LEARNING FROM SERIOUS FAILINGS IN CARE

EXECUTIVE SUMMARY & RECOMMENDATIONS

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

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.

A A Paterson

Prof Alan A Paterson OBE

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

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INTRODUCTION

In December 2014 the Academy of Medical Royal Colleges & Faculties in Scotland (Scottish Academy) established a short-life working group to review the four hospital reports on serious failings in care in Mid Staffordshire, Lanarkshire, the Vale of Leven and Aberdeen.

The working group comprised of:

Prof Alan Paterson OBE, Director, Centre for Professional Legal Studies, Strathclyde University (Chair)

Prof 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 & Surgeons of Glasgow and Vice Chair, Scottish Academy

FINDINGS

The working group reviewed the four reports and the subsequent responses of the Colleges and the Scottish Government. In doing so, they identified the following Key Issues which contributed to the serious failings in care –

- poor leadership from senior staff often resulting in a defective culture (disconnect with Management and lack of visible and appropriate leadership)
- poor leadership from Board Management frequently resulting in a defective culture (inappropriate targets, lack of pro-activity and poor accountability mechanisms)
- staff shortages, an inappropriate skills mix on the team, inappropriate use of inexperienced staff or failure to supervise
- poor staff morale and motivation
- poor dealings with patients (inadequate care and poor communication)
- inadequate complaints handling (poor feedback and complaints mechanisms, and inhibition to whistleblowing)
- limitations of external assessments of the hospitals (remit and nature of Reports, composition of the review teams, inappropriate methodologies, omissions, unclear follow-up and questions of confidentiality and disclosure)

In order to ensure that the NHS in Scotland, and throughout the rest of the UK, learns lessons from these serious and repeated failings in care, the working group has made 20 recommendations covering these key areas which we urge all stakeholders to work collaboratively to implement for the benefit of patients.

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.

Academy of Medical Royal Colleges and Faculties in Scotland

The Academy of Medical Royal Colleges and Faculties in Scotland – known as the 'Scottish Academy' – contributes to improvements in the health of the people of Scotland by the promotion and co-ordination of the work of the Medical Royal College and Faculties and giving the medical professions a collective voice on clinical and professional issues.

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