

Academy of Medical Royal Colleges & Faculties in Scotland  
News Release  
9 July 2015

## **ROYAL COLLEGES URGE ACTION TO ADDRESS SYSTEMIC FAILINGS IN NHS CARE**

The Academy of Medical Royal Colleges in Scotland has today (10 July 2015) published a series of major recommendations aimed at addressing systemic failings in NHS care in Scotland, evidenced in recent reports on hospital deficiencies, which it believes have been predominantly caused by the failure of clinical staff and NHS management to work together to deliver improved healthcare. Central to the recommendations are the urgent need to engender more effective team working, to place quality of care ahead of targets, to ensure appropriate staffing levels and to end the culture of “learned helplessness” experienced by staff when poor standards of patient care are condoned and perpetuated due to a combination of pressures.

Between December 2013 and December 2014 three reports were published into serious failings in care and management failings within the NHS in Scotland - in NHS Lanarkshire, the Vale of Leven Hospital and Aberdeen Royal Infirmary. These followed the publication of a similar report into serious failings in care in Mid Staffordshire in England. Against this background, the Academy of Medical Royal Colleges & Faculties in Scotland established a Working Group to review these reports and to determine whether there were any common themes to emerge from them and if so, how they might best be addressed. The Working Group was chaired by Prof Alan Paterson OBE, Centre for Professional Legal Studies, Strathclyde University, and contained senior experts from the Royal Colleges in Scotland. In addition to reviewing these reports, the Working Group has taken into account a number of other related reports published more recently which suggest the systemic issues identified in these four reports continue and require action [1, 2]. The Working Group’s findings and recommendations are published today in a new report entitled ‘Learning from serious failings in care’ [3].

### **KEY FINDINGS**

Key issues which contributed to the serious failings in care include –

- poor leadership at all levels (including senior clinical staff and management) resulting in a defective culture, a disconnect between clinical staff and management, inappropriate targets 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); and
- limitations of external assessments (remit and nature of the reports, composition of the review teams, inappropriate methodologies, omissions, unclear follow-up and questions of confidentiality and disclosure).

### **RECOMMENDATIONS**

The report makes 20 recommendations in the areas of Leadership, Culture & Professional Engagement, Inadequate Staffing, Quality of Care & Patient Experience and External Review, including -

- 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;
- **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**;
- **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;
- **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;
- 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 which is free from bullying**;
- 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;
- **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; and
- **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.

**Prof Alan Paterson OBE, Chair of the Scottish Academy Short Life Working Group on Hospital Reports and Director, Centre for Professional Legal Studies, Strathclyde University, said,**

“It is clear that serious failings in team working between clinical staff and NHS management played a significant role in the failings in care identified. These failings are deep-rooted and systemic. They must not be ignored if we are to learn from them and to prevent repetition. It is also clear that a combination of factors led to some appalling failings in care, a loss of basic compassion and the prioritisation of inappropriate targets over patient care. In addition, leadership and accountability were all too often sadly lacking and bullying endemic. While there have been responses to the individual published reports of inquiries and reviews into failings in care, there is little evidence to suggest that we are tackling the underlying systemic failings which exist. This includes recognising and acknowledging the commonality between the events in Mid Staffordshire and the incidents in Scotland. Opportunities to learn and prevent recurrence have been missed and this must change for the sake of patients.”

**Mr Ian Ritchie, Chair of the Academy of Medical Royal Colleges & Faculties in Scotland ('Scottish Academy'), and President, Royal College of Surgeons of Edinburgh, said,**

"The purpose of this report is not to denigrate any organisations or individuals. While recognising that a range of quality improvement work has been undertaken since the publication of the reports, we believe that much work remains to be done to improve the quality of care in Scotland. We recognise that as professionals we have a responsibility to do more to prevent further failings in care and we have accepted all of the recommendations in this valuable report. However, this cannot be done by any one group. Clinical staff and management must work more effectively together as teams. They must also be supported in doing so by ending the focus on inappropriate targets and making quality of care our over-riding priority."

ENDS

Contact: Graeme McAlister on 0131-247-3693 or 07733-263453

**Notes to Editors**

- [1] The Academy of Medical Royal Colleges & Faculties in Scotland (also known as the 'Scottish Academy'), is comprised of representatives of all of the Medical Royal Colleges and Faculties in the UK. It 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.

<http://www.scottishacademy.org.uk/>

**Membership of the Scottish Academy Short Life Working Group on Hospital Reports -**

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

- [2] In addition to reviewing the reports into failings in care in Lanarkshire, Vale of Leven, Aberdeen and Mid Staffordshire, the Working Group has taken into account the following more recent reports – a Royal College of Nursing Scotland report on continuing failings in care of older people in Scotland despite improvements in inspection (2015), reports into serious failings in care in Morecambe Bay (2015) and Barts NHS Trust (2015), General Medical Council reports on undermining in Ninewells hospital (2014) and undermining and bullying in medical education and training (2015) and recent reports of alleged bullying in several Scottish NHS Boards (2015).
- [3] Learning from serious failings in care, Scottish Academy Short Life Working Group on Hospital Reports, May 2015. Copies of the report can be obtained from Graeme McAlister – [g.mcalister@rcpe.ac.uk](mailto:g.mcalister@rcpe.ac.uk)/0131-247-3693 or 07733-263453

[4] Journalists wishing to interview Prof Alan Paterson and Mr Ian Ritchie should contact Graeme McAlister