonald Chief Officer

The Integration Joint Board is asked to :

- **Note** that management structure will go through appropriate staff consultation will be carried out and due process will be followed through the Staff Liaison and Organisational Change Groups.
- **Note** the follow up work to confirm lower levels of the structure, with a target date for full implementation by August 2019.

1. EXECUTIVE SUMMARY

- 1.1 There are a number of challenges that face the HSCP; delivery of the Strategic Plan, achieving a balanced budget and supporting our staff through professional leadership.
- 1.2 To meet some of the challenges, a revised structure is proposed to ensure we have the appropriate collective leadership support to manage challenges faced across existing services. The changes at the Strategic Leadership Team level will be implemented pending the conclusion of the consultation process. We will be engaging with second/third level managers and staff-side colleagues to plan the detail at lower levels.

2. INTRODUCTION

- 2.1 A review of the current HSCP management structure has been carried out and this report outlines the changing requirement to meet the needs of our delivery plans.

3. DETAIL

EXISTING HSCP MANAGEMENT STRUCTURE

- 3.1 The existing structure was put in place as part of an options appraisal in 2015. A number of options were considered prior to integration and the main variation under each of the options was the structure for Adult Services. The current structure includes two Heads of Service for Adult Services (East and West).

EVALUATION

- 3.2 There are a number of weaknesses with the current HSCP Management Structure, some of which impact specifically on the effective leadership and management of change across services:

- Two Heads of Service for Adult Services with an East/West split, has led to inconsistencies in standards, practices and the implementation of service change;
- Requirement for professional leadership for Social Work within Adult Services providing integrated managers with greater support and clarity;
- There is duplication of effort Adults Services Locality Managers and their Local Area Managers, leading to some confusions around accountability & role clarity
- There is limited capacity and direct support for the Chief Officer to deal with the strategic and corporate demands of the role, including the volume of information requests from elected representatives and stakeholders, this had led to an inefficient use of time from other senior officers;
- Our Communications team is not currently aligned to provide best support for our Chief Officer
- Better support for corporate functions

PROPOSED NEW MANAGEMENT STRUCTURE

- 3.3 In reviewing options, the starting point was the development of a more effective structure for Adult Services. There is also opportunities to simplify the structure, introduce professional leadership for social work and care and develop a shared services arrangement for HR with the Council.

- 3.4 The key changes are summarised as follows:

- Move from a geographical split for Heads of Adult Services to a portfolio-based approach
- Simplify the supporting management structure within Adult Services by investing in the Service/Area Manager level and removing the middle later of Local Area Managers so that Team Leads have a direct reporting line to the second level of our structure
- People & Change staff to be part of a collaborative shared service arrangement led by the council and managed through an SLA.

- Move the Communications function from Public Health to directly support the Chief Officer
- 3.5 These changes will be fully costed once the Level 1 & 2 structures have been finalised. Once the links between Level 2 and the Team Lead functions have been agreed, it is anticipated that we will save £500k in total as noted in the savings plan.

ANTICIPATED BENEFITS

- 3.7 The proposed structure will support a portfolio approach to service change across Adult Services. Professional leadership within the HSCP will be aligned and focused. Our four localities and Argyll & Bute wide services will have clearer reporting lines, leadership and accountability for all aspects of delivery.
- 3.8 There will be greater capacity and resource for handling external pressures and internal budget targets.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

A refreshed HSCP structure will provide the foundation for delivery of our Strategic Plan, Quality and Finance Plan and our transformation change programme.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

The full HSCP Management Restructure will aim to save £500k as a contribution to our wider savings plans.

5.2 Staff Governance

The new structure will strengthen leadership, resilience and improve communication. The appropriate staff consultation will be carried out and due process will be followed through the Staff Liaison and Organisational Change Groups to ensure implementation.

5.3 Clinical Governance

The proposed new structure will improve support for governance issues and address any gaps in professional leadership to reduce the risks at locality level.

6. EQUALITY & DIVERSITY IMPLICATIONS

These will be picked up through our agreed Organisational Change process, in conjunction with staff-side colleagues.

7. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Nothing to note, this paper complies with general GDPR.

8. RISK ASSESSMENT

The proposed changes to the HSCP Management structure are required to support a better pace of transformational change and ensure delivery of our HSCP Strategic Plan within budget. Any local risks to service delivery will be highlighted and addressed at the Locality level.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Following agreement through due process, the new structure will be communicated to our partners and stakeholders this will highlight our renewed focus on driving forward future sustainability.

10. CONCLUSIONS

A review of the management structure has been appropriate after 3 years of the HSCP. A number of changes are recommended to make the structure more effective in aligning roles and responsibilities to strategic delivery. Also to address a number of issues and gaps within the current structure supporting the corporate functions. It is imperative that there is effective leadership and support for the HSCP to address the current and future challenges.

It is recommended that the Integration Joint Board/committee accept this update on our direction of travel and support the SLT to work with managers and staff-side to advance the proposals in more detail and complete implementation within 3-4 months.

11. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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Integration Joint Board

Agenda item: 5.5

Date of Meeting: 29th May 2019

Title of Report: Financial Quarter 3 - Performance Exception Report

Presented by: Stephen Whiston - Head of Strategic Planning & Performance

The Integration Joint Board/Committee is asked to:

- **Note** overall scorecard performance for the FQ3 reporting period
- **Consider and Note** the HSCP performance against National Health and Well Being Outcome Indicator: 9 and the Ministerial Steering Group measures of integration for the HSCP
- **Note** the Head of Services performance commentary with regard to local actions to address exceptions against Indicator 9

1. EXECUTIVE SUMMARY

For Financial Quarter 3 (FQ3) there is an increase in overall performance when compared to the previous quarter. Measures reported 'on track' for Financial Quarter 3 (FQ3) were (35) compared to (34) reported on track for FQ2. For the third quarter the overall IJB scorecard performance is reporting an overall trend of red.

Performance exceptions across Health & Wellbeing Outcome Indicator (9) - notes (2 out of 6) measures reported as off-track.

With regards to the FQ3 performance for the Ministerial Steering Group (MSG) measures; Unplanned Admission is reporting 7.0% off target, Unplanned Bed Days is reporting 10.7% off target, and Accident & Emergency Attendance is reporting 4.9% off target but improved from FQ2 and Delayed Discharges reporting 41.7% off target but improved from FQ2.

Areas of improved performance for FQ3 note:

- Increase in the percentage of MMR uptake at 5years
- Reduction in the numbers of people waiting more than 12 weeks for Homecare Service- assessment authorised
- Increase in the total number of Telecare Packages
- Increase in the number of Community Payback Orders seen without delay (5 Days)

2. INTRODUCTION

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals. Currently there are 9 key National Health and Wellbeing Outcomes (NHWBOI's) and 23 sub-indicators and additional measures which form the foundation of the reporting requirement for the HSCP.

3. RELEVANT DATA AND INDICATORS

3.1 Overall Scorecard Performance for FQ3

Compared to FQ2 there is an increase in overall performance with FQ2 (34) measures reported as on-track against FQ3 which notes (35) on-track. For the third quarter the overall IJB scorecard performance is reporting a trend of red

Integrated Joint Board [IJB] Scorecard	Success Measures	65	R	Outcome 5 - Services reduce health inequalities FQ3 18/19	No of indicators	2	R
	On track	35	→		On track	0	→
Outcome 1 - People are able to improve their health FQ3 18/19	No of indicators	14	A	Outcome 6 - Unpaid carers are supported FQ3 18/19	No of indicators	1	R
	On track	7	→		On track	0	→
Outcome 2 - People are able to live in the community FQ3 18/19	No of indicators	17	A	Outcome 7 - Service users are safe from harm FQ3 18/19	No of indicators	6	R
	On track	13	→		On track	2	↓
Outcome 3 - People have positive service-user experiences FQ3 18/19	No of indicators	6	A	Outcome 8 - Health and social care workers are supported FQ3 18/19	No of indicators	4	R
	On track	4	→		On track	1	→
Outcome 4 - Services are centered on quality of life FQ3 18/19	No of indicators	9	R	Outcome 9 - Resources are used effectively in the provision of health and social care services, with FQ3 18/19	No of indicators	6	A
	On track	4	→		On track	4	→

Key areas of improved reported performance for 9 are:

- Percentage of Community Payback Order (CPO) cases seen without delay - 5 days

(**Appendix 1** gives the detail of each of the 65 measures and their associated performance for FQ3)

As requested by the Integration Joint Board (IJB) **Appendix 2** identifies the most recent **FQ3 SOURCE** performance data with regards to Argyll & Bute HSCP, benchmarked partnership performance against comparable IJBS for the 9 HWBOI's and their 23 sub-indicators.

3.2 Exceptions Performance Report for Outcome Indicator 9

The table below summarises the exception report for the 2 performance measures across indicator 9 which are off track, including performance against the previous quarter and Head of Service Performance Narrative identifying actions to improve.

Performance Indicator & Source Definitions		Target	Actual (FQ3)	Benchmark Performance Against Previous Quarter (FQ2)	Head of Service Actions to Improve Performance
9	SCRA43 - % of SCRA reports submitted on time	75%	54%	60%	Alex Taylor Actions to Improve Performance: The trajectory for the target is improving and the target will be achieved for FQ4
9	% of new outpatient appointments DNA rates	6.9%	8.8%	9.2%	Phil Cummings/Lorraine Paterson Actions to Improve Performance: The trajectory for this measure continues to improve from October 18 noting (9.2%) and reducing to December (8.8%). Work is ongoing with regards to improving the Waiting Times Performance across all hospitals. Work is being taken forward by Planning & Performance Teams and this should assist in improving the current DNA rate.

(Please note that a period of 4/5 months data lag is in place with regards to reporting of FQ3 data **Appendix 3** identifies the latest availability of data and its completeness at the time of this report. Longest data delays are due to data processing and validation from sources outside the HSCP Performance and Information Team.)

3.4 MSG Measures Performance Reporting FQ3 (18/19)

The Ministerial Steering Group (MSG) performance measures have been developed in addition to the National HWBOI's. The function of these performance measures is to examine macro performance activity trends relating to improved outcomes through the integration of service delivery across the HSCP. The data below notes the Argyll & Bute and Greater Glasgow & Clyde split with regards to the performance total against our four agreed target areas with MSG.

Quarterly overall MSG performance for FQ3 notes:

- Unplanned Admissions: 7.0% off target, **an increase from Q2 (4.9%)**
- Unplanned Bed Days: 10.7% off target, **an increase from Q2 (8.6%)**
- A&E Attendance: 4.9% off target, **down from Q2 (5.1%)**
- Delayed Discharges: 41.7% off target, **down from Q2 (42.5%)**

MSG Indicator	Objective	Target Q3 18/19	Actual Q3 18/19	A&B Actual	A&B Target	GG&C Actual	GG&C Target	Variance & Performance Analysis for FQ2
Unplanned Admissions	Expected FY 2018/19 target 8332 - based on 5% reduction in overall total compared to FY17/18	6241	6681	3256	3020	3425	3221	Quarterly performance is 7.0% off target. 48.7% (3425) unplanned admissions reported in Greater Glasgow and Clyde health board hospitals.
MSG Indicator	Objective	Target Q3 18/19	Actual Q3 18/19	A&B Actual	A&B Target	GG&C Actual	GG&C Target	Variance & Performance Analysis for FQ2
Unplanned Bed Days	Expected FY 2018/19 target 56687 - based on 0.6% reduction in overall total compared to FY17/18	42508	47056	23421	21304	23635	21204	Quarterly performance is 10.7% off target 50.2% (23635) unplanned bed days reported in Greater Glasgow and Clyde health board hospitals.
A& E Attendance	Expected FY 2018/19 target 16194 - based on sustained levels in overall total compared to FY17/18 **	12148	12748	5412	5198	7336	6950	Quarterly performance is 4.9% off target 57.5% (7336) A&E attendances reported in Greater Glasgow and Clyde health board hospitals.
Delayed Discharge Bed Days Occupied	Expected FY 2018/19 target 7037 - based on 10% reduction in overall total compared to FY 17/18	5274	7473	5853	4332	1620	942	Quarterly performance is 41.7% off target 73.3% (5853) Delayed Discharge bed days occupied reported in Argyll and Bute (NHS Highland) health board hospitals

** Please note that ISD only count the attendances at Lorn & Islands Hospital for this data set as a consultant led unit.

4. GOVERNANCE IMPLICATIONS

4.1 Financial Impact

There are a number of National Health & Wellbeing Outcome Indicators (NHWBOI's) which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

4.2 Staff Governance

A number of the National Health & Wellbeing Outcome Indicators (NHWBOI's) indicators under outcomes 9 are pertinent for staff governance purposes

4.3 Clinical Governance

A number of the National Health & Wellbeing Outcome Indicators (NHWBOI's) support the assurance of health and care governance and should be considered alongside that report

5. EQUALITY & DIVERSITY IMPLICATIONS

The National Health & Wellbeing Outcome Indicators (NHWBOI's) help provide an indication on progress in addressing health inequalities

6. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

None

7. RISK ASSESSMENT

None

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

9. CONCLUSIONS

It is recommended that the Integration Joint Board/committee:

Note overall scorecard performance for the FQ3 reporting period with regards to the National Health and Well Being Outcome Indicators: 9 and the Ministerial Steering Group measures of integration for the HSCP

10. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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Appendix 1- IJB Performance Scorecard (FQ3 18/19)

Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer				
Measure	R/G	Target	Actual	Lead Manager
% of adults able to look after their health very well or quite well	G	93 %	93 %	Lorraine Paterson
Rate of emergency admissions per 100,000 population for adults	R	12,183	12,678	Lorraine Paterson
Rate of premature mortality per 100,000 population	G	425.0	380.0	Lorraine Paterson
AC1 - % of Older People receiving Care in the Community	R	86 %	77 %	Phil Cummins
AC15 - No waiting more than 12 weeks for homecare service after assessment authorised	G	6	4	Phil Cummins
A&B - % of Learning Disability Service Users with a PCP	R	90 %	89 %	Phil Cummins
CA15B - % Looked After & Accommodated Children in Family Placements	G	75 %	77 %	Alex Taylor
CA17 - No of External Looked After & Accommodated Children	G	10	9	Alex Taylor
No of alcohol brief interventions in line with SIGN 74 guidelines	R	765	29	Sandra Cairney
NHS-H7 - Proportion of new-born children breastfed	R	33.3 %	31.9 %	Alex Taylor
No of ongoing waits >4 weeks for the 8 key diagnostic tests	R	0	134	Lorraine Paterson
% of MMR1 uptake rates at 5 years old	G	95.0 %	96.9 %	Alex Taylor
% <18 type 1 Diabetics with an insulin pump	G	25 %	44 %	Alex Taylor
% >18 type 1 Diabetics with an insulin pump	R	12 %	7 %	Lorraine Paterson
Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community				
Measure	R/G	Target	Actual	Lead Manager
A&B - Number of people 65+ receiving homecare - Quarterly Stats	G	1,180	1,238	Phil Cummins
% of adults supported at home who agree they are supported to live as independently	R	81 %	79 %	Phil Cummins
% of adults supported at home who agree they had a say in how their support was provided	G	76 %	76 %	Phil Cummins
Emergency Admissions bed day rate	G	123,035	108,833	Lorraine Paterson
Proportion of last 6 months of life spent at home or in a community setting	G	88 %	90 %	Phil Cummins
% of adults with intensive needs receiving care at home	G	61 %	67 %	Phil Cummins
AC14 - Total No. of Enhanced Telecare Packages	G	500	978	Stephen Whiston
AC2 - % of Mental Health Clients receiving Care in the Community	R	98 %	98 %	Phil Cummins
AC21 <=3 weeks wait between Substance Misuse referral & 1st treatment	G	90.0 %	90.5 %	Lorraine Paterson
AC5 - Total No of Delayed Discharge Clients from A&B	R	12	25	Phil Cummins
CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	G	90 %	91 %	Alex Taylor

% of patients wait no longer than 4 hours in A&E	G	95.0 %	98.6 %	Lorraine Paterson
% of patients who wait no longer than 18 weeks for Psychological therapies	G	90 %	94 %	Lorraine Paterson
No of days people spend in hospital when ready to be discharged, per 1,000 population	G	772 Days	634 Days	Phil Cummins
% of health & care resource spend on hospital stays, patient admitted in an emergency	G	24 %	22 %	Phil Cummins
Readmission to hospital within 28 days per 1,000 admissions	G	102	87	Phil Cummins
Falls rate per 1,000 population aged 65+	R	22	26	Lorraine Paterson

Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

Measure	R/G	Target	Actual	Lead Manager
% of adults receiving any care or support who rate it as excellent or good	G	80 %	80 %	Lorraine Paterson
% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	R	74 %	72 %	Lorraine Paterson
% of people with positive experience of their GP practice	G	83 %	85 %	Lorraine Paterson
AC16 - No of abbreviated customer service questionnaire sent to AC users- bi-monthly	G	5	10	Phil Cummins
No of patients with early diagnosis & management of dementia	R	890	795	Lorraine Paterson
% of SW care services graded 'good' '4' or better in Care Inspectorate inspections	G	83 %	86 %	Alex Taylor

Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Measure	R/G	Target	Actual	Lead Manager
% of adults supported at home who agree their support had impact improving/maintaining quality of life	R	80.0 %	74.0 %	Phil Cummins
AC11 - Average working days between Referral & Initial AP Case Conference	R	15 Days	25 Days	Phil Cummins
CA72 - % LAAC >1yr with a plan for permanence	R	81 %	65 %	Alex Taylor
CA34 - % of Care Leavers with a Pathway Plan	G	74 %	95 %	Alex Taylor
No of outpatient ongoing waits >12 weeks	R	0	498	Lorraine Paterson
% of outpatients on the waiting lists with medical unavailability	G	0.1 %	0.0 %	Lorraine Paterson
% of outpatients on the waiting lists with social unavailability	G	4.0 %	1.7 %	Lorraine Paterson
% of patients on the admissions waiting lists with medical unavailability	R	2.0 %	3.4 %	Lorraine Paterson
% of patients on the admissions waiting lists with social unavailability	G	15.7 %	10.5 %	Lorraine Paterson

Outcome 5 - Health and social care services contribute to reducing health inequalities

Measure	R/G	Target	Actual	Lead Manager
No of treatment time guarantee completed waits >12 weeks	R	0	2	Lorraine Paterson
No of treatment time guarantee ongoing waits >12 weeks	R	0	6	Lorraine Paterson

Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being				
Measure	R/G	Target	Actual	Lead Manager
% of carers who feel supported to continue in their caring role	R	37.0 %	33.0 %	Lorraine Paterson
Outcome 7 - People using health and social care services are safe from harm				
Measure	R/G	Target	Actual	Lead Manager
% of adults supported at home who agree they felt safe	G	83 %	83 %	Lorraine Paterson
AC17 - % of AC users reporting they feel safe at assessment	G	70 %	83 %	Phil Cummins
CP15 - % of Children on Child Protection Register with no Change of Social Worker	R	80 %	53 %	Alex Taylor
CP7 - % of Children on Child Protection Register with a current Risk Assessment	R	100 %	87 %	Mark Lines
CP16 - % of Children on Child Protection Register with a completed CP plan	R	100 %	91 %	Alex Taylor
CP17 - % of CP investigations with IRTD within 24 hours	R	95 %	93 %	Alex Taylor
Outcome 8 - People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide				
Measure	R/G	Target	Actual	Lead Manager
Health & Social Care Partnership % of PRDs completed	R	90 %	37 %	Alex Taylor
Social Work staff attendance	R	3.8 Days	5.2 Days	Phil Cummins
% of NHS sickness absence	R	4.00 %	5.64 %	Lorraine Paterson
% of staff who say they would recommend their workplace as a good place to work	G	67.0 %	71%	Lorraine Paterson
Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services				
Measure	R/G	Target	Actual	Lead Manager
CJ61 - % Criminal Justice Social Work Reports submitted to Court on time	G	92 %	96 %	Alex Taylor
CJ63 - % Community Payback Orders cases seen without delay - 5 days	G	80.0 %	84.8 %	Alex Taylor
CJ65 - Average hrs per week taken to complete Community Payback Order Unpaid Work/CS Orders	G	6.0 Hours	6.5 Hours	Alex Taylor
SCRA43 - % of Scottish Children's Reported Administration reports submitted on time	R	75 %	54 %	Alex Taylor
% of Scottish Morbidity Record 01 returns received	G	95.0 %	98.0 %	Lorraine Paterson
% of new outpatient appointments Did Not Attend rates	R	6.9 %	8.8 %	Phil Cummins

Appendix 2- A&B HSCP (FQ3) Benchmark HWBOI Performance

The table below identifies the most recent **FQ3 SOURCE** performance data with regards to Argyll & Bute HSCP, benchmarked partnership* performance, and the Scotland-wide performance against the 9 HWBOI's and their 23 sub-indicators.

Indicator	Title	Argyll & Bute	Angus	East Lothian	Highland	Midlothian	Moray	Scot Borders	Stirling	Scotland
NI - 1	Percentage of adults able to look after their health very well or quite well	93%	95%	94%	94%	92%	93%	94%	94%	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	76%	71%	86%	86%	83%	83%	84%	81%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	71%	68%	79%	80%	75%	74%	73%	76%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	72%	71%	66%	76%	71%	73%	75%	76%	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	77%	75%	83%	71%	80%	83%	79%	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	78%	80%	87%	76%	80%	88%	86%	83%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	74%	77%	75%	86%	73%	79%	80%	81%	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	33%	34%	36%	38%	32%	39%	36%	38%	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	83%	80%	81%	84%	79%	84%	86%	88%	83%
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA	NA	NA	NA	NA	NA

Indicator	Title	Argyll & Bute	Angus	East Lothian	Highland	Midlothian	Moray	Scot Borders	Stirling	Scotland
NI - 11	Premature mortality rate per 100,000 persons	380	384	372	373	389	372	324	360	425
NI - 12	Emergency admission rate (per 100,000 population)	12,678	11,060	10,325	10,666	11,563	9,198	12,366	10,045	12,183
NI - 13	Emergency bed day rate (per 100,000 population)	108,883	111,941	120,782	106,870	123,372	95,356	134,823	106,781	123,035
NI - 14	Readmission to hospital within 28 days (per 1,000 population)	87	103	105	107	114	83	104	102	102
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90%	90%	86%	90%	87%	90%	87%	87%	88%
NI - 16	Falls rate per 1,000 population aged 65+	26	21	19	15	20	15	22	20	22
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	77%	84%	85%	86%	89%	85%	81%	95%	85%
NI - 18	Percentage of adults with intensive care needs receiving care at home	67%	51%	64%	50%	70%	65%	62%	66%	61%
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	625	419	775	1,300	1,422	936	855	566	762
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	28%	24%	21%	25%	22%	23%	21%	25%
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA	NA	NA	NA
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA	NA	NA	NA
NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Improvement Service Benchmarking Family Groupings for Children, Social Work and Housing Indicators

Appendix 3- Data Lag & Latest Data Availability

IJB Reporting Dates	Data Lag	FQ Reports	Latest Data Availability & Completeness
Wednesday 29th May 2019	4/5 months – please note that the bulk of the data lag is due to National Data Validation required from the national Information Services Division , these are out-with the control of the team	FQ3 (Oct – Dec 18/19)	FQ4 Data completeness – 35% as at 03/05
Wednesday 7th August 2019	4/5 months	FQ4 (Jan – Mar 18/19)	

Integration Joint Board

Agenda item: 5.6

Date of Meeting: 29 May 2019

Title of Report: Ministerial Strategic Group (MSG) Integration Performance Targets 2019/20

Presented by: Stephen Whiston
Head of Strategic Planning & Performance

The Integration Joint Board/Committee is asked to:

- **Recognise** the importance of the MSG outcome measures with regards to tracking performance under integration and its alignment with the HSCPs 6 areas of focus
- **Acknowledge** the focus of this year's performance targets on the 65+ population
- **Approve** locality specific targets and acknowledge the inclusion of NHS Greater Glasgow & Clyde performance
- **Note** the inclusion of the MSG targets in the IJBs performance reports for 2019/20

1. EXECUTIVE SUMMARY

The content of this report establishes the new targets for MSG performance across the 6 focus areas. This year there is also an expectation for an age-band breakdown across each of the performance measures.

Analysis of our previous data trends and performance has identified that a sustained focus on the 65+ age group has the potential to generate the greatest performance improvement.

The rationale and approach for this year is detailed within the report and once again the plan is to maintain and improve performance levels as specified. As such targets are identified within the report for each of the four locality areas broken down to local and activity within Greater Glasgow & Clyde hospitals.

2. INTRODUCTION

In order to fully understand and develop a view of how partnerships are progressing under integration the Ministerial Strategic Group for Health and Community Care (MSG) has asked partnerships to prepare performance targets with regards their individual performance against the identified six outcome measures. Part of the focus for 2019/20 the HSCP's have been asked to

develop and project new targets utilising the age-band data made available by the Information Services Division and SOURCE Team (ISD).

3. RELEVANT DATA AND INDICATORS

3.1 MSG Performance Measures

The purpose of this report is to seek IJB approval with regard to local target setting across the 4 locality areas aggregated to HSCP level for submission to the MSG. The six MSG measures are identified below:

- 1. Number of emergency admissions into Acute (SMR01) specialties.**
- 2. Number of unscheduled hospital bed days, with separate objectives for Acute (SMR01), Geriatric Long Stay (SMR01E) and Mental Health (SMR04) specialties.**
- 3. Number of A&E attendances and the percentage of patients seen within 4 hours.**
- 4. Number of delayed discharge bed days. An objective can be provided to cover all reasons for delay or separate objectives for each reason type i.e. Health and Social Care, Patient/Carer/Family-related, Code 9.**
5. Percentage of last 6 months of life spent in the community.
6. Percentage of population residing in non-hospital setting for all adults and 75+. A suggested further breakdown would be: care home, at home (supported) and at home (unsupported).

(Please note that measures 5 & 6 are still under development with regards to locality reporting – ISD LIST are working with the Performance & Information team to develop data to support reporting. As such this report will primarily focus on measures 1-4)

3.2 Analysis and Development of Targets

The focus of the target setting for 19/20 used analysis of data trends across previous baseline years. From the data and trends identified the HSCP will focus for 19/20 on the 65+ population across the 6 MSG focus areas. Statistically the data supports this approach with the 65+ population using the greatest amount of service and having the greatest impact across the MSG measures. It is expected that this targeted approach to the MSG targets for this year will respond directly to projection modelling which notes the potential for continued increases in Unplanned admissions, Unplanned Beds Days, A&E Attendances and Delayed Discharges.

It is evident from analysis of the previous years data and baseline projections that there is a correlation and cyclical link across these measures which requires the focus for this year to address the growing numbers in the 65+ age band. The targets for 19/20 have been based on the delivery of

sustaining performance level and gradual improvement across all the MSG measures thereby managing the increasing demand on services as evidenced by improving productivity and preventing use.

Therefore the development of targets are based on them achievable and informed by robust data analysis and projection modelling.

3.3 MSG Quarterly National Reporting Target Template

Table 1: Identifies the new MSG targets for 19/20, the focus of the targets is the 65+ population and it is expected that this will deliver the potential for greatest improvement. The targets for 19/20 have been derived using projections based on the 18/19 projected baseline data- this approach ensures that the data is the most up to date and available at a national level.

The use of this data acknowledges that there may be further review by ISD and as such all projections may be subject to change across 19/20.

Table 1

Unplanned Admissions		
Objective	Baseline 18/19	Target 19/20
2% reduction 65+	4485	4395
Maintain 18-64 trajectory	3573	3573
Maintain<18 trajectory	601	601
Unplanned Bed Days		
Objective	Baseline 18/19	Target 19/20
1% reduction in 65+	44613	44167
Maintain 18-64 trajectory	13220	13220
Maintain<18 trajectory	1108	1108
A&E Attendances		
Objective	Baseline 18/19	Target 19/20
2% reduction 65+	5170	5067
Maintain 18-64 trajectory	8929	8929
Maintain<18 trajectory	2961	2961
Delayed Discharge Bed Days		
Objective	Baseline 18/19	Target 19/20
10% reduction 75+	6649	5984
10% reduction 18-74	2912	2621

4. MSG- Locality Targets Setting

The locality targets are detailed in the tables below: these targets have been set across the age bands for each of the localities and within the targets are the proportion of the target which is attributable to activity in NHS Greater Glasgow and Clyde (GG&C) Hospitals. The rationale for including the NHS GG&C data is to ensure that localities acknowledge their responsibility for hospital activity outwith the Argyll & Bute area which we fund via our SLA.

Population profiling has been used for the most part to determine the weighting of locality specific performance targets.

Bute & Cowal

Age-Bands	Unplanned admissions (2% Reduction 65+)		Unplanned Bed Days (2% Reduction 65+)		A&E Attendances (1% Reduction 65+)		Delayed Discharge Bed Days (10% reduction)	
	B&C All	GGC	B&C All	GGC	B&C All	GGC	B&C All	GGC
65+	1260	643	12665	6459	1453	1308	572 (75+)	189 (75+)
18-64	784	544	2900	2013	1959	1740	381 (18-74)	152 (18-74)
<18	130	123	240	227	641	568		

Helensburgh & Lomond

Age-Bands	Unplanned admissions (2% Reduction 65+)		Unplanned Bed Days (2% reduction 65+)		A & E Attendances (1% reduction 65+)		Delayed Discharge Bed Days (10% reduction)	
	H&L All	GGC	H&L All	GGC	H&L All	GGC	H&L All	GGC
65+	1145	1130	11502	11352	1320	1294	622 (75+)	622 (75+)
18-64	1130	1087	4183	4024	2825	2689	577 (18-74)	577 (18-74)
<18	187	183	345	338	921	897		

Mid Argyll & Kintyre

Age-Bands	Unplanned admissions (2% Reduction 65+)		Unplanned Bed Days (2% reduction 65+)		A & E Attendances (1% reduction 65+)		Delayed Discharge Bed Days (10% reduction)	
	MAKI All	GGC	MAKI All	GGC	MAKI All	GGC	MAKI All	GGC
65+	1070	199	10752	2000	1233	666	1830 (75+)	36 (75+)
18-64	804	257	2973	951	2008	964	848 (18-74)	25 (18-74)
<18	138	105	254	193	679	530		

Oban Lorn & The Isles

Age-Bands	Unplanned admissions (2% Reduction 65+)		Unplanned Bed Days (2% reduction 65+)		A & E Attendances (1% reduction 65+)		Delayed Discharge Bed Days (10% reduction)	
	OLI All	GGC	OLI All	GGC	OLI All	GGC	OLI All	GGC
65+	920	65	9247	657	1061	70	2960 (75+)	30 (75+)
18-64	855	144	3164	535	2137	141	813 (18-74)	32 (18-74)
<18	146	109	269	202	720	69		

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Performance improvement across each of the key MSG measures will be an essential mechanism in supporting a reduction in ongoing expenditure both at a clinical and community level

5.2 Staff Governance

The development of locality specific targets will ensure that there is a clear understanding of expected performance improvement and the contribution that staff make

5.3 Clinical Governance

The MSG Measures support the assurance of health and care governance and should be considered alongside that report

6. EQUALITY & DIVERSITY IMPLICATIONS

The MSG Measures help provide an indication on progress in addressing health inequalities within an integrated context

7. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

None

8. RISK ASSESSMENT

None

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

10. CONCLUSIONS

It is recommended that the Integration Joint Board/committee: Note the approach and agree the proposed MSG targets for 19/20

11. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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Appendix 1:

MSG Annual data : Source ISD Integration-performance-indicators-v1.11

1. Number of emergency admissions

Age Group	2015/16	2016/17	2017/18	2018/19p
Under 18	784	792	724	601
18+	7,854	7,923	8,294	8,058
18-64	3,324	3,329	3,407	3,573
65+	4,530	4,594	4,887	4,485

2a. Number of unscheduled hospital bed days; acute specialties

Age Group	2015/16	2016/17	2017/18	2018/19p
Under 18	1,137	1,400	1,105	1,108
18+	64,710	64,305	63,695	57,833
18-64	15,573	15,481	18,846	13,220
65+	49,137	48,824	44,849	44,613

2b. Number of unscheduled hospital bed days; geriatric long stay specialties

Age Group	2015/16	2016/17	2017/18	2018/19p
18+	2,573	1,075	355	316
65+	2,444	1,075	352	313

2c. Number of unscheduled hospital bed days; mental health specialties

Age Group	2015/16	2016/17	2017/18	2018/19p
Under 18	445	31	191	237
18+	12,976	12,600	12,583	14,187
18-64	8,645	8,282	6,795	7,773
65+	4,331	4,318	5,788	6,414

3. Number of A&E attendances

Age Group	2015/16	2016/17	2017/18	2018/19p
Under 18	2,631	2,710	2,693	2,961
18+	12,482	13,395	13,333	14,099
18-64	8,019	8,508	8,447	8,929
65+	4,463	4,887	4,886	5,170

4. Delayed discharge bed days

Age Group	2015/16	2016/17	2017/18	2018/19p
18+	8,857	6,803	8,414	9,561
18-74	2,954	1,234	2,496	2,912
75+	6,263	5,569	5,918	6,649

5. Percentage of last six months of life spent in the community

Age Group	2015/16	2016/17	2017/18 ^p
All Ages	89.3%	89.8%	89.6%

6. Percentage of 65+ population living at home (supported or unsupported)

Setting: Home unsupported & supported

Age Group	2015/16	2016/17	2017/18 ^p
65+	96.8%	96.9%	97.0%

Source: ISD spreadsheet *Integration-performance-indicators-v1.11*. Please note that completeness issues may still exist for unplanned bed days. Please note that although the latest spreadsheet will show the most recent data available, it is likely that indicator 2 in particular will be affected by completeness issues and also by patients who are yet to be discharged. The impact of this will vary depending on the area in question and so it is important to assess this locally before deciding which time period objectives can be reliably based upon.

Integration Joint Board

Agenda item: 5.7

Date of Meeting: 29 May 2019

Title of Report Updated Engagement Framework

Presented by: Sandra Cairney, Associate Director of Public Health

The Integration Joint Board is asked to:

- **note** the progress achieved outlined in the attached updated Engagement Framework (April 2019).

1. EXECUTIVE SUMMARY

The Integrated Joint Board approved the *HSCP Engagement Framework* at the Board meeting in May 2018. Since that date, a range of actions have been progressed to achieve a consistent, comprehensive and effective approach to engagement across Argyll and Bute. These actions are outlined in the updated Engagement Framework (attached).

2. INTRODUCTION

The period April 2018 to March 2019 saw a concerted effort to review and improve the ways in which the HSCP engages with people. The outputs of this work include a range of new structures, approaches, protocols, and tools.

3. DETAIL OF REPORT

The Engagement Framework sets out the intentions of the HSCP to continue to engage with people in Argyll & Bute who have an interest in health and social care and provides a comprehensive overview of how engagement will be approached. It describes a number of complimentary documents and processes that support the delivery and monitoring of engagement activity that can be used by HSCP staff, partners, communities and wider stakeholders alike. These include:

- a) a HSCP **Engagement Framework** providing a comprehensive overview and strategic direction for engagement work.;
- b) an **Annual Engagement Plan** to proactively plan and record engagement activity;

- c) An **Engagement Quality Standards Framework** to evidence how the HSCP is delivering best practice;
- d) a **Strategic Engagement Advisory Group** with key partner involvement to advise the Integrated Joint Board on engagement policy, strategy and best practice;
- e) revised model of **Locality Planning Groups** to strengthening planning at scale and to better align with Community Planning arrangements;
- f) new **Guide to Engaging** to widely publicise the range of ways that people can engage with the HSCP;
- g) new mechanisms to engage with people with an interest in health and social care services called '**Community Conversation Cafes**'; and
- h) an **engagement pathway and tools** to support managers responsible for local services to engage with people in a systematic and consistent way.

4. RELEVANT DATA AND INDICATORS

Engagement activity will be measured against and reported through the standards outlined in the Engagement Quality Standards Framework.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The purpose of engagement activity is to ensure stakeholder views are understood and considered when developing and implementing HSCP plans and/or service changes.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications identified in the report.

6.2 Staff Governance

Health and social care staff will be supported to participate in engagement processes outlined in the Engagement Framework.

6.3 Clinical Governance

Quality standards have been identified to benchmark against good practice.

7. EQUALITY & DIVERSITY IMPLICATIONS

Activity arising as a result of engagement will consider equality and diversity implications and this may, depending on the level of service change proposed, cross reference with Equality and Diversity Impact Assessments (EQIAs).

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

None.

9. RISK ASSESSMENT

The Engagement Framework and associated activity aims to mitigate risk associated with ineffective engagement in the development of the HSCP strategies, plans and service transformation.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The purpose of the engagement action is to achieve improved public, service user, staff and partner involvement.

11. CONCLUSIONS

Actions progressed over the last twelve months are intended to respond to the themes outlined in the '*Visible Changes Argyll & Bute IJB Improvement Plan*'. This Framework establishes the foundation for future engagement activity across all levels of the organisation and addresses structural, functional and governance arrangements.

12. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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NHS Highland: Preparedness for the new Health & Care (Staffing) (Scotland) Bill (Stage 3) legislation
Report by Elaine Dibden and Jennifer Bremner, on behalf of Heidi May, Board Nurse Director

1. Summary

The Health & Care (Staffing) (Scotland) Bill (Stage 3) was approved by the Scottish Parliament on 2nd May 2019. Health boards and other care providers in Scotland will now have a legal duty to make decisions on staffing on the grounds of safety and use live data in workforce planning. Safe staffing levels are necessary to ensure the safety of patients and the 'Bill' will be an enabler of high quality care and improved outcomes for service users. The Bill does not require Health Boards to meet minimum staffing levels, it is about putting in place an evidence based method to assess and monitor the workload associated with the delivery of care in a systematic way.

The Bill will ensure nationally agreed, evidence based workload and workforce planning tools are applied, and ensure key principles relating to professional judgement, local context and quality measures underpin workload and workforce planning.

Several amendments to the bill were also passed as part of the final stage, including capping spend on Agency staff and recognising the need to free up Senior Charge Nurses and their equivalent in community from carrying a direct patient caseload allowing them to coordinate safe care and develop nursing teams to ensure they have the skills and experience required.

Health boards will also have a duty to consider multi-disciplinary staffing tools in the future. Statutory guidance will now be developed and shared in 2019/20, led by the Chief Nursing Officer's office, and over the coming months it is expected that national guidance will be developed; also a plan for implementation. Enactment is unlikely before April 2020 and implementation is likely to be phased within this period.

2. Background

Scotland's First Minister made the commitment to put safe staffing on a statutory footing from the stage of the Royal College of Nursing (RCN) Congress in 2016 and the SNP made a Manifesto commitment that year stating *"we will enshrine safe staffing in law – we will put our innovative nursing and midwifery planning tools on a statutory footing, and explore how this model can be extended to cover other parts of the health and social care workforce"*. Following on from this, the Programme for Government 2017 to 2018 set out the actions that they would take in the forthcoming year stating a commitment to introducing a Safe Staffing Bill during the 2017-18 Parliamentary year to *"deliver on the commitment to enshrine in law the principles of safe staffing in the NHS, starting with the nursing and midwifery workforce planning tools. The Bill will ensure nationally agreed, evidence based workload and workforce planning tools are applied, and ensure key principles relating to professional judgement, local context and quality measures underpin workload and workforce planning."*

The following Parliamentary Processes in respect of the Bill were enacted:

- Stage 1 – May to Dec 2018
- Stage 2 – Dec 2018 to Feb 2019
- Stage 3 – May 2019
- Royal Assent – Shortly after Stage 3
- Statutory Guidance – 2019/20

- Enactment - unlikely before April 2020
- Implementation - Potentially Phased

The Health and Care (Staffing) (Scotland) Bill is the first comprehensive multi-disciplinary workload and workforce planning legislation in the UK.

3. Assessment/options/issues for consideration

What does this mean for NHS Highland?

- **Duty to Ensure Appropriate Staffing** - The common staffing methodology and tools set out in this Bill create an important evidence base upon which Health Boards will make decisions about their staffing. This evidence base will also inform wider local and national decisions about workforce planning and how best to respond to staffing challenges.
- **Duty to have Real-Time Staffing Assessment in Place** - The Bill does not require Health Boards to meet minimum staffing levels, it is about putting in place an evidence based method to assess and monitor the workload associated with the delivery of care in a systematic way.
- **Duty to have Risk Escalation Process in Place** - The Bill requires Health Boards to identify and take all reasonable steps to mitigate any risks and consider if changes are needed to staffing levels or the way in which it provides health care.

Reporting:

- NHS Boards will be required to publish and submit to ministers an annual report which details how they have complied with the duties in the Bill
- Scottish Ministers must collate these reports and produce a statement detailing how they have or will use the information in their policies for staffing in the Health Service

Since April 2019 NHS HEALTHCARE IMPROVEMENT SCOTLAND (HIS) have responsibility for:

- Monitoring and reporting on compliance with staffing duties
- Monitoring and review of Common Staffing Method
- Monitoring and development of staffing tools
- Duty to consider multi-disciplinary staffing tools
- Duty on Health Boards to assist and provide information to HIS

The work of the national Nursing and Midwifery Workload and Workforce planning Programme (NMWWPP) has been overseen by a steering group which has wide stakeholder engagement and representation including Executive Nurse Directors and professional leaders and partnership bodies.

National Steering Group

Several groups have been developed with the following roles and remit:

Sub Group 1

- -Tools Maintenance & Development Group
- -Develop e-enabled multidisciplinary workload tools

Sub Group 2

- Education & Training Group
- Develop Learning Resource

Project Management Prioritisation Matrix

- Prioritisation of developments
- Timeline

These national groups are further supported by Additional Resources:

- **NMWWPP National Team** – Programme Manager – Senior Programme Advisors – Programme Advisors – Assistant Programme Advisors

Board Resource Allocation (1xWTE. Elaine Dibden elaine.dibden@nhs.net / jenniferbremner@nhs.net until April 2021. Both undertake a job share equivalent to one whole time equivalent. Their role is to ensure processes are in place to support the full implementation in April 2020.

Current Situation and Recommendations

NHS Highland is currently awaiting further national guidance regarding the specifics of enacting the Bill and the reporting mechanism.

- NHS Highland have employed 1WTE Senior Nurses with a fixed term contract of two years (March 2021) funded by Scottish Government to support implementation
- Governance - implementation group to provide a structure for decision making around implementation
- Communication – Identified Forums/committees will receive regular updates on the Health & Care (Staffing) (Scotland) Legislation
- Scoping of Current Senior nurses supernumerary/supervisory status as a benchmark for financial implications and future decision making
- Identify clarity around the definition of capping on Agency spend
- Develop a risk register and Issues Log
- The Board is asked to support the development of a governance system and implementation plan for NHS Highland.

4. Contribution to NHS Highland Board Objectives

The Health & Care (Staffing) (Scotland) Legislation will address a range of Board objectives as follows:

Objective 3: Creating a Caring, Person-centred Experience by ensuring safe staffing levels and that staff are suitably qualified and competent individuals.

Objective 4: Providing Safe and Effective Care – duty to have real time staffing in place in all environments and as set out in the Policy Memorandum, professional risk assessment of short term staffing requirements may require a variety of mitigating factors to be put in place to ensure safety is maintained, for example through the redeployment of staff from one area to another or the use of supplementary staffing to support short term gaps.

Objective 5: Transforming Services - improving standards and outcomes with links to Excellence in Care.

Objective 7: Engaging our People – fundamentals of Bill built upon respect for dignity and rights and wellbeing of staff who be engaged in the process and staff feedback is core to the objectives.

Objective 9: Ensuring Value and Sustainability –Using the common staffing methodology and tools will require Health Boards to consider all aspects of the methodology, including the use of supplementary staffing and redesign of services, to ensure they are using their resources

in the best possible way to achieve high quality care. The methodology will support Health Boards to plan and use staff and, where required, redesign services to ensure existing safety and quality measures continue to be met.

5. Governance Implications

- Staff – Engagement with staff to ensure appropriate and transparent internal reporting, escalation and prioritisation. Building on current good practice such as safety huddles, rostering and use of supplementary staffing. There will be formalisation of current informal processes.
- Clinical: Ensuring that the right people with the right skills are in the right place at the right time and that they are appropriately trained and equipped to undertake their clinical responsibilities.
- Financial: **As detailed in the SBAR above**, the Bill does not require Health Boards to meet minimum staffing levels, it is about putting in place an evidence based method to assess and monitor the workload associated with the delivery of care in a systematic way. Current information is being sought to identify the financial implications of Senior Nurses having a supervisory status.

6. Risk Assessment

As part of Project Initiation document, a process for risk assessment will be formalised.

7. General Data Protection Principles Compliance

There are no risks to compliance with Data Protection Legislation

8. Planning for Fairness

The Bill will provide for all Health Boards and care service providers to have regard to the same shared guiding principles and to comply with the duty to ensure appropriate staffing for high quality care and the health, wellbeing and safety of service users. The current tools, to be used as part of the common staffing method within specified health care settings, identify the workload required to deliver service users' needs within the local population and context and allow Health Boards, integration authorities and local authorities to identify and agree staffing requirements on a shared understanding of the workload. Future tools are likely to be multi-disciplinary in nature and therefore the broader needs of a local population and associated workload needs will be established. It is recognised that there are currently significant challenges in recruitment in both health and care service settings. This legislation will not, in itself, address these challenges and should be viewed in conjunction with other measures that are being taken to support and sustain the health and care workforce. By taking an evidence-based approach to workload and workforce planning that takes account of identified risks, this legislation will not penalise organisations for factors beyond their control. It will, however, provide Health Boards with robust evidence on which to forecast workforce requirements which will in turn ensure that national level workforce planning is based on sound evidence.

9. Engagement and Communication

As part of Project Initiation document, the engagement process and communication strategies will be made explicit.

Elaine Dibden/Jennifer Bremner on behalf of Heidi May, Board Nurse Director
Date: 08/05/19

Integration Joint Board

Item 7

Date of Meeting: 29 May 2019

Title of Report: Governance Update

Presented by: Charlotte Craig

The Board is asked to:

- **Note** the wider scope of the review of Governance
- **Note** that a further paper will be presented at the IJB on August 7 2019 on the output of current review activity.
- **Appoint** to vacant Committee positions and **discuss** where deputising is acceptable
- **Note** and **approve** the request to commence recruitment to vacant IJB roles

1. EXECUTIVE SUMMARY

This paper presents a summary of high level Governance activity supporting the IJB business.

The scope of review activity has been consolidated with a view to producing a code of corporate governance for Argyll & Bute Health and Social Care Partnership.

A further paper delivering this will be presented on 7 August 2019 IJB.

The paper requests appointment to vacant committee and commencing recruitment to board positions.

INTRODUCTION

- 1.5 On 30 January IJB a request was made to the IJB to consider options to strengthen the financial governance of the IJB. Several options were presented.
- 1.6 The IJB has two key governing documents; The Argyll & Bute Scheme of Integration and Standing Orders. There is no separate scheme of delegation which permits approval at any level other than IJB. The committees are currently able to make recommendations only. In relation to the review of the Quality and Finance board, the terms of reference are scoping the capacity available to strengthen financial governance.

- 1.7 A parallel review of the Audit Committee terms of reference was underway and both were referred to the Standards Officer, for review and advisement with the interim CFO, this took place on 3 May 2019.
- 1.8 Further to this, a review of the other key IJB structures (see excerpt appendix 1) Clinical and Care Governance Committee and the Strategic Planning Group it was deemed advantageous to review all terms of reference for congruence between each and ensuring the clear roles and responsibilities of each committee/group.
- 1.9 There is a wider mapping of the boards and groups which operate under the key structures and a review of the flow of information to the IJB.
- 1.10 Key to active participation in the governance is attendance and the right people in attendance at each of the committees, boards and groups. Current membership is noted in appendix 3 with vacancies highlighted.
- 1.11 NHS Highland has indicated completion of permanent recruitment to the IJB will be complete by July 2019 and the HSCP would seek to proceed with recruitment to the IJB on completion of the Locality Planning Group recruitment campaign which will be complete by May 2019.

2. DETAIL OF REPORT

Scope of the Review of Governance

- 2.1 With a number of areas of the governance of the IJB being reviewed it was felt that definition is essential to contain the management of the work being undertaken and ensure the completion of the task.
- 2.1 In line with the requests of the Visible Changes Improvement Plan and the proposals for improvement from the Review of the Progress of Integration strengthening the management structure and the roles and responsibilities of the IJB members and senior officers' scope has extended beyond the review of terms of reference to produce a code of corporate governance comparable with other Health and Social Care Partnerships. This reflects better the current partnership approach to supporting governance and the internal and external requirements of the Health and Social Care Partnership as a public body.

Terms of Reference Review

- 2.2 Argyll & Bute Health and Social Care Partnership Standards Officer is looking at draft terms of reference for both Audit and Quality and Finance Board following a referral from the Audit Committee.
- 2.3 There is a further requirement to review Clinical and Care Governance Committee to strengthen the integrated approach and development of the role of the Strategic Planning Group. It is proposed that in line with good practice within other Health and Social Care Partnership's that the terms of reference are reviewed together and with the aim of aligning roles and responsibilities of the IJB and senior officers, resulting in these being mapped in a Code of Corporate Governance. This will act as clear guidance for both IJB members and senior officers which is consistent with proposed improvements and the visible changes improvement plan.
- 2.4 The standards officer is resourcing a review of Argyll & Bute Health &

Social Care Partnership's current terms of reference for the key governance groups as highlighted in appendix 1 to ensure alignment of roles and responsibilities for both IJB members and senior officers in the context of shared practice with other IJB's.

- 2.5 A further meeting will be arranged in early June to reconvene on the output and recommendations with a view to presenting this documentation to the board in August as a proposal for approval in keeping with the IJB's ability to determine "*remit, powers and quorum of any committee or working groups*" (Argyll & Bute Scheme of Integration, March 2015).

Current Board/Committee vacancies

Integration Joint Board

- 2.6 NHS Highland has indicated that it will seek to recruit to a permanent chair of the NHS board in June 2019.

Clinical & Care Governance Committee

- 2.7 The Clinical & Care Governance Committee asks the IJB to appoint a new chair as per the current terms of reference as per the noted vacancy in appendix 3.

Board, Committee and Group attendance

- 2.8 Review of all the Terms of Reference will take into account any discrepancies of required attendance and aim for consistency in approach. The IJB is asked to consider when and if deputising is acceptable with an excerpt from the standing orders in appendix 2.

Recruitment to the IJB

- 2.9 The IJB currently has two vacancies noted for a Medical Practitioner (deputised at present) and Service User (vacant). Following the completion of Locality Planning Group recruitment in June 2016 the HSCP would seek to commence recruitment.

3. RELEVANT DATA AND INDICATORS

IJB/committee attendance registers inform on regular attendance.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

All business supports the strategic priority of the IJB.

5. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

No direct financial impact.

5.2 Staff Governance

Final output will align the roles and responsibilities of senior officers directly to the governance structures.

5.3 Clinical Governance

Final output should facilitate the opportunity for continued development of integrated clinical and care governance.

6. EQUALITY & DIVERSITY IMPLICATIONS

Aligned with the development of good practice, no implications for quality of practice or service delivery.

7. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Improved structures for the central management of IJB documentation.

8. RISK ASSESSMENT

- 8.1 Good governance is an ongoing target within the Visible Changes Improvement Plan, the Review of the Progress of Integration and a central tenet that underpins and support both the IJB and the officer of the Health & Social Care Partnership to undertake their role.
- 8.2 This is an area for continuous improvement and central in maintaining engagement and communication with all stakeholders.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

There is no public and user involvement required at this stage.

10. CONCLUSIONS

In summary the paper seeks to indicate the value of the wider scope of review which has gained some momentum. In support of general activity we seek to appoint to our current committees, discuss the challenge and value of deputation and recruit to consolidate a strong IJB.

11. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

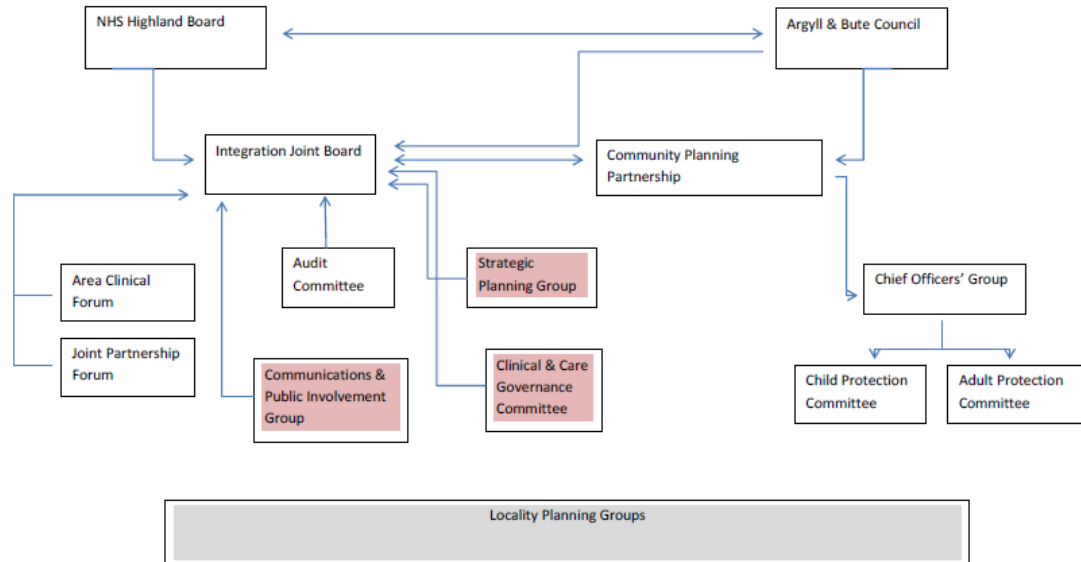
Author Name Charlotte Craig
Email charlotte.craig@argyll-bute.gov.uk

Appendix 1

Annex 3 Scheme of Integration

Annex 3: Systems Governance.

System Governance Schematic



*note Strategies on Engagement and Communications have developed Communications & Public Involvement.

Appendix 2

Attendance excerpt from standing orders (May 2018)

2.8 If a member has not attended three consecutive meetings of the Integration Joint Board, and their absence was not due to illness or some other reasonable cause as determined by the Integration Joint Board, the Integration Joint Board may, by giving one month's notice in writing to that member, remove that person from office.

2.12 If a member is unable to attend a meeting, a suitably experienced proxy may be appointed by the constituent authority which nominated the member. The appointment of such proxy members will be subject to the same rules and procedures for members. Proxy members shall receive papers for meetings of the Integration Joint Board and shall be entitled to attend or vote at a meeting, only in the absence of the principal member they represent. If the Chairperson or Vice Chairperson is unable to attend a meeting of the Integration Joint Board, any depute member attending the meeting may not preside over that meeting

4.4 Adequate provision will be made to allow for members to attend a meeting of the Integration Joint Board or a committee of the Integration Joint Board either by being present together with other members in a specified place, or in any other way which enables members to participate despite not being present with other members in a specified place.

Appendix 3

IJB Membership

NHS Highland (voting members)

1. Vacant
2. Professor Boyd Robertson (Interim Chair)
3. Sarah-Compton Bishop
4. Gaener Rodger

Argyll & Bute Council (voting members)

1. Councillor Kieron Green
2. Councillor Aileen Morton
3. Councillor Sandy Taylor
4. Councillor Gary Mulvaney

Professional Advisors (non-voting)

1. Chief Officer
2. Chief Social Work Officer
3. Chief Financial Officer
4. Lead Nurse
5. Associate Medical Director
6. Registered General Practitioner
- 7. Medical Practitioner (not a GP) Vacant**
8. Public Health Specialist
9. Lead Allied Health Professional
10. Lead Pharmacist

Stakeholder Members (non-voting)

1. Staff Representative (Council)
2. Staff Representative (Health)
3. Independent Sector -Dennis McGlennan
4. Third Sector Interface –Kirsteen Murray
5. Service User (Public) - Elizabeth Rhodick
- 6. Service User (Public) - Vacant**
7. Service User (Carer) - Heather Grier
8. Service User (Carer) - Catriona Spink

Additional Members - locally determined (non-voting)

Head of Strategic Planning & Performance
Head of Adult Services
Head of Adult Services
Head of Finance Health
Principle Accountant Social Work
Business Improvement Manager
PA to the Chief Officer as minute taker

Clinical and Care Governance (under current terms of reference v2 April 2018)

Chair of Clinical and Care Governance Committee (vacant)

Chair of Integrated Joint Board

Chief Officer

Associate Medical Director Argyll & Bute HSCP

Lead Nurse Argyll & Bute HSCP

Head of Adult Service West

Head of Adult Service East

Head of Children and Families

Chief Social Work Officer

Lead Pharmacist

Senior Dental Officer

Lead AHP

Clinical Governance Manager

1 Councillor

Patient/Public Representatives x 1

Staffside

In attendance

Locality manager x4

Strategic Planning Group (attendance under current terms of reference)

Head of Strategic Planning and Performance, Chair SPG
Chief Officer Health and Social Care
Chair, Integrated Joint Board
Vice Chair, Integrated Joint Board
Associate Medical Director
Head of Service, Children & Families and Criminal Justice, Chief Social Work Officer
Head of Adult Services East
Head of Adult Services West
Lead Nurse
Chief Financial Officer HSCP
Senior Service Planning Manager HSCP
Service Planning Manager HSCP
Associate Director Public Health
Public Health Principal
Housing Director, ACHA, Director, Dunbritton Housing
Strategic Housing Manager A&B Council
Third sector CEO, Argyll TSI, Divisional General Manager, Marie Curie, Scotland
Independent Sector Representatives, Scottish Care
Health & Care Forum x 2
Carers' Act Implementation Officer

Audit Committee

Chair IJB Member (Heather Grier)
Chief Officer
Chief Financial Officer
Head of Finance (Health)
IJB Vice Chairperson
Councillor (Sandy Taylor)
Senior Auditor, Audit Scotland
Audit Director, Audit Scotland
Scott Moncrieff
Scott Moncrieff
Chair NHS Highland

Attending
Business Improvement Manager
Argyll & Bute Council Chief Internal Auditor

Quality & Finance Board

Chief Officer (co-chair)

Chief Financial Officer (co-chair)

IJB Chair

IJB Vice Chair

IJB Board Member (x2)

Lead AHP

Lead Nurse

Head of Adult Care East

Head of Children and Families and Criminal Justice

Staff Representative Council (UNISON)

Staff Representative

Head of Finance Health

Principal Accountant Social Work

Head of Strategic Planning and Performance

Attending

Business Improvement Manager

Integration Joint Board

Item 8a

Date of Meeting: 29 May 2019

Title of Report: Review of the Progress of Integration Self Evaluation

Presented by: Charlotte Craig

The Board is asked to:

- **Note** the submission to the Scottish Government

1. EXECUTIVE SUMMARY

The document 8b is the Review of the Progress of Integration self-evaluation. As a partnership submission we invited both NHS Highland and Argyll & Bute Council to review and provide comment prior to its formal submission on 15 May 2019.

IJB members and officers also contributed and it is completed on the basis of the feedback including an IJB non-business development session.

2. INTRODUCTION

2.1 The Review of Progress with Integration of Health and Social Care final report informed the structure of the support that will be given to Health & Social Care Partnerships to accelerate the process of integration.

2.2 It identified a number of proposals and committed to providing resource to support these. The first step in progressing this is in completing a partnership self-evaluation.

2.3 The impact for Argyll & Bute is potentially an accelerated amount of activity moving toward integrated practice and strengthening the ability to deliver this.

3. DETAIL OF REPORT

3.1 The Review of the Progress of Integration self-evaluation states the assessed stage of establishment for integration and supporting evidence/notes and proposed improvements actions. The self-evaluation works through the proposed recommendations. This self-evaluation will be reviewed in 2020 with a view to establishing progress.

3.2 The proposed improvements will become part of the 2019-20 work plan and be reported and monitored through current governance structures.

4. RELEVANT DATA AND INDICATORS

The evidence and notes section indicates data/reports used. Appendices will be provided as evidence for the final submission.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The recommendations proposed are congruent will national policy and as such are consistent with the direction of travel in the draft strategic plan 2019-22.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The self-evaluation highlights proposed improvements which are within the tolerance of the direction of travel so no financial impact is forecast at this stage.

6.2 Staff Governance

The self-evaluation highlights proposed improvements which are within the tolerance of the direction of travel so no staff governance impact is forecast at this stage.

6.3 Clinical Governance

The self-evaluation highlights proposed improvements which are within the tolerance of the direction of travel so no financial impact is forecast at this stage.

7. EQUALITY & DIVERSITY IMPLICATIONS

The self-evaluation has been authored in compliance with partner policies on equality and diversity. No EQSEIA was deemed required at this stage.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

The self-evaluation has been authored in compliance GDPR principles.

9. RISK ASSESSMENT

No formal risk assessment has been undertaken but some discussion on the short timescales and risk of completing of all areas of improvement has been voiced. This will be mitigated by the extraction of the proposed improvements and these will be monitored through the senior leadership meetings and subsequently the IJB.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

IJB members and HSCP Officers were invited to provide information to inform the narrative for evidence/notes and the proposed improvements. There has been no public involvement in the self-evaluation outwith board representation.

11. CONCLUSIONS

Argyll & Bute Council and NHS Highland were requested to review and comment to enable the collation of a final draft for circulation prior to the submission on 15 May.

12. DIRECTIONS

Directions required to Council, NHS Board or both.	Directions to:	tick
	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	x

REPORT AUTHOR AND CONTACT

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Ministerial Strategic Group for Health and Community Care

Integration Review Leadership Group

Self-evaluation

For the Review of Progress with Integration of Health and Social Care

March 2019



MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE (MSG) REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE - SELF EVALUATION

There is an expectation that Health Boards, Local Authorities and Integration Joint Boards should take this important opportunity to collectively evaluate their current position in relation to the findings of the MSG review, which took full account of the Audit Scotland report on integration published in November 2018, and take action to make progress. This evaluation should involve partners in the third and independent sectors and others as appropriate to local circumstances. This template has been designed to assist with this self-evaluation.

To ensure compatibility with other self-evaluations that you may be undertaking such as the Public Services Improvement Framework (PSIF) or those underpinned by the European Foundation for Quality Management (EFQM), we have reviewed examples of local self-evaluation formats and national tools in the development of this template. The template is wholly focused on the 25 proposals made in the MSG report on progress with integration published on 4th February, although it is anticipated that evidence gathered and the self-evaluation itself may provide supporting material for other scrutiny or improvement self-evaluations you are, or will be, involved in.

Information from local self-evaluations can support useful discussions in local systems, sharing of good practice between local systems, and enable the Integration Leadership Group, chaired by the Scottish Government and COSLA, to gain an insight into progress locally.

In completing this template please identify your rating against each of the rating descriptors for each of the 25 proposals except where it is clearly marked that that local systems should not enter a rating. Reliable self-evaluation uses a range of evidence to support conclusions, therefore please also identify the evidence or information you have considered in reaching your rating. Finally, to assist with local improvement planning please identify proposed improvement actions in respect of each proposal in the box provided. Once complete, you may consider benchmarking with comparator local systems or by undertaking some form of peer review to confirm your findings.

We greatly appreciate your assistance in ensuring completion of this self-evaluation tool on a collective basis and would emphasise the importance of partnership and joint ownership of the actions taken at a local level. **Please share your completed template with the Integration Review Leadership Group by 15th May 2019 – by sending to Kelly.Martin@gov.scot**

It is our intention to request that we repeat this process towards the end of the 12 month period set for delivery of the all of the proposals in order that we can collectively demonstrate progress across the country.

**Thank you.
Integration Review Leadership Group
MARCH 2019**

Features supporting integration



Name of Partnership	Argyll & Bute Health and Social Care Partnership
Contact name and email address	charlotte.craig@argyll-bute.gov.uk
Date of completion	14 May 2019

Key Feature 1 Collaborative leadership and building relationships				
Proposal 1.1 All leadership development will be focused on shared and collaborative practice.				
Rating Descriptor	Not yet established	Partly established	Established	Exemplary
Indicator	Lack of clear leadership and support for integration.	Leadership is developing to support integration.	Leadership in place has had the ability to drive change with collaboration evident in a number of key areas. Some shared learning and collaborative practice in place.	Clear collaborative leadership is in place, supported by a range of services including HR, finance, legal advice, improvement and strategic commissioning. All opportunities for shared learning across partners in and across local systems are fully taken up resulting in a clear culture of collaborative practice.
Our Rating			✓	
Evidence / Notes	<p>Each of the following structures which support collaborative practice is supported by meeting minutes, terms of reference and action planning</p> <ul style="list-style-type: none"> • Chief Officer national representation as Chair of the Adult Social Care Committee, Social Work Scotland • IJB Bi-monthly meetings; The IJB offers support and leadership at a strategic level and facilitates collaborative working and decision making through policy support, Minutes and papers published online. https://www.argyll-bute.gov.uk/health-and-social-care-partnership • Partner Leadership meetings(Joint leadership) • Argyll & Bute Council SMT/NHS Highland SLT participation, • Argyll & Bute Health and Social Care Partnership Senior Leadership Team, • Collaborative Planning Groups e.g. EU Exit, Emergency Planning • Strategic planning for collaborative service delivery/Community Planning Partnership • The development of shared service capacity • Policy support in collocating leadership and multidisciplinary teams, shared learning through test of change. 			

	<ul style="list-style-type: none"> • NHS Highland Project Management Office • Committee and sub groups of the Integration Joint Board • Staff Liaison • Professional Leadership Group • Joint Inspections • Community Planning Partnership • Outcome 4 • Chief Officers Group Public Protection • Multi Agency Public Protection Arrangements • Violence Against Women Partnership • Community Justice Partnership • Adult Protection Committee • Alcohol and Drugs Partnership • Children’s Strategic Group • Corporate Parenting Board • Child Protection Committee • Practice and Quality Assurance Group • Community Planning Partnership
<p>Proposed improvement actions</p>	<ol style="list-style-type: none"> 1. Consolidating shared strategic planning to benefit the communities of Argyll & Bute by engagement in wider planning groups 2. Sharing best practice in health and social care nationally and with partners 3. Benchmarking with other Health and Social Care partnerships measureable with a minimum of two focused benchmarking visits 4. Policy development on shared corporate capacity around HR, supporting Governance and Strategic Commissioning 5. Developing community relationships through the Local Planning Groups measurable through Engagement Assurance Framework reported at Audit Committee 6. Development of Locality Planning Groups as part of the 2019 Engagement Strategy 7. Locality Managers and professional leads take ownership of actions.

Proposal 1.2				
Relationships and collaborative working between partners must improve				
Rating	Not yet established	Partly established	Established	Exemplary
Indicator	Lack of trust and understanding of each other's working practices and business pressures between partners.	Statutory partners are developing trust and understanding of each other's working practices and business pressures.	Statutory partners and other partners have a clear understanding of each other's working practices and business pressures – and are working more collaboratively together.	Partners have a clear understanding of each other's working practices and business pressures and can identify and manage differences and tensions. Partners work collaboratively towards achieving shared outcomes. There is a positive and trusting relationship between statutory partners clearly manifested in all that they do.
Our Rating		✓		
Evidence / Notes	<p>The collaborative structures identified in 1.1. offer opportunity for the development of collaborative practice.</p> <p>It provides the accountability for forums to highlight practices, pressures and business drivers and takes into account the statutory roles assigned to each partner which both enable and restrict integration. Argyll & Bute Health and Social Care Partnership is adept at utilising these structures both internal and public facing to ensure that through our strategic engagement and communications approach all stakeholders within the partnership are considered including our engagement with communities in developing the collaborative approach.</p> <p>The IJB has council and NHS representation, third sector, carer and public representation. This offers a cross section of input from both voting and non-voting members that guides the policy developments.</p> <p>The recent grip and control initiative provided an opportunity to take a whole business approach and harmonise processes within separate and existing systems, sharing the benefit of each partner's expertise to find the best route forward in the interim and inform longer term planning.</p> <p>The rating of partly established reflects the recent changes in leadership in the HSCP and NHS Highland and the aim to achieve and an embedded collaborative working relationship.</p>			

Proposed improvement actions	<ol style="list-style-type: none">1. Programme of development sessions for IJB members based on IJB business requirements and development opportunities2. Supporting partner leadership teams in developing knowledge of business drivers evidenced through focused discussion in the identified structures.3. Joint planning will be evidenced through meeting minutes of committees and other partnership committees and groups which highlight planning and delivery.
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Proposal 1.3				
Relationships and partnership working with the third and independent sectors must improve				
Rating	Not yet established	Partly established	Established	Exemplary
Indicator	Lack of engagement with third and independent sectors.	Some engagement with the third and independent sectors.	Third and independent sectors routinely engaged in a range of activity and recognised as key partners.	Third and independent sectors fully involved as partners in all strategic planning and commissioning activity focused on achieving best outcomes for people. Their contribution is actively sought and is highly valued by the IJB. They are well represented on a range of groups and involved in all activities of the IJB.
Our Rating		✓		
Evidence / Notes	<p>Argyll & Bute Health and Social Care Partnership has third sector strategic representation on the IJB.</p> <p>We are actively working with third sector and independent agencies operationally across a challenging geographical area in a challenging financial environment. Third and Independent sector agencies will be key to the transformational delivery of services which will require further strategic engagement. In 2019-20 we seek to develop and present our strategic commissioning position and process which will enhance the effectiveness of our working relationship, development of workforce opportunities and subsequently the longer term provision of services by these sectors.</p> <p>Add further evidence carers partnership forum/participation in the board/further third sector representation</p> <p>Both partners are Living Wage Employers evidenced through Argyll & Bute's Contract Standing Orders and NHS Highland's Local Development Strategy 2017.</p>			

Proposed improvement actions	<ol style="list-style-type: none">1. Delivery and monitoring of the Engagement Strategy and Communication Strategy2. Development of Argyll & Bute Health and Social Care joint Strategic Commissioning3. Consistently engaging the third sector in active representation from Third Sector Interface4. Workforce planning presented to the IJB as ongoing development and monitoring
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Key Feature 2 Integrated finances and financial planning				
Proposal 2.1 Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Lack of consolidated advice on the financial position of statutory partners' shared interests under integration.	Working towards providing consolidated advice on the financial position of statutory partners' shared interests under integration.	Consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions.	Fully consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions. Improved longer term financial planning on a whole system basis is in place.
Our Rating		✓		
Evidence / Notes	<p>The two partner agencies operate differing accounting policies. The disparate methodologies do not currently allow reporting of year to date spend information to be combined. This can prove challenging in providing a consistent joint financial picture to the board.</p> <p>Despite this, an integrated financial planning and reporting mechanism was developed and delivered in 2018-2019 which has significantly improved the understanding of the joint financial position.</p> <p>A single, integrated budget pack including the development of a financial risk register has been developed and provided to the IJB and partner management teams which covers the current financial position of the IJB and its constituent services as well as the medium term financial outlook for the partnership.</p>			

	<p>This is evidenced by published IJB papers available online on both partner websites.</p> <p>All financial reporting, further including progress on the delivery of agreed savings and financial risks, is presented regularly to the IJB and management through the current Governance structures.</p>
<p>Proposed improvement actions</p>	<ol style="list-style-type: none"> 1. The HSCP is currently exploring a move to a single consistent method of recording year to date spend on a cash or accruals basis is being considered as a longer term measure. In the next 12 months there will be a consideration of an alignment of policy which potentially will significantly simplify the reporting of year to date figures for the board and improve their understanding of the financial position of the IJB. 2. While financial reporting has improved in terms of the integrated approach the process and suite of reports requires to be embedded and become business as usual. 3. Implementation of Audit Scotland Recommendations

Proposal 2.2 Delegated budgets for IJBs must be agreed timeously				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Lack of clear financial planning and ability to agree budgets by end of March each year.	Medium term financial planning is in place and working towards delegated budgets being agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium term financial and scenario planning in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium to long term financial and scenario planning is fully in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB as part of aligned budget setting processes. Relevant information is shared across partners throughout the year to inform key budget discussions and budget setting processes. There is transparency in budget setting and reporting across the IJB, Health Board and Local Authority.
Our Rating			✓	
Evidence / Notes	Budget planning for 2019/20 was completed jointly by the lead financial officers from both partners who worked closely with the IJB Section 95 Officer to produce the IJB's medium term financial plan and develop the 2019/20 which was subsequently presented to and agreed by the IJB at its meeting at the end of March 2019. Going into the current financial year it is planned to look at a longer term approach to financial planning, this ties with joint strategic decision making, service development and redesign.			
Proposed improvement actions	<ol style="list-style-type: none"> 1. The budget planning process for 2020/21 and beyond is planned to commence during early 2019/20 in order to provide more time in the process for the development of the service redesigns which will be critical to sustaining the quality of services and financial position of the IJB in the future. 2. Review of financial Governance 3. These are new processes that require to be embedded to become business as usual and will be monitored. 			

Proposal 2.3				
Delegated hospital budgets and set aside budget requirements must be fully implemented				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Currently have no plan to allow partners to fully implement the delegated hospital budget and set aside budget requirements.	Working towards developing plans to allow all partners to fully implement the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance, to enable budget planning for 2019/20.	Set aside arrangements are in place with all partners implementing the delegated hospital budget and set aside budget requirements. The six steps for establishing hospital budgets, as set out in statutory guidance, are fully implemented.	Fully implemented and effective arrangements for the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance. The set aside budget is being fully taken into account in whole system planning and best use of resources.
Our Rating			N/A	
Evidence / Notes	Budgets for all hospital services are held by Argyll & Bute HSCP and have been since date of establishment. There are no set aside budgets in Argyll & Bute.			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Although directly managed budgets are in place, there are practical difficulties in influencing service delivery and cost, most notably through external service level agreements with significant partners such as NHS Greater Glasgow & Clyde. 2. Argyll & Bute Health and Social Care Partnership is currently working with NHS Highland and NHS Greater Glasgow & Clyde to review the methodology of contracting to allow the HSCP to influence service delivery and shift the balance of care, including use of resources, from hospital settings. 			

Proposal 2.4				
Each IJB must develop a transparent and prudent reserves policy				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	There is no reserves policy in place for the IJB and partners are unable to identify reserves easily. Reserves are allowed to build up unnecessarily.	A reserves policy is under development to identify reserves and hold them against planned spend. Timescales for the use of reserves to be agreed.	A reserves policy is in place to identify reserves and hold them against planned spend. Clear timescales for the use of reserves are agreed, and adhered too.	A clear reserves policy for the IJB is in place to identify reserves and hold them against planned spend and contingencies. Timescales for the use of reserves are agreed. Reserves are not allowed to build up unnecessarily. Reserves are used prudently and to best effect to support full implementation the IJB's strategic commissioning plan.
Our Rating			✓	
Evidence / Notes	<p>Policy in place, reserves being managed effectively although to date little opportunity to generate free reserves. Improvement actions indicate the commitment to financial stability and may result in generating reserves with recognition that the HSCP requires to repay outstanding debt to parent bodies.</p> <p><i>Appendix 1 Argyll & Bute HSCP Reserves Policy</i></p>			
Proposed improvement actions	<p>1. Argyll & Bute has committed to achieving financial stability which may result in generation of reserves for the future. There is recognition that contingency arrangements would offer opportunity to support the development of health and care services for Argyll & Bute Communities.</p>			

Proposal 2.5				
Statutory partners must ensure appropriate support is provided to IJB S95 Officers.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	IJB S95 Officer currently unable to provide high quality advice to the IJB due to a lack of support from staff and resources from the Health Board and Local Authority.	Developments underway to better enable IJB S95 Officer to provide good quality advice to the IJB, with support from staff and resources from the Health Board and Local Authority ensuring conflicts of interest are avoided.	IJB S95 Officer provides high quality advice to the IJB, fully supported by staff and resources from the Health Board and Local Authority and conflicts of interest are avoided. Strategic and operational finance functions are undertaken by the IJB S95 Officer. A regular year-in-year reporting and forecasting process is in place.	IJB S95 Officer provides excellent advice to the IJB and Chief Officer. This is fully supported by staff and resources from the Health Board and Local Authority who report directly to the IJB S95 Officer on financial matters. All strategic and operational finance functions are integrated under the IJB S95 Officer. All conflicts of interest are avoided.
Our Rating		✓		
Evidence / Notes	<p>The IJB Section 95 officer has a strategic role with the two finance leads from the partner organisations delivering the operational role.</p> <p>The development of the aforementioned integrated financial planning and reporting mechanism in 2018-19 has offered a more streamlined opportunity for joint working and planning and the Section 95 officer to have an operational oversight through reporting. This can be evidenced through the approval of a balanced budget and savings plan for 2019-20</p> <p>Further strategic planning and joint working will enable the partnership to deliver a congruent plan for the communities of Argyll & Bute.</p> <p>Finance teams provide financial reporting evidence to the Section 95 officer.</p>			

Proposed Improvement actions	<ol style="list-style-type: none">1. Restructuring of the Senior Leadership Team including the Section 95 officer role to reflect the requirement for greater joint strategic and operational capability through management oversight2. Co-location of finance teams for increased joint working and capacity.3. Establish regular formal liaison between the chief financial officers of each partner.
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Proposal 2.6 IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Total delegated resources are not defined for use by the IJB. Decisions about resources may be taken elsewhere and ratified by the IJB.	Total delegated resources have been brought together in an aligned budget but are routinely treated and used as separate health and social care budgets. The totality of the budget is not recognised nor effectively deployed.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority. The IJB's strategic commissioning plan and directions reflect its commitment to ensuring that the original identity of funds loses its identity to best meet the needs of its population. Whole system planning takes account of opportunities to invest in sustainable community services.
Our Rating		✓		
Evidence / Notes	An integrated budget has been approved by the IJB with funds allocated to the delivery partners as directed by the IJB as necessary to deliver the IJB's strategic objectives. Appendix 2 Argyll & Bute Draft Strategic Plan			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Review of the Scheme of Integration 2. Review of opportunities available through whole system planning and potential impact on statutory delivery. 3. Review of capital planning and resources. 4. Identifying a period of planning to work towards outcome based service redesign is key to an outcome based approach 			

Key Feature 3				
Effective strategic planning for improvement				
Proposal 3.1				
Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Lack of recognition of and support for the Chief Officer's role in providing leadership.	The Chief Officer is not fully recognised as pivotal in providing leadership. Health Board and Local Authority partners could do more to provide necessary staff and resources to support Chief Officers and their senior team.	The Chief Officer is recognised as pivotal in providing leadership and is recruited, valued and accorded due status by statutory partners. Health Board and Local Authority partners provide necessary resources to support the Chief Officer and their senior team fulfil the range of responsibilities	The Chief Officer is entirely empowered to act and is recognised as pivotal in providing leadership at a senior level. The Chief Officer is a highly valued leader and accorded due status by statutory partners, the IJB, and all other key partners. There is a clear and shared understanding of the capacity and capability of the Chief Officer and their senior team, which is well resourced and high functioning.
Our Rating		✓		
Evidence / Notes	<p>The Chief Officer has membership within the senior leadership teams of each partner agency and is recognised as having both strategic and operational responsibilities in delivering the statutory responsibilities of each.</p> <p>Argyll & Bute can evidence a continued positive trajectory enabling the Chief Officer to lead the Health and Social Care Partnership with cognisance taken of the IJB as a separate public entity with corresponding responsibilities.</p> <p>The IJB has highlighted the importance of the Governance structure in providing accountability and the flow of information and subsequently the approval of any policy decisions which enable the Chief Officer to implement key strategic and operational decisions.</p>			

Proposed improvement actions	<ol style="list-style-type: none">1. Continued development of the collaborative working relationship through the existing structure outlined in 1.1 and evidenced through outputs of joint strategic planning.2. Using the technical supporting role of HR in staff and organisational development.3. Requirement for NHS Communications at local level to reinforce the role of Chief officer4. HSCP to develop and implement own policies and procedures to support strategic and operational decisions e.g. colocation
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Proposal 3.2				
Improved strategic inspection of health and social care is developed to better reflect integration.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL INSPECTORATE BODIES RESPONSIBLE			

Proposal 3.3				
National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Proposal 3.4				
Improved strategic planning and commissioning arrangements must be put in place.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Integration Authority does not analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. There is a lack of support from statutory partners.	Integration Authority developing plans to analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide some support for strategic planning and commissioning.	Integration Authority has undertaken an analysis and evaluated the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide good support for strategic planning and commissioning, including staffing and resources which are managed by the Chief Officer.	Integration Authority regularly critically analyses and evaluates the effectiveness of strategic planning and commissioning arrangements. There are high quality, fully costed strategic plans in place for the full range of delegated services, which are being implemented. As a consequence, sustainable and high quality services and supports are in place that better meet local needs. The Local Authority and Health Board provide full support for strategic planning and commissioning, including staffing and resources for the partnership, and recognise this as a key responsibility of the IJB.
Our Rating		✓		
Evidence / Notes	<p>Strategic planning is undertaken with all key stakeholders through public consultation and managed through the Strategic Planning Group.</p> <p>Strategic Planning supports the direction of travel as an evidence base for commissioning strategies. This is further supported by local authority procurement strategies for all Adult Care and Children and Families contracts that have been subject to a procurement process, this is a planning tool to ensure that the that the resulting contracts meet the needs of clients.</p> <p>The Health & Social Care Partnership are in the early stages of a wider project to develop its market facilitation plan and commissioning strategy, with input from the Strategic Planning Team; Strategic Finance team; Procurement and Commissioning Team and our local Third Sector Interface. The group are currently gathering information on existing contracts and services (including grants) and analysing spend in order to baseline the current provision. Gathering this market intelligence is the first</p>			

	<p>stage of the process, thereafter they will assess the gap between current provision and desired future provision and how the market can be influenced to deliver this in the medium and longer term.</p>
<p>Proposed improvement actions</p>	<ol style="list-style-type: none"> 1. Develop role and effectiveness of the Strategic Planning Group to support the IJB 2. Completion of initial market facilitation 3. Development of partnership practice in strategic commissioning aligned with partnership process and increased financial and performance monitoring to be built in to the accountability structure. 4. Commitment to having a strategic commissioning plan 5. Reference to strategic needs assessment 6. Cognisance taken of thematic areas arising from Adult and Childrens Resource Group 7. Future contact management support

Proposal 3.5				
Improved capacity for strategic commissioning of delegated hospital services must be in place.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	No plans are in place or practical action taken to ensure delegated hospital budget and set aside arrangements form part of strategic commissioning.	Work is ongoing to ensure delegated hospital budgets and set aside arrangements are in place according to the requirements of the statutory guidance.	Delegated hospital budget and set aside arrangements are fully in place and form part of routine strategic commissioning and financial planning arrangements. Plans are developed from existing capacity and service plans, with a focus on planning delegated hospital capacity requirements with close working with acute sector and other partnership areas using the same hospitals.	Delegated hospital budget and set aside arrangements are fully integrated into routine strategic commissioning and financial planning arrangements. There is full alignment of budgets. There is effective whole system planning in place with a high awareness across of pressure, challenges and opportunities.
Our Rating		✓		
Evidence / Notes	<p>IJB approved budget 2019-20 submitted policy savings proposals which support the shift in the balance of care. Ongoing relationship with NHS Highland and NHS Greater Glasgow and Clyde in developing “the right service at the right time”</p> <p>The HSCP has a well-established financial and planning process for acute services from its main provider in NHS GG&C. This has been in place for over 12 years in the form of an SLA.</p> <p>The HSCP has delegated resources and responsibility for the acute services within Argyll and Bute. It adopts a whole system capacity and service planning across all its local hospital services (RGH, community hospital, Acute psychiatry)</p>			

	<p>The HSCP is part of the WoS Regional Health and Social care planning group and participates in the design, delivery and shaping of the WoS West of Scotland Health and Social Care Deliver Plan.</p>
<p>Proposed improvement actions</p>	<ul style="list-style-type: none"> • The HSCP beyond its financial negotiation with NHS GG&C will need to establish a formal arrangement with its fellow HSCPs who use the service (GGC, Renfrew, Inverclyde, West Dumbarton etc) once the delegated/set aside budget is enacted in October 2019 to examine how it can influence /shape and ultimately commission acute activity. • It will need to enhance and/or designate focused resource across commissioning, finance and contracting/procurement will be required to support this. • Strengthen its role in supporting the implementation of the West of Scotland Health and Social Care Deliver Plan once approved by the Cabinet Secretary

Key Feature 4				
Governance and accountability arrangements				
Proposal 4.1				
The understanding of accountabilities and responsibilities between statutory partners must improve.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	No clear governance structure in place, lack of clarity around who is responsible for service performance, and quality of care.	Partners are working together to better understand the governance arrangements under integration to better understand the accountability and responsibilities of all partners.	Clear understanding of accountability and responsibility arrangements across statutory partners. Decisions about the planning and strategic commissioning of delegated health and social care functions sit with the IJB.	Clear understanding of accountability and responsibility arrangements and arrangements are in place to ensure these are reflected in local structures. Decisions about the planning and strategic commissioning of delegated functions sit wholly with the IJB and it is making positive and sustainable decisions about changing the shape of care in its localities. The IJB takes full responsibility for all delegated functions and statutory partners are clear about their own accountabilities.
Our Rating		✓		
Evidence / Notes	<p>The Health and Social Care Partnership has a Scheme of Integration and Standing Orders. It has a committee structure relating to Audit, Clinical and Care Governance and is supported by partnership groups and committees which have accountability to the IJB. This incorporates Strategic Planning, Quality and Finance, Partnership, Primary Care Modernisation, Adult and Children's Services, Staff Liaison and Transformation.</p> <p>The HSCP is currently reviewing its Governance arrangements to increase clarity on the roles and accountabilities.</p>			

Proposed improvement actions	<ol style="list-style-type: none">1. Review of the Scheme of Integration 20202. Review of Governance arrangements:<ol style="list-style-type: none">a. Development of a Health and Social Care Partnership Code of Corporate Governanceb. Mapping of the governance structurec. Review of current terms of referenced. Review delegated authority and explore if change is required.3. Iterate statutory duties of each partner4. Repository of control documents, policies and operating procedures5. Planned external Audit of Governance Arrangements
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Indicator 4.2				
Accountability processes across statutory partners will be streamlined.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Accountability processes unclear, with different rules being applied across the system.	Accountability processes being scoped and opportunities identified for better alignment.	Accountability processes are scoped for better alignment, with a focus on fully supporting integration and transparent public reporting.	Fully transparent and aligned public reporting is in place across the IJB, Health Board and Local Authority.
Our Rating		✓		
Evidence / Notes	<p>Argyll & Bute HSCP has over the past twelve months seen development in this area but as referenced in 4.1 there is not yet the governance structure in place that offers a fully transparent flow of information.</p> <p>Current developments have ensured that minutes of committees are published in conjunction with IJB papers to the public.</p> <p>Argyll & Bute HSCP operates a streamlined process maximising the expertise of the partnership organisation and preventing duplication of services.</p>			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Supported by activities highlighted in 4.1 2. Review of accountabilities and responsibilities as a public body e.g. publications, complaints handling, FOI, Records Management 3. Regular Scheme of Integration Review as prescribed 			

Proposal 4.3				
IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	IJB lacks support and unable to make effective decisions.	IJB is supported to make effective decisions but more support is needed for the Chair.	The IJB Chair is well supported, and has an open and inclusive approach to decision making, in line with statutory requirements and is seeking to maximise input of key partners.	The IJB Chair and all members are fully supported in their roles, and have an open and inclusive approach to decision making, going beyond statutory requirements. There are regular development sessions for the IJB on variety of topics and a good quality induction programme is in place for new members. The IJB has a clear understanding of its authority, decision making powers and responsibilities.
Our Rating			✓	
Evidence / Notes	Statutory membership is met and in place. Prescribed inclusive leadership approach of the Chair/Vice Chair to supporting the IJB members Review of effectiveness of supporting systems to ensure that decision making is based on evidence and direction Regular review of IJB and Committee Action Logs to ensure delivery Monthly informal meetings with Chair/Vice Chair and senior officers			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Review of membership to evaluate if additional representation would improve outcomes for Argyll & Bute 2. Continued development of accountability and responsibility roles 3. Ensure directions and actions are logged for follow up 4. Use of the Audit process to support the development of IJB practice. 5. Bi-monthly meetings 			

Proposal 4.4				
Clear directions must be provided by IJB to Health Boards and Local Authorities.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	No directions have been issued by the IJB.	Work is ongoing to improve the direction issuing process and some are issued at the time of budget making but these are high level, do not direct change and lack detail.	Directions are issued at the end of a decision making process involving statutory partners. Clear directions are issued for all decisions made by the IJB, are focused on change, and take full account of financial implications.	Directions are issued regularly and at the end of a decision making process, involving all partners. There is clarity about what is expected from Health Boards and Local Authorities in their delivery capacity, and they provide information to the IJB on performance, including any issues. Accountability and responsibilities are fully transparent and respected. Directions made to the Health Board in a multi-partnership area are planned on an integrated basis to ensure coherence and take account of the whole system.
Our Rating		✓		
Evidence / Notes	<p>The HSCP has instigated a more directional approach in recent months with direction given through IJB papers and will evaluate and reflect on the effectiveness of this in the coming year.</p> <p>Updated board/committee/meeting templates to reflect requirement for direction and ensure the flow of information</p> <p>IJB minutes</p> <p>Integrated financial reporting</p>			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Continued development of accountability and responsibility roles through the development of the corporate governance of the Health and Social Care Partnership. 2. Seek the development of shared practice and congruence where appropriate in multi-partnership area e.g. NHS Highland/NHS Greater Glasgow & Clyde. 3. Ensure directions and actions are logged for follow up 4. Use of the Audit process to support the development of IJB practice. 			

Proposal 4.5				
Effective, coherent and joined up clinical and care governance arrangements must be in place.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	There is a lack of understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making is not well understood. Necessary clinical and care governance arrangements are not well established.	There is partial understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making. Arrangements for clinical and care governance are not clear	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. There are fully integrated arrangements in place for clinical and care governance.	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. Arrangements for clinical and care governance are well established and providing excellent support to the IJB. Strategic commissioning is well connected to clinical and care governance and there is a robust process for sharing information about, for example, inspection reports findings and adverse events information, and continuous learning is built into the system.
Our Rating			✓	
Evidence / Our Notes	<p>There is a strong understanding of the key role clinical and professional leadership plays in supporting decisional making. The 2017-18 annual report indicators highlight we we are just marginally away from our target. The HSCP is working very hard to improve this and we are seeing real progress in coping with the increasing demand and ensuring best practice.</p> <p>With a rising older population and constrained services we need to ensure that resources are deployed in the best way to improve outcomes for local populations.</p> <p>The Clinical and Care Governance Committee continues to ensure the delivery of safe and effective person-centred care and the continuous monitoring of professional standards of care and practice. The committee continues to provide the Argyll and Bute HSCP Integrated Joint Board with assurance that procedures and processes are in place to deliver effective clinical and care governance.</p> <p>The safety of people who use HSCP services is at the forefront of everything we do and overall performance against the national outcome is very good and the following examples highlight the work we are doing.</p>			

	<ul style="list-style-type: none"> • Clinical and Care Governance Framework in place • Clear structure of Clinical and Care Governance meetings and reporting, with standard agenda covering health and social care. • Minutes of Clinical and Care Governance Committee on IJB agenda • Significant Adverse Events Review scrutiny group established – members include senior officers, professional leads and clinical governance staff. • Single point of access for Health and Social work complaints • Professional Leads forum established • Further work required to harmonise joint reporting processes <p>The following report highlights the recent joint inspection for children and young people’s services and the structures available to support the clinical and care governance committee in this area.</p> <p><i>Appendix 3 Joint Inspection of services for children and young people in need of care and protection in Argyll & Bute.</i></p>
<p>Proposed improvement actions</p>	<ol style="list-style-type: none"> 1. Clinical and care Governance Committee Terms of Reference are currently under review to further strengthen the integrated approach. 2. Strengthen inclusion of social care 3. Ensuring greater engagement with clinical and care governance structures across the partnership

Key Feature 5				
Ability and willingness to share information				
Proposal 5.1				
IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Work is required to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on by July 2019.	Work is ongoing to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019. Some benchmarking is underway and assisting consistency and presentation of annual reports.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, to ensure public accessibility, and to support public understanding of integration and demonstrate its impact. The annual report well exceeds statutory required information is reported on. Reports are consistently well presented and provide information in an informative, accessible and readable format for the public.
Our Rating		✓		
Evidence / Notes	The annual report is structured in reporting the 9 National Health and Wellbeing Outcomes, Integration Joint Board measures, Customer Services, Governance, financial performance and inspection findings. Children and Families and Community Justice are currently reported separately.			
Proposed improvement actions	<ol style="list-style-type: none"> 1. Performance monitoring is scrutinised through the audit committee and subsequently the board on a regular basis and is being reviewed to look at a further integrated approach. 2. Benchmark against a comparable HSCP annual report 3. Review trend data including LGBF indicators to be reported. 			

Proposal 5.2				
Identifying and implementing good practice will be systematically undertaken by all partnerships.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Work is required to improve the Integration Authority annual report to identify, share and use examples of good practice and lessons learned from things that have not worked.	Work is about to commence on development of the annual report to enable other partnerships to identify and use examples of good practice. Better use could be made of inspection findings to identify and share good practice.	The Integration Authority annual report is presented in a way that readily enables other partnerships to identify, share and use examples of good practice and lessons learned from things that have not worked. Inspection findings are routinely used to identify and share good practice.	Annual reports are used by the Integration Authority to identify and implement good practice and lessons are learned from things that have not worked. The IJB's annual report is well developed to ensure other partnerships can easily identify and good practice. Inspection findings and reports from strategic inspections and service inspections are always used to identify and share good practice. All opportunities are taken to collaborate and learn from others on a systematic basis and good practice is routinely adapted and implemented.
Our Rating		✓		
Evidence / Notes	<p>Specific evidence is presented below which a direct is output of recent inspection and review.</p> <p><i>Appendix 3 Joint inspection of services for children and young people In Argyll and Bute</i> <i>Appendix 4 Annual Report 2017-18</i></p> <ul style="list-style-type: none"> • Joint inspection improvement plan • Child protection plan • Chief social workers report • Self-evaluation • Integrated financial reporting • Highland Quality Report 			

	<ul style="list-style-type: none">• Children & Families improvement group
Proposed improvement actions	<ol style="list-style-type: none">1. Benchmarking of practice nationally2. Updates on implementation of learning from lessons learned3. Review implications for Governance and accountability

Proposal 5.3				
A framework for community based health and social care integrated services will be developed.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Key Feature 6 Meaningful and sustained engagement				
Proposal 6.1 Effective approaches for community engagement and participation must be put in place for integration.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	There is a lack of engagement with local communities around integration.	Engagement is usually carried out when a service change is proposed.	Engagement is always carried out when a service change, redesign or development is proposed.	Meaningful engagement is an ongoing process, not just undertaken when service change is proposed. Local communities have the opportunity to contribute meaningfully to locality plans and are engaged in the process of determining local priorities.
Our Rating		✓		
Evidence / Notes	<p>Argyll & Bute has recently approved both a new engagement strategy and a communication strategy. This will be deployed through 2019-20 with performance against the intentions reported through the Governance structure.</p> <ul style="list-style-type: none"> • IJB published papers and minutes available on each partner website • Engagement Strategy • Communications Strategy • Strategic Plan Consultation • IJB meeting • Quality Impact Assessments • Locality Planning Groups • Community Café 			

Proposed improvement actions	<ol style="list-style-type: none">1. Engagement assurance framework reporting to Audit committee to monitor the deployment of the engagement strategy2. Chair and Vice Chair providing regular opportunity to support the contribution of carers and representatives on the IJB3. Robust Governance to ensure that information is provided in a timely manner and two way communication is the norm.4. Review of the deployment of the Communications strategy to ensure appropriate communication and channels are being utilised to full effect.
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Proposal 6.2				
Improved understanding of effective working relationships with carers, people using services and local communities is required.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Work is required to improve effective working relationships with service users, carers and communities.	<p>Work is ongoing to improve effective working relationships with service users, carers and communities.</p> <p>There is some focus on improving and learning from best practice to improve engagement.</p>	<p>Meaningful and sustained engagement with service users, carers and communities is in place.</p> <p>There is a good focus on improving and learning from best practice to maximise engagement and build effective working relationships.</p>	<p>Meaningful and sustained engagement with service users, carers and communities is in place. This is given high priority by the IJB.</p> <p>There is a relentless focus on improving and implementing best practice to maximise engagement. There are well established and recognised effective working relationships that ensure excellent working relationships.</p>
Our Rating		✓		
Evidence / Notes	<p>Argyll & Bute is a wide geographical area with diverse needs across an ageing population. We have the benefit of a population who are invested in their public services and in 2018-19 restructured the engagement structure for a more effective way of communicating with key communities. We hope to achieve the sustained engagement required to work with communities and increase our mutual understanding of needs and constraints to innovate and deliver modern services</p> <ul style="list-style-type: none"> • IJB published papers and minutes available on each partner website • Carers strategy (Appendix 5) • Strategic Planning Group • Locality Planning Groups • Community Café • Strategic Needs Assessment • Carers Partnership • Carers Collaborative • Life Changes Trust 			

	<p>The aforementioned benchmarking offers the opportunity to seek and share best practice and further improve effective working relationships with service users, carers and communities</p>
<p>Proposed improvement actions</p>	<ol style="list-style-type: none"> 1. Benchmarking on shared and best practice with other HSCP's/Independent and Third Sector 2. Engagement assurance framework reporting to Audit committee to monitor the deployment of the engagement strategy 3. Review of Communications channels and engagement

Proposal 6.3				
We will support carers and representatives of people using services better to enable their full involvement in integration.				
Rating	Not yet established	Partly Established	Established	Exemplary
Indicator	Work is required to improve involvement of carers and representatives using services.	Work is ongoing to improve involvement of carers and representatives using services.	Carers and representatives on the IJB are supported by the partnership, enabling engagement. Information is shared to allow engagement with other carers and service users in responding to issues raised.	Carers and representatives of people using services on the IJB, strategic planning group and locality groups are fully supported by the partnership, enabling full participation in IJB and other meetings and activities. Information and papers are shared well in advance to allow engagement with other carers and service users in responding to issues raised. Carers and representatives of people using services input and involvement is fully optimised.
Our Rating		✓		
Evidence / Notes	<ul style="list-style-type: none"> • IJB published papers and minutes available on each partner website • Carers Consultation • Strategic Planning Group • Locality Planning Groups • Community Café • Carers Partnership • Children's engagement 			

Proposed improvement actions	<ol style="list-style-type: none">1. Engagement assurance framework reporting to Audit committee to monitor the deployment of the engagement strategy2. Chair and Vice Chair providing regular opportunity to support the contribution of carers and representatives on the IJB3. Robust Governance to ensure that information is provided in a timely manner and two way communication is the norm.4. Review of the deployment of the Communications strategy to ensure appropriate communication and channels are being utilised to full effect.
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Integration Joint Board

Agenda item: 9

Date of Meeting: 29 May 2019

Title of Report: Chief Officer Report

Presented by: Joanna Macdonald, Chief Officer

The Integration Joint Board is asked to:

- Note the following report from the Chief Officer

Comments from some of the people using the HSCP's Services

Islay Hospital patient - *"I spent sometime at Islay Hospital recently and I'd like to thank all the staff for all their kindness and care. I couldn't have asked for more compassion and help. I especially wanted to mention the quality of the food – it was wonderful. Thank you all"*

X-PERT diabetes course participant - *"the value to diabetics in what you do for us. The fact that experts like you exist and that you present your topic so effectively and dynamically is, in my opinion, a considerable help to folk like me who would otherwise just read books and not get as much out of controlling our condition - and also being able to interact with our peers in the group and you."*

Senior Management Moving On

Sandra Cairney, Associate Director of Public Health, is retiring after 39 years of public sector service and her last day is the 29th May.

Lorraine Paterson, Head of Adult Services (West), will be leaving the HSCP after 13 years of service in Argyll & Bute at the end of June to take up a senior post with Falkirk Health and Social Care Partnership.

The Chief Officer would to thank them both for making a real positive difference in their roles and wishes them well for the future.

Staff Deaf Awareness Sessions

Deaf Awareness Week was held from 6-12 May and one of the HSCP'S Senior Planning Managers held a number of awareness sessions for staff.

The sessions were held in Campbeltown and Lochgilphead and staff had an opportunity to learn how to sign the alphabet and their name using British Sign Language.

Chief Health Professions Officer Visit

Tracy MacInness, Interim Chief Health Professions Officer for the Scottish Government visited Argyll and Bute on the 17th April with Claire Wood, Associate Director of AHPs for NHS Highland. They spent time visiting staff in Mid Argyll Hospital, met with the uni-professional AHP leads and Children's AHP team leads to find out more about local services.

The day was facilitated by the HSCP's Lead AHP, Linda Currie, and the group were joined by the Chief Officer for an afternoon session where Linda outlined the AHP accountability wall. She also discussed new initiatives, waiting times and the newly established Value Management Programme that the AHP team are developing to provide an overview of key performance indicators, workforce and budgets.

NHS Highland Interim Chair Meets Staff in Argyll and Bute

NHS Highland Interim Chair, Professor Boyd Robertson, recently met with HSCP staff during a visit to Mid Argyll Community Hospital and Integrated Care Centre, Campbeltown Community Hospital, Lorn & Islands Hospital and Lochgilphead Medical Centre.

Professor Robertson discussed with staff, as well as a number of patients, the importance of the HSCP continuing to deliver quality services that meet the needs of patients and service users.

Lorn & Islands Hospital Celebrates 2 Years of Obstetric Scanning Success

Lorn & Islands Hospital has recently celebrated 2 years of success with women accessing the obstetric scanning service. The service started on the 10 April 2017 and allows women to access all the planned diagnostic and screening services that are now recommended in pregnancy. So far over 1700 women have been saved from having to travel to Glasgow for antenatal scans.

Technology Enabled Care Helping Mums-to-Be in Argyll

Until recently a Consultant Obstetrician travelled from Glasgow to Oban once a week to see women at various stages of their pregnancy. That's all changed due to the introduction of secure technology-enabled care with NHS Highland and NHS Greater Glasgow & Clyde introducing a virtual antenatal clinic from the Royal Alexandra Hospital in Paisley.

This means every second week the doctor runs her clinic from Paisley, saving a 180 mile round trip and freeing up more precious clinic and theatre time.

Foster Carer Day at Furnace Primary School

The Chief Officer attended a Foster Carer Day event in Furnace Primary School on Saturday 11 May to highlight Foster Care Fortnight (13-26 May). The annual campaign raises the profile of fostering and show how foster care can transform lives. For more information search #changeafuture.

Further Success for Jean's Bothy Mental Health and Wellbeing Centre

Jean's Bothy Mental Health and Wellbeing Centre in Helensburgh held an Open Day at the end of April. Members of the community were invited along to register an interest in using the services and they were provided with an opportunity to meet partner agencies and health and social care staff.

The event also showcased the café, gardens, and the facilities available to those individuals using the service.

Argyll & Bute Attend Anywhere Orthopaedic Service launched in Kintyre

At the end of April five Campbeltown Hospital orthopaedic out-patients were the first to use the HSCP's Attend Anywhere (NHS Near Me) newly developed service in Kintyre.

The remote video-link service is offered at Campbeltown Hospital to provide an instant link to medical specialists located more than 135 miles away in Glasgow.

Tender issued for Bute dialysis unit

The Bute Dialysis Unit project has now reached tendering stage with responses being welcomed from prospective suppliers with the appointed contractors tasked with undertaking the adaptation of the existing hospital ward to provide a dedicated dialysis facility while maintaining the current bed complement.

Getting it Right for Every Child Leadership Programme

The Scottish Government has selected Argyll and Bute Children's Services Strategic Partnership as a trial site for the GIRFEC Leadership Programme.

The Scottish Government especially highlighted that they welcomed the enthusiasm and engagement from local partnerships and that applications were notable in their quality, ambition and detail.

Argyll and Bute HSCP

Meeting:
Clinical and Care Governance Committee

Venue:
A01, Dunoon / Multi Site VC

Date and Time
Tuesday 5th March 2019

MINUTE

No	Item	Actions
1.	<p>WELCOME</p> <p>PRESENT Liz Higgins (LH)– A&B Lead Nurse (Chair) Joanna Macdonald (JMcD) – Chief Officer Donald Watt (DW) – Locality Manager MAKI Kieron Green (KG)– Elected Member Alison McKerracher (AMcK)– Locality Manager Cowal Fiona Thomson (FT) – Lead Pharmacist Donald McFarlane (DMcF)– Lead Dental Officer</p> <p>IN ATTENDANCE Morven Gemmell (MG)– Locality Manager Oban, Lorn & Islands Julian Gasgoine (JG) Health and Safety Manger Jane Williams (JW) – Acting Locality Manager Cowal/Bute Sarah Compton Bishop (SCB) – IJB Member Charlotte Morbey (CM) – Clinical Risk Midwife Claire Higgins (CHg) – PA to Lead Nurse (minute taker)</p> <p>APOLOGIES Robin Creelman (RC) – Chair IJB Phil Cummins (PC) – Head of Service Lorraine Paterson (LP) – Head of Adult Services, West Fiona Campbell (FC)–Clinical Governance Manager Rebecca Helliwell (RH) – Associate Medical Director Dawn MacDonald (DMCD) – Staff side rep Alex Taylor (AT)– Head of Service C&F Catriona Dreghorn (CD) – Interim Lead Midwife Argyll & Bute</p>	

2.	<p>MINUTES OF PREVIOUS MEETINGS</p> <p>Agreed with no amendments.</p>	
3	<p>SCHEDULED REPORTS</p> <p>3.1 Bute and Cowal No formal report from B&C. Interim Locality Manger talked through by Committee what is required for future reports.</p> <p>3.1.2 Helensburgh and Lomond Reported tabled. NO representative from H&L to talk to the report.</p> <p>3.1.3 Mid Argyll, Kintyre and Islay DW spoke to his detailed report.</p> <p>3.1.4 Oban, Lorn and Isles HSMR some work done locally in Oban regarding data and coding.</p> <p>3.1.5 Maternal & Newborn Detailed report on recent reportable incidents including vaccinations and Scottish Ambulance Service. Liz to discuss level of review and wider learning to be undertaken and will meet with Charlotte to discuss.</p> <p>3.1.6 Children and Families No report. LH to continue to request report and to meet with AT to discuss importance of C&F rep at these meetings.</p> <p>3.3 NHSH Operational Unit Exception Reports For noting</p>	<p>LH/CM</p> <p>LH</p>
4.	<p>QUALITY AND EFFECTIVENESS OF CARE</p> <p>4.1 Quality and Patient Safety Dashboard Dashboard deemed to be helpful but supplementary information would help understanding. It was agreed it would be helpful to timetable a deep dive into themes within the dashboard data set.</p> <p>4.2 Children’s Inspection JMCD provided a verbal update on the feedback from the inspection which was very positive. Indicative grades are 3 goods and 1 adequate. Highlight of report – Children are safe in Argyll and Bute and achieving good outcomes. Adult Support and Protection inspection is likely to happen within the next 2 years.</p>	<p>FC</p>

	<p>The Committee would like to note huge thanks to all the staff involved for their hard work.</p> <p>4.4 Care Home and Care at Home Work ongoing within Care Home transformation work stream. Future papers on Care Home and Care at Home should include risks and successes across Argyll & Bute services. LH to discuss with Adult Heads of Service</p> <p>4.6 HSMR Assurance work conducted by Rod Harvey and clinical leads in Oban, there remains no concerns around HSMR data in Oban.</p> <p>4.7 Community Hospitals Case Reviews MAKI are testing documentation and process and some suggested improvements have been identified. Further update and roll out plan to be brought to next meeting.</p>	<p>LH/LP/PC</p> <p>RH/FC</p>
<p>5.</p>	<p>SAFETY</p> <p>5.1 HSCP Health and Safety Group Action log Noted. Actions picked up through Health and Safety Group.</p> <p>5.2 Falls (see 3.7) Data shows sustained improvement over an 8 month period across Argyll and Bute. Oban showing improvement for 2 months and important this is sustained by current actions e.g. cohorting patients. Well done to all staff involved, the Committee recognises how difficult this can be and that this is the result of staff hard work and dedication.</p> <p>5.3 Medicines Management and Incident Deferred to next meeting</p> <p>5.4 Learning from SAERs / Incident Reviews Deferred to next meeting</p>	
<p>6.</p>	<p>EXPERIENCE</p> <p>6.1 Care Opinion Evidence of growing awareness of Care Opinion as a way to feedback to services. Argyll and Bute Maternity services have been in receipt of a number of very positive Care Opinion posts which highlight the very high standard of maternity care offered to women in our partnership.</p> <p>SCB suggested it would be helpful to add in an action column to this report to allow for shared learning and benchmarking.</p>	<p>FC</p>

7.	<p>FOR NOTING</p> <p>7.1 NHH SAER Chair Training 05 April 2019</p> <p>7.2 Review of HSCP Clinical and Care Governance Framework Review required – date currently being sought for 1st meeting.</p>	LH/FC
9.	<p>DATE, TIME AND VENUE FOR NEXT MEETINGS</p> <p>Thursday 25th April 9.30am – 1.30pm</p> <p>J05-J07, Lochgilphead VC available – dial in details to follow.</p>	