LEARNING FROM SERIOUS FAILINGS IN CARE
MAIN REPORT

MAY 2015

Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy) Short-Life Working Group on Hospital Reports

Chaired by Professor Alan Paterson OBE

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May 2015

26 May 2015

Dear Scottish Academy Member,

At the meeting of the Scottish Academy in December 2014 I was appointed to chair a short life working group to look into the lessons to be learnt from the recent reports on the quality of hospital care (Mid Staffordshire, Lanarkshire, Vale of Leven and Aberdeen Royal Infirmary). I am most grateful to the other members of the working group (Professor Derek Bell (PRCPE and Vice Chair, Scottish Academy); Dr John Colvin (RCoA); Dr Bernie Croal (RCPath) and Dr Frank Dunn (PRCPSG and Vice Chair, Scottish Academy) for all their assistance throughout the last six months. Particular thanks are also due to Maggie Farquhar of the Scottish Academy and Graeme McAlister, RCPE, without whose support this Report would never have seen the light of day.

I believe that the working group has identified a number of key issues to emerge from the hospital reports and I hope that the Scottish Academy will give serious consideration to the working group's recommendations.

Prof Alan A Paterson OBE

Director, Centre for Professional Legal Studies, Strathclyde University (Chair)

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SECTION 1: BACKGROUND

At the meeting of the Scottish Academy in December 2014 it was unanimously agreed that a short life working group should be established to look into the lessons to be learnt from the recent reports on the quality of hospital care (Mid Staffordshire, Lanarkshire, Vale of Leven and Aberdeen Royal Infirmary).[1,2,3,4]

The membership of the working group was:

> Professor Alan Paterson OBE (Chair, Working Group)
>
> Professor Derek Bell (President, Royal College of Physicians of Edinburgh and Vice Chair, Scottish Academy)
>
> Dr John Colvin (Royal College of Anaesthetists)
>
> Dr Bernie Croal (Royal College of Pathologists)
>
> Dr Frank Dunn (President, Royal College of Physicians and Surgeons of Glasgow and Vice Chair, Scottish Academy)

Support to the Group has been provided by Maggie Farquhar of the Scottish Academy and Graeme McAlister, Royal College of Physicians of Edinburgh.

The remit of the working group was to consider the high level findings and recommendations from the Mid Staffordshire, Lanarkshire, Vale of Leven and Aberdeen Royal Infirmary hospital reports and to report back to the Scottish Academy within six months on any common themes and lessons to emerge from the reports, with suggestions for further action.

The scope of this report is largely restricted to these four Inquiry and Review reports (the "Reports"). Further reviews have been undertaken in Scotland into quality of care in NHS Tayside and waiting times activity in NHS Lothian. In the interest of transparency and consistency, we believe that the recommendations made in this report should not just apply to serious failings in care, but also to all failings in culture and operational activity/ practice in hospitals.

Data gathering

The Chair of the working group wrote to every member of the Scottish Academy (with a covering note from the Chair of the Scottish Academy) asking for details of any working parties, reports or position statements produced by their organisations in relation to any of these Reports and for copies of any of these. An approach was also made to the Royal College of Nursing Scotland. Where responses were not received, related information in the public domain was sourced. The responses were then collated and a summary of emerging themes was shared with the working group.

The report and its conclusions

In parallel, each of the members of the working group (who were all familiar with general and particular aspects related to these Hospital Reports) read at least one of the Hospital Reports in detail and in some cases all of them, and from the resulting synopses an overall summary of the high-level issues to emerge from the reports was compiled and agreed by the working group (Section 2). Following discussion the working group has produced a series of recommendations for approval by the Scottish Academy (Section 5), and for consideration by all stakeholders at Government and organisational level.

SECTION 2: KEY ISSUES FROM THE FOUR REPORTS

The following Key Issues were identified during our examination of the published Reports (some of which have been reinforced in other Reports which have since been published).[*] Whilst we recognise that not all the issues identified appeared in every hospital within the scope of these Reports, we consider that there is sufficient commonality between the Report findings to suggest that there are a range of systemic failings evidenced by these, and other, Reports.

1. Poor leadership from senior medical staff often resulting in a defective culture.

a) *Disconnect with Management:* There was a reluctance by senior clinicians in certain hospitals to engage in management activities e.g. by serving as Medical Director or to engage with medical managers, coupled with at times very poor relations with the Board and Management, as was the case in Aberdeen Royal Infirmary. This could be triggered by decisions of the Board which were considered by the clinicians to be fundamentally flawed. Some clinical staff felt that they were not being well represented by their medical management colleagues, but did not feel suited for these roles themselves. The breakdown in relationships between clinicians and their medical management colleagues had the inevitable effect of increased tension with Health Board executives. There has always been a dilemma for clinicians in becoming engaged in management since this requires relinquishing significant amounts of direct clinical care. They may not wish to do this because of the risk of disengaging from clinical colleagues and deskilling.

b) *Lack of visible and appropriate leadership:* There was a need for senior clinicians to be more visible and generally to provide active medical leadership at each hospital. This should have included proper supervision of junior staff and the encouragement of good record keeping by all members of the medical team and the preparation of proper care plans. In the Aberdeen Royal Infirmary some senior medical staff were felt to engage in open and aggressive criticism of the work of other staff.

2. Poor leadership from Board Management frequently resulting in a defective culture.

a) *Lack of pro-activity:* Several reports pointed to insufficiently pro-active Boards when it came to the anticipation of risks to the delivery of appropriate healthcare, evidenced by a failure to ask questions, "a management culture that relied upon being told of problems rather than actively seeking assurance about what was in fact happening" (Vale of Leven) and/or to carry out appropriate audits. This was evident in relation to planning decisions which had led to the running down or consolidation of hospitals (as in Lanarkshire and the Vale of Leven). The resulting 'planning blight' from such situations had unintended consequences for the morale of the staff. The lack of pro-activity may also have been due, in part, to a disinclination to engage with bad news – especially if it had budgetary consequences. Such Boards had a culture which would overlook warnings from external reviews or incident reports submitted by staff and thus failed to learn from mistakes and missed the opportunity to improve patient care. This also led to these Boards appearing remote from the hospital staff as in the Aberdeen Royal Infirmary. The Reports suggest that management requires to be clinically engaged and to ensure that all the standards within a hospital are met. In Mid Staffordshire they failed in all the key areas and yet, because of inertia, incompetence and recklessness, no action was taken. The red light warnings were missed time and again and external monitoring also failed.

b) *Inappropriate targets:* Not all targets are inappropriate, but the Reports suggest that some key performance indicators (KPIs) and financial targets can be problematic when they are inappropriately prioritised to the detriment of patient care. For example the Lanarkshire Report noted a focus on meeting target response times and that they needed to instil a culture in which time was taken to learn from mistakes with the aim of improving patient care. This was also a feature of Mid Staffordshire with a change from the care of patients to a financially and target-driven culture where balancing the books and meeting KPIs and other management targets took precedence over a good service to patients. (There is research evidence which might suggest that Scottish Boards devote less time on their agendas to quality issues

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[*]   e.g. GMC *Report of undermining check to Ninewells Hospital (2014),* GMC *Building a supportive environment: a review of undermining and bullying in medical education and training (2015)*, Morecambe Bay (2015) and an RCN Scotland report on continuing failings in care of older people in Scotland despite improvements in inspection (2015). [5,6,7,8] In addition, concerns have recently been raised about alleged bullying in several Scottish NHS Boards. [9,10]

than some of their English counterparts.[11]) While it is likely that there was financial under-resourcing, this is not a new challenge for the NHS. It remains the case that the priorities for spending must have patient care at the centre. Targets while having merit can divert finances from key areas. This clearly happened in Mid Staffordshire and elsewhere as NHS chiefs rewarded achievement of targets rather than quality of care. If it could not be measured and was not monitored it became unimportant.

This culture was recognised, accepted and embraced by middle management and was a major factor in promotion. A patient-centred approach was lost and as a consequence of this standards fell and continued to fall to the level where the patients were treated inhumanely and without dignity. This combination of events contributed to the demonstrated increased morbidity and mortality. Whilst such drastic consequences did not happen in all the hospitals reviewed (see 5(a) below), the focus on inappropriate targets and the associated culture contributed to bullying by some managers and to poor relations with senior clinical staff. There were also occasional instances of deliberate fabrication of records in response to bullying by managers over targets.

c) *Poor accountability mechanisms:* Management structures and appraisal systems were insufficiently defined with a consequential lack of clarity about accountability lines and decision-making responsibilities (as in Lanarkshire and the Aberdeen Royal Infirmary) leading to a failure to bring decisions under scrutiny. In the Vale of Leven, clinical governance structures were in place, but management failed to establish proper reporting systems.

3. Staff shortages, inappropriate use of inexperienced staff or failure to supervise

a) *Staffing shortages:* The Reports highlighted the risks associated with inadequate staffing levels in medical and nursing teams. "Staff in care of the elderly told us that there never seemed to be enough staff" (Aberdeen Royal Infirmary) and "The number of emergency medicine consultants is well below that required" (Aberdeen Royal Infirmary). This had an effect not only on patients but on staff.

b) *Insufficient skills mix or experience:* Often the problem was not just one of numbers. Sometimes it was a matter of an inappropriate mix of specialisms in the team, or of over-use of inexperienced and/or unsupervised staff (as in the Lanarkshire and the Vale of Leven) leading sometimes to over-prescribing, poor record keeping "too frequently to be attributable to isolated poor practice on the part of individuals" (Mid Staffordshire), or poor incident reporting e.g. of falls. "In effect, there was a layer of middle grade medical staffing missing, with the result that the brunt of the day to day care had to be borne by inexperienced junior doctors" (Vale of Leven).

4. Poor staff morale and motivation

Several Reports suggest that a combination of issues 1, 2 and 3 led to poor staff morale and motivation, an acceptance of poor standards, staff disengagement and attitude problems. As noted above (see 2(a)) planning decisions to close or consolidate hospitals have the potential to affect staff motivation. The Reports also indicate that there is a need to address the 'learned helplessness' which can be experienced by staff. Successive Inquiry reports have shown that in many instances poor standards of care have been condoned and perpetuated due to a combination of organisational and external pressures and a sense that this cannot be changed at an individual level.

5. Patient experience

a) *Poor care:* Although the Aberdeen Royal Infirmary report did not evidence adverse effects on patient care, the other Reports did. The Mid Staffordshire and Vale of Leven reports pointed to bad infection control and a lack of cleanliness and Lanarkshire was triggered by concerns over a higher than predicted hospital mortality. Several descriptions of poor environmental cleanliness are found in the reports. Others pointed to over-prescription by junior staff or poor nursing care.

b) *Poor communication:* Several of the Reports featured poor, inadequate or inappropriate communication to patients and their relatives by doctors and nurses. Comments might be rude or insensitive, or simply the result of not listening to relevant information (see complaint handling).

6. Inadequate complaints handling

a) *Poor feedback and complaints mechanisms:* A litany of deficiencies in feedback and complaints handling emerged. In some, the processes for complaints and those for staff raising concerns did not operate to facilitate the recognition of bad practice and appropriate action being taken in consequence. Mid Staffordshire had a "mechanistic and defensive complaints system that was absolutely useless" with a "pre-occupation with process rather than substance" – impressive action plans with little substance. In the Vale of Leven relatives were given "inaccurate and misleading information" in response to a complaint. The Lanarkshire Report indicated that Management was not consistently and appropriately sensitive in the handling of complaints when received and the responses were sometimes defensive and not always sufficiently person-centred – "[some] responses gave the impression of being impersonal and defensive". "Did not feel that my concerns were taken seriously or listened to. No meetings with consultant, very poor communication." (Lanarkshire). In the Aberdeen Royal Infirmary the leadership and management of complaints was poor "with evidence of defensiveness in some responses to complainants" and "there was no evidence of any independent, objective and robust system for the review of the clinical aspects of draft complaints responses".

b) *Inhibition to whistleblowing:* Whistleblowing was not encouraged in the hospitals reviewed. Where there is lack of leadership bullying can follow. Staff become intimidated and, therefore, desist from whistleblowing. Complacency and 'keeping the head down' are also factors in staff deciding not to raise issues of concern. All of this reflects cultural failings. One hospital had impressive documentation on whistleblowing, but in fact the law protecting the whistleblower was not followed.

7. Limitations of external assessments of the hospitals.

Although the above list of key issues relates to the findings from the Reports, there were also issues relating to the ways in which the reviews were carried out. These are addressed in Section 3 of this report.

SECTION 3: OTHER ISSUES

Issues connected to the conduct of the Reviews

Certain issues emerged from the way in which the Reports were conducted, some of which suggest that a greater approach to standardisation of reviews would be an advantage:

1. Setting the remit and determining the length of the inquiry

It is unclear who determines these matters and to what extent they are open to challenge. It seems that there were attempts by the Health Board to exclude the general standards of nursing care from the Vale of Leven review. It would also appear that Lord MacLean clashed with the Scottish Government over the duration of the review.

2. Composition of the review team

Clearly this must be independent and have the appropriate skill set to undertake the task.

3. Inappropriate methodologies

There was a failure in the Lanarkshire review to triangulate with other available data e.g GMC reports for medical trainees. In several reviews there was a failure to focus on any clinical staff other than doctors and nurses.

4. Omissions in the reports

There was a general failure in the Reports to refer to the lessons learned from earlier reviews and Reports. Thus the Lanarkshire review says little about culture and behaviours, when discussing accountability it relates it to an organisation rather than individuals or team (hence it is unclear who is responsible at different levels of the organisation for delivery) and also says little about responsibility for resolving the issues highlighted, monitoring and review procedures.

5. Unclear follow-up

There is no mention in the Lanarkshire Report of a repeat planned review. There seems to be an assumption that the Report will change practice in itself and there are few if any pointers to best practice. A clearer identification of who will monitor developments (and how they will be monitored) going forward is required. The Aberdeen Royal Infirmary report, however, has produced pathways for addressing the issues identified in the NHS Health Improvement Scotland Review, with regular meetings between NHS Grampian and the Scottish Government to review progress. Other Health Boards have followed suit with regard to the Vale of Leven review.

6. Questions of confidentiality and disclosure

a) Following the Aberdeen Royal Infirmary review, issues arose over the contents of an unpublished report emanating from an invited review of surgical services by the Royal College of Surgeons England (RCSEng), which was thought to contain allegations about named individuals. The associated media and political scrum that followed raised acutely the question of the confidentiality of such reviews, which may have repercussions for the willingness of health professionals to co-operate in future reviews. Although there were no adverse events relating to patient safety at the Aberdeen Royal Infirmary, the position of the RCSEng is that where the review team in an invited review detect a 'very serious issue concerning patient safety' they will inform the Standards Office. It is understood that the College takes the view that it can insist on reporting such matters to the relevant authorities and that the College believes that this position is acceptable to the GMC.

b) The legal position:

   i) *Data Protection:* The Data Protection Act 1998 (DPA) relates to personal data - i.e. any data that can be used to identify a living individual, including any expression of opinion about the individual. The DPA prevents personal data which is held on computer, in a relevant filing system or is held by

a public authority from being processed without the consent of the data subject. The DPA further requires that personal data be processed 'fairly and lawfully', that it be accurate, kept secure and only used for limited, and stated, purposes. Accordingly, the personal data of patients and medical staff is covered by the DPA. However, mortality rates or recovery time rates will generally not be regarded as personal data since anonymised or aggregated data is not regulated by the Act, providing the anonymisation or aggregation has not been done in a reversible way. On the other hand surgeons' success rates in operations do relate to the personal data of the surgeons, but may be processed if it is necessary for the purposes of the management of healthcare services .[†] Again, interviews in reviews are covered by the DPA, but consent agreements with the interviewee allows the data to be used for purposes agreed with the interviewee. Certain personal data, including health records, political opinions and membership of a trade union, known as 'sensitive personal data' (s.2 DPA 1998) is even more strongly protected from disclosure by the law.

ii) *Freedom of Information:* The Freedom of Information (Scotland) Act (FOISA) relates to information held by an organisation designated as a "Scottish Public Authority". This would mean that in practice it probably only applies to hospital data and not to the transcripts of interviews with a College review team, held by the College, unless for some reason they were held by a Scottish Public Authority (e.g. e-mailed to the interviewee for accuracy checking). This is on the assumption that the Colleges are not subject to the FOI legislation. However data held in hospital records is subject to FOISA.[‡] Where the request is from the data subject then the information is absolutely exempt from FOISA. The data subject will be expected to use the DPA to get the information. Where the request for personal data is from a third party then the decision is more complex. In summary, the decision to withhold/ disclose is rooted in DPA, conditions 1 and 6 of Schedule 2. Condition 1 asks "has consent been given?" Even if it has, this does not automatically mean it is disclosed as the question of "is it fair and lawful?" should also be considered. This requires balancing the privacy rights of the person whose personal data has been requested, and the FOI rights of the person who has asked for the information. This is similar in principle to a public interest test approach but more specific, and in up to three steps. If the answer is no at any stage, information is withheld. Step One is (i) does the requester have a legitimate interest in obtaining the personal data? If yes, (ii) is disclosure necessary to achieve those interests? If yes, (iii) would disclosure cause unwarranted prejudice to the rights and freedoms or legitimate interests of the data subject(s)? This is the real balancing exercise. The information can only be disclosed if the FOI rights of the requester outweigh the privacy rights of the data subject. In addition, even if disclosure might otherwise be permitted under the main provisions of FOISA there are other exceptions which may prevent disclosure of third party personal data under FOISA e.g. that it is contained in a draft Report which will be published in the future; that disclosure would prejudice the effective conduct of public affairs; that the information is part of an investigation by a public authority OR that the information is confidential (although this exception can be trumped by the public interest). It would be fair to say that it is not common for third party information to be disclosed under FOISA.

iii) *Whistleblowing:* The overlap between the DPA and FOISA is not always clear. Each information / subject access request would have to be considered on its merits, including who is asking for the information: the whistleblower to inform their actions, or the organisation.

iv) *Confidentiality:* This exists under the common law of voluntary obligations (contract) and professional ethics. Both of these, however, can be overridden if a Court deems this to be required by the public interest.

v) *The Duty of Candour*: This may arise in future under the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill currently in the Scottish Parliament. It relates to situations where there are unexpected or unintended incidents resulting in death or harm unrelated to the clinical condition of the person.

7. Publication of reports

While these reports were fully published, concerns have arisen regarding other related reviews and the transparency and timing of the publication of review findings, including the NHS Healthcare Improvement Scotland report on quality of care in Tayside about which concerns were raised in the Scottish Parliament. [12]

[†]   Schedule 3, Section 8(2) of the Data Protection Act 1998.
[‡]   Nonetheless, under s.38(1)(d) of FOISA the medical records of a deceased person cannot be obtained under the Act although there is a limited right of access to this information under the Access to Health Records Act 1990.

SECTION 4: RESPONSES TO THE FOUR REPORTS

1. Scottish Academy Member Organisations

Mid Staffordshire

The majority of member Colleges and Faculties issued statements directly or through their London offices in response to the Francis report on Mid Staffordshire (2013). In the main these endorsed the statement issued by the Academy of Medical Royal Colleges and Faculties of the UK in which it was accepted that serious failings in basic care had been encountered, that all professionals had a share in the responsibility for these failings and that the Colleges would review their activities in response to the Francis report. Following this initial media activity, a number of Colleges and their lay groups mapped Francis's recommendations against their activities to identify where improvements could be made and convened events or published further output aimed at increasing awareness about the issues raised (position statements and journal or newsletter content). After this initial flurry, the level of activity reduced.

Lanarkshire, Vale of Leven and Aberdeen Royal Infirmary

Rather less activity was undertaken in Scotland by the Scottish Academy and its members in response to the reports on Lanarkshire (2013), Vale of Leven (2014) and the Aberdeen Royal Infirmary (2014). The Scottish Academy did not make any public comment on these reports and the only statements issued by members of the Scottish Academy appeared to be by the Royal College of Physicians of Edinburgh (RCPE), Royal College of Physicians and Surgeons of Glasgow (RCPSG), the Royal College of Surgeons of Edinburgh (RCSEd) and BMA Scotland (Observer).

The RCPE went further and recently published an editorial 'Preventing 'where next?" Patients, professionals and learning from serious failings in care' (February 2015) which reviewed the reports of 10 major Inquiries and Reviews into serious failings in care in the UK since 2000 (including the subjects of this exercise) and considered why the NHS was failing to learn lessons from these and even earlier Inquiries.[13] During this review four recurring themes were identified which it is believed had contributed to the reported failings in care – poor leadership, insufficient staffing, poor communication and poor professional engagement – and made six recommendations for change, including encouraging all political parties to commit to minimum safe staffing and a range of measures to engage staff. The editorial and its recommendations have subsequently been endorsed by the RCPSG and RCSEd.

Since then a report has been published on an inquiry into serious failings in care in Morecambe Bay, RCN Scotland have highlighted continuing failings in care of older people in Scotland despite improvements in inspection and a report has just been published on serious failings in care in Barts Health Trust in London.[14]

While not commenting directly or publicly on these individual reports, the Scottish Academy chose to focus its response on some of the wider issues raised by chairing the Professional and Excellence in Scottish Medicine Group which is working on a range of initiatives with the Scottish Government to promote professionalism and strengthen medical leadership skills, aligned with the Scottish Government's Quality Strategy (2010) and 2020 Workforce Vision.[15,16] A progress report on the Group's work was published in 2014.[17]

A summary of the Scottish Academy Members' responses to and actions following the publication of the four Reports is provided in Appendix 1. We recognise that many clinicians who are members of the constituent Colleges and Faculties within Scottish Academy have been involved in responding to issues raised by these reports at a professional level in their local employing NHS Boards. We have not specifically included this in the summary of activity of the Colleges and Faculties.

2. Royal College of Nursing

While not being a member of the Scottish Academy, contact was made with RCN Scotland as part of this scoping exercise. The RCN had been criticised in the Francis Report and at a UK level produced a very detailed and comprehensive response to the Inquiry report which echoed many of the recurring themes identified above. Since then the RCN at a Scottish and English level has continued to be active in publishing related reports and convening events aimed at highlighting the on-going risk of recurrences

of serious failings in care and advocating solutions. Central to this at an English level has been support for legally binding safe nursing levels, while RCN Scotland have favoured the use of evidence-based workforce planning tools instead of mandatory staffing levels.

3. Scottish Government

Mid Staffordshire

Initial media comment noted the failings in care, that the Scottish Government would consider what lessons could be learned from Mid Staffordshire for application in Scotland and highlighted the success of the Scottish Patient Safety Programme, introduced in 2008, in improving patient safety in Scotland. It subsequently published a Route Map to the 2020 Vision for Health and Social Care which "develops our strategy for engaging and empowering our workforce, providing our response in Scotland to addressing many of the issues raised by the Mid-Staffordshire/Francis Inquiry, and equipping them to work in an integrated way which reflects the different needs of different people and different places across Scotland".[18]

Lanarkshire

The Scottish Government accepted the findings of the review conducted by NHS Healthcare Improvement Scotland and appointed an expert Governance and Improvement Support team to work with NHS Lanarkshire in implementing the review's recommendations.

Vale of Leven

The Scottish Government accepted all 75 of the recommendations of the Inquiry report and committed to establishing an implementation group to take the recommendations forward.

Aberdeen Royal Infirmary

The Scottish Government agreed an Action Plan, under the direction of a new interim Chief Executive, and is monitoring progress.

The publication of Route Map to the 2020 Vision was followed by the 2020 Workforce Vision Everyone Matters in 2013 and the 2020 Workforce Vision Implementation Plan 2015-16 at the end of last year.[16,19] This builds on the previous 2014-15 plan and has been developed through "continuing engagement with staff and key stakeholders". The five priorities have not changed. They are:

- Healthy organisational culture

- Sustainable workforce

- Capable workforce

- Integrated workforce

- Effective leadership and management

4. On-going quality improvement activity

It was not possible to summarise all quality improvement activity which has taken place since the publication of these Reports within the scope of this exercise. It is recognised that further work has been undertaken, and is on-going and is acknowledged within our analysis and recommendations.

SECTION 5: RECOMMENDATIONS

Since the Reports were published there are a number of on-going quality improvement initiatives underway. While we acknowledge and commend this work, we also note that a number of other related reports, outwith the scope of the original remit of this exercise, have been published subsequently which would suggest that the systemic issues identified continue. These include a report on serious failings in care in Morecambe Bay (2015), an RCN Scotland report on continuing failings in care of older people in Scotland despite improvements in inspection (2015) and a recent General Medical Council report on bullying and harassment, based on 12 hospitals around the UK (2015). In addition, concerns have recently been raised about alleged bullying in some Scottish NHS Boards.

As such, it appears much still remains to be done and that the Scottish Government, Scottish Academy and related stakeholders should work collaboratively to implement the following recommendations for the benefit of patients.

Leadership

1. Loss of leadership at all levels has been a key feature in many of the recent reports on failing hospitals. The atmosphere within any institution is dictated by those at the top. Caring for and appreciating staff is at the core of this. Emphasising the importance of good communication comes with good leadership. A supportive, listening environment must be created to produce a culture which instils confidence in staff, patients and relatives and in which innovation is encouraged. This provides a conduit which facilitates dealing with complaints or concerns from all quarters.

2. The work of the Professionalism & Excellence Group in developing leadership capacity within NHS Scotland is recognised, but the Scottish Government, NHS Boards, Scottish Academy and related stakeholders should give greater priority and urgency to working collaboratively to support the implementation of the Group's recommendations. The Professionalism & Excellence Group should cross-check their current accountabilities and work plan in the context of the recommendations made in this report.

3. More medical staff should be encouraged to develop their careers in senior NHS management. Job plans should also be adjusted to enable senior clinical staff to develop management experience. There is now increasing recognition of the value of better understanding between clinical and management staff. It follows that even where senior clinicians are not part of management, ways should be developed for their voices to be heard at senior management level. Rotation of trainees to spend time in management and leadership training is to be applauded.

4. Boards should be encouraged to be pro-active when it comes to risk-assessment with respect to patient care.

Culture & Professional Engagement

5. The Scottish Government, NHS Boards and other stakeholders should work together to develop more meaningful performance indicators in relation to quality of care to ensure that implementation of the Quality Strategy and associated wider patient safety work is not compromised by a focus on financial or activity performance targets. The Scottish Academy should contribute to this work (see also 'Quality of Care & Patient Experience').

6. Action needs to be taken by NHS Boards to improve the working culture within the NHS and in particular to address the 'learned helplessness' which can be experienced by staff when poor standards of care are condoned and perpetuated due to a combination of organisational and external pressures and a sense that this cannot be changed at an individual level. All NHS Boards should be required to develop, publish and promote policies aimed at engaging staff, understanding and responding to professional concerns and valuing staff.

7. The Scottish Government should work together with the Scottish Academy, the General Medical Council and other stakeholders to foster a work culture in the NHS free from bullying and to support the introduction of measures in medical education and training designed to prevent the occurrence

of bullying and undermining behaviour in the workplace.

8. While the NHS had made some progress in providing channels for whistleblowing, much work requires to be done in creating a 'no blame culture' in which staff are encouraged to and fully supported in raising concerns, without recrimination or adverse impact upon their careers. This will require the involvement and support of all stakeholders.

Inadequate Staffing

9. The Scottish Government and NHS Boards should work together to develop minimum, safe staffing levels for all professions in hospital settings, providing the required skills mix and under appropriate supervision, so as to ensure that all patients receive safe and high quality care delivered by appropriately trained and experienced professional staff. These staffing levels should be based upon best evidence and take into account population variations. Priority should be given to developing minimum, safe staffing levels for Acute Medicine and Medicine for the Elderly wards. The Scottish Academy should actively contribute to this work.

10. The population being looked after now in hospital has changed radically over the past 15 years or so. Patients are more dependant and their cases more complex. Many have associated cognitive impairment or even established dementia. Staff numbers should reflect this and the new tools for determining numbers of trained and support staff should be rigorously applied.

11. Recognising that many of the workforce pressures are exacerbated by recruitment and retention problems, the Scottish Government and NHS Boards should give greater priority to reducing the reliance on locums and agency staff and working collaboratively with related stakeholders to make careers in the NHS more attractive, so as to provide a more sustainable workforce capable of responding to the future care needs of our population. The Scottish Academy should contribute to these initiatives through active participation in the StART Alliance, the work of the Scottish Government Shape of Training Transition Group and in strategic service redesign through the Sustainability and Seven Day Services Task Force.

12. Staff sickness in the NHS is increasing; this should be monitored by Occupational Health, as it can often be a sign of deteriorating morale within employees. It should be used to act as an early warning system within hospitals.

Quality of Care & Patient Experience

13. Quality of care must become the primary influence on patient experience and NHS Boards, a routinely discussed and acted upon agenda item at Board level and the primary indicator of performance (see also 'Culture & Professional Engagement').

14. Increased awareness of potential quality vacuums needs to be recognised, being created as a result of not just the imminent closure of a service or hospital but also when there exists the mere possibility. Policymakers also need to be mindful that in instances in which decisions to close hospitals have been reversed, the services may have degraded to a point below the required level to provide safe, quality care. This may also occur when hospitals are kept under constant review.

15. We recognise work has been done by the Scottish Health Council, NHSScotland and NHS Healthcare Improvement Scotland amongst others in relation to complaints handling. However, the Aberdeen Royal Infirmary Report (which emerged after some of these initiatives) suggests that more needs to be done to streamline and improve complaints procedures, to eliminate defensiveness, to reduce the emphasis on process and to increase the opportunity for patients' complaints to be encouraged, openly and sensitively reported, and considered independently. Attention should be paid to the pertinent recommendations of the *Freedom to Speak Up Report* http://freedomtospeakup.org.uk on whistleblowing.

16. The principles of the Quality Strategy to deliver safe, person-centred and effective care are supported. All stakeholders need to encourage and support more patient-centred healthcare through appropriate and empathetic communication with patients and their relatives by all staff.

External Review

17. The Royal Colleges have considerable expertise to undertake external, independent, reviews where concerns arise about standards of care and performance. This resource should be developed further, but in doing so it is essential that confidentiality is maintained, where appropriate, so as to encourage full and open professional engagement and disclosure in such reviews and that the findings of the external reviews are acted upon promptly to maintain public, professional and political confidence in the process.

18. A common methodology should be developed and used nationally for investigating serious failings in NHS care, culture, operational activity/practice and performance to eliminate potential bias, maintain confidence, ensure transparency and consistency, increase triangulation with other available data and to include monitoring and review.

19. Failings should not be viewed as isolated, localised incidents and reported on without reference to failings in other parts of Scotland and throughout the UK. It is clear such an approach has led to missed opportunities to learn valuable lessons from other parts of the NHS. When Inquiry or Review reports are published and are of national significance, all Boards should be required to demonstrate their compliance with the recommendations.

20. Trainee doctors have a unique perspective as they rotate around units and give regular feedback to General Medical Council surveys; consistently poor performance in training surveys should trigger an investigation not only of the training practices, but of the overall culture, patient safety environment and workload of unit.

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Scottish Academy Working Group on Hospital Reports: Member Response/Actions Matrix

The following summary is based upon information supplied by Member Colleges and Faculties; where no responses to requests for information were received, searches of websites were conducted to access publicly available information. It is also recognised that the members of Scottish Academy are involved in a range of standard-setting activities on an on-going basis, not detailed below, and that the majority of members of the Academy of Medical Royal Colleges of the UK participated in a workshop to identify shared priorities post-Francis.

Member	Mid Staffs Response	Lanarkshire Response
Faculties of Dental Surgery	N/A	N/A
Faculty of Occupational Medicine	• Endorsed NHS Health at Work statement (http://www.nhshealthatwork.co.uk/news-latest.asp?info=FrancisReportResponse)	No
Faculty of Public Health	• UK response (detailed) (http://www.fph.org.uk/uploads/FPH%20Full%20Response%20to%20Francis%20Inquiry%20-%20FINAL.pdf)	No
Royal College of Anaesthetists	• UK press statement (https://www.rcoa.ac.uk/node/11829) • Audit Compendium was re-written (2012) to focus on Quality Improvement and Patient Safety (http://www.rcoa.ac.uk/document-store/audit-recipe-book-3rd-edition-2012) • Anaesthesia curriculum now contains a specific module on science, safe and reliable systems	No
Royal College of Emergency Medicine	• UK statement to Fellows and Members • UK Safety Checklist for Emergency Departments (against Francis recommendations) (http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Francis%20Inquiry%20Report)	No
Royal College of General Practitioners	• UK position statement (detailed) (http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Response-to-Francis-Recommendations.ashx)	No
Royal College of Obstetricians and Gynaecology	• UK 'manifesto for change' (https://www.rcog.org.uk/globalassets/documents/news/rcog_manifesto_francis.pdf)	No
Royal College of Ophthalmologists	• UK response (detailed)	No
Royal College of Pathologists	• UK press statement (http://www.rcpath.org/Resources/PDF/Francis%20report%20-%20media%20statement%205.02.13.pdf)	No

Vale of Leven Response	Aberdeen Response	Other
N/A	N/A	N/A
No	No	No
No	No	No
No	No	• On-going operation of Safe Anaesthesia Liaison Group • Guidelines for the Provision of Anaesthetic Services updated (http://www.rcoa.ac.uk/GPAS2014)
No	No	No
No	No	No
No	No	No
No	No	No
No	No	No

Member	Mid Staffs Response	Lanarkshire Response
Royal College of Physicians and Surgeons of Glasgow	• Detailed response (internal) • Lay Advisory Board report and 5 priorities identified by each LAB member (internal)	• Press statement (https://www.rcpsg.ac.uk/news/latest/review-of-care-in-nhs-lanarkshire.aspx)
Royal College of Physicians of Edinburgh	• Press statement (http://www.rcpe.ac.uk/press-release/rcpe-warns-nhs-has-lost-focus-mid-staffordshire-deaths-risk-being-repeated-any) • Editorial in JRCPE / RCPE response to Mid Staffordshire (http://www.rcpe.ac.uk/journal/issue/journal_43_1/dewhurst.pdf) • Policy response to DoH consultation on strengthening corporate accountability in health and social care (http://www.rcpe.ac.uk/consultation-response/strengthening-corporate-accountability-health-and-social-care-consultation) • Policy response to DoH consultation on the Introduction of a Duty of Candour (http://www.rcpe.ac.uk/consultation-response/introducing-statutory-duty-candour-consultation-proposals-introduce-new-cqc) • Policy response to DoH consultation on new offence of ill treatment or wilful neglect (http://www.rcpe.ac.uk/consultation-response/new-offence-ill-treatment-or-wilful-neglect-consultation-document) • Policy response to GMC/NMC consultation on Duty of Candour draft guidance (http://www.rcpe.ac.uk/consultation-response/openness-and-honesty-when-things-go-wrong-professional-duty-candour-public)	• Press statement (http://www.rcpe.ac.uk/press-release/rcpe-comment-rapid-review-acute-care-nhs-lanarkshire) • • Lay Advisory Committee report (main priorities) (internal)
Royal College of Psychiatrists	• Occasional paper based upon analysis of Francis report and providing formal (detailed) response – Driving quality implementation in the context of the Francis report (http://www.rcpsych.ac.uk/files/pdfversion/OP92.pdf)	No

Vale of Leven Response	Aberdeen Response	Other
• Press statement (link unavailable)	• Press statement (https://www.rcpsg.ac.uk/news/latest/nhs-grampian-patient-care-reviews.aspx)	• Press statement on Introduction of Radical Changes to the NHS in England (https://www.rcpsg.ac.uk/news/latest/introduction-of-radical-changes-to-the-nhs-in-england.aspx)
		• Press statement in response to and endorsing RCPE editorial on serious failings in care (https://www.rcpsg.ac.uk/news/latest/safe-staffing-levels-needed-to-avoid-failings-in-patient-care.aspx)
• Press statement (http://www.rcpe.ac.uk/press-release/rcpe-comment-vale-leven-report)	• Press statement (http://www.rcpe.ac.uk/news/rcpe-comment-nhs-grampian-care-reviews)	• Outgoing President's, Dr Neil Dewhurst's, statement on the NHS (http://www.rcpe.ac.uk/press-release/outgoing-presidents-dr-neil-dewhurst-statement-nhs)
		• 'Preventing "where next?"' Editorial and press statement on serious failings in care (http://www.rcpe.ac.uk/sites/default/files/bell_final.pdf) (http://www.rcpe.ac.uk/press-release/preventing-where-next-political-parties-urged-commit-minimum-staffing-prevent-serious)
		• Press statement on whistleblowing in the NHS (http://www.rcpe.ac.uk/press-release/rcpe-comment-whistleblowing-nhs)
		• Evening Update meeting
No	No	No

Member	Mid Staffs Response	Lanarkshire Response
Royal College of Radiologists	• UK press statement supporting AoMRC statement (https://www.rcr.ac.uk/sites/default/files/RCR_response_Francis_Report.pdf) • Follow-up UK press statement reporting that RCR has analysed the recommendations and identified where it can act (https://www.rcr.ac.uk/sites/default/files/RCR%20Francis%20statement%20260313.pdf)	No
Royal College of Surgeons of Edinburgh	• Visited Stafford Hospital before report was published • Press statement supporting AoMRC statement (http://www.rcsed.ac.uk/the-college/news/2013/february-2013/francis-report.aspx) • Press statement commenting on Government's response to Francis report (http://www.rcsed.ac.uk/the-college/news/2013/november-2013/post-francis-discussions.aspx) • Representation on Clinical Advisory Group to the Trust Special Administrators for Stafford and Cannock Chase hospitals • Blog and newsletter articles • Established working groups on raising concerns within the NHS and bullying and harassment (trainees) • Policy consultation response to Berwick Report • Policy consultation response to 'Freedom to speak up' review	• Attended meeting in relation to conduct in NHS Lanarkshire
Trainee Representative - SATDG Chair	No	No
Observers		
BMA Scotland	• UK press statement in response to Francis report (http://web2.bma.org.uk/pressrel.nsf/wall/BA741F9A3A2BE6D580257B3A0052B27D?OpenDocument) • UK press statement in response to Government's response to Francis report (http://web2.bma.org.uk/pressrel.nsf/wall/AD322127FD2621DC80257C2800495EA6?OpenDocument)	• BMA Scotland press statement (http://web.bma.org.uk/pressrel.nsf/wall/78F491878E4F63E080257C4400603560?OpenDocument)

Vale of Leven Response	Aberdeen Response	Other
No	No	No
• Responded to Scottish Government consultation on Vale of Leven	No	• Hosted event on Professionalism and Excellence in Scottish Healthcare • Website statement supporting RCPE editorial on serious failings in care
No	No	• Contributed to Professionalism and Excellence in Scottish Medicine Group • Initiated annual SATDG symposium on Professionalism • Original statement produced for WG exercise
• BMA Scotland press statement (http://web.bma.org.uk/pressrel.nsf/wall/59D8B662BE8C557D80257D9A0058E2BF?OpenDocument)	• BMA Scotland press statement (http://bma.org.uk/news-views-analysis/news/2014/december/call-to-lead-hospital-out-of-cultural-difficulty)	No

Member	Mid Staffs Response	Lanarkshire Response
UK Academy	• UK press statement (http://www.aomrc.org.uk/general-news/academy-responds-to-government-statement-on.html) • Convened a workshop attended by all AoMRC members to identify shared priorities post-Francis	No
Other		
RCN and RCN Scotland	• The RCN, at a UK level, produced a very detailed response (72pp) to the Francis Report which had criticised the RCN and recommended splitting its employee representation and professional functions. The RCN proposed a number of actions, including strengthening education, leadership and the introduction of legally binding safe nursing levels (http://www.rcn.org.uk/__data/assets/pdf_file/0004/530824/francis_response_full_FINAL.pdf) • In April 2013 the RCN (at a UK level) published a report 'Nursing on red alert', as part of its Frontline First campaign, which highlighted a number of warning signs in nursing post-Francis and made recommendations regarding improving workforce planning, protecting nursing posts from cuts and safe nursing levels (http://www.rcn.org.uk/__data/assets/pdf_file/0003/518376/004446.pdf)	No
General Medical Council	• UK press statement (http://www.gmc-uk.org/news/14380.asp) • GMC/NMC consultation on Duty of Candour draft guidance	No
NHS Tayside		

Vale of Leven Response	Aberdeen Response	Other
No	No	No
• RCN Scotland press statement (http://www.rcn.org.uk/newsevents/news/article/scotland/vale_of_leven_public_inquiry_rcn_scotland_response)	No	• In March 2015 RCN Scotland published a report 'Amber warning: RCN briefing on care of older people in hospitals in Scotland' which reported that despite improvements in national inspection, problems in relation to standards of care for older people continued and hospitals were still struggling to learn from each other (http://royalnursing.3cdn.net/35f4c04ab8b473edb0_k9m6idhsv.pdf) • RCN Scotland convened 4 Integration Seminars under Chatham House rules (high level workshops attended by Directors of Nursing and funded by the Scottish Government) on Integrated Commissioning (http://www.rcn.org.uk/__data/assets/pdf_file/0018/600462/Report_of_the_RCN_Chatham_House_Commissioning_event_1_July_2014.pdf) • Care & Clinical Governance (http://www.rcn.org.uk/__data/assets/pdf_file/0017/600461/Report_of_the_RCN_Chatham_House_Care_and_Clinical_Governance_event_Sept_2014.pdf) • Nursing leadership in integration (http://www.rcn.org.uk/aboutus/scotland/professionalissues/scotland_integration/?a=606425) • Integrated workforce planning (http://www.rcn.org.uk/__data/assets/pdf_file/0008/616229/Report-of-the-RCN-Chatham-House-event-on-workforce-Feb-2015-Final.pdf)
No	• Letter to Scottish Academy	No
• Mapping exercise of infection control practices against Vale of Leven report recommendations		