Aberdeen Royal Infirmary: Short-Life Review of Quality and Safety

December 2014
Healthcare Improvement Scotland is committed to equality. We have assessed the review process for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

© Healthcare Improvement Scotland 2014

First published December 2014

The publication is copyright to Healthcare Improvement Scotland. All or part of this publication may be reproduced, free of charge in any format or medium provided it is not for commercial gain. The text may not be changed and must be acknowledged as Healthcare Improvement Scotland copyright with the document’s date and title specified.

www.healthcareimprovementscotland.org
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of figures</td>
<td>4</td>
</tr>
<tr>
<td>1 Executive summary</td>
<td>5</td>
</tr>
<tr>
<td>2 Recommendations</td>
<td>13</td>
</tr>
<tr>
<td>3 Context</td>
<td>18</td>
</tr>
<tr>
<td>4 The short-life review: structure, scope and methodology</td>
<td>22</td>
</tr>
<tr>
<td>5 Patient outcome</td>
<td>29</td>
</tr>
<tr>
<td>6 Patient experience data</td>
<td>39</td>
</tr>
<tr>
<td>7 Complaints management</td>
<td>43</td>
</tr>
<tr>
<td>8 Leadership and culture</td>
<td>52</td>
</tr>
<tr>
<td>9 Governance and accountability</td>
<td>65</td>
</tr>
<tr>
<td>10 Staff governance</td>
<td>75</td>
</tr>
<tr>
<td>Appendix 1 – Key lines of enquiry</td>
<td>93</td>
</tr>
<tr>
<td>Appendix 2 – Interviews and focus groups</td>
<td>94</td>
</tr>
<tr>
<td>Appendix 3 – Clinical areas visited</td>
<td>95</td>
</tr>
<tr>
<td>Appendix 4 – Review team</td>
<td>97</td>
</tr>
<tr>
<td>Appendix 5 – Expert advisory group</td>
<td>99</td>
</tr>
<tr>
<td>Appendix 6 – Unannounced inspection of the care for older people in acute hospitals: Aberdeen Royal Infirmary and Woodend Hospital – areas identified for improvement</td>
<td>100</td>
</tr>
<tr>
<td>Appendix 7 – Glossary</td>
<td>103</td>
</tr>
</tbody>
</table>
List of figures

Figure 1: NHS Grampian executive structure. 20

Figure 2: Standardised Mortality Ratio for intensive care units and combined units. 2013 data. 30

Figure 3: Hospital Standardised Mortality Ratio (HSMR), for deaths within 30 days of admission to hospital. Data presented by hospital of admission. April–June 2014. 31

Figure 4: Hospital Standardised Mortality Ratio (HSMR), for deaths within 30 days of admission to hospital. Data presented for Aberdeen Royal Infirmary. October–December 2007 to April–June 2014. 31

Figure 5: Rate of Staphylococcus aureus bacteraemia infections. Data presented by NHS board. 1 April 2014–30 June 2014. 32

Figure 6: Incidence rate of Clostridium difficile infections in patients aged ≥65 years. Data presented by NHS board. 1 April 2014–30 June 2014. 32

Figure 7: Percentage of patients treated within 4-Hour Emergency Care Standard. Data presented for Aberdeen Royal Infirmary and Scotland. Data for July 2007–September 2014. 33

Figure 8: Percentage compliance with Treatment Time Guarantee. Data presented for NHS Grampian and Scotland. October 2012–June 2014. 34

Figure 9: Patient Service Score. Data presented for NHS Grampian. Data collected since July 2013. 40

Figure 10: Complaints sent to the Scottish Public Services Ombudsman prematurely: complaints upheld by the Scottish Public Services Ombudsman. 45

Figure 11: Overall Medical Engagement Scale results compared to other NHS organisations. 53

Figure 12: Specialties within the highest and lowest ranges of medical engagement. 53

Figure 13: Whole-time equivalent nursing staff and costs 2009–2010 to 2012–2013. 75

Figure 14: Ratio of hospital nursing staff in post (Agenda for Change bands 1-9) to average available staffed beds for all acute specialties. Data for NHS boards 76

Figure 15: Nursing whole-time equivalents for funded establishment, actual staff in post and assessed establishment. 77

Figure 16: Hospital nurse vacancies (all bands) as a percentage of establishment. Data for NHS boards. Data for January–March 2014. 80

Figure 17: Number of consultant vacancies as a percentage of establishment. Data for NHS board. January to March 2014. 83

Figure 18: Trainee rota monitoring. 87
1 Executive summary

This executive summary presents the findings of the short-life review of quality and safety in Aberdeen Royal Infirmary.

The review team considered a large amount of evidence in reaching its findings and recommendations. We spoke with a wide range of staff, patients and carers, and drew on national data and information provided by NHS Grampian. A survey of medical staff and managers was also undertaken and considered alongside the results of recent surveys by the General Medical Council (GMC) and NHS Education for Scotland (NES) of doctors in training at Aberdeen Royal Infirmary.

We are extremely grateful for the openness of staff throughout the review. It is clear that most staff spoken with had a sense of pride regarding Aberdeen Royal Infirmary, but felt very concerned that the prevailing leadership, cultural and operational difficulties were eroding both the hospital’s effectiveness and the goodwill of staff. We are also grateful for the assistance of patients and carers in describing their experiences.

Introduction

In March 2014, the chief executive of the NHS in Scotland invited the director of scrutiny and assurance of Healthcare Improvement Scotland to lead, alongside the medical director of NHS Lothian, a short validation exercise to review concerns that had been raised with the Cabinet Secretary for Health and Wellbeing.

The validation exercise identified a range of concerns and issues. These included:

- the relationship between some senior medical staff and the NHS Grampian senior leadership
- the accountability, governance and performance management arrangements in acute services
- follow-through in translating strategy into operational delivery, and
- specific concerns about the quality and safety of key specialties.

The results from the validation visit were discussed with senior executives from NHS Grampian who subsequently invited Healthcare Improvement Scotland to undertake a detailed review of the leadership, culture, behaviours and values of Aberdeen Royal Infirmary. This included a review of how these factors impacted on the quality and safety of care. The review also looked at a number of specific areas including emergency medicine, general surgery, care of the elderly, obstetrics and gynaecology, and critical care.

Structure of review

Members of the review team visited Aberdeen Royal Infirmary and NHS Grampian on three occasions and spoke with approximately 530 members of staff of all disciplines and grades. The team also reviewed the following:

- a substantial amount of evidence from NHS Grampian
- a range of data from nationally available sources
An unannounced inspection of the care for older people in acute hospitals was undertaken at Aberdeen Royal Infirmary and Woodend Hospital from 6–10 October 2014.

The Royal College of Surgeons (England) (RCS) also undertook a review of general surgery in September 2014, at the invitation of NHS Grampian, and they shared their summary findings with us.

We are grateful to the many members of staff who took time to be interviewed or provided data and information to inform the review. We are also grateful to patients and their carers and visitors who shared their experiences with us.

While not exhaustive, the data, feedback from staff and patients, and direct observation has allowed us to form a comprehensive picture of the issues identified through the validation exercise in Aberdeen Royal Infirmary.

Findings

Our primary purpose was to form an objective and independent view on the quality and safety of care delivered in Aberdeen Royal Infirmary.

We found sufficient evidence from national comparative audits and benchmarking to confirm that patients achieve broadly similar outcomes in Aberdeen Royal Infirmary compared to similar patients in other Scottish hospitals. We also noted from the recent national survey of inpatients that Aberdeen Royal Infirmary provides a quality of care that patients rate as highly as care delivered in any other Scottish hospital.

Through this review process we found examples of good and also poor patient care. We found dedicated and hard working individuals, particularly those in frontline roles, who are committed to delivering the highest standard of healthcare to the people of Grampian. However, we are concerned that many aspects of the current working arrangements, particularly those dependent upon goodwill, will be unable to meet future demands on the system. The potential for patient care and safety to be further compromised is overwhelmingly evident in the findings of this report.

We found a range of areas requiring improvement and have made a number of recommendations. The report outlines these recommendations and aims to help NHS Grampian to meet its ongoing commitment to providing a high quality and safe system of care.

Throughout the report, we have used examples that staff have provided us. These examples have only been included where they are representative of a general theme.
Patient outcome data

Patient outcome data did not show consistent or widespread concerns about patient safety at Aberdeen Royal Infirmary. However, there is a need to ensure effective action in addressing current shortcomings in systems and governance to prevent potential future harm to patients.

When viewed as a whole, the data do not highlight consistent or widespread concerns about the quality of patient care at Aberdeen Royal Infirmary. Aberdeen Royal Infirmary is not significantly different from the Scottish average for a range of established measures about the quality and safety of patient care.

It is recognised that high level data are not always sensitive to the underlying risks, and are retrospective. The Berwick report\(^1\) highlighted the danger of relying on aggregated data and the importance of understanding what is happening ‘on the frontline’. We found a range of issues that considerably reduce quality and safety, and that are mitigated through the actions of talented and dedicated frontline staff. The inspections carried out in departments during the unannounced inspection of the care of older people in acute hospitals identified sufficient incidents to raise concern about the system of care. Relying on individual dedication to compensate for poor systems is inappropriate and carries unacceptable risk.

Leadership and culture

There have been weaknesses in the leadership and management of the Board, the executive team and the senior management team, in respect of Aberdeen Royal Infirmary. A small number of consultants have acted to undermine management and have exhibited poor behaviour.

We found a number of issues relating to leadership and culture which reduce the quality and safety of care. There is an urgent need for NHS Grampian to address these in order to ensure safe care. Some specific examples are listed below, but we have concerns about the leadership, culture and behaviours witnessed throughout the organisation.

- The Board was insufficiently aware of several of the problems facing Aberdeen Royal Infirmary, specifically in relation to the emergency department and the poor reports from doctors in training.

- The culture within Aberdeen Royal Infirmary varies considerably from department to department. We saw good collaborative working within a number of departments, most notably in care of the elderly. However, in a number of other departments, we heard of low morale, disengagement from management, a forceful style of management which some staff perceived to be bullying, poor supervision and education for doctors in training.

- We confirmed there are very poor relations between some senior medical staff and management at all levels. This is in part due to poor management visibility, communication and engagement with medical staff. But it is also a result of unprofessional behaviour of some medical staff which has not been resolved. We were particularly concerned about the behaviour of a minority of consultants in general surgery, a department we had specifically been asked to include in the review. The failure of management to resolve these issues has had an adverse effect on morale, team working and patient care.

---

\(^1\) Berwick review into patient safety (August 2013)
There are serious issues within the emergency department, another area specifically included in the review. Concerns about staff behaviour, the lack of engagement from a small number of consultants, and a lack of confidence in the leadership’s ability to resolve the situation has compounded matters further. Whilst plans to address a number of these issues have been presented to the NHS Grampian Board at recent meetings, the present situation is not sustainable and the efforts to resolve it have so far been unsuccessful.

We also heard examples of unprofessional and unacceptable conduct which had not been addressed, open and aggressive criticism of the work of other staff and poor communication between professionals. There was a belief amongst some senior medical staff that hospital policies did not apply to them. Such behaviour is contrary to the values and behaviours expected of all staff employed within NHSScotland.

Annual job planning is a requirement of the 2004 Consultant Contract. The documentation supplied by NHS Grampian showed that only 60% of consultants had completed job plans at 15 July 2014 and this is a recurrent problem. We heard that senior consultants in general surgery had actively urged colleagues not to sign job plans. This is unacceptable and should have resulted in managerial action.

One of the surgical units is significantly dysfunctional and there are serious allegations about individual consultants which must be resolved. We heard of serious and specific allegations regarding the performance and behaviour of individual consultants in general surgery from other consultants within this department. The RCS also noted these concerns during their review carried out in September 2014. NHS Grampian has known about these concerns for several months, but has been unable to resolve them. It is not the role of Healthcare Improvement Scotland, nor we understand of the RCS, to investigate concerns about alleged misconduct by individuals. We have recommended that NHS Grampian undertakes an urgent investigation to establish the facts to inform the need for further action.

We also identified serious issues with the flow of patients through the hospital. Difficulties in transferring patients from the emergency department to wards was a recurrent theme in our interviews with staff. The most recent response from senior management to the serious problems that exist was to issue a letter to all consultants seeking to impose new and controversial arrangements, rather than consulting with them and by negotiation, gaining common agreement to an effective plan.

The issues with lack of clarity of management and leadership have made consultants reluctant to take on formal management roles. Those who have done so have sometimes been undermined by their peers. Failure to resolve this leads to increasing disengagement between clinicians and managers.

There is a need for senior managers to take concerns raised by clinicians seriously and to develop effective change management strategies. The majority of consultants in Aberdeen Royal Infirmary maintain high standards of conduct and professionalism, and are committed to continually improving standards within the hospital. This ‘silent’ majority needs to be listened to more and encouraged to participate. There is also a need for senior doctors to accept that managers have the right to manage and a legitimate expectation that clinicians co-operate with change.

The minutes of the medical staff committee suggest that this group sees itself as an alternative management structure rather than as an advisory body. This is not
appropriate. It was also not clear if the medical advisory structure sought views from the wider medical staff body. In particular, the consultant sub-committee did not seem to have an appropriately representative number of younger or female doctors on the committee.

**Governance and accountability**

Some systems of accountability, governance and performance management within Aberdeen Royal Infirmary are absent or weak and need to be improved.

- The executive team is seen as remote, except by some individuals who rely on personal contacts. The Aberdeen Royal Infirmary management team is also seen as remote by frontline staff. The system of leadership walkrounds did not remove this perception. The Aberdeen Royal Infirmary management team went four months without having a formal meeting. Minutes of the meetings which did take place suggested that the management team did not consider data or make meaningful decisions. There is little evidence of an effective performance management framework. All of this is of significant concern given the known issues with scheduled surgery, cancer waiting times, nurse staffing and the emergency department.

- The uncertainty about management structure and accountability has led to a reduction in the effectiveness of managers.

- A lack of clarity in the management structure is compounded by a lack of leadership at Board, executive and hospital management level. The executives gave the impression that they believe the problems that Aberdeen Royal Infirmary faces are in large part due to external factors and cannot be resolved by NHS Grampian management. We acknowledge the general challenges that face the NHS, and some particular challenges affecting NHS Grampian, but consider that the executive team should be leading work to mitigate these. This lack of leadership has contributed to the situation where a minority of staff have behaved poorly.

- Staff told us that there had been repeated restructuring of management. Individual managers at junior level are often not in post long enough to understand the department and its issues. Junior managers, and most clinical managers, have little or no decision-making authority. There is a general belief that when decisions are escalated to hospital or Board level management, decisions are either not made or not communicated. We heard multiple comments about emails and letters to managers raising important concerns going unanswered and unaddressed. It was a frequently expressed view that actions were not taken until a crisis was imminent, and then senior managers were drawn in to “fire-fight” and that responses were “knee jerk”.

- We heard concerns about the lack of learning from reviews of complaints, adverse events and the General Medical Council training reports. We felt there was minimal evidence that the clinical governance structures resulted in learning from these sources being spread across the organisation. We also heard about some mortality and morbidity meetings within general surgery being settings for clinicians to aggressively criticise others rather than forums to share learning. Individual behaviours of some consultants in these settings need to be addressed promptly.

- There are further concerns about governance included in the staff governance section below.
Staff governance

There are considerable staffing difficulties, particularly medical staffing within the emergency department, that require urgent attention to maintain safety.

- Throughout Aberdeen Royal Infirmary and Aberdeen Maternity Hospital, we found dedicated and hardworking individuals who are committed to delivering the highest standard of healthcare to the people of Grampian.

- However, there are considerable staffing difficulties, mostly relating to medical staffing within the emergency department at Aberdeen Royal Infirmary, that require urgent attention to maintain safety. These have been repeatedly raised by consultants in the department and to date the plans to address these have not been adequate. We acknowledge the difficulty nationally in recruiting at both consultant and senior trainee level in this specialty. The present arrangements, which depend on cover by registrars from other departments, who may not be trained in emergency or trauma medicine, are not sustainable and are considered by many staff to be unsafe.

- Members of the Board appear to have been unaware of the depth of the developing crisis in the emergency department, and this raises serious concern about the adequacy of governance.

- There are serious issues with nurse staffing, as evidenced by feedback from nurses and doctors that we spoke with and the findings from the care for older people in acute hospital inspection carried out in October 2014. As with some medical staff groups, there are national difficulties in recruitment, but NHS Grampian had planned reductions in nurse numbers over recent years (see Section 10). While NHS Grampian has tried to address recent issues through a prioritised investment programme, this has not yet produced the staffing levels and skills required.

- For a number of years, the annual survey of training doctors has revealed very poor results in some departments (although some departments have produced creditable results). These deficiencies have been known about for some time and require to be addressed effectively. Board members seem to have been unaware and some consultants complacent. As a result of the failure to address issues so far, the emergency department has now been escalated to ‘Enhanced Monitoring’ by the General Medical Council. There is a real risk that if service pressures are used to justify poor training, then trainees may be withdrawn, or fail to apply, resulting in significant consequences. Many medical staff members mentioned increasing difficulties in recruiting consultants. It is unsurprising that doctors who experience poor training and an unsupportive atmosphere choose to find consultant jobs elsewhere and do not recommend Aberdeen as a place to work to their peers.

Complaints management

The leadership and management of complaints is poor with evidence of defensiveness in some responses to complainants.

- We undertook a review of the handling of complaints to assess how NHS Grampian meets the expectations of legislation and related good practice guidance in ‘Can I Help You?’ Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services’ (Scottish Government, 2012). The complaints review found poor and delayed management of complaints and evidence of
defensiveness in some responses to complainants. Further training for those involved in addressing complaints would be helpful, as would a greater number of face to face meetings with complainants.

**Unannounced inspection of the care of older people in acute hospitals**

The unannounced inspection of the care of older people in acute hospitals resulted in one area of strength and 22 areas for improvement. These included:

- Woodend Hospital has a person-centred approach to patient care, particularly at mealtimes where food was served in a manner that ensured dignity and respect
- the management of patient flow and capacity in Aberdeen Royal Infirmary and Woodend Hospital is not fit for purpose and puts patient safety at risk
- senior nurse and medical leadership must regain the confidence of staff by addressing the issues of staffing, staff motivation, and patient flow and capacity
- ineffective discharge processes are affecting timely discharge
- the care provided in Aberdeen Royal Infirmary is only possible because medical and nursing staff commitment and dedication in repeatedly covering gaps in the system, and
- inconsistent documentation completed across the wards inspected relating to a number of key assessments.

The areas for improvement identified following this inspection are listed in Appendix 6 of this report. The full inspection report can be found at [http://www.healthcareimprovementscotland.org/opah.aspx](http://www.healthcareimprovementscotland.org/opah.aspx).

**In conclusion**

- Patient outcome data did not show consistent or widespread concerns about patient safety at Aberdeen Royal Infirmary. However there is a need to ensure effective action in addressing current shortcomings in systems and governance to prevent future harm to patients.
- A number of issues relating to staffing, leadership and management have the potential to impact on the quality and safety of care. They do not appear to have a detectable adverse impact at present, which is likely due to the hard work of dedicated and hard working frontline staff. The issues, which are outlined in detail in the report, are serious enough to warrant urgent attention to prevent any future adverse impact on patient care.
- There have been significant deficiencies in leadership and management in relation to Aberdeen Royal Infirmary.
- There is widespread disengagement of medical staff in Aberdeen Royal Infirmary and responsibility for this rests with both managers and doctors. There has been a lack of leadership within the organisation which has resulted in the failure to unite staff behind a common purpose. There is also disengagement among other professions in Aberdeen Royal Infirmary.
- Some systems of accountability, governance and performance management in Aberdeen Royal Infirmary are absent or weak, and need to be improved.
• NHS Grampian has great difficulty in translating strategy into change at Aberdeen Royal Infirmary, due in part to weaknesses in leadership and poor clinical engagement.

• There are considerable medical and nursing staffing difficulties, particularly medical staffing within the emergency department, that require urgent attention to maintain safety.

• National and locally collected data on patients and carers, report, on the whole, positive experiences of the care they received whilst at Aberdeen Royal Infirmary. This was supported through our work with the Scottish Health Council and through patient and carer conversations with public partners during the visits.

• There is a lack of clarity in the management structure which compounds the lack of leadership at executive and hospital management level.

• A small number of consultants have acted to undermine and disengage from management and have exhibited poor behaviour. It is unlikely that the optimum care for patients can be provided in the settings where this behaviour was most evident.

• There are significant weaknesses in how patient complaints are managed and ultimately responded to.

We have identified recommendations (see Section 2) and we expect that these recommendations will be used to provide guidance and support for those working in NHS Grampian to help them to deliver the necessary improvements.

We expect NHS Grampian to develop an action plan to implement the recommendations. It is important that the recommendations are carefully considered and a detailed improvement plan developed, with appropriate timescales, ownership, accountability and measures incorporated.
2 Recommendations

Patient outcome

1  
NHS Grampian executive team with senior staff in emergency department and other key stakeholders should develop a plan for a sustainable emergency department service that provides patients with safe, effective and person-centred care.

The plan should:

- be sustainable in terms of ability to recruit and retain medical staff
- recognise the reality that the emergency department requires senior input from specialist emergency medicine medical staff
- recognise that senior trainees will continue to be in short supply
- recognise that staff from other specialties whilst valuable in their own roles cannot be used to substitute for the expertise of senior emergency medicine medical staff
- recognise that senior trainees can make a valuable service contribution, but are also entitled to expect support and training that adheres to the appropriate GMC mandatory regulatory standards
- explore the potentially valuable contribution that can be made by non-medical staff, such as advanced nurse practitioners, while recognising that senior doctors leading care will always be required, and
- be approved and progress monitored by the Board.

2  
NHS Grampian executive team should work with senior clinical colleagues and local managers to review the management of unscheduled care across the hospital, with emphasis on the effective transfer of emergency patients from the emergency department to inpatient areas.

This will mean:

- recognising the complexity of the systems involved
- developing an effective system of flow of patients through the hospital that will improve patient care, reduce wastage of clinical time, and improve the quality of care for patients
- using visible leadership to ensure that all stakeholders involved sign up to agreed and defined protocols, and then work in line with the protocols, and
- working closely with health and social care partnerships to support effective discharge planning.

3  
NHS Grampian should ensure that the escalation policy for patients whose Scottish Early Warning System score is high is understood and implemented by all relevant clinical staff.

---

Patient experience data

4 NHS Grampian should continue to build on collecting real-time patient experience data ensuring this is done reliably and consistently across the services.

This work should include the following:

● continue to use patient feedback as a resource for continuous improvement
● ensure that collated patient feedback is passed on to staff to encourage improvement, and
● monitor progress so that agreed improvements are initiated within a reasonable timescale.

Complaints management

5 NHS Grampian should improve the way it investigates, responds to and learns from complaints.

This improvement should include:

● clear, unambiguous and effective leadership on complaints at senior/executive level and ensure that appropriate priority is given to continuously improving the approach of listening to and learning from complaints consistently across NHS Grampian’s acute services
● clarity and consistency in decision-making about whether a complaint has been upheld or not
● a more robust approach to the quality assurance of complaints management
● more face to face meetings between staff, patients and relatives to resolve complex complaints
● confirmation that clinical aspects of responses address the questions posed and that responses are clear and empathetic, and
● a way in which to build on the positive impact of a nominated post in acute services who can liaise with the feedback service and managers or clinicians to support good practice in the handling of complaints and learning from these.

Leadership and culture

6 NHS Grampian should carry out a fundamental review of the acute sector leadership with the emphasis on ensuring clear accountability and a delivery focus in respect of acute services and Aberdeen Royal Infirmary in particular.

These arrangements should include:

● an appropriate balance between structural redesign and establishment of effective leadership, whilst securing a strong focus on delivery of key objectives
● reporting lines, remits and performance of committees and individuals that are clear, unambiguous and regularly measured
● executive level professional leadership for escalation and governance of concerns regarding the currently disjointed and unclear workforce data
opportunities for leaders and managers at all levels of the organisation to be supported through training, their peers and the managerial hierarchy to fulfil their respective roles

- a review and revision of the medical management structure (medical director, divisional clinical directors, clinical directors and clinical leads) to ensure there is clarity and consistency of job role and purpose and include job descriptions, contracts objectives and resource, and

- a review and revision of the medical advisory structure to ensure appropriate, representative, valued and effective engagement and contribution. The final structure should be integral to the overall multidisciplinary professional advisory structure, and should not appear to operate outwith that professional advisory structure.

7 NHS Grampian should take urgent action to engage fully with all clinical and non-clinical staff.

The plan should:

- build on recent work to address engagement of clinicians
- acknowledge the large positive contribution made by the majority of staff, whilst addressing behaviours that undermine the organisation and where applicable adhere to GMC mandatory regulatory standards3
- specifically include work to address the issues identified in the Medical Engagement survey, and
- include a consistent, fair and comprehensive approach to dealing with adverse staff behaviour in all groups of staff.

Governance and accountability

8 NHS Grampian should introduce strong and effective governance mechanisms for the clinical, operational and managerial control of services at Aberdeen Royal Infirmary.

These mechanisms should include the following:

- a thorough examination of the effectiveness of the clinical governance function ensuring that it meets the expected objectives of NHS Grampian’s clinical governance strategy
- defined and clear roles and responsibilities of the management and advisory structure (see recommendation 6) to ensure appropriate involvement in the clinical governance function
- sufficient capacity, for the NHS Grampian Board members, to constructively challenge and to assert their position as a body focused on securing improved health outcomes for the population of NHS Grampian
- defined and clear strategic organisational objectives which link to the objectives of leaders and management of the organisation
- a clear and prioritised operational plan for the delivery of strategic objectives across

the acute sector, with accountability for delivery expressed

- a robust performance management framework to monitor delivery of the operational plan. The performance management framework should be based on data which should be routinely collected, distributed and used. Data will come from a variety of sources and should allow managers to share and learn from emerging themes and improve services. For example, adverse incidents, patient experience data and complaints
- arrangements for the acute management team to have regular meetings focusing on delivery, accompanied by minutes and action tracking of progress, and
- arrangements for the medical director to have regular meetings with the associate medical directors and divisional clinical directors accompanied by minutes and action tracking of progress.

**Staff governance**

9 **NHS Grampian should develop and implement a robust nursing workforce plan using mandated national workforce tools.**

These plans should include the following:

- detail on how to ensure that there are sufficient numbers of nurses with the appropriate skill mix at all times in all wards
- detail on how to fill the gaps, with defined dates and hierarchical ordering of wards
- be based on assessed priority. Through this process, nursing staff should be made aware of the most recent results of the national nursing workforce and workload tool
- consideration of the current bed model in the context of a 20% gap between staff establishment in-post and establishment-assessed-as-being-required, especially in the absence of a robust plan to successfully recruit and retain nursing staff, and
- opportunities to create learning and communication sessions with senior charge nurses regarding workforce requirements. This should include positive communication regarding the funded skill mix and patients-per-registered nurse-per-shift ratio.

10 **NHS Grampian should develop and implement a robust medical workforce plan.**

This plan should:

- have a significant focus on securing full recruitment, including anticipating retirals and proactively working to prevent gaps
- ensure that the experience of trainees in their training is consistently good so that they will be attracted to work in NHS Grampian after completing training
- ensure all consultants and specialty doctors complete a job plan review annually, and have an up-to-date job plan that explicitly and fairly outlines what is expected of them, and
- have a clear and consistent consultant appointment process that includes a list of desirable professional and behavioural characteristics for candidates.
11 NHS Grampian should ensure that the training of trainee medical staff is given a sufficiently high priority, ensuring that the General Medical Council and National Training Survey results are reviewed by the Board.

This arrangement should:

- ensure that adverse trainee survey results are noted and action plans produced to address them in line with the GMC’s mandatory regulatory standards\(^4\)
- monitor the progress of such action plans
- ensure that particular attention is paid to the current training experience in general surgery and emergency medicine, and
- ensure that trainee rotas are monitored and that valid returns are produced.

**Recommendations from the Royal College of Surgeons (England) and the unannounced Older People in Acute Hospitals inspection**

12 NHS Grampian should ensure that the recommendations made by the Royal College of Surgeons (England) following their visit in September 2014 are implemented in full.

13 NHS Grampian should work to address the areas of improvement outlined following the unannounced inspection of the care for older people in acute hospitals at Aberdeen Royal Infirmary and Woodend Hospital on 6–10 October 2014.

- The areas for improvement indentified following the inspection are listed in Appendix 6 of this report. The full inspection report can be found at [http://www.healthcareimprovementscotland.org/opah.aspx](http://www.healthcareimprovementscotland.org/opah.aspx).

\(^4\) [http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf](http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf) (Standards 7.2 and 7.3)
3 Context

3.1 This chapter briefly describes the operating and strategic context in Aberdeen Royal Infirmary. Throughout this report when we refer to Aberdeen Royal Infirmary, we also include Aberdeen Maternity Hospital.

Operating context

3.2 Aberdeen Royal Infirmary is a major teaching hospital, for which NHS Grampian has responsibility. The focus of this report is on Aberdeen Royal Infirmary.

3.3 Aberdeen Royal Infirmary is the major acute hospital in the north east of Scotland and provides healthcare for the population of Grampian and the northern isles. As a teaching hospital, it also plays a key role with the University of Aberdeen in scientific research.

3.4 Aberdeen Royal Infirmary is within the Foresterhill campus. It has approximately 900 staffed beds and a complete range of medical and clinical specialties. In November 2012, the new purpose-built emergency care centre opened, bringing together emergency and urgent care facilities into one building. There are 353 inpatient and day beds in the emergency care centre.

3.5 From 1 October 2013 to 30 September 2014, NHS Grampian employed 4,500 staff (excluding bank staff) at Aberdeen Royal Infirmary and 500 staff (excluding bank staff) at Aberdeen Maternity Hospital. Aberdeen Royal Infirmary has a budget of £272.7 million and Aberdeen Maternity Hospital a budget of £28.1 million.

3.6 As well as providing specialist services to the region, the hospitals are also the major provider of most routine hospital care to the local population. This includes healthcare provided on an outpatient and day care basis. Aberdeen Royal Infirmary had 46,595 inpatient admissions, 30,967 day cases and 308,326 outpatients between 1 October 2013 and 30 September 2014. For the same period, Aberdeen Maternity Hospital had 10,705 inpatient admissions and 38,326 outpatients.

Leadership and management arrangements

3.7 It is important to provide the leadership and management context for Aberdeen Royal Infirmary.

3.8 The acute sector in NHS Grampian consists of Aberdeen Royal Infirmary, Aberdeen Maternity Hospital, the Royal Aberdeen Children’s Hospital and Dr Gray’s Hospital in Elgin. The acute sector is overseen by an acute sector management team.

3.9 The acute sector management team is led by the general manager (acute sector), associate director of nursing (acute sector) and the deputy medical director/clinical lead (acute sector). The acute sector management team oversees five operational divisions, each led by a similar team of divisional general manager, lead nurse and clinical director. The divisions have a management infrastructure consisting of unit operational managers, clinical nurse managers and specialty level clinical leads.

3.10 The general manager (acute sector) reports directly to the deputy chief executive. The deputy chief executive is the executive director responsible for the acute sector in NHS Grampian. The general manager (acute sector) has day to day operational management responsibility for Aberdeen Royal Infirmary.
3.11 The executive team led by the chief executive, is accountable for the management of the system of healthcare in NHS Grampian, which includes Aberdeen Royal Infirmary. The executive team includes the deputy chief executive, medical director, finance director, director of nursing and director of workforce. Figure 1 (see page 20) sets out the executive structure.

3.12 The executive team reports to the NHS Grampian Board. The Board, led by the non executive chair, has overall responsibility to ensure the efficient, effective and accountable governance of the local NHS system and in providing strategic leadership and direction for the system as a whole. The Board consists of non executives and executives appointed by the Cabinet Secretary for Health and Wellbeing. The Board operates within an assurance framework which delegates specific governance functions to Board sub-committees, including clinical governance, staff governance and audit.

**Performance**

3.13 Performance targets aim to ensure that NHS boards focus on making improvements in areas the Scottish Government has identified as priorities, to help to achieve its overall purpose and objectives. In recent years, the Scottish Government has reduced the number of HEAT targets and has committed to focusing more on outcomes. A number of HEAT targets continue to be monitored after their delivery date. These targets are then referred to as HEAT standards. Many of the HEAT targets relate to waiting times which over the past 10 years have been shortened to support patients being seen more quickly across a range of services. These targets have become more challenging for NHS boards recently.

3.14 The treatment time guarantee (TTG) was introduced on 1 October 2012 under the Patient Rights (Scotland) Act 2011. All eligible patients now have a legal right to receive planned inpatient or day case treatment within 12 weeks of the treatment being agreed. NHS Grampian has not met this target since December 2012, with performance below that of NHSScotland as a whole.

3.15 Urgent referral to first treatment for patients who are diagnosed with cancer should be no more than 62 days. For the year end to March 2014, NHS Grampian has not met this target, with performance below that of NHSScotland as a whole.

3.16 Since April 2013, NHS boards have been working to the target that no patient should wait in hospital for more than 28 days from when they are clinically ready for discharge (reduced from 42 days previously). From April 2015, this is due to reduce further, to 14 days. NHS Grampian did not meet this 28-day target at the end of April 2014 (only three NHS boards met this target by the end of April 2014).
Figure 1: NHS Grampian executive structure.
Financial position

3.17 The majority of core funding for the NHS boards is allocated using the formula introduced in 2009 by the NHSScotland Resource Allocation Committee (NRAC). This covers funding for hospital and community health services and GP prescribing, which together cover around 70% of the NHS budget. The formula predicts a target share of the overall budget for each of the 14 territorial NHS boards. This target share is based on a weighted capitation that takes account of a number of factors that predict the need for healthcare including age, morbidity and life circumstances, and geographical factors that is aggregated across the entire NHS board population. Due to the combination of these factors in NHS Grampian relative to other NHS boards, the formula has consistently predicted a per capita share for NHS Grampian that is the lowest among NHS boards.

3.18 At the start of the financial year 2014/15 NHS Grampian’s core allocation was £34.7m less than the Board’s target NRAC share. NHS Grampian has recently confirmed an agreement with the Scottish Government which will increase the NHS board’s financial allocation by a total of £43m over the next 3 years. This uplift will bring NHS Grampian to within 1% of NRAC parity by 2016/17. NHS Grampian has stated that whilst it welcomes the positive commitment from the Scottish Government towards this financial parity, it highlighted that even at parity its funding share relative to other NHS boards is impacted by further issues of weighting.

3.19 The self-assessment produced by NHS Grampian and published ahead of its annual review with the Cabinet Secretary for Health and Wellbeing (originally scheduled to take place on 17 November 2014 but postponed until early 2015) states that:

“NHS Grampian remains the lowest funded NHS board per capita under the NRAC formula and our funding level remains below the parity level suggested by the formula. Our performance as an NHS board has been significant in the context of our funding position relative to all other Boards. We very much welcome the plan we have agreed with the Scottish Government to move towards a parity level. The resources that this will provide will enable us to invest in key clinical services in order to bring service provision up to comparable levels with other parts of Scotland and will help us to provide healthcare for the ever expanding population of Grampian.”

5 Financial Plan 2014/15 (update) paper to 1 August 2014 NHS Grampian Board meeting
4 The short-life review: structure, scope and methodology

4.1 The purpose of this report is to present the detailed findings against the issues and concerns highlighted to Healthcare Improvement Scotland. It also provides an agreed set of recommendations which NHS Grampian, with support, will implement over the coming months.

4.2 The findings and recommendations describe the consideration and verification of a range of sources of evidence including documents, statements, reports and conversations the review team had with the patients and staff at Aberdeen Royal Infirmary. The methods we employed during this review process allow us to be confident that what we have written reflects the beliefs of a number of staff throughout the organisation. It is vital that we sensitively include all of these views and perceptions in our report.

4.3 The review team is grateful for the welcome, hospitality and candour of patients, carers, members of the public and staff during this whole process.

Background

4.4 In March 2014, the chief executive of the NHS in Scotland invited the director of scrutiny and assurance of Healthcare Improvement Scotland to lead, alongside the medical director of NHS Lothian, a short validation exercise to review concerns that had been raised with the Cabinet Secretary for Health and Wellbeing.

4.5 The central approach to the validation exercise was to interview a range of individuals in NHS Grampian. Around 30 individuals were spoken with about their perceptions relating to the issues. On 31 March 2014, an initial verbal report was presented to the chief executive of the NHS in Scotland and other officials, and subsequently to the chair, chief executive and deputy chief executive of NHS Grampian.

4.6 The validation exercise identified a range of concerns and issues. These included:

- the relationship between some senior medical staff and the NHS Grampian senior leadership
- the accountability, governance and performance management arrangements in acute services
- follow-through in translating strategy into operational delivery, and
- specific concerns about the quality and safety of key specialties.

4.7 The validation visit identified:

“A fracture between the senior leadership and a strong and influential clinical community in NHS Grampian’s acute services. The roles and accountabilities of clinical directors were unclear and the visibility and engagement between the management and clinical staff could be improved. In particular there was a loss of confidence in the senior medical management in NHS Grampian by some senior clinicians.

“The review team had identified a lack of clarity in the lines of accountability and governance in acute services. This was expressed, for instance, by the bypassing of
structures and systems of governance by some individuals going directly to the chief executive to seek approval for their objectives. This sometimes led to a lack of clarity about who was actually ‘in charge’ and about how and why decisions were made. The management of waiting lists was a particular area that required improvement.”

4.8 In addition, “The review team observed a lack of shared values which impacted on the culture that was necessary to facilitate the Board’s ambitions for quality and safety of care. The work on the 2020 vision in NHS Grampian was important but needed to be more broadly owned.”

4.9 Given the short space of time, the validation visit did not examine in depth the range of issues raised. The team that conducted the validation visit believed that there were sufficient grounds to warrant a fuller and more considered examination of the issues raised.

4.10 Given the significance of the concerns identified, it was important that they were rigorously, systematically and independently followed up by the appropriate agencies. Therefore, NHS Grampian invited Healthcare Improvement Scotland to carry out a short-life review of the quality and safety of care in Aberdeen Royal Infirmary.

4.11 On 6 June 2014, the short-life review was announced and the terms of reference for the review were published on the Healthcare Improvement Scotland website.

Scope of the short-life review

4.12 As the chief executive of NHS Grampian had invited a service review, the terms of reference were agreed between Healthcare Improvement Scotland and NHS Grampian. The focus of the short-life review was to:

- assess the leadership, culture, values and behaviours which support and ensure the quality and safety of care
- identify the areas for improvement, and good practice, in relation to the specific services under review
- advise if any additional support should be made available to NHS Grampian to help strengthen and accelerate their improvement programme, and
- advise on any areas that may require further action, including improvement support.

4.13 The review broadly covered two main areas.

- The culture, leadership, values and behaviours which support and ensure the quality and safety of care. This report provides an independent assessment of the approach of leadership to support the delivery of a safe and high quality system of care. Leadership is defined as all levels of leadership in the organisation.

The review considered the extent to which the Board leads the development of a safety culture that leads to improvement. The review also considered the

---

6 Extract from the minute of 31 March 2014 meeting between the Scottish Government, Healthcare Improvement Scotland and NHS Grampian

opportunities to build stronger and more effective engagement with the clinical community in the design and operation of services. It also examined the skills and capacity to sustain future improvement. At the service level, we assessed the local leadership in supporting and driving the commitment to a safer health service.

- **Quality and safety of care in a focused number of specialties and services.** We considered the key issues relating to the quality and safety of care in a small number of services that were flagged as areas of concern in the validation visit in March 2014. These services were:
  - emergency department
  - surgical specialties – general surgery and trauma/orthopaedics
  - care of the elderly
  - obstetrics and gynaecology[^8], and
  - critical care[^9].

4.14 We focused on issues which are known to have a significant impact on the safety and effectiveness of the clinical care provided. These included:

- the patient and carer experience within Aberdeen Royal Infirmary
- workforce issues within Aberdeen Royal Infirmary, such as staffing levels and skill mix
- the operational effectiveness of Aberdeen Royal Infirmary, in particular the management of patient flow through the hospital
- the leadership and culture in delivering a quality and safety of care within the individual services being reviewed, and
- the capacity and capability within Aberdeen Royal Infirmary to both identify key quality and safety issues in a timely way and to then implement appropriate improvements.

4.15 Whilst the review was focused on Aberdeen Royal Infirmary, it also considered the overall leadership and accountability arrangements in NHS Grampian.

4.16 Where appropriate, we also investigated current clinical practice in relation to the safe provision of care and the effective implementation of the Scottish Patient Safety Programme (SPSP).

**Review team and expert advisory group**

4.17 The short-life review was conducted by a review team. The review team was chaired by the medical director of NHS Dumfries & Galloway. The review team included a wide range of experienced healthcare professionals from across the NHS in Scotland and members of the public. See Appendix 4 for the list of review team members.

4.18 The review team was supported by a separate expert advisory group chaired by the executive clinical director of Healthcare Improvement Scotland. See Appendix 5 for the list of expert advisory group members.

[^8]: A decision was made on 22 August 2014 to extend the review to obstetrics and gynaecology
[^9]: Critical care was not specifically included in the review terms of reference, but was subsequently taken into account given its key role
Structure of the short-life review

4.19 The short-life review consisted of three broad phases:

- gathering data and intelligence from June to August 2014, including a Medical Engagement Scale survey
- assessing the quality and safety of care through a review team visit (12–15 August 2014), a follow-up service visit (16 September 2014 and 9 October 2014) and an unannounced inspection of care for older people in acute hospitals (6–10 October 2014), and
- developing the short-life review report underpinned by the triangulation of data, intelligence and observing care provided to patients.

4.20 Throughout the short-life review process we:

- conducted meetings with or visits to a total of approximately 11 groups and clinical areas
- spoke with approximately 530 members of staff working in NHS Grampian
- received feedback through surveys and interviews from 362 patients and carers about their experience of the care received (see Appendix 2)
- reviewed 32 complaints records from a sample of 50 consecutive records
- reviewed the case records of 49 patients who had died within a set time period in Aberdeen Royal Infirmary, and
- analysed 13 adverse events and their subsequent management.

Building the data and the intelligence for the review

4.21 In the first phase of the short-life review, we focused on assembling the data and intelligence on the quality and safety of care in Aberdeen Royal Infirmary. We drew on the experience and learning from a previous rapid review of NHS Lanarkshire to help determine the evidence that would be useful. We considered a range of data from nationally available sources.

4.22 On 22 August 2014, a data pack was circulated to the review team members.

4.23 We reviewed recent care for older people in acute hospitals inspection reports to identify any key themes where patient care could be improved and to consider how NHS Grampian had responded to the recommendations made. An inspection was undertaken at Aberdeen Royal Infirmary from 16–18 June 2013 which identified 11 areas for improvement and four areas for continuing improvement. After the inspection, NHS Grampian put in place an action plan to address the recommendations.

4.24 An unannounced inspection of the care for older people in acute hospitals was undertaken at Aberdeen Royal Infirmary from 6–10 October 2014 to assess progress against the action plan and to inform the short-life review. The inspection identified concerns with patient flow, a lack of co-operation between medical staff to resolve issues, lack of structure in general management resulting in continual short term fixing, evidence of weak leadership and lack of visibility from senior nursing staff and concerns regarding the skill mix of staff on wards.
Medical Engagement Scale

4.25 A major area of concern identified in the validation visit was the perceived poor engagement between senior management in NHS Grampian and an influential group of clinicians in Aberdeen Royal Infirmary. Medical engagement is related to clinical outcomes\(^{10}\). Healthcare Improvement Scotland commissioned a baseline assessment of the level of engagement between senior management and all medical staff at the Aberdeen Royal Infirmary site.

4.26 The Medical Engagement Scale survey has been used across the UK and has surveyed around 8,000 doctors. It provides a benchmark against which NHS hospitals can assess their level of medical engagement. The definition of engagement is:

“The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care.”

4.27 The survey was circulated to 960 staff in Aberdeen Royal Infirmary and was completed by 326 medical staff and 49 management staff (39% response rate).

4.28 The full survey report is available on the Healthcare Improvement Scotland website at: [http://www.healthcareimprovementscotland.org/ari_review.aspx](http://www.healthcareimprovementscotland.org/ari_review.aspx). The analysis of the results of the survey is included in Section 8.

4.29 The Medical Engagement Scale is only validated for use with medical staff. We considered the level of clinical and managerial engagement in Aberdeen Royal Infirmary across other staff groups during the visits. This included nursing, allied health professional and support or administrative staff.

4.30 We considered the output from this exercise with other strands of intelligence, such as surveys of the training experience of junior doctors undertaken by the GMC and NES.

Review team visit 12–15 August 2014

4.31 Members of the review team undertook an intensive 4-day visit to Aberdeen Royal Infirmary between 12–15 August 2014. During the visit, we spoke with a wide cross-section of staff working in NHS Grampian, and Aberdeen Royal Infirmary in particular.

4.32 We worked within the broad parameters of ‘key lines of enquiry’ (see Appendix 1). The key lines of enquiry sought to follow up on the concerns raised in the validation visit and queries arising from intelligence gathered since that visit.

4.33 The review visit consisted of:

- individual interviews
- focus group meetings
- visits to clinical areas, and
- drop-in sessions for staff to share their experiences.

---

\(^{10}\) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (July 2013) (Keogh Report)
4.34 There was strong interest and participation in the drop-in sessions for staff. We met with around 130 people at these sessions and a significant number asked for a one to one session with members of the review team. Across the four days in August, we met over 300 members of staff through drop-in sessions, individual interviews, focus group meetings and visits to clinical areas.

4.35 We operated within an agreed protocol to feedback any areas of concern to the management team in NHS Grampian.

4.36 On 18 August 2014, the chair of the review team escalated a clinical governance matter in writing to the chief executive of NHS Grampian concerning serious allegations made by a small group of surgeons about the behaviour, competence and probity of colleagues.

4.37 The matters identified in this visit formed the basis for further investigation in the following weeks.

**Service visits on 16 September 2014 and 9 October 2014**

4.38 Members of the review team undertook further one-day service specific visits during September and October 2014. These visits followed up specific concerns initially identified in the validation visit in March 2014 and subsequently established by the review team. These visits covered the following areas:

- emergency medicine
- surgical specialties – general surgery and trauma/orthopaedics
- care of the elderly
- obstetrics and gynaecology, and
- critical care.

4.39 We visited emergency medicine, surgical specialties, care of the elderly and obstetrics and gynaecology at the Aberdeen Royal Infirmary site on 16 September 2014. The team met with 177 members of staff during visits to clinical areas and through requested one to one sessions with staff.

4.40 In response to issues identified on this visit, the chair of the review team escalated three serious clinical governance matters to the chief executive of NHS Grampian on 16 September 2014 and subsequently in writing on 23 September 2014:

- the health and safety risk from a leaking roof
- loss of dignity and privacy in respect of two patients, and
- staffing levels in the emergency department.

We asked NHS Grampian to investigate these issues further.

4.41 We visited the critical care department at Aberdeen Royal Infirmary on 9 October 2014. The team met with approximately 35 members of staff during the visit to relevant clinical areas within critical care.

4.42 A member of the review team participated in the NES re-visit to the emergency department in October 2014.
Feedback and follow-up

4.43 We presented the initial findings of our report to NHS Grampian’s executive team on 28 October 2014. NHS Grampian received the draft report on 4 November 2014 for factual accuracy checking.

4.44 We expect NHS Grampian to develop an action plan to implement the recommendations contained within this report. It is important that the recommendations are carefully considered and a detailed improvement plan developed, with appropriate timescales, ownership, accountability and measures incorporated.

4.45 Healthcare Improvement Scotland, with other key stakeholders, will support the development of the NHS Grampian action plan to implement the recommendations set out in this report. Through this process, additional improvement support will be identified to help implement the actions.
5 Patient outcome

5.1 To inform the short-life review, we assembled data and intelligence on the quality and safety of care in Aberdeen Royal Infirmary. We reviewed and analysed data from nationally available sources and also evidence provided by NHS Grampian. We reviewed patient outcome data through:

- compiling a data pack, and
- a review of patient case notes.

Compiling a data pack

5.2 We prepared a data pack which helped us develop key lines of enquiry and to formulate conclusions. It is important to note that the data considered for the short-life review cannot be used as a sole basis for making reliable judgements about quality and performance at Aberdeen Royal Infirmary.

5.3 Preparation of the data pack involved identifying and prioritising key pieces of existing data, most of which were derived from Scotland-wide data sets and with some additional data provided by NHS Grampian. The data in the pack covered a wide range of issues relating to the quality of patient care (including clinical outcomes) and operational performance. The data pack can be found at http://www.healthcareimprovementscotland.org/ari_review.aspx.

5.4 Available data on patient experience were included, as were data on patient outcomes such as hospital-related deaths, healthcare associated infections, emergency admissions/readmissions, and length of stay. We also reviewed data for some relevant clinical specialties, for example analyses on emergency medicine, and national clinical audit data for intensive care, arthroplasty (joint replacement surgery) and stroke. NHS Grampian collects a range of data for the SPSP, and these were also considered. The data pack also contained data on the workforce (both nursing and medical), waiting times, bed occupancy, delayed discharges, and theatre utilisation.

5.5 When viewed as a whole, the data in the pack do not show consistent or widespread concerns about the quality of patient care at Aberdeen Royal Infirmary. Aberdeen Royal Infirmary is not significantly different from the Scottish average for a range of established measures about the quality and safety of patient care. However, the data for some measures, for example on specific aspects of operational performance, do highlight areas of potential concern. It should be noted that, when considering such a wide range of data, it might reasonably be expected that data drawing attention to potential areas of concern would be identified for any NHS board.

5.6 Some of the key pieces of data from the pack are presented or summarised below to illustrate the broad themes. Some specific items of data are also presented in subsequent chapters of this report, for example patient experience, complaints and staff governance.

5.7 The Information Services Division (ISD) of NHS National Services Scotland manages a number of national clinical audits, and data from three audits that are of particular relevance were considered as part of the review. Specifically, when reviewing the various measures reported for the Scottish Intensive Care Society Audit Group, the Scottish Arthroplasty Project and the Scottish Stroke Care Audit, the data for
Aberdeen Royal Infirmary are not significantly different from the national average. For example, the Standardised Mortality Ratio for the Intensive Care Unit at Aberdeen Royal Infirmary is not significantly different from the Scottish average (Figure 2).

**Figure 2: Standardised Mortality Ratio for intensive care units and combined units. 2013 data**. The intensive care unit at Aberdeen Royal Infirmary is denoted ‘W’ on this chart.

Data source: Information Services Division, Scottish Intensive Care Society Audit Group

5.8 Data points within the control limits are said to exhibit common cause variation or to be ‘in control’. Data points outwith the control limits (sometimes called ‘outliers’) are said to exhibit something called ‘special cause variation’. This is where further investigation might be beneficial. Variations observed on an indicator may reflect a number of factors, such as characteristics of the patients being cared for (case-mix), the quality of clinical care, or errors in the data submitted.

5.9 ISD also publishes quarterly Hospital Standardised Mortality Ratios (HSMRs) for all hospitals taking part in the SPSP. The HSMR for Aberdeen Royal Infirmary is not significantly different from the Scottish average (Figure 3). However, an aim of the SPSP is to reduce the HSMR by 20% by December 2015, and the HSMR for Aberdeen Royal Infirmary has remained fairly constant (Figure 4).

---

11 The funnel plot allows comparisons to be made between each NHS board, hospital or unit and the average for Scotland. There are three key lines on the funnel plot. The first is the average for Scotland, which is the horizontal line through the chart. Plotted on either side of the average is a set of curved lines called control limits. The reason these lines are curved (and the limits are wider at the left hand side of the graph) is because the data points plotted at this side of the graph are made up of fewer observations and are therefore subject to greater variability.
Figure 3: Hospital Standardised Mortality Ratio (HSMR), for deaths within 30 days of admission to hospital. Data presented by hospital of admission. April–June 2014.

Data source: Information Services Division’s SMR01 database linked with National Records of Scotland death records. Published 18 November 2014.

Figure 4: Hospital Standardised Mortality Ratio (HSMR), for deaths within 30 days of admission to hospital. Data presented for Aberdeen Royal Infirmary. October–December 2007 to April–June 2014.

Data source: Information Services Division’s SMR01 database linked with National Records of Scotland death records. Published 18 November 2014.

5.10 Health Protection Scotland produces routine quarterly reports and data for the surveillance programmes it runs for *Staphylococcus aureus*, *Clostridium difficile* and surgical site infection, together with associated annual reports. When considering various measures about these healthcare associated infections, the data for NHS Grampian do not differ statistically from the Scottish average (Figures 5 and 6).
Figure 5: Rate of *Staphylococcus aureus* bacteraemia infections. Data presented by NHS board, with NHS Grampian denoted ‘GR’. 1 April 2014–30 June 2014.

Data source: Health Protection Scotland. Quarterly Scottish Staphylococcus aureus bacteraemia surveillance report, 1 April 2014 to 30 June 2014.

Figure 6: Incidence rate of *Clostridium difficile* infections in patients aged ≥65 years. Data presented by NHS board, with NHS Grampian denoted ‘GR’. 1 April 2014–30 June 2014.

5.11 Current data-led assessment under the acute adult programme for the SPSP does not indicate that NHS Grampian is performing significantly differently to other NHS boards. According to the programme’s new assessment process, NHS Grampian and primarily Aberdeen Royal Infirmary are on trajectory for all but two elements of the programme. Being on trajectory means that many sustained improvements have been made and that these are being spread throughout the NHS board around the ‘Essentials of Safety’.

5.12 There is an emergency care standard target for NHSScotland for 98% of patients to be treated within 4 hours. Performance against the 4-hour standard has decreased, both at Scotland-level and at Aberdeen Royal Infirmary (Figure 7). This is despite the number of attendances at Aberdeen Royal Infirmary’s emergency department remaining fairly constant in recent years. The recent performance at Aberdeen Royal Infirmary is not markedly different from other similar sized emergency departments.

Figure 7: Percentage of patients treated within 4-Hour Emergency Care Standard. Data presented for Aberdeen Royal Infirmary and Scotland. Data for July 2007–September 2014. Aberdeen Royal Infirmary is denoted by the red line on this chart.

Data source: Information Services Division Scotland. Scotland Monthly Management Report - September 2014

5.13 When considering a range of waiting times measures, the performance of NHS Grampian is below that of NHSScotland and/or deteriorating over time. For example, NHS Grampian’s performance against the treatment time guarantee is below target (which is 100%), with performance below that of NHSScotland as a whole (Figure 8).
Figure 8: Percentage compliance with Treatment Time Guarantee. Data presented for NHS Grampian and Scotland. October 2012–June 2014.

Performance against TTG for a Inpatient or Day case admission, Completed waits for patients seen (Added to Waiting List from 1st Oct 2012 onwards)

Data source: Information Services Division. Waiting Times Warehouse.

**Review of patient case notes**

5.14 A review of patient case notes was undertaken using the ‘A Matter of Life and Death’ (3x2 matrix tool) developed by the NHS Modernisation Agency. This tool was developed to identify problems with health and care systems rather than examine individual cases, with the aim of improving Hospital Standardised Mortality Rates and the quality of care for all patients. It states:

- “While death is a rare event, it is a useful lens to view the system as it is a clearly defined event, which is accurately recorded and is generally thought to be associated with the quality of health care. Furthermore, those patients who do die in hospital are likely to have accessed a significant section of hospital services and therefore their experience can shed light on a range of system issues. Overall, the objective is to develop a system level perspective of the care received and uncover system defects. We have found that the review demands a mindset to focus on system issues around the quality of care rather than identify individual causal factors that may or may not contribute towards death.”

5.15 A case note review is a tool to help identify areas for improvement and is not designed to be used to make judgements about levels of avoidable harm.

5.16 Two experienced reviewers undertook a review of the case notes of 49 consecutive patients who died at Aberdeen Royal Infirmary. The case notes reviewed related to 49 consecutive deaths within Aberdeen Royal Infirmary from 1 January 2014 to 11 January 2014. For patients identified as being admitted into a ward for treatment, the Global Trigger Tool (GTT) is then applied to the patient journey. The methodology used in this review used the same standardised approach that has been used in other NHS board areas within Scotland as part of the SPSP work to reduce HSMR.

5.17 The case notes of the patients reviewed suggest that reasonable care is being provided. Generally, the patients reviewed were elderly and frail with significant comorbidities.

5.18 It is clear that there are areas where further improvements could be made to the
quality of care provision. The reviewers are of the opinion that there are likely to be similar areas for improvement within other Scottish hospitals.

5.19 The review of Aberdeen Royal Infirmary case notes found the following:

- average age at death was 79 years (median 80, interquartile range (IQR) or middle 50% between 68-88, range 53-109)
- median length of stay was nine days (range 1-41)
- seven patients reviewed were in hospital for only one day before they died
- 11 patients were admitted for more than one month, and
- the majority of patients were admitted as part of general medicine and geriatric medicine acute receiving.

**Patient case note review conclusions**

5.20 The reviewers identified the following areas of good practice.

- There was good reference to the Scottish Early Warning Score (SEWS) in nursing notes (a guide used by staff to quickly determine the degree of illness of a patient). The SEWS score was often recorded in the medical notes both at the time a doctor was called to review a patient and also at the time of regular ward rounds. Both medical and nursing staff paid attention to SEWS scores.
- Patients were seen by experienced trainees and consultants early in their admission.
- Patients were reviewed by consultants, and on a number of occasions, there was evidence of good interaction between consultants from different specialties, each contributing to the care of a patient.
- Clear plans were made and documented.
- Medical trainees had good access to consultant support.
- When a patient was deteriorating, there was communication with the patient and relatives and this was clearly recorded in the medical records. Families were involved in decision-making.
- An orthopaedic morning trauma meeting checklist was used to make sure that important points for preoperative preparation were completed.
- In care of the elderly, staff used a ward round template note in the format of daily goals, and similar documentation was used in gastroenterology.

5.21 The reviewers identified the following areas (detailed below) that should be followed up and considered by NHS Grampian to bring about improvements:

- SEWS scoring
- care to patients with sepsis
- anticipatory care planning
- patient flow, and
- communication.
a) **SEWS scoring**

5.22 The policy for responding to elevated SEWS scores is unclear. For example, when and who to call for support when SEWS scores are high or increasing. In one case note that was reviewed, there was evidence of a document describing such a policy, but this was from an admission five years previously. No similar document was seen for current admissions. The reliability of SEWS scoring could also be improved.

5.23 It is important in addressing this issue to separate writing a document (a policy) from making change happen at the frontline (using improvement science).

b) **Care to patients with sepsis**

5.24 Sepsis is an extremely serious blood borne infection. Once sepsis is identified, antibiotics should be given within 60 minutes.

5.25 The case note review identified patients who received antibiotics within 60 minutes and other patients who received antibiotics later than 60 minutes after sepsis identification, suggesting variability.

5.26 There is a sepsis prompt sticker attached to many admission documents, this allows checking for systemic inflammatory response criteria and prompts the user to think about sepsis. It was rarely filled out.

5.27 Sepsis is a focus on the current SPSP work programme. Support from individuals with improvement skills and monitoring needs to be given to this important quality improvement work so that progress can be made.

c) **Anticipatory care planning**

5.28 Several of the case notes reviewed involved elderly patients with severe co-existing health problems, who had a number of hospital admissions in the previous 12 months, and many were admitted from nursing homes. These individuals were in the last phase of life. The reviewers did not see any mention of pre-existing anticipatory care planning in this group of patients. This may have simply been due to the sample of case records that were reviewed.

d) **Patient flow**

5.29 There were examples of delay in transfers to other units due to unavailable beds. There were also examples of patients being held in a receiving ward for six to eight hours, then moved on (often late into the evening) to another ward where they were re-clerked. This highlights a patient flow issue and also repetition of clerking work already done.

e) **Communication**

5.30 There were examples of delay to treatment for patients. The provision of care to a patient involves multiple professionals and shift changes. Communication between healthcare professionals may benefit from standardisation, using a recognised tool such as the Situation, Background, Assessment and Recommendations (SBAR) tool.

5.31 In 3 out of 49 case notes reviewed, there was no evidence of a discharge summary.
Patient outcome conclusions

5.32 When viewed as a whole, the data do not highlight consistent or widespread concerns about the quality of patient care at Aberdeen Royal Infirmary. Aberdeen Royal Infirmary is not significantly different from the Scottish average for a range of established measures about the quality and safety of patient care. However, the data for some measures, for example, specific aspects of operational performance, do highlight areas of concern. It should be noted that, when considering such a wide range of data, it might reasonably be expected that data drawing attention to potential areas of concern would be identified for any NHS board.

5.33 It is recognised that high level data are not always sensitive to the underlying risks, and are retrospective. The Berwick report\(^\text{12}\) highlighted the danger of relying on aggregated data and the importance of understanding what is happening ‘on the frontline’. We found a range of issues that considerably reduce quality and safety, and that are mitigated through the actions of talented and dedicated frontline staff. The inspections carried out in departments during the unannounced Older People in Acute Hospitals inspection identified sufficient incidents to raise concern about the system of care. Relying on individual dedication to compensate for poor systems is inappropriate and carries unacceptable risk.

5.34 We expect NHS Grampian to develop an action plan to address the following recommendations.

Patient outcome recommendations

1 NHS Grampian executive team with senior staff in emergency department and other key stakeholders should develop a plan for a sustainable emergency department service that provides patients with safe, effective and person-centred care.

The plan should:

- be sustainable in terms of ability to recruit and retain medical staff
- recognise the reality that the emergency department requires senior input from specialist emergency medicine medical staff
- recognise that senior trainees will continue to be in short supply
- recognise that staff from other specialties whilst valuable in their own roles cannot be used to substitute for the expertise of senior emergency medicine medical staff
- recognise that senior trainees can make a valuable service contribution, but are also entitled to expect support and training that adheres to the appropriate GMC mandatory regulatory standards\(^\text{13}\)
- explore the potentially valuable contribution that can be made by non-medical staff, such as advanced nurse practitioners, while recognising that senior doctors leading care will always be required, and
- be approved and progress monitored by the Board.

\(^{12}\) Berwick review into patient safety (August 2013)
\(^{13}\) [http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf](http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf)
2 NHS Grampian executive team should work with senior clinical colleagues and local managers to review the management of unscheduled care across the hospital, with emphasis on the effective transfer of emergency patients from the emergency department to inpatient areas.

This will mean:

- recognising the complexity of the systems involved
- developing an effective system of flow of patients through the hospital that will improve patient care, reduce wastage of clinical time, and improve the quality of care for patients
- using visible leadership to ensure that all stakeholders involved sign up to agreed and defined protocols, and then work in line with the protocols, and
- working closely with health and social care partnerships to support effective discharge planning.

3 NHS Grampian should ensure that the escalation policy for patients whose Scottish Early Warning System score is high is understood and implemented by all relevant clinical staff.
6 Patient experience data

6.1 We reviewed data and evidence to assess the quality of the patient experience. We did this through undertaking a review of the following:

- Scottish Inpatient Experience Survey
- data provided by NHS Grampian
- NHS Grampian approach to listening to patient experience, and
- direct patient and carer feedback.

Introduction

6.2 There has been an increasing focus in NHSScotland on the need for complaints and feedback to be encouraged and valued as a vital source of intelligence about what is working well, or not working well, in NHS services. Genuinely listening to people and responding to their concerns is critical for improving the quality and safety of care and ensuring that services are person-centred. This also supports the identification of necessary improvements.

6.3 Complaints tend to happen after a service has been provided or in relation to failure to provide a service, and there is much to be learned from the experiences captured through complaints. There is also much to be learned from proactively gathering views from patients and carers at the time a service is provided, whether those views reflect positive or negative experiences.

6.4 In Scotland, there have been a number of developments that have placed greater emphasis on complaints and feedback including: the Patient Rights (Scotland) Act 2011; the Scottish Government guidance: ‘Can I help you? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services’ (April 2012); and the Listening and Learning report published in April 2014 by the Scottish Health Council.

6.5 Before beginning this review, Healthcare Improvement Scotland had received information from the Patient Action Co-ordination Team (PACT), a local patient action group, and from individual complainants that was extremely critical of NHS Grampian’s approach and attitude to handling complaints. They informed us that there was a culture of denial and dismissal in the way NHS Grampian manages complaints. Given the importance of complaints as a key indicator of service quality, we were keen to explore this further.

Scottish Inpatient Experience Survey

6.6 The fourth Scottish Inpatient Experience Survey was sent by Scottish Government, in January 2014, to a random sample of people aged 16 years or older who had an overnight hospital stay between April and September 2013. The national and local results were published on 26 August 2014.

6.7 The survey asked patients about seven aspects of care: admission to hospital; the hospital and ward; care and treatment; operations and procedures; staff; leaving hospital; and after leaving hospital.

6.8 The survey indicated that, in the majority of areas, the proportions of patients at
Aberdeen Royal Infirmary who reported a positive score were not significantly
different compared to the Scottish average. The overall rating of care or support
services after leaving hospital was the only area where a lower percentage of patients
gave a positive score for Aberdeen Royal Infirmary compared to the Scottish average.

6.9 Some specific questions from the 2014 survey are pertinent to this review. For the
questions on whether ‘Patients felt there were enough nurses on duty’ and on ‘How
patients felt about the time they waited to be admitted to hospital after they were
referred’, Aberdeen Royal Infirmary patients were similarly positive to other patients
in Scotland. The question on ‘Overall rating of hospital admission process’ revealed
that Aberdeen Royal Infirmary patients were significantly more positive than the
Scottish average.

Data provided by NHS Grampian

6.10 Collecting and acting upon data on patient experience is of critical importance, yet
health services generally face many challenges in this regard. NHS Grampian provided
data on both patient and staff experience, collected from the national Person-
Centred Health and Care Collaborative. NHS Grampian reports that it has collected
real-time data on patient and staff experience since July 2013, and this has involved
more than 50 clinical areas to date, primarily from secondary care. Of the patients
which took part in this exercise, 96% rated the service they received as being good,
very good, or excellent (Figure 9). However, it should be recognised that experience
reported by patients at point of care is often more positive than that reported after a
period of reflection.

Figure 9: Patient Service Score. Data presented for NHS Grampian. Data collected
since July 2013.

Data source: NHS Grampian

NHS Grampian approach to listening to patient experience

6.11 In common with other NHS boards, NHS Grampian receives feedback in a variety of
ways including: feedback cards; letters and emails; telephone calls; social media such
as Twitter and Facebook; and the national Patient Opinion website.

6.12 There is much to be learned from proactively gathering views from patients and
carers at the time a service is provided. We heard some good examples of how NHS Grampian is gathering real-time patient experience data and using this to make immediate improvements to services. Real-time patient surveys have been used and sessions have been held with some ward staff to identify ‘always events’ and to assist in making improvements to patient care. Staff have undertaken pilot initiatives using iPads to gather patient experience and using the electronic information management system, Datix, to speed up collection and turnaround of data. ‘Improvement trees’ have been introduced involving the use of wall stickers to gather patient, family and visitor feedback.

6.13 This demonstrates that progress is being made in gathering real-time patient experience at the point of care in a proactive way. However, we noted that this is not yet happening reliably and consistently across all services. The team also identified a lack of a fully joined-up approach between this activity, which sits in the quality, governance and risk unit, and complaints handling, which sits in the corporate communication and Board secretariat.

**Direct patient and carer feedback**

6.14 A vital element of the short-life review was to ensure that the voices of patients, carers and members of the public in Grampian were heard. Members of the public were an integral part of the review team, bringing their own experience and expertise. We had four public partners on the review team who provided a public perspective. The public partners spoke with a number of inpatients, carers and visitors and observed levels of care on wards on the visits to Aberdeen Royal Infirmary. We extend our grateful appreciation to our public partners for providing a valuable public perspective throughout the review.

6.15 We considered a range of existing data on patient and carer experience and we set up a variety of mechanisms to obtain direct feedback from patients, carers and public partners.

6.16 The Scottish Health Council, which is part of Healthcare Improvement Scotland, works to improve patient and public participation in NHSScotland. During the weeks beginning 4 August and 1 September 2014, the Scottish Health Council obtained feedback from patients and carers who had used the services of Aberdeen Royal Infirmary during the past year. Local staff carried out focus groups in Orkney, Shetland, Aberdeenshire and Aberdeen City. They also spoke with patients and carers within the Aberdeen Royal Infirmary concourse and rotunda area, received phone calls and emails, and conducted one to one interviews. A survey and a dedicated phone line with the Citizens Advice Bureau were also available to members of the public during the month of August.

6.17 A total of 362 patient or carer experiences were obtained during the review period. There was a diverse range of patients and carers engaged in the feedback process including representation from older people, young people, people with disabilities and people from ethnic minority communities.

6.18 Six focus groups were held during August and September 2014, through which a total of 35 individuals attended. Thirty-eight inpatients completed questionnaires and 289 individuals gave feedback through interviews, telephone calls and written correspondence. Before each focus group and interview session, a comprehensive introduction and outline of the purpose of the exercise was given. This included
advising patients and carers of the anonymity involved in providing information. Throughout the engagement process, a high number of individuals reported positive experiences of care with the service provided at Aberdeen Royal Infirmary. They indicated they valued the staff and quality of care that they experienced. In particular, the professionalism, working attitudes and care provided by all healthcare staff. Many of the individuals who did not provide direct comments stated that there were no areas they would recommend for improvement.

6.19 Patients and carers provided feedback on their experience of care and suggested key areas where improvements could be made. Feedback focused primarily on care of the elderly, emergency medicine, general surgery, and obstetrics and gynaecology areas. The information provided to patients and carers made it clear that we could not respond directly to issues raised or to investigate individual complaints. Instead the purpose of this exercise was to identify any key themes (both positive and negative) from the feedback to inform the focus of the review and the subsequent findings and recommendations of this report. The most common positive experiences included good communication between staff and patients, quality of care and friendly staff. Suggested areas for improvement included staff shortages and discharge procedures.

Patient experience data conclusions

6.20 We concluded that through the reviewed national and locally collected data, patients and carers reported, on the whole, positive experiences of the care they received whilst at Aberdeen Royal Infirmary. This was supported through our work with the Scottish Health Council and through patient and carer conversations with public partners during the visits.

Patient experience data recommendation

4 NHS Grampian should continue to build on collecting real-time patient experience data ensuring this is done reliably and consistently across the services.

This work should include the following:

- continue to use patient feedback as a resource for continuous improvement
- ensure that collated patient feedback is passed on to staff to encourage improvement, and
- monitor progress so that agreed improvements are initiated within a reasonable timescale.
7 Complaints management

7.1 We undertook a review of the handling of complaints to assess how NHS Grampian meets the expectations of legislation and related good practice guidance in ‘Can I Help You? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services’ (Scottish Government, 2012). We did this through reviewing the following:

- NHS Grampian’s processes for handling complaints
- complaints data and themes
- review team audit of complaints
- organisational culture
- process and procedure
- accessibility
- quality of handling responses
- learning from complaints, and
- complaints handling performance.

7.2 An internal audit of NHS Grampian’s complaints process was carried out by PricewaterhouseCoopers (PwC) at NHS Grampian’s request in 2013–2014. The audit findings were presented to NHS Grampian in June 2014 and considered by the audit committee. Some steps have been taken by NHS Grampian to address the issues raised in the audit report, including increasing staff capacity within the feedback service. However, there are still issues to be addressed.

NHS Grampian’s processes for handling complaints

7.3 NHS Grampian’s feedback service handles all feedback, comments, concerns and complaints. It covers all NHS Grampian services except those provided by independent practitioners such as GPs, dentists and opticians. The feedback service was redesigned in early 2012. The redesign shifted responsibility for investigating and responding to complaints within the required timescales from the central team to individual clinical services. This was to encourage greater ownership of complaints at service level. The feedback service retained responsibility for central administration and performance reporting of complaints and feedback, as well as providing advice, support and training to staff.

7.4 NHS Grampian reported that it uses the Datix system to record all feedback and complaints. However, our review of complaints management did not provide assurance that this is done consistently and thoroughly.

7.5 Processes and procedures for handling complaints were provided to us in a number of separate documents. These processes and procedures were being revised by NHS Grampian at the time of this review.

7.6 All complaints responses are currently signed by the chief executive or another executive team member in the absence of the chief executive.

7.7 A number of performance reports are produced including:
• a twice yearly ‘Joint Incident, Feedback and Claims Report’ which is considered by NHS Grampian’s clinical governance committee and its patient focus and public involvement committee. This includes information on complaints reviewed by the Scottish Public Services Ombudsman (SPSO).

• a monthly ‘highs and cats’ report on high and catastrophic risks, incidents and complaints, including cases considered by the SPSO, is considered at a meeting involving senior staff. This includes the deputy chief executive, director of corporate communications and Board secretariat, director of nursing and quality, director of workforce, feedback service manager, risk management advisor and nurse consultant for patient experience. Complaints trends, new complaints themes, complaints severity scoring, late complaints and complaints performance or situation reports are also considered at this meeting, and

• reports to the Board such as the ‘Stakeholder Engagement’ report considered by the Board on 7 February 2014.

Complaints data and themes

7.8 ISD routinely publishes data on complaints for all NHS boards.

7.9 The number of complaints received by NHS Grampian has increased in each of the last three reporting periods (2011–2012, 2012–2013, 2013–2014). The increase in number of complaints is similar in other NHS boards across Scotland. There does not appear to be an abnormal number of complaints for NHS Grampian in respect of its size.

7.10 In 2013–2014, NHS Grampian had the lowest performance in acknowledging complaints within three days, at 68% compared to a national average of 94%.

7.11 In 2013–2014, NHS Grampian had the lowest performance in responding to complaints within 20 days, at 33% compared to a national average of 66%. NHS Grampian had a median response time of 25 days compared to the national figure of 18 days.

7.12 Evidence provided by NHS Grampian indicated that Aberdeen Royal Infirmary’s top three complaints themes for 2013–2014 were clinical treatment; attitude and behaviour; and date for appointment. These themes are similar to those of other NHS boards.

7.13 In October 2014, the SPSO wrote to NHS Grampian providing statistics about complaints to the SPSO in 2013–2014. The number of complaints received by the SPSO does not appear to be markedly high for NHS Grampian compared to the rest of NHSScotland. Specifically, 6% of all health sector complaints were about NHS Grampian. This is less than the percentage (11%) of the Scottish population who are resident in this region.

7.14 The profile of complaints to the SPSO about NHS Grampian was similar to that for the health sector as a whole. Specifically, 66% of complaints were about clinical treatment or diagnosis. The next three most frequent categories were: communication/staff attitude/dignity/confidentiality (9%); appointments/admissions (delay, cancellations, waiting lists) (5%); and policy/administration (4%).

7.15 The level of NHS Grampian complaints that are sent to the SPSO prematurely
(referred before the local process was complete) and the proportion that are upheld were numerically higher than the health sector average in 2012–2013\textsuperscript{14} and 2013–2014\textsuperscript{15} (statistical tests have not been carried out to ascertain whether these differences are significant). A consistently high level of premature complaints tends to suggest people may be confused, lost or frustrated with the local complaints handling process. A consistently high level of complaints upheld by the SPSO may suggest that the local decision-makers (complaints handlers or senior managers) may not be making the right decisions in terms of their conclusions or responses.

**Figure 10: Complaints sent to the Scottish Public Services Ombudsman prematurely: complaints upheld by the Scottish Public Services Ombudsman.**

<table>
<thead>
<tr>
<th>Category</th>
<th>NHS Grampian</th>
<th>Health sector average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint sent to SPSO prematurely (before local process was complete) 2012–2013</td>
<td>43.8%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Complaint sent to SPSO prematurely (before local process was complete) 2013–2014</td>
<td>40.8%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Upheld rate (SPSO agree fully or partly with the complaint) 2012-2013</td>
<td>64.7%</td>
<td>51.9%</td>
</tr>
<tr>
<td>Upheld rate (SPSO agree fully or partly with the complaint) 2013-2014</td>
<td>66.7%</td>
<td>55.4%</td>
</tr>
</tbody>
</table>

**Review team audit of complaints**

7.16 To understand NHS Grampian’s approach to complaints, we considered the following:

- various papers received from NHS Grampian including the June 2014 PwC internal audit report
- 32 complaints records and 20 pieces of feedback, comments, concerns and compliments relating to Aberdeen Royal Infirmary. We randomly selected complaints from a sample of 50 consecutive complaints dating from 1 January 2014. Our focus was on the quality of complaints handling rather than on the substance of the complaints and related responses, and
- information obtained through interviews with staff in NHS Grampian, including some who have particular roles relating to complaints and feedback.

7.17 Our findings are set out below under six headings informed by a draft framework developed by the SPSO:

- organisational culture
- process and procedure
- accessibility
- quality of handling responses

\textsuperscript{14}Annual letter 2012–13 from the Scottish Public Services Ombudsman to NHS Grampian

\textsuperscript{15}Annual letter 2013–14 from the Scottish Public Services Ombudsman to NHS Grampian
• learning from complaints, and
• complaints handling performance.

\textbf{a) Organisational culture}

7.18 NHS Grampian’s ‘Handling and Learning from Feedback Annual Report 2013/14’ opens by stating: “NHS Grampian values all feedback and is committed to ensuring that the information and learning gathered from all our feedback systems informs the aspiration of continuous improvement and the further development of a person centred approach to planning.” The importance of listening to and engaging with patients, families and carers is also a key part of NHS Grampian’s organisational values – “caring, listening, improving”. Each Board meeting now incorporates a ‘patient story’.

7.19 Whilst NHS Grampian clearly recognises the importance of listening to people using its services and acting on what they say, this commitment is not being fully delivered in practice. The PwC internal audit report gives the complaints process an overall classification of ‘high risk’. It highlights a number of failures to comply consistently with expectations in legislation and guidance, such as time limits for complaints responses and lack of recording of lessons learnt. It also highlights weaknesses and deficiencies in NHS Grampian’s systems and processes, for example a lack of assessment of the severity of complaints scoring and poor working practices regarding re-opened cases. Our review confirmed the key findings in the PwC report and identified additional issues which are outlined below.

7.20 The PwC report states: “Approximately 18 months ago there was a significant redesign of the feedback team, which resulted in a significant reduction to the size of the core team and a consequent transfer of responsibility to sectors, with no reflection of the capacity required to deliver this model.” From our review, it appears that this redesign was poorly handled and implemented and had an adverse impact on the complaints handling performance in the acute sector and on some of the key staff who were affected by the change. A number of risks were identified at the outset in relation to the change, and there appears to have been insufficient management of these risks and lack of timely associated remedial action.

7.21 Our interviews with staff led us to conclude that leadership was not visible at senior and executive level. We also had serious concerns regarding accountability and clarity of responsibility for complaints management. The responsibility sits with corporate communications and Board secretariat which has responsibility for the feedback service, whilst the responsibility for investigation and drafting of responses sits in each clinical service. Each area of responsibility has different lines of accountability. Members of staff, including those at a senior level, were generally uncertain about who was providing leadership on complaints.

7.22 When responsibility for responding to complaints shifted from the central team to each clinical service, a number of training needs were identified such as investigation skills and letter writing. However, this training was not provided to support the change, despite the identification of a part-time training post, as the post-holder did not have capacity to deliver the training due to other demands. This may have led to some of the variation across the services that we identified in terms of levels of confidence and knowledge about complaints. NHS Grampian has advised us that steps are now being taken to roll out an e-learning training module on complaints...
from the end of September 2014. We were informed that the roll-out had been delayed due to compatibility issues with NHS Grampian’s systems, and the need to supplement the training with support from staff in the feedback service.

7.23 We noted that the NHS Grampian ‘Handling and Learning from Feedback Annual Report 2013/14’ and the ‘NHS Grampian Stakeholder Engagement Framework’ refer to the training role “introduced within the feedback team in 2013” and to e-learning modules without mention of capacity issues and delays that have been experienced in delivering training and e-learning, and which were shared with us. The reports produced by NHS Grampian, therefore, suggest a more favourable position than would appear to be justified in reality.

7.24 We heard that complaints are viewed as “an irritation” in some parts of the acute services, rather than being welcomed as valuable sources of intelligence for improvement. We heard that there has been a significant backlog of overdue complaints leading in some cases to a focus on “chasing people” to allow responses to be issued.

7.25 Our review of complaints also found that some responses appeared to be extracts from statements provided by staff, rather than a high quality response. Therefore, when responses are completed, it appears there is a culture of ‘cut and paste’ from the statements provided by staff rather than a focus on ensuring a high quality, coherent and meaningful response.

7.26 We were informed that NHS Grampian has a robust process for quality assuring complaints and that these are all signed off by the chief executive or another executive team member in the absence of the chief executive. Through discussion, it became evident that this quality assurance process relates to checking the spelling, grammar and tone of responses. There is an absence of a clear and consistent system for quality assuring the clinical aspects of the responses. There is no one with clinical knowledge who has oversight of all complaints responses for clinical issues. We had significant concerns that there was no evidence of any independent, objective and robust system for the review of the clinical aspects of draft complaints responses.

**b) Process and procedure**

7.27 The PwC report identifies a need to consolidate complaints handling procedures into one document. We saw at least 16 different documents, each picking up separate aspects of the complaints process or procedures. These processes and procedures were being revised at the time of our review to address this issue.

7.28 The PwC report highlighted that the severity rating for complaints is assigned by the feedback service and that a number of complaints leads were unaware of their responsibility to check this and to change the rating if it was incorrect. Our review identified several complaints where it appeared to us that the rationale for the severity rating was unclear and that the rating had been underestimated. For example, one complaint from a bereaved relative about end of life care was categorised as ‘minor’.

7.29 The PwC report referred to inconsistencies in practice around removing the closed date in re-opened cases. Our review identified a number of cases where a complaint appeared to have been closed on the system when a response letter was sent, and the dates were not subsequently changed when the complainant came back with
further issues, which sometimes took months to resolve. Complaints would then not show as ‘live’ on the system and the actual time taken to resolve the complaint would be inaccurately recorded and not reflect the true length of the process. The clinical governance committee has been advised that the number of re-opened cases has been going down. However, given the inconsistencies in recording practice that both PwC and this review have identified, it appears that the data supporting this conclusion may be flawed.

7.30 We also heard that the organisational change process for complaints management resulted in ‘confusion’ and ‘chaos’ in the service around the process and requirements. We were advised that this has been compounded by subsequent changes to sign-off procedures which have been poorly communicated to staff.

7.31 There is an inconsistent approach to recording whether a complaint is ‘fully upheld’, ‘partially upheld’ or ‘not upheld’. Sometimes the complaints leads record this and sometimes the feedback service. There is no independent quality check on this and at times the rationale for how it was recorded was unclear to us. Figures are reported to the clinical governance committee and our review would suggest that more needs to be done to ensure the robustness and reliability of the data. This was not identified in the PwC report.

7.32 We were informed that there is a separate procedure for handling complaints received through MPs and MSPs whereby these are dealt with by the chief executive’s office to ensure they are prioritised and timescales met. This raises issues of equity and risks creating a perception that complaints made through elected representatives are given greater priority than complaints received directly from patients and their carers.

c) Accessibility

7.33 Information about the complaints process is available on NHS Grampian’s website.

7.34 Feedback cards are available across acute services so that people to give feedback and tick a box to indicate whether it is a complaint. Many of the complaints we saw were received through this route, but we were told that the cards are not consistently available across all services.

7.35 People can complain by telephone, although they are encouraged to put their complaints in writing or to get support from the Patient Advice and Support Service (PASS) first. PASS is an independent service delivered by the Scottish Citizens Advice Bureau Service. It provides free, confidential information, advice and support to anyone who uses the NHS in Scotland.

7.36 NHS Grampian also receives feedback and complaints through other routes, such as social media, email and the independent Patient Opinion website.

d) Quality of handling responses

7.37 We considered 32 complaints records. Whilst some of the responses we saw were in line with good practice, some were not. Some of the responses were defensive and did not demonstrate an apology or a willingness to learn. There was also a lack of evidence of meaningful action taking place in response to complaints.

---

16 Clinical Governance Committee: Joint Incident, Feedback and Claims Report February 2014
7.38 It would be good practice, particularly in sensitive or complex complaints, to make personal contact with the complainant either through a phone call or meeting. This would help to understand the issues and to identify what the patient would want as an outcome from the complaint. Whilst there were some examples of this happening, there was no systematic and reliable approach to this. We saw examples of complaints where early contact with the complainant could have prevented their subsequent dissatisfaction. For example, the complainant being dissatisfied that the response did not address the main points. We have been advised that NHS Grampian is now moving to a more direct personal contact with complainants at the start of the process to try to address these issues.

7.39 Some of the responses we saw had extensive use of clinical jargon and acronyms, and some appeared to include unnecessary or irrelevant detail. These responses were not clear and easy to understand, as required by the guidance.

7.40 Guidance requires that responses to complainants should “indicate that, if they are not satisfied with the outcome, they may seek a review by the SPSO – with details of how to contact SPSO included.” We saw a standard practice of advising complainants about the SPSO in the initial acknowledgement letter and not in the actual response letter. This is not in line with guidance. There would appear to be little value in advising people about going to the SPSO if they are dissatisfied with the response, before they have actually received a response. This could also lead to premature complaints being sent to the SPSO. We noted that where a complaint had been re-opened and a further response sent to the complainant, the SPSO details were included at that stage.

7.41 Staff in the feedback service send reminders to senior managers and clinicians in the service to ensure timely responses to complaints. However, this system does not always appear to have been effective. One positive development has been the involvement of a unit operational manager since March 2014 who has been tasked with addressing the outstanding complaints in acute services. This individual is in a more senior position to staff in the feedback service and has knowledge of the service staff. This has been helpful in ensuring appropriate priority is given to responding to complaints in a more person-centred and timely manner. This has made a significant impact in a relatively short space of time and examples were given of improvements that have been made to services as a result. However, it was unclear whether funding for this post would continue.

e) Learning from complaints

7.42 Datix is an information system for capturing and monitoring risks and it enables a connection to be made between the recording of a complaint and a related adverse incident. It is essential that the system for connecting these is consistent and reliable so that all relevant intelligence is shared. Healthcare Improvement Scotland noted in its review of the management of adverse events across NHS Grampian in March 2013, the innovative use and plans for an integrated Datix system for complaints, incidents and risks and highlighted then the need to ensure that this information is consistently stored in Datix across the organisation.

The PwC report states: “NHS Grampian cannot consistently evidence that lessons are being learned from complaints, or other forms of feedback. Datix has functionality to record lessons learned and assign actions to allow accountability and monitoring of the progress in addressing these. This functionality is not routinely used.” This was confirmed by our review of complaints and the assessment of adverse events as part of this short-life review. This is a significant concern and presents a challenge for NHS Grampian in demonstrating that it is compliant with the legislation and guidance. It also represents missed opportunities for the service to improve quality, safety and to provide a genuinely person-centred response.

We were advised that staff have been struggling with capacity to respond to complaints within the timescales and this has been made worse by the backlog. This has led to little time and priority for ensuring lessons are identified and appropriately shared.

Key themes are reported at a high level, but it is not clear what is being done to tackle all of these issues across acute services. Whilst there are some examples of improvements being made in response to complaints provided in the ‘Handling and Learning from Feedback Annual Report 2013/14’, we heard that there is no clear system for ensuring that this happens reliably and consistently across acute services.

We were informed that operational managers have not been provided with the service-specific data they need to make improvements.

Complaints handling performance

Compliance with response times in NHS Grampian, and in acute services in particular, is poor. Only 31% of complaints within the acute sector were responded to within the 20 working day target between January and December 2013. Fields in Datix which can capture reasons for response times being greater than 20 working days or 40 working days were not completed.

It is difficult to ascertain a true picture of average response times given that the figures for re-opened complaints may not be reliable.

Whilst reports are regularly provided to governance committees, managers in the service have not routinely received reports that would support them to understand themes and issues in their own areas of responsibility.

Whilst NHS Grampian does not proactively seek customer feedback on how complaints have been handled, the number of complaints which are re-opened due to complainant dissatisfaction with responses received may provide some indication of this. However, we have identified that the data for re-opened cases may not be reliable. We noted that the number of complaints to the SPSO that included concerns about complaints handling was slightly above sector average for NHS Grampian.

We saw little evidence of improvements routinely being made in response to how complaints were handled, following monitoring. However, additional resources provided to the feedback team more recently should support addressing some of the key issues which were highlighted in the PwC audit report.

---

18 Annual letter 2012–13 from the Scottish Public Services Ombudsman to NHS Grampian
Complaints management conclusions

7.52 We concluded that NHS Grampian is clear in its stated commitment to feedback and ensuring that information and learning gathered from complaints is used for continuous improvement. However, we identified substantial weaknesses in the leadership and management of systems and processes for the handling of complaints.

7.53 The ‘Listening and Learning: how feedback, comments, concerns and complaints can improve NHS services in Scotland’ report published by the Scottish Health Council in April 2014 sets out a range of recommendations for all NHS boards in Scotland to improve their practices around complaints and feedback. NHS Grampian should take full account of these in improving its own systems and practices, and seek to learn from approaches taken by other NHS boards where appropriate.

7.54 We expect NHS Grampian to develop an action plan to address the following recommendation.

Complaints management recommendation

5 NHS Grampian should improve the way it investigates, responds to and learns from complaints.

These improvements should include:

- clear, unambiguous and effective leadership on complaints at senior/executive level and ensure that appropriate priority is given to continuously improving the approach of listening to and learning from complaints consistently across NHS Grampian’s acute services
- clarity and consistency in decision-making about whether a complaint has been upheld or not
- a more robust approach to the quality assurance of complaints management
- more face to face meetings between staff, patients and relatives to resolve complex complaints
- confirmation that clinical aspects of responses address the questions posed and that responses are clear and empathetic, and
- a way in which to build on the positive impact of a nominated post in acute services who can liaise with the feedback service and managers or clinicians to support good practice in the handling of complaints and learning from these.
8 Leadership and culture

8.1 The terms of reference for this review emphasised the importance of understanding the leadership and culture in Aberdeen Royal Infirmary. Our findings are contained below under the following headings:

- engagement between clinicians and senior management
- inappropriate behaviours and leadership, and
- relationships between operational services, clinicians and strategic planning.

Engagement between clinicians and senior management

8.2 A major concern identified in the initial validation visit was the fracture between the senior leadership and a strong and influential community in NHS Grampian’s acute services at Aberdeen Royal Infirmary. The evidence gathered in the validation visit pointed to a serious breakdown in relationships between senior management and clinicians in Aberdeen Royal Infirmary.

8.3 We concentrated our immediate efforts on establishing the overall culture of clinical engagement, particularly between medical staff and management on the Aberdeen Royal Infirmary site. We used the Medical Engagement Scale survey as one tool to help determine the level of clinical engagement.

8.4 The Medical Engagement Scale survey has nine domains. Taken as a whole, Aberdeen Royal Infirmary was in the lowest 20% of hospitals for three of these and the lowest 40% for the other six.

8.5 The survey results when compared with the other 70 NHS trusts and NHS boards in the database indicated that:

- although there were pockets of better (middle range) engagement at a divisional level, the results were more polarised at specialty level with some specialties being entirely in the lowest range and others in the highest
- trainees accounted for 29% of responses and consultants for 60%. It would appear that grade is not the defining factor, although consultants exhibit lower levels of relative medical engagement than others, and
- analysis of results by length of service shows a low level of relative medical engagement regardless of length of service, although engagement is high in the first year of service and high again between 10 and 15 years of service. It is likely that medical staff with longer service could be significant ‘influencers’ (whether formal or informal) within the organisation.

8.6 Figure 11 highlights Aberdeen Royal Infirmary’s overall results across the nine domains compared to other NHS organisations.
Figure 11: Overall Medical Engagement Scale results compared to other NHS organisations.

<table>
<thead>
<tr>
<th>In the lowest 20% of organisations</th>
<th>In the second lowest range of organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Having a purpose and direction</td>
<td>• Working in a collaborative culture</td>
</tr>
<tr>
<td>• Participation in decision-making</td>
<td>• Climate for positive learning</td>
</tr>
<tr>
<td>and change</td>
<td>• Appraisal and rewards effectively</td>
</tr>
<tr>
<td>• Good inter-personal relationships</td>
<td>aligned</td>
</tr>
<tr>
<td></td>
<td>• Being valued or empowered</td>
</tr>
<tr>
<td></td>
<td>• Development orientation</td>
</tr>
<tr>
<td></td>
<td>• Work satisfaction</td>
</tr>
</tbody>
</table>

8.7 Figure 12 below shows the Aberdeen Royal Infirmary specialties that were in the highest and lowest ranges of medical engagement.

Figure 12: Specialties within the highest and lowest ranges of medical engagement.

<table>
<thead>
<tr>
<th>In the lowest 20% of organisations for all scales</th>
<th>In the highest 20% of organisations for all scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cardiology</td>
<td>• Acute Geriatric</td>
</tr>
<tr>
<td>• Emergency Medicine</td>
<td>• Neurosurgery and Neurosciences</td>
</tr>
<tr>
<td>• General Internal Medicine</td>
<td>• Gastroenterology</td>
</tr>
<tr>
<td>• General Surgery</td>
<td></td>
</tr>
<tr>
<td>• Gynaecology</td>
<td></td>
</tr>
<tr>
<td>• Plastics</td>
<td></td>
</tr>
<tr>
<td>• Trauma and Orthopaedics</td>
<td></td>
</tr>
</tbody>
</table>

8.8 In summary, the survey indicates that Aberdeen Royal Infirmary “has a low proportion of highly engaged medical staff and a high proportion of very poorly engaged medical staff. Such a result gives cause for concern and suggests that any interventions to address the situation need to be fundamental (structural and cultural) rather than examining particular processes or functions.”

8.9 More broadly, we found there was a climate of mistrust between clinicians and higher levels of management in several specialties. This mistrust was particularly apparent in general surgery and in emergency medicine. Consultants with designated management roles reported better engagement than those without such roles. However, it was clear that many consultants were distrustful of, and un-cooperative with, senior management.

8.10 We heard repeated instances of a lack of engagement of clinicians in management decisions. In some cases, clinicians said that they had not been consulted or even informed, in others they reported that their concerns had been ignored, and in other cases they had declined to co-operate.

8.11 We were conscious that, given changes in healthcare, there is an increasing emphasis on multidisciplinary working within teams. Therefore, we did not restrict ourselves to reviewing medical and managerial relationships. Box 1 below lists example comments made by a number of staff we spoke with, concerning leadership and engagement with staff.

---

Medical Engagement Scale survey report (August 2014)
In the emergency department, senior medical management were aware that some consultants were disrespectful to colleagues and spent time in their offices rather than leading the team, but failed to take effective action. Clinicians have a high level of mistrust in the management hierarchy, including the medical management. In this department, we could find no demonstrable support for clinical leaders at lower levels from more senior managers, and the absence of a leadership strategy or organisational values that bound the organisation together.

We noted in various minutes of advisory committee meetings there was extensive reference to difficult issues and poor working relationships, which sometimes resulted in matters being escalated within and beyond NHS Grampian. For instance, the 12 December 2013 minutes of the Consultants Sub-Committee of the Area Medical Committee stated: “Opened the discussion by summarising the position from the perspective of general and vascular surgeons that the proposed plans to relocate general surgery would be the equivalent to a 40% reduction in bed space provision...the general surgeons sub-committee has written to the area medical committee, the chairman of the board and the Cabinet Secretary.” The escalation to the Cabinet Secretary appears to indicate a lack of confidence, whether justified or not, in the management arrangements.

Staff in general surgery told us they felt disengaged from both clinical and non-clinical senior leaders (those above middle management) within the organisation. They felt senior leaders had little knowledge of what was going on in their clinical areas and were not engaged with staff generally. Staff told us they felt valued by their colleagues and immediate managers, but not by senior managers. A number of senior consultants told us of their poor relationship with managers and what they felt was unwillingness by managers to accept medical advisory input.

Staff in general surgery provided an example where clinical areas were being refurbished, but staff working in these areas had not been consulted or involved in the process. They were, therefore, unclear how the finished area would look and if it was practical for patients. Some staff felt there was a lack of information and communication from managers about what was going on generally within the hospital and NHS board. However, we did speak to some staff who were positive about their relationship with their managers up to middle manager level. The majority of staff we spoke with felt that after this level, the engagement was lost. For example, staff in care of the elderly were mostly positive about immediate line managers and felt supported by them, but felt that communication fell down beyond that.

We spoke with a senior charge nurse whose nurse manager was on sick leave. We were told senior charge nurses were taking turns in taking the bleep and covering the shift. The senior charge nurse felt disconnected due to poor communication from senior management. They did not feel as supported or as informed as they should be as information was not filtered through due to the nurse manager being on sick leave. As a result, the senior charge nurse felt out of the loop.

As with other specialties, discussions with staff in obstetrics and gynaecology gave a picture of disconnect between frontline staff and senior management. Staff

---

Box 1

In the emergency department, senior medical management were aware that some consultants were disrespectful to colleagues and spent time in their offices rather than leading the team, but failed to take effective action. Clinicians have a high level of mistrust in the management hierarchy, including the medical management. In this department, we could find no demonstrable support for clinical leaders at lower levels from more senior managers, and the absence of a leadership strategy or organisational values that bound the organisation together.

We noted in various minutes of advisory committee meetings there was extensive reference to difficult issues and poor working relationships, which sometimes resulted in matters being escalated within and beyond NHS Grampian. For instance, the 12 December 2013 minutes of the Consultants Sub-Committee of the Area Medical Committee stated: “Opened the discussion by summarising the position from the perspective of general and vascular surgeons that the proposed plans to relocate general surgery would be the equivalent to a 40% reduction in bed space provision...the general surgeons sub-committee has written to the area medical committee, the chairman of the board and the Cabinet Secretary.” The escalation to the Cabinet Secretary appears to indicate a lack of confidence, whether justified or not, in the management arrangements.

Staff in general surgery told us they felt disengaged from both clinical and non-clinical senior leaders (those above middle management) within the organisation. They felt senior leaders had little knowledge of what was going on in their clinical areas and were not engaged with staff generally. Staff told us they felt valued by their colleagues and immediate managers, but not by senior managers. A number of senior consultants told us of their poor relationship with managers and what they felt was unwillingness by managers to accept medical advisory input.

Staff in general surgery provided an example where clinical areas were being refurbished, but staff working in these areas had not been consulted or involved in the process. They were, therefore, unclear how the finished area would look and if it was practical for patients. Some staff felt there was a lack of information and communication from managers about what was going on generally within the hospital and NHS board. However, we did speak to some staff who were positive about their relationship with their managers up to middle manager level. The majority of staff we spoke with felt that after this level, the engagement was lost. For example, staff in care of the elderly were mostly positive about immediate line managers and felt supported by them, but felt that communication fell down beyond that.

We spoke with a senior charge nurse whose nurse manager was on sick leave. We were told senior charge nurses were taking turns in taking the bleep and covering the shift. The senior charge nurse felt disconnected due to poor communication from senior management. They did not feel as supported or as informed as they should be as information was not filtered through due to the nurse manager being on sick leave. As a result, the senior charge nurse felt out of the loop.

As with other specialties, discussions with staff in obstetrics and gynaecology gave a picture of disconnect between frontline staff and senior management. Staff

---

20 Minutes of the Consultants Sub-Committee meeting of the Area Medical Committee 12 December 2013
reported that they felt supported by their immediate manager. One consultant felt there was no feeling of leadership or vision within the division and there is a general disengagement with senior management.

Staff in obstetrics and gynaecology wards told us that senior management assume staff will just cope and get the job done. We were given many examples of staff coming together and helping each other out, for example coming in on days off to cover a shift where someone was off sick. Staff felt that they were continually “fighting fires” and never got the chance to give the quality of care they felt their patients deserve. Some days they were only able to deal with emergency situations.

Staff, particularly doctors, told us about their relationship with hospital management. We were told that management support was very mixed and that there was a high turnover of managers and, therefore, there was little managerial continuity. Staff also acknowledged that some groups of staff monopolised managers’ time. We were also told that the “relationship between clinicians and managers had gone badly awry” and that, while this had not affected patient care, it had the potential to do so.

One clinical director told us they felt there was not a lot of interaction with executive management. They assume everyone has the knowledge to do their job. The clinical director told us there was no development or support for their role. Clinical director group meetings had felt very one sided and more like a team brief led by the medical director.

A clinical director and a clinical nurse manager told us they felt there was a reliance on staff at their level just to get on and do the right thing without being guided or led. The clinical director said they had been given no idea from higher management of how they were performing. The clinical nurse manager told us that they felt out of their depth and swamped at times. They had little or no support from their line manager and no formal one to ones and said this was not because the line manager was disinterested, but because they were too busy and stressed in their role.

Both clinical and managerial staff complained of frequent restructuring and movement of junior managers as soon as they became familiar with an area.

A large number of staff reported that they would welcome more leadership walkrounds in their area, as this was currently not common practice. One senior charge nurse in a ward told us that on the rare occasion that there had been a leadership walkround, they had been told by senior management to bring extra staff in to ensure that the chief executive saw there was enough staff on the ward.

8.12 We noted that feedback from allied health professionals and pharmacy staff was generally positive in terms of relationships within their own internal management structure. Most of these staff felt engaged with their line managers, but, consistent with the wider picture, they did not feel engaged with levels of management above their line manager.

8.13 We did hear positive views about the value and potential of the clinical lead role. There are around 25 clinical lead roles in Aberdeen Royal Infirmary, covering a range of specialties and services. However, we recognised that the role needed to be clarified and strengthened. In December 2013, the Area Medical Committee
undertook a survey of clinical leads. The survey report noted that the role of lead clinician had diminished since it replaced the head of service role. Twenty five clinical leads from Aberdeen Royal Infirmary were interviewed in the survey. Nine out of 25 believed they did not have sufficient time to do the job and eight of the 25 reported they did not feel involved in strategic decision-making. Only eight out of 25 had received a job description.

8.14 NHS Grampian had initiated work since the validation visit to try to improve relations and interaction between the Board and the advisory structures. For example, it held an event on 10 June 2014 to “bring the whole advisory structure together to review the position and identify how its contribution and influence can be enhanced.”\(^{21}\) However, we acknowledge the continued difficult relationships and more recent organisational upheaval in NHS Grampian.

8.15 Based on the Medical Engagement Scale survey results, review team visits and evidence provided, we concluded that the ‘fracture’ between management and clinicians is very significant. There is a deep seated mistrust and poor communication between senior management and some senior staff in particular.

8.16 The underlying causes for this are complex and varied, but it was evident that there were exceptionally poor levels of clinical (especially medical) and managerial engagement on the Aberdeen Royal Infirmary site that ultimately impede the effective and efficient management of operational and clinical services.

8.17 In summary, there was:

- in general, a substantial disengagement between medical staff and management in Aberdeen Royal Infirmary
- poor working relationships between management and medical staff in several major clinical services over a significant period of time
- evidence of some positive working relationships, but generally fragile working relationships between clinical staff and senior management in Aberdeen Royal Infirmary
- poor communication between layers of management and clinicians and with more senior management, with evidence of better working relationships at lower levels, and
- insufficient clarity on the role of the clinical leads and inconsistent understanding about their leadership contribution.

**Inappropriate behaviours and leadership**

8.18 We were told of examples of extremely poor behaviours and practices by a minority of medical staff that had been left unresolved. These included:

- undermining colleagues
- bullying and threatening colleagues
- airing conflicts in front of patients
- not spending adequate time in ward areas, and

\(^{21}\) Letter of 2 April 2014 from Chief Executive of NHS Grampian
• excluding colleagues from meetings.

8.19 The evidence pointed to the management in Aberdeen Royal Infirmary and NHS Grampian being unable to consistently, visibly and robustly resolve such behaviours. This has had a demoralising effect and has allowed issues to grow.

8.20 There were also intra-departmental tensions, adversarial relationships and poor team working in several specialties that staff reported had a consequentially, negative impact on the effectiveness of the service, such as obstetrics and gynaecology, the emergency department, and general surgery.

8.21 The poor behaviour displayed by a small number of consultants has had a disproportionate impact on colleagues and on the working environment. We noted the absence of meaningful action by those in leadership positions to address such behaviours and were therefore complicit in allowing the behaviours to continue.

8.22 We heard there has been a culture within general surgery where clinical and managerial colleagues are often discussed behind their backs, which can lead to significant misunderstanding. The Royal College of Surgeons (England) (RCS), at the invitation of NHS Grampian, also carried out a review of the general surgical service in September 2014. The RCS review confirmed the poor team working and inappropriate behaviours. “Significant number of the surgeons working within general surgery had exhibited unprofessional, offensive and unacceptable behaviour. This included examples of conflicts between surgeons in the presence of trainees and on some occasions even in front of patients. These disruptive behaviours and the breakdown in team working were said to have affected the quality of the delivery of patient care.”22

8.23 During the course of the review, some consultants from general surgery made serious allegations about the behaviour, competence and probity of colleagues. These are very serious allegations and we have referred these to NHS Grampian for further urgent investigation.

8.24 We heard evidence from individuals in clinical leadership roles about a lack of practical and timely support or intervention from more senior leaders in NHS Grampian in resolving such behaviours. These behaviours manifested themselves in examples such as refusal to engage in the consultant job planning exercise and in the allocation of on-call rotas.

8.25 Box 2 below lists examples that a number of staff told us about concerning the behaviour of other staff.

Box 2

We heard of highly inconsistent consultant approaches to ward rounds and ward care in general surgery. Some consultants would not see patients who did not have a condition within their specialty interest. A few consultants were sometimes openly critical of each other’s management of patients. Consent for major surgery was sometimes obtained inappropriately by junior staff so that patients did not understand what was proposed. Such consent cannot be regarded as fully informed.

---

22 Royal College of Surgeons (England) summary feedback letter to NHS Grampian Medical Director dated 9 September 2014
and in line with GMC guidance 23 even if the plan is clinically sound.

We heard evidence that some consultant surgeons did not always attend the safety brief before surgery, with often the anaesthetist leading the safety brief and nursing staff leading the safety pause. Consequently, consultants then ask for different or additional equipment during surgery, which means that theatre staff have to then leave the theatre mid-surgery to find the equipment. Had the consultant taken part in the safety brief, this would have been discussed at that point in time. We had serious concerns about non-attendance at safety briefs before surgery. In many NHS boards, non-attendance by the consultant would mean the consultant would be prevented from operating. Staff told us that they had reported this to senior colleagues or through Datix, but nothing had been done, so they had stopped reporting these concerns.

Behaviours of consultants in some general surgery mortality and morbidity meetings were reported to be particularly unprofessional and aggressive on occasions. Some staff had reported that they had left the meetings or others had been asked to leave due to the aggressive nature of the behaviours. Some staff also told us that they did not believe these meetings were multidisciplinary or inclusive. As a consequence, not all appropriate staff attended these meetings.

Staff from general surgery cited examples of inappropriate behaviour, including questioning of clinical decisions and rudeness being displayed in front of staff, including trainees and patients in some instances. Patients had on occasion then complained to ward staff about the behaviour of some consultants.

Some consultants pressurised their colleagues not to apply for management posts. They have then refused to recognise the legitimacy of individuals they did not approve of in these roles.

We were told by several interviewees, in general surgery and the emergency department that a small group of senior consultants dominated their departments and that relatively minor issues were handled by conflict rather than support. On the other hand, serious issues were allowed to fester and were not addressed. Many consultants simply kept their heads down. The 29 November 2013 minutes of the acute sector management team stated that the deputy medical director “…felt that there was little benefit to communicating the dress code policy to medical staff again in a global fashion as in the past it had little effect. That said, he advised if someone is posing an actual ‘risk’ to the patient in terms of their attire, then it was entirely acceptable to address it with them directly.” 24 A consultant told us that they had written saying that they did not agree with the dress code. The failure of management to take action contributed to a feeling amongst other staff that consultants can simply ignore the rules.

A large number of staff told us there is a perception that there are no consequences for consultants who behave inappropriately; therefore, they continue to do this, seeing it as acceptable behaviour.

Several managers told us that some consultants see themselves as ‘untouchable’. These consultants told managers that clinicians would tell managers what to do and

---

24 Acute Sector Management Board meeting 25 November 2013
threatened escalation to Scottish Government. We heard remarks by some consultants that confirmed this.

Some staff in obstetrics and gynaecology reported they are made to feel undermined and isolated by a small group of senior staff. We heard examples where staff members are advised to keep their “head down”. Staff reported that there were a “small group of consultants that controlled everything” and that there was certain equipment that was only available to certain members of staff.

Various staff from the labour ward reported that there was undermining of junior staff that could be considered to be bullying or harassment. Most staff reported a strong working relationship with their colleagues, but there were one or two individuals who were more abrasive than others. Other staff members felt that everyone was stressed due to the low staffing cover and tempers could sometimes fray or that some people could not handle reflective criticism.

We heard examples within care of the elderly of an engaged service where consultants retained responsibility for patients ensuring good continuity of care. The service had excellent multidisciplinary relationship across a number of teams including respiratory medicine.

8.26 We can summarise that there was:

- evidence of poor behaviours and inability of senior management to resolve issues regarding inappropriate behaviour, and
- an acceptance by staff that inappropriate behaviours will inevitably occur, thereby allowing issues to persist rather than seeking appropriate avenues to address them.

Relationships between operational services, clinicians and strategic planning

8.27 We identified a lack of engagement of clinicians in some service development initiatives.

8.28 In some areas, such as geriatric medicine and respiratory medicine, there were good examples of initiatives to transform the service. However, in other services there was a serious disconnect between the views of clinicians and the NHS Grampian perspective for the development of the service. This was especially the case in the emergency department.

8.29 In April 2010, the Board approved an emergency care centre following approval of an earlier outline business case in 2008. This was a major development intended to change clinical pathways and, therefore, impacted on the way many staff work. The centre is much more than the emergency department. It has over 300 beds including most of acute medical, geriatric and medical specialty beds. The emergency care centre was opened in December 2012. The unscheduled care plan was approved by the Board on 4 June 2013, and a further update was provided to the Board in December 2013.

8.30 At the validation visit, and subsequently in the course of the short-life review, there was repeated mention that concerns had been raised about the practical delivery of
the model of unscheduled care as expressed in the unscheduled care plan approved by the Board. A key element of the model was the proposal to establish a multidisciplinary team of unscheduled care advanced clinical practitioners, to contribute to managing the demands on the ‘front door’ of Aberdeen Royal Infirmary. The briefing for staff contained within the December 2013 Board paper refers to:

“A flexible advanced clinical practitioner workforce including advanced/emergency nurse practitioners, physician assistants and paramedic practitioners will also be developed in collaboration with primary care practices. This will significantly increase the number of trained staff available.”

8.31 In our view, it was clear that the vision outlined to the Board did not command the confidence of many important clinical staff, who were fundamental to the successful implementation of the redesigned service. Attempts to persuade them or a revision of the plans had not achieved success.

8.32 A large number of staff referred to the model of a multidisciplinary team being unsafe and unworkable without equal attention being given to the need to secure round-the-clock senior medical expertise in the management of the most severely ill and trauma patients.

8.33 Before the papers were submitted to the Board in 2013, concerns were expressed by staff about the sustainability of the service. An emergency medicine workshop was held on 25 January 2013 to explore the future design of the service. It concluded that an expansion in the consultant workforce was required to sustain a safe and comprehensive service.

8.34 On 15 February 2013, all 10 emergency medicine consultants wrote to the unit operational manager expressing concerns about the “perceived risks to the continued provision of emergency care in Grampian...we are concerned that there will be a collapse in the ‘middle grade rota.” There was no response to this letter. On 1 May 2013, the consultants escalated a further letter to the chief executive of NHS Grampian. The response received from the then acute sector general manager, responding on behalf of the chief executive, acknowledged that they recognised the “emergent middle grade staffing issues cannot be attributed to any single event, it is unfortunate that these were not fully addressed by the sector. I note these had been highlighted to the unit operational management level, but with only marginal progress being made in resolving or indeed escalating such challenges further.”

8.35 The clinical lead wrote again on 24 September 2013 to senior management in NHS Grampian stating that: “It should come as no surprise that NHS Grampian’s performance against the 4-hour standard has deteriorated since August. This was predicted by the emergency medicine consultants many months ago due to the reduction in trainees in the department.....In the next few months the emergency department will face a crisis in middle-grade staffing. For us to avoid a catastrophic reduction in both performance and safety in the emergency department we have a very short time to have a clear plan of how this will be managed.”

25 Report to NHS Grampian Board meeting 3 December 2013
26 Letter from emergency department consultants to Unit Operational Manager 15 February 2013
27 Letter from Acute Sector General Manager to Clinical Lead for Emergency Department 2 May 2013
28 Email from Clinical Lead to Senior Management in NHS Grampian 24 September 2013
8.36 In late January 2014, a paper was produced by the sector general manager on emergency department pressures\(^{29}\). It highlighted the significant implications of changes in middle grade staffing with effect from August 2014. We were informed by senior management that the paper was deemed to be unaffordable and unviable, at that time, with regard to the proposals for an expansion of the consultant establishment.

8.37 An email in March 2014 from one emergency medicine consultant to the chief executive of NHS Grampian drew attention to “beyond the consultant resignations….our medical staffing will undergo a startling reduction between now and August primarily because of a precipitous fall in trainee numbers. This will further compound the difficulties that we have in delivering a safe, efficient and sustainable emergency department.”

8.38 The most recent report\(^{30}\) as of September 2014 produced by the then medical director identifies serious difficulties in delivering the proposed model of care approved by the Board, especially regarding the multidisciplinary team. The report acknowledges that the redesign of emergency services “has not produced the desired outcomes to date.” The report also points to the fact that the “multidisciplinary team of specialists at the front door never materialised.” The report states:

> “Without the multidisciplinary capacity on the clinical floor and with the acceptance of admissions determined by concerns around bed availability, the emergency department’s clinicians are unable to focus on their main responsibilities relating to major illness, resuscitation and trauma. They are forced to provide clinical capacity to manage the high volume of a wide range of clinical and non-clinical presentations to the department. As a result, out of an existing number of 16 emergency department clinicians, some nine are required during any one episode of 24 hours to maintain the service safely. This is unsustainable even if and when the clinical capacity in emergency medicine was restored to its full establishment. This has given rise to representation by these clinicians to the NHS Grampian Board and the Scottish Government to express their concerns on two consecutive occasions three months apart.”

8.39 The position set out in the September 2014 report reflects the outcome that many of those raising concerns, over many months, both feared and predicted. Therefore, we are extremely concerned that the serious warnings raised by staff were not heard or effectively responded to by the senior management in NHS Grampian. This represents a serious failure by NHS Grampian.

8.40 More generally, we heard concern expressed about a perceived disconnect between strategic planning and the operational and clinical services on the Aberdeen Royal Infirmary site. We heard about a range of initiatives being progressed spanning service improvement, organisational development and service planning. A large number of individuals (some at a senior level) who spoke with us appeared to be unaware of how the strategic planning process was aligned to support the operational and clinical improvement activities at Aberdeen Royal Infirmary.

8.41 We consider that NHS Grampian has tended to adopt a ‘top down’ approach to the

\(^{29}\) Paper by Acute Sector General Manager ‘Aberdeen Royal Infirmary (ARI) Emergency Department’ January 2014

\(^{30}\) Situation, Background, Assessment and Recommendations report by Medical Director September 2014
strategic planning and redesign of services. We are concerned that there is serious disconnect between the strategic planning processes and clinical and operational services. As a consequence, there is a mismatch in priorities and understanding regarding the practical delivery of clinical services and the development of strategic plans.

8.42 The box below lists further examples about the nature of relationships.

**Box 3**

<table>
<thead>
<tr>
<th>We heard from staff working in general surgery that they felt like they were working in silos across the hospital and the NHS board. They reported that they did not know what was going on in other services or departments. This made it difficult to provide a seamless service for patients and also to share good practice or learn from any mistakes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff working in the intensive care unit told us they felt they had little or no connection with the high dependency units. Following a serious incident in the neurology high dependency unit, which saw the unit close temporarily and transfer to the intensive care unit, staff felt they worked well together. However, they were critical of how management communicated about the situation and felt it could have been handled in a much better way.</td>
</tr>
<tr>
<td>While staff in care of the elderly felt that relationships with other parts of the hospital had improved since the move from Woodend Hospital to the Foresterhill site, they acknowledged they could still be improved. In orthopaedics, we were told that, while consultant geriatricians visited patients on the ward, there was little communication. Consultants did not provide feedback when leaving the ward and nurses on the ward did not have the time to join them on ward rounds. As a result, the majority of communication was through patients’ medical records. Staff in care of the elderly and other associated services also reported that they felt like they were working in silos across the hospital.</td>
</tr>
<tr>
<td>Staff in surgical wards informed us about the boarding of medical patients. Instances were reported of patients not being reviewed properly and/or having to be returned to their original wards to be properly reviewed. We also heard that some consultant surgeons would not allow their foundation doctors to provide basic care to these patients, which again is not in line with GMC guidance(^{31}) and potentially placed patients at risk. Staff reported that some patients had multiple moves between wards during their stay. This was demonstrated during the unannounced inspection of the care for older people in acute hospitals. Staff in orthopaedic wards reported that they sometimes have problems moving orthopaedic patients from their ward to rehabilitation wards or units within NHS Grampian. This results in beds in their wards being blocked and unavailable for acute patients.</td>
</tr>
<tr>
<td>In care of the elderly, staff also told us that patients were sometimes boarded in other specialty wards. Staff told us that patients were sometimes moved between wards overnight. Again, this was demonstrated in the unannounced inspection of the care for older people in acute hospitals. Staff told us that local policy restricts patients with an abbreviated mental test (AMT) score of 8 or lower being boarded, but that it was not clear how strictly this is applied. Staff stated that consultants are</td>
</tr>
</tbody>
</table>

generally good at identifying patients who should not be moved. We were also told that, as patients still required care of the elderly input, the distance to patients who had been moved to other areas of the hospital, or to Woodend Hospital, could pose a problem.

Staff in the emergency department told us that there were often difficulties moving patients from the emergency department to wards, especially in care of the elderly, as ward staff were selective in the patients they took. Staff in care of the elderly stated that they often felt put upon and blamed for patient flow problems and resented the historical view that they did not do enough to help patient flow.

Leadership and culture conclusions

8.43 We concluded that there has been a lack of leadership and effective management by the Board, the executive team and the hospital management team. In addition, a small number of consultants have acted to undermine management and have exhibited poor behaviour. It is unlikely that optimum care for patients can be provided in the settings where this behaviour was most evident.

8.44 We found dedicated and hard working individuals at all levels, particularly those in frontline roles, who are committed to delivering the highest standard of healthcare to the population of Grampian. However we are concerned that many aspects of the current working arrangements, particularly those dependent upon goodwill, will be unable to meet future demands on the system.

8.45 We found that the failings of leadership had manifested itself in a number of ways and has contributed to a culture in which communication, engagement and support to develop, plan and implement change has become difficult to manage across a number of key specialties. Examples include:

- a perception of poor leadership and management visibility, communication and engagement with medical staff
- failure of leadership to effectively engage with key service staff, for example the emergency care centre and issues of patient flow resulting from this major service development
- a lack of clarity of management and leadership have made consultants reluctant to take on formal management roles
- poor behaviour, including bullying which has not been resolved over a considerable length of time
- poor supervision and education for doctors in training
- a breakdown in professional relationships within and across some specialties, resulting in an inability for key staff to effectively collaborate, develop and manage
- low morale, disengagement from management, a forceful style of management
- only 60% of consultants had completed job plans at 15 July 2014 and this is a recurrent problem. We heard that senior consultants in general surgery had actively urged colleagues not to sign job plans, and
• one of the surgical units is seriously dysfunctional and there are serious allegations about individual consultants which have not, to date, been resolved.

8.46 We expect NHS Grampian to develop an action plan to address the following recommendations.

Leadership and culture recommendations

6 NHS Grampian should carry out a fundamental review of the acute sector leadership with the emphasis on ensuring clear accountability and a delivery focus in respect of acute services and Aberdeen Royal Infirmary in particular.

These arrangements should include:

• an appropriate balance between structural redesign and establishment of effective leadership, whilst securing a strong focus on delivery of key objectives
• reporting lines, remits and performance of committees and individuals that are clear, unambiguous and regularly measured
• executive level professional leadership for escalation and governance of concerns regarding the currently disjointed and unclear workforce data
• opportunities for leaders and managers at all levels of the organisation to be supported through training, their peers and the managerial hierarchy to fulfil their respective roles
• a review and revision of the medical management structure (medical director, divisional clinical directors, clinical directors and clinical leads) to ensure there is clarity and consistency of job role and purpose and include job descriptions, contracts objectives and resource, and
• a review and revision of the medical advisory structure to ensure appropriate, representative, valued and effective engagement and contribution. The final structure should integral to the overall multidisciplinary professional advisory structure, and should not appear to operate outwith that professional advisory structure.

7 NHS Grampian should take urgent action to engage fully with all clinical and non-clinical staff.

The plan should:

• build on recent work to address engagement of clinicians
• acknowledge the large positive contribution made by the majority of staff, whilst addressing behaviours that undermine the organisation and where applicable adhere to GMC mandatory regulatory standards
• specifically include work to address the issues identified in the Medical Engagement Survey, and
• include a consistent, fair and comprehensive approach to dealing with adverse staff behaviour in all groups of staff.

9 Governance and accountability

9.1 We assessed the governance and accountability arrangements to inform our review. Our findings are contained below under the following headings:

- advisory committee relations
- clinical, operational and managerial control
- clinical governance of services
- Datix system, and
- use of data to raise performance and the quality of care.

Advisory committee relations

9.2 The review team noted a particularly difficult, and often extremely adversarial, relationship between the Board and the executive team, and two particular professional advisory committees - the area medical committee and the consultants sub-committee. The consultants sub-committee is not a formal advisory committee but a sub-Committee of the area medical committee.

9.3 The review team heard strong views from both the senior management of NHS Grampian and the members of the area medical committee and the consultants sub-committee about their roles and responsibilities, in shaping the future priorities and direction for acute services. It was evident that there was a significant difference in views regarding roles and responsibilities and ultimately this impinged on perceptions about how and where decisions should be made in NHS Grampian.

9.4 The relationship between professional advisory committees and senior management is a crucial one, dependent upon trust and open channels of communication. Each has a different role, but equally each needs to give appropriate respect to the other’s position and their contributions.

9.5 Scottish Government guidance (CEL 16 (2010)) states that NHS boards should:

“ensure effective arrangements are in place to promote and encourage the active involvement of all clinicians from across the local NHS system...to inform NHS Board decision making processes”.

9.6 This guidance emphasises the central role of the local Area Clinical Forum (which includes representation from the professional advisory committees) in acting as a conduit of clinical advice to the NHS board. It has a pivotal role in contributing to the effective engagement of clinical staff in the design and delivery of healthcare. The chair of the area clinical forum is, like other NHS boards, a non-executive member of the board of NHS Grampian.

9.7 The review team acknowledged the difficult relations evidenced between the NHS board and the executive team with the two professional advisory committees, but also noted the apparent absence of the Area Clinical Forum in resolving these differences.

9.8 The review team believes that there is a fundamental need to establish a new basis for the relationship between the Board of NHS Grampian and the area medical
committee and the consultants sub-committee. This should reflect - more broadly - the role of the professional advisory committees in playing a visible, active and meaningful role in providing professional clinical advice to the Board. NHS Grampian should acknowledge the contribution of such expertise in its decision-making processes. Similarly, the professional advisory committees must respect the role of the Board, the executive team and the acute sector management team in providing the strategic leadership and in the operational management of services. The Area Clinical Forum should play an active part in the establishment of a new and more productive set of relationships.

**Clinical, operational and managerial control**

9.9 The acute sector on the Foresterhill site consists of five divisions. The review was initially confined to Aberdeen Royal Infirmary, but subsequently extended to the Aberdeen Maternity Hospital to include a review of the obstetric service.

9.10 The acute sector has been through a series of organisational changes in recent years, with the creation of new divisions and the more recent re-allocation of services between divisions. One senior manager pointed out that they had three different line managers in the space of two years and another individual commented that they had three changes in 18 months and the reasons for the changes were unclear.

9.11 The minutes of the 2 September 2013 Area Medical Committee noted the rationale for the changes as expressed by the then general manager for the acute sector:

“Historically the acute sector had five divisions and there had been inequity across the platform regarding targets and hence it was felt that a more robust structure with six divisions was required...and the revised structure was implemented on 1 July 2013 to provide a better balance of a range of services and financial aspects with agreement to review after 3 months.”

9.12 The acute sector management team is intended to be the focal point for the operational leadership of acute services in NHS Grampian, which includes Aberdeen Royal Infirmary. It is chaired by the general manager for the acute sector.

9.13 Despite its significant role, we heard evidence that the acute sector management team lacked sufficient focus, authority and presence.

9.14 We found that there was a lack of clarity about the organisational structure, lines of accountability and leadership in Aberdeen Royal Infirmary. The vast majority of staff we spoke with said that they were unable to understand how decisions were made and were also unable to consistently describe to us the lines of accountability. There was a strong and consistent reference to a dysfunctional management structure and a ‘reactive culture’. This perception was shared by those who themselves are in senior roles. In the words of one divisional clinical director: “There is confusion, uncertainty about how things are done...a complex structure, ripe for confusion.”

9.15 We heard a strong and consistent message that there was not a cohesive, visible and effective senior management team for the acute sector. One senior manager reported that their primary focus was on managing the “fortress” of their particular

---

33 Foresterhill site encompasses Aberdeen Royal Infirmary, the Aberdeen Maternity Hospital and the Royal Aberdeen Children’s Hospital
34 Area Medical Committee minutes 2 September 2013
division, rather than contributing to the collective leadership of the acute sector.

9.16 We expressed serious concern during the review visit that there was no operational or work plan for the acute sector and Aberdeen Royal Infirmary in particular. There was reference to work under way to develop an operational plan, but it was confirmed that such a plan did not formally exist, beyond the drafting stage, nor had it existed in recent years. This shortcoming impacted on the focus and clarity concerning the delivery of objectives and resultant performance management.

9.17 We considered the minutes of the acute sector management team and the previous acute sector Board. We noted a particular absence of expected performance management data and operational issues in the minutes, and an inconsistent approach to recording proceedings. There was no clarity about decisions made or actions to be taken. The level of attendance at the meetings was highly variable. There were no formal meetings of the acute sector management team from the start of December 2013 to the end of March 2014 due to cancellation of meetings or the decision to hold informal meetings.

9.18 As at August 2014, we noted that (at month five) personal objectives for the current year had not been finalised and agreed with the divisional general managers or the divisional lead nurses.

9.19 In the absence of clear and decisive leadership and well-understood governance arrangements, we noted examples of staff operating outside normal lines of accountability to achieve their required objective. For example, by going direct to the chief executive of NHS Grampian to seek resolution.

9.20 We were informed that a new set of management arrangements were being introduced. We heard different interpretations of how the model would work in practice and differing perspectives about the relationship between quality management and the governance of operational services. However, it was noted that there was currently no consistent approach to bring together the divisional general managers, lead nurses and clinical directors as a single, effective and cohesive leadership unit for the acute sector. We were told that the medical director attends a clinical directors forum.

9.21 The new divisions, established in 2013, have wide areas of responsibility. The span of control of managers in the divisions is considerable. We also noted the change in the responsibilities of divisional nurse managers who had moved into divisional lead nurse roles in 2013. In being appointed to the position of divisional lead nurse, they initially had no line management responsibility. However, the post now holds line management responsibility for nursing staff.

9.22 The unit operational management expressed concern about their span of control, remit and heavy workloads. There was consistent concern expressed about the lack of involvement in the design of the new management structures and the turnover in senior management in recent years. The absence of a forum for bringing key managers together was highlighted as a significant deficiency, which prevented resolution of operational issues and mitigated against a concentrated effort in addressing hospital-wide performance issues.
9.23 The box below lists examples of issues staff told us about clinical, operational and managerial control.

**Box 4**

<table>
<thead>
<tr>
<th>The emergency care centre was cited as an example where there was a lack of clarity about the accountability for ensuring strong, visible and cohesive operational leadership and management. Difficulties in resolving the issue of boarding patients into general surgical care beds and ensuring continuity of care was one example of a failure to define where responsibility lay.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We heard multiple accounts of a lack of clarity around the decision-making processes in Aberdeen Royal Infirmary. We heard from clinicians and managers that there was a failure to make decisions when issues were escalated. Equally, a large cohort of managers (both senior and middle) expressed concern and frustration that they were unable, or prevented from making decisions that matched the authority vested in their roles. One divisional clinical director informed us that processes around decision-making and decisions around priorities were obscure.</td>
</tr>
<tr>
<td>We heard of frustration from those in less senior managerial positions and in clinical roles. Staff in these roles informed us of a lack of performance management information, lack of clarity as to how or why decisions are made by those above them and insufficient clinical input into decision-making. They also informed us of disengagement between high level and the front line, competing challenges and inconsistent responses.</td>
</tr>
</tbody>
</table>

9.24 We noted a lot of activity at ward level, but disengagement from above, a lack of joined-up thinking and a sense of learnt helplessness pervaded the evidence presented. Fundamentally, there was a lack of clarity about the executive leadership for acute services, and for quality and safety of care in Aberdeen Royal Infirmary. We noted a significant disconnect between the senior leadership team and the clinical and operational services at Aberdeen Royal Infirmary. One charge nurse commented that: “Senior management are very detached from day to day frontline work and don’t understand how serious things are.” There was a consistent message of issues being escalated up the chain of command, but not being satisfactorily addressed or being met with silence. Junior and middle managers reported feeling that they were not well supported by senior managers.

9.25 We noted the absence of a strong and well-understood governance structure, such as the lack of an operational plan, unclear management arrangements and clarity of decision-making processes. We, therefore, concluded that there were serious weaknesses in the underlying system of clinical, operational and managerial control in Aberdeen Royal Infirmary. These deficiencies manifested themselves in a lack of transparency in decision-making and prioritisation, and reactive and ineffectual management.

**Clinical governance of services**

9.26 NHS boards have had clinical governance arrangements in place since 1999. Clinical governance is defined as the “system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care
will flourish.”35

9.27 We considered the work of NHS Grampian’s acute sector clinical governance group which reports to the Board clinical governance committee. The team noted that the primary aim of this group is “to question whether the NHS Grampian acute sector is appropriately managing clinical issues related to the delivery of person centred, safe and effective care.”36

9.28 We noted the consistent absence of senior management and senior clinicians from the acute sector clinical governance group meetings over the course of 2013 and 2014. NHS Grampian acknowledges in various minutes and the 2013 acute sector clinical governance group review that attendance is generally low. Given that the meeting’s purpose is to assess whether NHS Grampian’s acute sector is appropriately managing clinical issues related to the delivery of person-centred, safe and effective care, the low senior leadership attendance at the meeting was of serious concern.

9.29 We noted ambiguity for the clinical governance arrangements that were in place and how they came together to form a coherent and robust system of assurance. The minutes of 8 April 2014 meeting highlighted that:

“The way that issues/reports brought to this acute sector clinical governance group needs to be more robust than it currently is...[and] that it is not always clear to others that acute sector clinical governance group is actually an assurance group, as it can sometimes be thought of as a “solving” group. It was clarified that issues should only be brought to the acute sector clinical governance group if there is a plan already in place to deal with the issue being tabled. [It was] suggested having a divisional slot at each meeting/on the agenda and confirmed that the divisions did not have to follow the same governance “system” but a confirmation each division was using a system was required.”36

9.30 It was noted that an acute sector quality steering group was also established to support the delivery of the quality strategy. The steering group is described as being “responsible for leading and delivering the quality agenda in the acute sector.”36 The group had five sub-groups to lead work covering: education and training; clinical operations; medication and devices; incidents, complaints and feedback; and the communications group. One of the papers for the July 2014 meeting said there were now four strands of work, and it appeared that the ‘incidents, complaints and feedback’ strand had been deleted.37

9.31 At the 8 April 2014 meeting of the acute sector clinical governance group: “It was noted that the quality and safety steering group had not met in some time. The 5 sub-groups were continuing to meet and it was suggested that it can be difficult to motivate members of these group to carry out the work discussed at the sub-groups when there is no reporting forum for them...the main reason for the lack of recent quality and safety steering group meetings was due to lack of attendance by members...there is always the intention to have the meeting but often too many apologies are received in advance to make the meeting worthwhile.”38

36 NHS Grampian Acute Sector Quality Steering Group report (April 2013) presented to ASCCG
37 Acute Sector Clinical Quality Strategy Update by Deputy Medical Director (July 2014)
38 Acute Sector Clinical Governance Group meeting minutes 8 April 2014
9.32 We considered that there were weaknesses in the established system of clinical governance. There was a lack of focus, structure, follow-up and meaningful executive and clinical engagement in the work of the acute sector clinical governance group. This was partly acknowledged in the paper produced by the deputy medical director. In our view, the current arrangements did not comply with the NHS Grampian clinical governance statement of intent to “ensure that the necessary structures and processes [to] create a culture that promotes responsibility and accountability for clinical governance at all levels within the organisation.”

**Datix system**

9.33 Datix is an information system for capturing and monitoring risks. We heard repeated concerns about the management of risks in the Datix system. There was particular concern expressed about the escalation of issues into the Datix system and the feedback on the management of risks.

9.34 It was reported to us that three out of four surgical groups regularly meet to discuss performance and issues are entered into Datix. However, concerns were raised with us that not all issues, including deaths, have been recorded on Datix and those that have are often recorded months after the death.

9.35 In March 2013, Healthcare Improvement Scotland published a report on the findings from its review of the management of adverse events across NHS Grampian. The report identified some areas of good practice, including the use of information management systems (Datix) and the general engagement and positive culture of reporting. Areas for improvement included the consistent management of adverse events across the organisation, engagement with patients and families, open and transparent decision-making and system-wide learning following investigation or review. During the visits to Aberdeen Royal Infirmary in August and September 2014, we heard from staff (predominantly nursing) that while, in general, they recorded adverse events onto the Datix system they did not always get feedback or see evidence of change or action resulting from their reporting. We asked NHS Grampian to provide us with the details of all the Datix risks and incidents reported during a 12-month period, so that we could see what action had been taken. The key points of that assessment are provided below.

- The majority of adverse events recorded on the Datix system have identified actions. However, it is not clear how these actions are reviewed and monitored through the organisations governance structures.
- There is no recorded rationale on Datix for deciding on the level of investigation.
- There is variation in the way investigations are reported, including different formats and level of detail.
- There is no detailed evidence of feedback provided to staff who report adverse events on Datix.

9.36 Staff informed us of a lack of information or feedback following the recording of adverse events on Datix. Staff within general surgery told us repeatedly that the feedback or action for reporting through Datix is so poor or non-existent that many of

---

39 Acute Sector Clinical Quality Strategy Update by Deputy Medical Director (July 2014)
them no longer use it to record risks or incidents. Concerns were highlighted that, in
terms of clinical incidents, there is often little or no feedback to staff and, therefore,
there is little or no learning to be taken from the incident.

9.37 One clinical director told us they get all Datix entries. However, they and their unit
manager are so busy, they rarely have time to do anything about them.

9.38 Some nurses we spoke with said they had been told by senior charge nurses and
clinical nurse managers not to complete Datix entries about staffing. Consultants also
reported being told not to complete Datix entries about staffing.

9.39 Only one member of staff in obstetrics and gynaecology could tell us what happened
to data collated from Datix. We were informed of ‘communication board’ or ‘safety
board’ that is produced from these data, but we did not hear about this from any
other members of staff.

9.40 We are concerned that restrictions are being placed on the recording of incidents
within the Datix system. It is crucial that NHS Grampian fosters a system that
encourages reporting of incidents and concerns and appropriately embeds a culture
of learning and improvement across its services.

Use of data to raise performance and the quality of care

9.41 We could find no evidence of a robust and consistent performance management
system in the delivery of services in Aberdeen Royal Infirmary.

9.42 We noted that there was material absence of a robust, consistent and comprehensive
suite of performance data to inform operational management and decision-making.
Senior managers informed us that they had to rely on basic, bespoke and ad hoc
systems, such as Excel spreadsheets, to capture performance data. Each division
adopted a different approach to meet their needs. We could find no evidence of
robust data to inform the management of services in the acute sector, nor a system
that used data to challenge and scrutinise the delivery of services. As noted earlier,
there was no evidence that the acute sector management team considers data
systematically and comprehensively.

9.43 There was general and universal concern expressed about the apparent absence of an
effective and obvious system of performance management. An operational manager
commented that: “There is no performance management here. I'm not performance
managed. There is no performance management infrastructure or expectation.” The
deputy medical director reported that a system of performance reviews was in its
“infancy”.

9.44 There was very little awareness among staff we spoke with at divisional level and
below, of the ‘cross system performance reviews’ that are held between the
executive team and service general managers, such as the direct reports to the
deputy chief executive. These meetings are held every second month and cover NHS
Grampian wide service provision.

9.45 The quality of data is crucially important in the management of healthcare. Nurse
managers reported that ward-level data could be extracted from the Lanarkshire
Quality Improvement Portal (LanQIP), an electronic performance management
recording system. However, the data were not extracted proactively or used
systematically. It was also extremely difficult to share and compare data beyond the confines of the division.

9.46 The Scottish Government noted that there was no confirmed bed complement data for hospitals in NHS Grampian and that NHS Grampian had not updated ISD records for over two years. In failing to ensure completeness of local and national statistics, NHS Grampian has compromised the planning of services.

9.47 A separate waiting time management review by the Scottish Government indicated that: “There are currently no prioritised action plans in place for each specialty to deliver improved performance. Minutes of meetings have only very recently been introduced to evidence decisions taken and actions agreed that are then subject to monitoring and review. Dialogue with Business Intelligence and the Waiting List centralised function is limited with little evidence of a coordinated approach to improve and refine access to information to inform future management of waiting times.”

9.48 We noted that NHS Grampian recently introduced an Exemplar Ward Programme as an ambitious programme to improve the quality of care and the patient environment. The overall objective was to deliver ‘excellence in quality care 24-7, for every person, every time’. The Board minutes of 5 November 2013 stated that: “[the general manager] explained work to be done to achieve exemplar status and the aim of having the first exemplar ward by early 2015 then rolling the programme out across Grampian.” We heard that the Exemplar Ward Programme team was dissolved a few months later on 31 March 2014. However, it was reported that the exemplar ward project board continues to meet every two to three months. There was confusion among staff as to whether the initiative was being rolled out and, if so, the resources that would be committed to its successful delivery. There was very variable understanding, awareness or recognition of the Exemplar Ward Programme, back to the floor exercise and the SPSP walkround initiatives amongst individuals we spoke with. NHS Grampian reported that there is continuing commitment to the Exemplar Ward Programme while it is being delivered in a different way to encourage appropriate ownership at division, service and ward level.

9.49 In summary, there was:

- very limited evidence of a co-ordinated and robust arrangement for performance management beyond the cross-system performance review arrangements
- an inconsistent and fragmented approach to the use of performance information across the divisions, and
- a lack of systematic and open challenge of performance in Aberdeen Royal Infirmary.

**Governance and accountability conclusions**

9.50 We concluded that systems of accountability, governance and performance management are absent or weak and need to be substantially improved. We noted a difficult and often adversarial relationship between on one side the Board and executive team and on the other the Area Medical Committee and consultants subcommittee. It was evident that there was a significant difference in views

---

41 Scottish Government review of waiting time management (June 2014)
regarding roles and responsibilities which has impinged on how and where decisions should be made.

9.51 There is a lack of clarity in the management structure which is compounded by a lack of leadership at executive and hospital management level. The executives gave the impression that they believe that the problems that Aberdeen Royal Infirmary faces are in large part due to external factors and cannot be resolved by them. We acknowledge the general challenges that face the NHS, and some particular challenges affecting NHS Grampian, but consider that the executive team should be leading work to mitigate these.

9.52 There has been little stability in management due to both restructuring and rapid turnover. Individual managers at junior level are seldom in a post long enough to understand the department and its issues. Junior managers, and most clinical managers, have little or no decision-making authority. There is a general belief that when decisions are escalated to hospital or Board level management, decisions are either not made or not communicated. We heard multiple comments about emails and letters to managers raising important concerns going unanswered and unaddressed. It was a frequently expressed view that actions were not taken until a crisis was imminent, and then senior managers were drawn in to “fire-fight”.

9.53 The executive team is seen as remote, except by some individuals who rely on personal contacts. The Aberdeen Royal Infirmary management team is also seen as remote by frontline staff. Several months passed before the Aberdeen Royal Infirmary management team met formally. The minutes of the meetings which did take place suggested that they did not consider data or make meaningful decisions. There is little evidence of an effective performance management framework. All of this is of significant concern given the known issues with scheduled surgery, cancer waiting times, nurse staffing, and the emergency department.

9.54 We heard concerns about the lack of learning from reviews of complaints and adverse events. We felt there was inadequate evidence that the clinical governance structures resulted in learning from these sources being spread across the organisation. We also heard about some mortality and morbidity meetings within general surgery being settings for clinicians to aggressively criticise others rather than forums to share learning. Individual behaviours of some consultants in these settings need to be addressed promptly.

9.55 We expect NHS Grampian to develop an action plan to address the following recommendation.

**Governance and accountability recommendation**

8 NHS Grampian should introduce strong and effective governance mechanisms for the clinical, operational and managerial control of services at Aberdeen Royal Infirmary.

These mechanisms should include the following:

- a thorough examination of the effectiveness of the clinical governance function ensuring that it meets the expected objectives of NHS Grampian’s clinical governance strategy
- defined and clear roles and responsibilities of the management and advisory structure (see recommendation 6) to ensure appropriate involvement in the clinical
governance function

- sufficient capacity, for the NHS Grampian Board members, to constructively challenge and to assert their position as a body focused on securing improved health outcomes for the population of NHS Grampian

- defined and clear strategic organisational objectives which link to the objectives of leaders and management of the organisation

- a clear and prioritised operational plan for the delivery of strategic objectives across the acute sector, with accountability for delivery expressed

- a robust performance management framework to monitor delivery of the operational plan. The performance management framework should be based on data which should be routinely collected, distributed and used. Data will come from a variety of sources and should allow managers to share and learn from emerging themes and improve services. For example, adverse incidents, patient experience data and complaints

- arrangements for the acute management team to have regular meetings focusing on delivery, accompanied by minutes and action tracking of progress, and

- arrangements for the medical director to have regular meetings with the associate medical directors and divisional clinical directors accompanied by minutes and action tracking of progress.
10 Staff governance

Nursing workforce

10.1 Like many NHS boards, NHS Grampian faces challenges in a number of areas relating to nursing workforce, including:

- general recruitment and retention of nursing staff
- configuration of substantive nursing and midwifery establishments, including the use of national workforce tools
- the use of temporary or additional staffing
- governance and escalation arrangements when clinical staff are concerned that staffing is so inadequate that it may be jeopardising patient quality of care and safety
- senior nursing structure and visibility, and
- ward staffing.

General recruitment and retention of nursing staff

10.2 We heard concerns from some staff who felt it took too long to recruit staff, although senior charge nurses and clinical nurse managers were, by and large, content with the time period between vacancy approval and the commencement of the staff member in-post. However, they felt they had little or no control in the recruitment process.

10.3 Data provided by NHS Grampian described the actual and budgeted nursing workforce in NHS Grampian between 2009–2010 and 2012–2013. These data indicate a reduction of actual whole time equivalent (WTE) nursing staff from 5,657 to 5,192 across NHS Grampian between 2009–2010 and 2012–2013. There was also a reduction in the budgeted WTE nursing staff across the same period from 5,416 to 5,196.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual £m</th>
<th>Actual WTE</th>
<th>Budget £m</th>
<th>Budget WTE</th>
<th>Difference £m</th>
<th>Difference WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009–2010</td>
<td>£189.1m</td>
<td>5,657</td>
<td>£181.9m</td>
<td>5,416</td>
<td>(£7.2m)</td>
<td>(241)</td>
</tr>
<tr>
<td>2010–2011</td>
<td>£189.4m</td>
<td>5,269</td>
<td>£179.7m</td>
<td>5,105</td>
<td>(£9.7m)</td>
<td>(164)</td>
</tr>
<tr>
<td>2011–2012</td>
<td>£187.7m</td>
<td>5,120</td>
<td>£180.9m</td>
<td>5,122</td>
<td>(£6.8m)</td>
<td>2</td>
</tr>
<tr>
<td>2012–2013</td>
<td>£190.1m</td>
<td>5,192</td>
<td>£186.0m</td>
<td>5,196</td>
<td>(£4.1m)</td>
<td>4</td>
</tr>
</tbody>
</table>

Data source: Nursing Allocation Resource paper, 2013

10.4 Figure 14 shows the ratio of hospital nursing staff in post compared to the average available staffed beds for all acute specialties, presented for all NHS boards in Scotland. Nursing numbers do not include paediatric, mental health or neonatal. This shows NHS Grampian (the solid point on the chart) as having a relatively low number of hospital nursing staff to staffed beds, being between 2 and 3 standard deviations below the Scottish average.
Figure 14: Ratio of hospital nursing staff in post (Agenda for Change bands 1-9) to average available staffed beds for all acute specialties. Data for NHS boards, with NHS Grampian highlighted as the solid point.

Data source: Information Services Division, Scottish Workforce Information Standard System (SWISS)

10.5 We did not receive evidence from NHS Grampian on the average time taken to recruit staff. Minutes of the 4 March 2014 NHS Grampian short-life working group on nursing resources implementation group meeting state: “some wards were working under because of difficulties in recruitment and retention.” There is no action arising from this statement, nor any data in the paper describing the size of the issue or risk profile.

Configuration of substantive nursing and midwifery establishments

10.6 Figure 15 shows the staff establishment submitted as part of a report to the short-life working group on nursing resources on 26 March 2014. The table indicates a shortfall between funded and assessed establishment of 244 WTE and a shortfall between actual staff in post and assessed establishment of 350 WTE across NHS Grampian acute services.
Figure 15: Nursing whole-time equivalents for funded establishment, actual staff in post and assessed establishment.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Funded Establishment (WTE)</th>
<th>Actual Staff in Post (WTE)</th>
<th>Assessed Establishment (WTE)</th>
<th>Difference Between Funded &amp; Assessed Establishment (WTE)</th>
<th>Difference Between Actual Staff in Post &amp; Assessed Establishment (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Div 1 – Acute Medicine</td>
<td>1009</td>
<td>971</td>
<td>1034</td>
<td>25 (2.4%)</td>
<td>63 (6.1%)</td>
</tr>
<tr>
<td>Acute Div 2 – Digestive Diseases &amp; Surgery</td>
<td>356</td>
<td>330</td>
<td>398</td>
<td>42 (10.5%)</td>
<td>68 (17.1%)</td>
</tr>
<tr>
<td>Acute Div 3 – Children, Women &amp; Support Profs</td>
<td>655</td>
<td>639</td>
<td>786</td>
<td>131 (16.7%)</td>
<td>147 (18.7%)</td>
</tr>
<tr>
<td>Acute Div 4 – Complex Care</td>
<td>267</td>
<td>261</td>
<td>283</td>
<td>16 (5.7%)</td>
<td>22 (7.8%)</td>
</tr>
<tr>
<td>Acute Div 5 – MSK &amp; Neurosciences</td>
<td>184</td>
<td>164</td>
<td>214</td>
<td>30 (14.0%)</td>
<td>50 (23.4%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2471</td>
<td>2365</td>
<td>2715</td>
<td>244 (8.9%)</td>
<td>350 (12.9%)</td>
</tr>
</tbody>
</table>

Data source: NHS Grampian, Short-life working group report on nursing resources, 26 March 2014

10.7 The report produced by NHS Grampian provides some narrative on specific areas of concern and concludes that:

- the assessed establishment would not be affordable for NHS Grampian
- even if funding were available, it is not clear whether there would be a supply of nurses to fill posts
- other options are likely to be required, for example altering the number of beds, and
- the short-life working group is invited to discuss how the exercise to review nursing establishments should be progressed.

10.8 The Board is aware that the calibration, recruitment and deployment of the nursing and midwifery resource is a significant issue. A paper at the open Board session on 1 August 2014 describes that an internal short-life working group “made 20 recommendations to improve the utilisation of nursing and midwifery staff across the Board and improve the quality of care provided in NHS Grampian.” The paper states that the executive team agreed that the implementation of these recommendations is extremely important and that an implementation group would be established following the private Board session in August 2014.

10.9 The nursing resources implementation group describes the following key actions, taken from the paper at the open Board session on 1 August 2014:

- agreement of a baseline establishment
• identification of the estimated difference between historical establishments and current requirements
• presentation of findings at a review-and-challenge peer-review workshop
• consideration of ‘policy deficits’, particularly in relation to allocation of leave, utilisation of bank staff and rostering practice
• consideration of 12-hour shift patterns and a tool to monitor staff attitude
• an outline business case for e-rostering
• working with Robert Gordon University to improve the conversion of students into NHS Grampian nurses, and
• a ‘strategic review’ of recruitment.

10.10 NHS Grampian documentation shows an awareness and consideration of issues relating to workforce including:

• the variation in tools used for workforce planning
• long-standing vacancies
• an aim to reduce the use of bank and agency staff, and
• increased investment in some areas to facilitate the recruitment of nursing staff.

10.11 Minutes of the NHS Grampian short-life working group on nursing resources (Implementation Group meeting on 4 March 2014) state that: “[the Director of Workforce] advised that the current projection discussed under nursing establishments were unlikely to reduce much and this was not affordable.”

10.12 The minutes further state that: “There were differences of interpretation of the figures requested, ie - some areas had taken the figure derived by triangulating the outputs from different workload tools and local knowledge, whilst other areas had taken it to be the current staff in-post. A range of tools had been used to arrive at the figures.”

10.13 In its general adult inpatient wards, Aberdeen Royal Infirmary has a funded nursing establishment of 904 WTE. Of these, 611 WTE (68%) are registered staff. It should be noted that these data exclude:

• emergency department
• children’s services
• maternity services
• high dependency areas, either as substantive units or wards with mixed ‘standard’ and enhanced/HDU activity
• level 3 critical care
• day case areas
• outpatient areas
• specialist, advanced practice and consultant nurses
• nurse leadership, and
• operational support roles filled by registered staff.

10.14 Data we received for Aberdeen Royal Infirmary general inpatient wards showed that:

• there are 785 WTE staff in-post versus a funded establishment of 904 WTE, and thus an apparent vacancy rate of 119 WTE (13%)
• the establishment assessed as being required is 981 WTE, versus a funded establishment of 904 WTE, a gap of 77 WTE (8%)
• the establishment assessed as being required is 981 WTE, versus an in-post establishment of 785 WTE, a gap of 196 WTE (20%)
• the average skill-mix in Aberdeen Royal Infirmary inpatient wards is 68% registered nursing to 32% unregistered
• 11 out of 29 wards (38%) have a registered nurse to non-registered nurse skill-mix ratio of less than 65%:35%
• the average number of patients per registered nurse per shift in the Aberdeen Royal Infirmary inpatient wards is 6.5, and
• 11 out of 29 wards (38%) have a ratio of more than seven patients per registered nurse per shift.

The use of temporary and additional staffing

10.15 During the site visits, there was a frequent and unanimous theme of concern around the use of temporary staffing. NHS Grampian has separate stand-alone nurse banks across its delivery units. The organisation is working towards these stand-alone units adopting a consistent response.

10.16 NHS Grampian data describe the current (June, July and August 2014) fill-rate for the bank nursing (registered and unregistered) shifts in its general wards as being 56% (the fill rate is the actual number of bank nurses on the wards in response to requests made by staff for bank nurses). In discussion with nine senior charge nurses, they stated that they were dissatisfied with the bank staff arrangements.

10.17 The deployment of bank staff appears to mitigate the gap described in paragraph 10.15 between funded establishment and staff in-post. There are 899 WTE staff deployed versus a funded establishment of 904 WTE, and, therefore, an apparent gap of 5 WTE (<1%).

10.18 Figure 16 shows the hospital nurse vacancies as a percentage of the staff establishment using data from January to March 2014. This shows the percentage of hospital nurse vacancies at NHS Grampian to be more than 3 deviations higher than the Scottish average.
Figure 16: Hospital nurse vacancies (all bands) as a percentage of establishment. Data for NHS boards, with NHS Grampian highlighted as solid point. Data for January–March 2014.

Governance and escalation arrangements

10.19 It was difficult during the course of the review to elicit a consistent description of the governance and escalation processes around nursing workforce. Clinical and non-clinical staff, up to and including lead nurses, clinical directors and unit operational managers, consistently described the escalation of concerns with nursing numbers. They go on to describe what they perceive to be an absence of meaningful action or decision-making.

10.20 In June, July and August 2014, there were between 14 and 46 incidents relating to staffing submitted to Datix. This accounted for between 2–6% of the total incidents reported to Datix each month. However, these data should be treated with caution, given the assertion by many staff that there is no point in documenting staffing concerns on the Datix system due to an absence of feedback or action. Some staff also told us they had been told not to use Datix for staffing issues.

Senior nursing structure and visibility

10.21 Professional nursing in the acute services division, including Aberdeen Royal Infirmary, is led by an associate director of nursing. Each of the five divisions within the acute services division is led by a divisional lead nurse who reports professionally to, but is not line managed by, the associate director of nursing. Each divisional lead nurse has a number of clinical nurse managers reporting to them.

10.22 Ward-based staff told us they regularly saw the clinical nurse managers in their areas, being generally very supportive. There was some mention of the divisional lead nurse being seen occasionally, but that this was on the mandatory Wednesday morning clinical sessions and was not consistent or directed towards direct patient care. The
review team heard from a significant number of nurses and midwives, at various grades, express concern that wards are not adequately staffed, particularly at busy times of the day. In addition, when staff escalated these concerns they told us that they frequently got no meaningful response or feedback.

**Ward staffing**

10.23 Staff in surgical wards told us that staff nurses and healthcare support workers are being taken away from their ward duties for long periods of the day, to escort patients to and from theatre. In busy surgical wards, up to 20 patients a day can often be going to and from theatre.

10.24 Some staff in surgical wards also told us that even if their ward was fully staffed, a staff nurse would often be removed from the ward and sent to an understaffed ward. Nurses in the intensive care unit and high dependency units also told us this happened on their units. They said they had concerns that often they do not have the correct skill-mix for the ward they go onto and are not familiar with the equipment. Often they have no proper handover. Sometimes they are in charge of the ward they are sent to with no knowledge of the ward or the patients. Senior charge nurses reported that they often feel under considerable pressure to release their staff and they feel it is difficult for them to refuse to release staff.

10.25 Staff in care of the elderly also told us that there never seemed to be enough staff, particularly when it came to nursing patients with delirium who may require more attention than other patients. This was demonstrated during the unannounced inspection of the care for older people in acute hospitals. In areas where they had the full establishment of staff, there were often issues regarding backfilling sickness leave. While bank staff are used, we were told that ward staff would do extra shifts to provide cover. In the majority of instances, shifts that were short staffed were escalated through Datix. However, some senior charge nurses told us that this was not always possible as staff were inevitably busier when short staffed.

10.26 Some senior charge nurses told us of their concerns about being the nurse in charge for the hospital at night. All Band 7 nurses are on a rota for this. Staff said they often felt “out of their depth” doing this. One Band 7 senior charge nurse is now taking a Band 6 post so that they will not have to take the responsibility of being the nurse in charge for the hospital at night.

10.27 In the intensive care unit, staff on maternity leave are not back filled. The department is currently overspent each month on its salary budget, as they have 15 Band 6 nurses, but are only funded for 8, due to a legacy issue with Agenda for Change. As these Band 6 nurses leave due to natural wastage, they are replaced by Band 5 nurses. However, over time there then becomes an issue with staff turnover, as there is nowhere in the career structure for the Band 5 staff within the unit, so these staff then leave and find work elsewhere.

10.28 We heard of an example where the human resources department advised a nurse manager that they would perhaps prefer not to undertake exit interviews, as the interviews would give the person a lot of issues that they could not resolve. Given the issues that NHS Grampian has in recruiting staff, this is not helpful advice to give to managers.

10.29 There were also instances in which senior charge nurses were unable to dedicate
time to their non-clinical work as they were needed on the ward to cover staff absences. Instances were also given of nursing staff having to attend training or do their objectives and personal development plan in their own time.

10.30 Staff informed us during our visit in October 2014, that NHS Grampian had started doing mass monthly recruitment over the weekends to try and address the issues with staffing. However, vacancies were still high.

10.31 It has been difficult throughout the review process to gain a clear understanding of how the nursing workforce in Aberdeen Royal Infirmary is assessed, signed off and areas of concern escalated and managed. This difficulty, in addition to the challenges in securing consistent and reliable workforce information, is likely to contribute to problems in NHS Grampian with the deployment of, and communications concerning nursing workforce.

10.32 The number of nursing staff to staffed beds (January to March 2014) for NHS Grampian is low compared to the Scottish average. The funded establishment appears to be 77 WTE (8%) short of the establishment assessed as being required to provide a safe service. However, neither of these figures reflect the level of real multi-professional anxiety in Aberdeen Royal Infirmary with nursing workforce numbers, particularly given the favourable position of an average skill mix of 68% registered staff and a ratio of 1:6.5 for registered nurses per patient per shift.

10.33 Staff may continue to feel as though the hospital is short staffed due to the fact that the funded establishment is some 119 WTE (13%) short of being filled by staff in-post. There is little doubt that this, combined with a sense of being the ‘victims’ of recruitment issues in NHS Grampian, and a lack of faith in the bank staff arrangements, is at the core of these anxieties. This is the case even though the use of bank staff seems to fill 114 WTE posts of the 119 WTE posts currently vacant. Using bank staff to backfill on a regular basis creates pressure for staff compared with filling vacant posts substantively (which provides better support and continuity of care). Continually briefing and orientating bank staff puts pressure on core busy staff teams and has significant impact on patient, families and other members of the multidisciplinary team.

10.34 NHS Grampian is unable to demonstrate satisfactory governance and escalation arrangements around a number of issues, including staffing. Ward-based clinical staff were consistently very clear in their view that the organisation failed to support them in dealing with their concerns. Senior staff were also unable to convincingly describe a satisfactory approach to dealing with issues.

Medical workforce

10.35 We looked at the following in relation to medical staffing in NHS Grampian:

- the total number of medical staff
- the use of locum staff
- appraisal and revalidation
- consultant and specialty doctors job planning
- consultant appointments
- trainee rota monitoring, and
• support for trainees.

**Total number of medical staff**

10.36 NHS Grampian had 462 medical and dental consultants in post during January to March 2014, the highest quarter figure for two years. The number of consultants per staffed bed (0.262) for the same quarter is below the average for Scotland (0.276), and for the other large NHS boards (0.288)\(^42\), but these differences are not significant.

10.37 For January to March 2014, the number of consultant vacancies in NHS Grampian as a percentage of establishment was 9.8%. Figure 17 shows that this is double the rate for the other large NHS boards (4.9%), but not statistically different to consultant vacancy rates in NHSScotland overall.

10.38 The ratio of doctors in training to consultants is 1.33:1, which is higher than the average for Scotland (1.13:1) and for the other large NHS boards (1.23:1). However, these differences are not significant in either case.

*Figure 17: Number of consultant vacancies as a percentage of establishment. Data for NHS board, with NHS Grampian highlighted as solid point. January to March 2014.*

**The use of locum staff**

10.39 Staff told us that in some areas, trainees and consultants are doing locum work to support their colleagues. NHS Grampian was unable to supply data for the number of locums employed. Total reported locum expenditure was £628,038 for 2013–2014 and is projected to be similar this year. The figure is probably an underestimate. We noted that there was no internal locum expenditure identified for emergency medicine consultants despite evidence that they had been doing considerable additional hours. NHS Grampian advised that this was because pay rates had not been agreed. Given that this is a regular feature, we do not consider this to be good governance.

10.40 We heard serious concerns about the impact of shortages of medical staff on the

\(^{42}\) NHS Greater Glasgow and Clyde, NHS Lothian, NHS Lanarkshire, and NHS Tayside.
cardiac surgical intensive care unit. Whilst trainees working at middle grade in cardiac surgery are recruited nationally, service provision requires additional non-training staff. This is challenging nationally and NHS Grampian has had difficulty providing cover. As a consequence NHS Grampian is using resident consultant surgeons to provide cover for the cardiac intensive care unit at locum rates. This has been going on for five to six months and sustainability is questioned with no apparent long-term strategy. These consultants can also sometimes be the consultant surgeon on-call on the same shift, meaning that if they are in theatre or elsewhere, there may not be cover in the cardiac surgical intensive care unit at nights.

10.41 We noted that there were shortages of medical staff in key specialties, including emergency medicine, radiology, anaesthetics and oncology. Difficulties exist nationally in recruitment to several of these specialties. NHS Grampian attributed their difficulties to under-funding by the Scottish Government (see 3.17-3.18), the relatively high cost of living in Aberdeen and the remoteness of Aberdeen. However, we consider that factors within NHS Grampian’s control are at least as important as relative funding. The recruitment challenges have been apparent for several years, but there is little evidence that NHS Grampian has developed, implemented and monitored plans to address these. Although the workforce plan43 states that NHS Grampian’s ambition is to be the ‘employer of choice’, this is a long way from the reality. Indeed, the unresolved issues in Aberdeen Royal Infirmary make recruitment more difficult.

10.42 In several specialties, Aberdeen has become an unpopular place to be a trainee and there has been insufficient effort to address this. A culture of mutual distrust between consultants has also developed within some specialties in some significant areas. The relations between consultant and managerial staff have also broken down. The medical director and deputy medical director have been undermined by some consultants and have been unable to respond to problems identified in areas such as general surgery, the emergency department, and obstetrics and gynaecology. All of this makes NHS Grampian a less attractive place to work and inhibits clinical and managerial staff from working together to address challenges.

10.43 The situation in the emergency department illustrates many of the issues. NHS Grampian is facing a substantial and significant challenge in sustaining an emergency department. This is a specialty in which there are shortages of senior and middle grade staff across the UK. Other NHS boards have developed and implemented effective plans to address or at least mitigate these. There is no evidence that NHS Grampian had a plan at senior decision-maker level to address this, or that Board members were made fully, and adequately, aware of the unresolved issues whilst there was still time. During the visits, senior management continued to downplay the issue to us and seemed to regard the problems as essentially beyond solution. The poor trainee experience and the failure to address issues of behaviour by some consultant staff have also contributed to a further deterioration in the situation.

10.44 The number of emergency medicine consultants is well below that required. Those who remain are working excessively, and several are considering leaving. In recent months, one has resigned and another has signalled that they will do so. NES visited the emergency department on 8 October 2014. During that visit, consultants said that they have been told to reduce their Supporting Professional Activities (SPA) time and

43 NHS Grampian Workforce Plan 2013
this may impact on their ability to provide educational and clinical governance activities, which have already been highlighted as an area requiring improvement.

10.45 A new rota for middle grade staff in the emergency department was implemented in August 2014. This was due to the reduced numbers of this staff group. It has significantly improved the training environment for the senior emergency medicine trainees, and this should benefit the department’s reputation and recruitment. However, it does mean that the emergency department cannot always provide a registrar level decision-maker overnight. NHS Grampian has, therefore, required trainees in medical specialties to undertake ‘twilight’ shifts to cover duties that would normally be covered by the emergency department registrar. Trainees in these specialties expressed concern about the appropriateness of this for patients and for their own training and work patterns.

10.46 We also heard from staff that there had been no consultation about these new arrangements and that they were simply imposed by a letter or email. This is not an effective approach to engaging staff with change which is likely to be unwelcome. Whilst the greater emphasis on training for senior emergency medicine trainees will address some concerns within the trainee survey, the changes to duties for doctors in medical specialties are likely to reduce satisfaction among staff. We are concerned that the arrangements for covering the emergency department may not be safe. It does not meet the standard expected by the College of Emergency Medicine and more junior trainees reported increased stress for them and delays in patient management. These factors put patients at risk.

10.47 We are concerned that the approach of NHS Grampian management remains complacent. During the review, individual Board members seemed unaware of the gravity of the issue. We were told that it just has to be managed and that the emergency department will require a completely different model in future that is less dependent on emergency medicine doctors.

**Appraisal and revalidation**

10.48 In 2013–2014, 86% of eligible consultants and 76% of eligible staff grade/associate specialist/specialty doctors had a completed appraisal. These figures are similar to other NHS boards. Of the 230 doctors (including GPs) due for revalidation in 2013–2014, 221 had a positive recommendation and nine were deferred. Of the 439 doctors due for revalidation in 2014–2015, 53 did not have an appraisal in 2013–2014 and only eight of these had a valid reason for exemption.

10.49 We concluded that compliance with the appraisal process is noticeably better than with job planning. There is potential to improve and avoid difficulties in revalidation that may arise for individual doctors, with consequences for NHS Grampian, but the situation in NHS Grampian is broadly similar to other NHS boards in Scotland.

**Consultant and specialty doctors job planning**

10.50 Consultant job planning is one key mechanism through which consultants and managers agree, monitor and deliver objectives over the year. It describes how the...
consultant, working as part of a team, will contribute to achieving the organisation’s objectives. It should be reflective of the professionalism of being a doctor and, therefore, contributes to maintaining the professional standards set out by the GMC in Good Medical Practice. Annual job planning is a requirement of the 2004 Consultant Contract.

10.51 The documentation supplied by NHS Grampian showed that only 60% of consultants had completed job plans at 15 July 2014 and this is a recurrent problem. The figures for 2013–2014 showed that in some specialties all consultants had job plans, in others no job plans had been completed. The NHS Grampian Workforce Plan 2013 Table of Performance reported that 70% of consultants had job plans in 2012–2013.

10.52 NHS Grampian told us that where no job plan was submitted there was no referral for mediation. We heard that senior consultants in general surgery had actively urged colleagues not to sign job plans. The result was that only 3 out of 19 had job plans last year. This is unprofessional behaviour and yet has been allowed to persist. The lack of job plans in oncology was identified as a problem. A clinical director who had sought support to achieve job planning reported that they were not supported by senior management.

10.53 Another interviewee described job planning as being essentially ‘self certification’, which raises concerns as to the quality of actual job plans. We did not examine individual job plans.

10.54 We concluded that although NHS Grampian has a job planning process, it is not delivered in practice. Some consultants have simply refused to engage and no meaningful action has been taken by management.

**Consultant appointments**

10.55 We heard several concerns from consultants about the appointment process.

10.56 It was alleged that a consultant was appointed to undertake a sub-specialty in which they were not adequately trained. In another case, it was alleged that a job description was specifically tailored to a candidate to the exclusion of better qualified candidates. In a third case, it was alleged that a large number of consultants were added to the appointments panel at short notice to prevent an appointment.

**Trainee rota monitoring**

10.57 NHS Grampian provided evidence of 17 trainee rotas. These rotas should be monitored either every six months or annually to ensure that trainees are compliant with the European Working Time Regulations and the New Deal, and are being paid correctly. The process is cumbersome and resented by many trainees and consultants. We requested details of the output of this monitoring. No collated return was available, but individual rota sheets were obtained from which it appears that NHS Grampian is achieving monitoring for about 40% of rotas. The output is shown in Figure 18.
**Figure 18: Trainee rota monitoring.**

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of rotas monitored</th>
<th>Number compliant</th>
<th>Number signed as correct by a trainee</th>
</tr>
</thead>
<tbody>
<tr>
<td>February–July 2013</td>
<td>11</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>August 2013–January 2014</td>
<td>7</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>February–July 2014</td>
<td>27</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

Data source: NHS Grampian

10.58 The process requires that both the consultant in charge of the rota and a trainee working on the rota sign off the summary of the monitoring return. This is not happening in NHS Grampian. The same individual has signed in the consultant signature box for all rotas in the second period and there are almost no trainee signatures. For the third period none of the returns are signed by either a consultant or trainee. In the most recent period, 10 returns were declared invalid as too few trainees returned monitoring forms.

10.59 We understand that a consultant used to lead the monitoring process. That consultant has left the organisation and there have been gaps in the administrative team. The evidence is that NHS Grampian is not consistently monitoring trainee hours or considering the collated information. Some trainees reported pressure to produce a compliant return. This is a risk, particularly as we heard that some trainees were doing additional work when officially off duty. In the absence of recent monitoring, NHS Grampian would be vulnerable to substantial claims for retrospective re-banding. We heard that the monitoring of the middle grade rota in the emergency department was cancelled by management whilst in progress in October 2013 and was non-compliant in May 2014. Trainees reported that they have not yet received their back pay.

10.60 The information about trainee hours monitoring was not provided in a collated form and it is almost impossible to assess the actual position. What is clear is that the process is not being followed, that many rotas are not monitored because of insufficient returns, and that no assurance can be given that contractual and legislative requirements are complied with.

**Support for trainees**

10.61 We received information from NES including:

- the NES Scottish Trainee Survey (STS)
- the GMC National Training Survey (NTS), and
- data from the NES Quality Management service.

10.62 This information was also available to NHS Grampian (except the 2014 STS survey which at point of publication had not been shared with NHS Grampian). We also received the Local Education Provider report dated 23 August 2013.

10.63 During the review visit in August, Healthcare Improvement Scotland scheduled time
for a discussion session with trainees, but only two trainees were scheduled by NHS Grampian to attend. Whether this represented unwillingness on the part of the trainees, or a failure of management, it was of concern to us. It was noted that a deanery visit with so few trainees would normally be cancelled. We spoke with an additional four trainees during the drop-in sessions.

10.64 Four specialties specifically highlighted in the scope of the review were considered in detail: care of the elderly, emergency medicine, general surgery, and obstetrics and gynaecology.

Care of the elderly trainees

10.65 The information from the 2014 GMC, NTS and STS returns from trainees in care of the elderly was very positive. In this specialty, the North of Scotland region of Scotland Deanery is ranked second of 19 Deaneries/Local Education and Training Boards in the UK for ‘overall satisfaction’. No serious concerns with training were identified in either the Scottish or National Training Surveys.

Emergency medicine trainees

10.66 For emergency medicine, the North of Scotland region of Scotland Deanery is ranked bottom of the 19 Deaneries/Local Education and Training Boards in the UK for ‘overall satisfaction’ in the 2014 GMC National Training Survey. Aberdeen Royal Infirmary is also either a statistical outlier within the bottom quartile or lies within the bottom quartile for 9 of the 12 indicators (reflected as either ‘red’ or ‘pink’ flags in the survey, respectively) for foundation and/or core and/or specialist trainees. For 4 of these 9 indicators (overall satisfaction, clinical supervision, workload, study leave), this poor rating has been persistent for three successive years.

10.67 The 2014 Scottish Training Survey has similar findings and places Aberdeen Royal Infirmary between the bottom and eighth centile for five domains. The emergency department is an outlier for team culture with 39% of specialist trainees saying that they “work in an environment where there is a culture of undermining of staff confidence.” The prevailing view is that teaching trainees and their learning is not perceived as a key priority of the department.

10.68 We spoke with emergency medicine trainees who reported concerns about their training experience. They perceived a situation of undue exposure due to less than optimal clinical supervision by a minority of consultants. The trainees also had limited input into the clinical governance work of the department. This was perceived to impact on patient care.

10.69 During the review, NES conducted a follow-up Training Quality Management visit on 8 October 2014 to the emergency department to assess how NHS Grampian had addressed the conditions and recommendations imposed in May 2013. It was noted that responses from the director of medical education had been inadequate and the GMC has placed the department into enhanced monitoring status. The NES visit report46 states:

“The Visit Team have seen some evidence of improvement, particularly led by the training programme director. However the Visit Team still have considerable concerns

46 NES Scotland Deanery (North) Quality Management Revisit Report (8 October 2014)
with regard to education for trainees in this department and the lack of support from NHS Grampian. Therefore, the [emergency] department in [Aberdeen Royal Infirmary] has now been escalated to enhanced monitoring by the GMC. The Visit Team would expect an update on all conditions and recommendations in January 2015 with direct evidence i.e. outcomes and outputs in relation to each of these.”

10.70 This is an unusual step which indicates serious concern on the part of the GMC.

**General surgery trainees**

10.71 Overall, the North of Scotland region of Scotland Deanery region ranks 16th out of 19 across the UK for ‘overall satisfaction’ for training in general surgery in the 2014 GMC National Training Survey, and the detailed analysis for general surgery training in Aberdeen Royal Infirmary specifically adds further concern.

10.72 On the 2014 GMC National Training Survey, Aberdeen Royal Infirmary is either a statistical outlier within the bottom quartile or lies within the bottom quartile for 8 of the 12 indicators (reflected as either ‘red’ or ‘pink’ flags in the survey, respectively) for foundation and/or core and/or specialist trainees. For 2 of these 8 indicators (clinical supervision, adequacy of experience), and this has been persistent for three successive years. The National Training Survey highlights undermining and cites bullying.

10.73 The 2014 Scottish Training Survey has similar findings and places Aberdeen Royal Infirmary on the 5th to 8th centile among specialty training sites in Scotland. The unit is an outlier for team culture with 32% of foundation trainees, 22% of core trainees and 40% of specialist trainees saying that they “work in an environment where there is a culture of undermining of staff confidence.” In the survey 22-30% of trainees describe the training environment as ‘not supportive’. The prevailing view is that teaching of trainees and their learning is not perceived as a key priority of the department.

10.74 During the review, feedback from trainees largely confirmed this view. Although individual consultants were identified as supportive, the overall picture was of disorganisation, a tendency to blame individuals, favouritism and pressure on trainees to cover additional shifts and to attend when off duty to assist in theatre. We did not see any monitoring returns for surgical trainees’ hours of work. Trainees reported pressure to undertake additional hours. Some had concerns about aspects of clinical care.

**Obstetrics and gynaecology trainees**

10.75 The North of Scotland is ranked bottom (20th out of 20) of UK Deaneries/ Local Education and Training Boards for overall satisfaction. On the National Training Survey, there are six red/pink flags for the 12 domains and three of these have been persistent across three successive years. specialist trainees in particular rated it as poor for team culture. A substantial minority, between 25–38% perceived that teaching and learning for trainees was not a key priority.

**Summary findings**

10.76 Overall, NHS Grampian is clearly struggling to deliver the basic management of both career grade and trainee medical staff. This can be seen by considering the information available for job planning and trainee hours of work. There has also been a failure to plan for foreseeable issues with medical staffing and respond to poor
feedback from trainees.

10.77 Many medical staff members mentioned increasing difficulties in recruiting consultants. It is noted that doctors who experience poor training and an unsupportive atmosphere may choose to find consultant jobs elsewhere and not recommend Aberdeen Royal Infirmary to their peers.

Actions taken by NHS Grampian

10.78 We did not see evidence of trainees’ feedback being discussed at NHS Grampian Board meetings and were told that trainee feedback was never discussed by the Board. This is contrary to GMC guidance and it is surprising considering the serious and persistent issues across a range of specialties.

10.79 The annual Local Education Provider report submitted by NHS Grampian in August 2013 (in response to the 2013 GMC National Training Survey results) summarised the following main issues.

- The training quality lead responsibilities have been realigned this year as some work-streams have come to an end.
- There have been a number of clinical areas with training and education issues as identified from Deanery visits and triggered by the GMC survey of 2012. The trainee survey of 2013 reports a more positive picture across NHS Grampian.
- Patient safety concerns from the GMC survey have been actioned and have further developed links between educational governance and operational hospital management.
- Equality and diversity training has been provided by a ‘Dignified Workplace Training Programme’ in some clinical areas. This was in response to the suggestion of ‘undermining’ in an earlier GMC trainee survey.
- Some national projects (for example Revalidation and UK Shape of Training review) have provided an opportunity for NHS Grampian to offer an NHS Grampian view on medical education and training.
- The annual Local Education Provider report also included the following comments in relation to specialties examined in the review.
  - In relation to emergency medicine, the reports says: “Deanery visit in May 2013. Training for junior trainees is well supported. Training experience for senior trainees as concern. Although the GMC survey reports one red flag and one green flag. With the opening of the new emergency care centre patient pathway work is ongoing and progressing. Improvement action plans are in place to develop the workforce in emergency medicine.”
  - In relation to general surgery, it says: “Workload for foundation programme doctors has been identified as an issue. Alternative staffing model is being pursued that will create additional capacity and flexibility.”
  - In relation to obstetrics and gynaecology, it says: “No problems identified.”

10.80 Given the serious and persistent issues identified, this response is worryingly complacent. In particular, the comments on emergency medicine do not reflect the degree of improvement that NES indicated was required and which the recent re-visit shows has not occurred. During the review visit, individual Board members denied
that there was any issue.

**Staff governance conclusions**

10.81 We concluded that there are considerable medical and nursing staffing difficulties.

10.82 Medical staffing within the emergency department requires urgent attention to maintain safety. Emergency department staffing has been repeatedly raised by consultants in the department and to date the plans to address these have not been adequate.

10.83 Whilst we acknowledge the difficulty in recruiting at both consultant and senior trainee level in this specialty. The failure to address the local issues, particularly issues of training, set out in this section has resulted in doctors leaving Aberdeen. The present arrangements, which depend on cover by registrars from other departments, who may not be trained in emergency or trauma medicine, are not sustainable and are considered by many staff to be unsafe.

10.84 In addition, members of the Board appear to have been unaware of the developing crisis in the emergency department, and this raises serious concern about the adequacy of governance. We are unable to say whether this is because the executive team did not inform the Board or whether the executive team underestimated the problem.

10.85 There are serious issues with the nursing staff numbers. There is variation in the use of national and local workforce planning tools which hampers the ability of NHS Grampian staff to have a complete understanding of their nursing workforce plans. Whilst NHS Grampian has begun to address these issues through a prioritised investment programme, this has not yet produced the staffing levels and skills required.

10.86 We expect NHS Grampian to develop an action plan to address the following recommendations.

**Staff governance recommendations**

9 NHS Grampian should develop and implement a robust nursing workforce plan using mandated national workforce tools.

These plans should include the following:

- detail on how to ensure that there are sufficient numbers of nurses with the appropriate skill mix at all times in all wards
- detail on how to fill the gaps, with defined dates and hierarchical ordering of wards
- be based on assessed priority. Through this process, nursing staff should be made aware of the most recent results of the national nursing workforce and workload tool
- consideration of the current bed model in the context of a 20% gap between staff establishment in-post and establishment-assessed-as-being-required, especially in the absence of a robust plan to successfully recruit and retain nursing staff, and
- opportunities to create learning and communication sessions with senior charge nurses regarding workforce requirements. This should include positive
communication regarding the funded skill mix and patients-per-registered nurse-per-shift ratio.

10 **NHS Grampian should develop and implement a robust medical workforce plan.**

This plan should include the following.

- have a significant focus on securing full recruitment, including anticipating retirals and proactively working to prevent gaps
- ensure that the experience of trainees in their training is consistently good so that they will be attracted to work in NHS Grampian after completing training
- ensure all consultants and specialty doctors complete a job plan review annually, and have an up-to-date job plan that explicitly and fairly outlines what is expected of them, and
- have a clear and consistent consultant appointment process that includes a list of desirable professional and behavioural characteristics for candidates.

11 **NHS Grampian should ensure that the training of trainee medical staff is given a sufficiently high priority, ensuring that the General Medical Council and National Training Survey results are reviewed by the Board.**

This arrangement should:

- ensure that adverse trainee survey results are noted and action plans produced to address them in line with the GMC’s mandatory regulatory standards\(^47\)
- monitor the progress of such action plans
- ensure that particular attention is paid to the current training experience in general surgery and emergency medicine, and
- ensure that trainee rotas are monitored and that valid returns are produced.

\(^47\) [http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf](http://www.gmc-uk.org/The_Trainee_Doctor_1114.pdf_56439508.pdf) (Standards 7.2 and 7.3)
## Appendix 1 – Key lines of enquiry

<table>
<thead>
<tr>
<th>Focus</th>
<th>Key line of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culture, Leadership, Values and Behaviours</strong></td>
<td>- Are roles, responsibilities and accountabilities in relation to improving quality and safety of care, clear across the hospital?</td>
</tr>
<tr>
<td></td>
<td>- Are there effective working relationships between senior clinical staff and NHS Grampian senior leadership?</td>
</tr>
<tr>
<td></td>
<td>- How does the leadership take account of clinical opinion and views when making decisions?</td>
</tr>
<tr>
<td><strong>Accountability, Governance and Performance Management</strong></td>
<td>- Can the NHS board articulate its governance processes for assuring the quality of treatment and patient care and can staff at all levels of the organisation describe key elements of the governance process?</td>
</tr>
<tr>
<td></td>
<td>- Are the risks to the delivery of safe and high quality care identified and managed?</td>
</tr>
<tr>
<td><strong>Translating Strategy into Operational Delivery</strong></td>
<td>- Is the organisation able to effectively prioritise actions associated with the quality and safety of care and then implement improvement? If not why not?</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>- How does the organisation approach workforce planning to ensure that patient safety is managed effectively including skill-mix?</td>
</tr>
<tr>
<td></td>
<td>- How does the organisation ensure staff have the skills to deliver safe and effective care?</td>
</tr>
<tr>
<td><strong>Patient and Carer Experience</strong></td>
<td>- Is there a culture of proactively and positively engaging with patients to obtain their views?</td>
</tr>
</tbody>
</table>
## Appendix 2 – Interviews and focus groups

<table>
<thead>
<tr>
<th>Options for providing information on experiences of using or working within Aberdeen Royal Infirmary services</th>
<th>Number of people who used this route</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focus groups (6) held in Aberdeenshire and the City, NHS Orkney and NHS Shetland</td>
<td>35</td>
</tr>
<tr>
<td>• Aberdeen Royal Infirmary concourse and maternity hospital</td>
<td>203</td>
</tr>
<tr>
<td>• Telephone calls</td>
<td>5</td>
</tr>
<tr>
<td>• Written correspondence</td>
<td>8</td>
</tr>
<tr>
<td>• Link to Survey Monkey</td>
<td>62</td>
</tr>
<tr>
<td>Telephone line (Patient Advice and Support Service)</td>
<td>11</td>
</tr>
<tr>
<td>Interviews and discussions with Aberdeen Royal Infirmary staff</td>
<td>530</td>
</tr>
<tr>
<td>Inpatient interviews</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>892</strong></td>
</tr>
</tbody>
</table>
## Appendix 3 – Clinical areas visited

<table>
<thead>
<tr>
<th>Clinical areas visited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12–14 August 2014 – Core team visit</strong></td>
</tr>
<tr>
<td>Emergency surgery</td>
</tr>
<tr>
<td>Intensive Treatment Unit (ITU)</td>
</tr>
<tr>
<td>Ward 101 (acute medical assessment)</td>
</tr>
<tr>
<td>Ward 107 (respiratory medicine)</td>
</tr>
<tr>
<td>Ward 504 (general surgery)</td>
</tr>
<tr>
<td>Ward 507 (vascular surgery)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>16 September 2014 - Care of the Elderly</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 102 (geriatric assessment unit)</td>
</tr>
<tr>
<td>Ward 105 (general medicine)</td>
</tr>
<tr>
<td>Ward 107 (respiratory)</td>
</tr>
<tr>
<td>Ward 109 (cardiology)</td>
</tr>
<tr>
<td>Ward 204 (stroke)</td>
</tr>
<tr>
<td>Ward 209 (urology)</td>
</tr>
<tr>
<td>Ward 213 (orthopaedics)</td>
</tr>
<tr>
<td>Ward 303 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 304 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 305 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 306 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 507 (vascular)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>16 September 2014 - Emergency Medicine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
</tr>
<tr>
<td>Ward 216 (cardiothoracic)</td>
</tr>
<tr>
<td>Ward 303 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 501 (general surgery elective)</td>
</tr>
<tr>
<td>Ward 502 (general surgery elective)</td>
</tr>
<tr>
<td>Ward 208 (ophthalmology/5 Day (Monday – Friday))</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>16 September 2014 - Obstetrics and Gynaecology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashgrove Ward (Aberdeen Maternity Hospital)</td>
</tr>
<tr>
<td>Labour ward (Aberdeen Maternity Hospital)</td>
</tr>
<tr>
<td>Neonatal unit (Aberdeen Maternity Hospital)</td>
</tr>
<tr>
<td>Ward 309 (gynaecology/breast)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>16 September 2014 – General Surgery, Trauma/Orthopaedics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 210 (ears, nose and throat)</td>
</tr>
<tr>
<td>Ward 211 (short stay surgical)</td>
</tr>
<tr>
<td>Ward 212 (orthopaedics)</td>
</tr>
<tr>
<td>Ward 213 (orthopaedics)</td>
</tr>
<tr>
<td>Ward 214 (plastics)</td>
</tr>
<tr>
<td>Ward 305 (care of the elderly)</td>
</tr>
<tr>
<td>Ward 402 (short stay surgical male)</td>
</tr>
</tbody>
</table>
16 September 2014 – General Surgery, Trauma/Orthopaedics - continued
Ward 403 (short stay surgical female )
Ward 501 (general surgery elective)
Ward 503 (high dependency unit)
Ward 504 (emergency surgery)
Ward 505 (emergency surgery)
Ward 506 (high dependency unit)
Ward 507 (vascular)

Aberdeen Royal Infirmary 16 September 2014 – night visit
Labour ward (Aberdeen Maternity Hospital)
Neonatal unit (Aberdeen Maternity Hospital)
Ward 107 (respiratory)
Ward 303 (care of the elderly)
Ward 308 (gynaecology/breast)
Ward 309 (gynaecology/breast)
Ward 501 (general surgery elective)
Ward 502 (general surgery elective)
Ward 504 (emergency surgery)

9 October 2014 - Critical Care
Cardiac ITU
General ITU
Ward 106 (critical care unit )
Ward 217 (high dependency unit)
Ward 503 (high dependency unit)
Ward 506 (high dependency unit)

This list excludes the clinical areas visited during the Older People in Acute Hospital inspection of Aberdeen Royal Infirmary and Woodend Hospital on 6–10 October 2014.
## Appendix 4 – Review team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Angus Cameron (Chair)</td>
<td>Medical Director</td>
<td>NHS Dumfries and Galloway</td>
</tr>
<tr>
<td>Mr Ken Barker</td>
<td>Public Partner</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Ms Nicky Berry</td>
<td>Senior Nurse/Midwife</td>
<td>NHS Borders</td>
</tr>
<tr>
<td>Dr Dave Caesar</td>
<td>Clinical Director, Emergency Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Dr Brian Cook</td>
<td>Medical Director</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Dr Malcolm Daniel</td>
<td>Consultant in Anaesthesia &amp; Intensive Care</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Dr Frances Dow</td>
<td>Lay Member</td>
<td></td>
</tr>
<tr>
<td>Mr Graeme Foubister</td>
<td>Consultant Trauma &amp; Orthopaedic Surgeon</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>Ms Amy Fox</td>
<td>Senior Nurse</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Ms Clair Gamble</td>
<td>Student Nurse</td>
<td>University of Abertay</td>
</tr>
<tr>
<td>Dr Claire Gordon</td>
<td>Clinical Director, Acute Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Mr Colin Howie</td>
<td>Consultant Orthopaedic Surgeon</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Ms Penny Leggat</td>
<td>Public Partner</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Ms Bette Locke</td>
<td>Allied Health Professional Strategic Lead and Service Manager</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>Ms Jennifer Lynch</td>
<td>Student Nurse</td>
<td>University of Abertay</td>
</tr>
<tr>
<td>Dr Sheena MacDonald</td>
<td>Medical Director</td>
<td>NHS Borders</td>
</tr>
<tr>
<td>Ms Sandra McDougall</td>
<td>Head of Policy</td>
<td>Scottish Health Council</td>
</tr>
<tr>
<td>Dr Brian McGurn</td>
<td>Consultant Geriatrician</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Ms Celia McKiernan</td>
<td>Clinical Nurse Manager</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Professor Scott McLean</td>
<td>Director of Nursing</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Professor Alistair McEllan</td>
<td>Postgraduate Dean</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>Mr Howard McNulty</td>
<td>Public Partner</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Mr Robbie Pearson</td>
<td>Director of Scrutiny and Assurance</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Ms Susan Siegal</td>
<td>Public Partner</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Mr David Stewart</td>
<td>Associate Medical Director</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Mr Gordon Thomson</td>
<td>Lead Clinical Pharmacist, Urgent Care and Medicine</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>Dr Katherine Walesby</td>
<td>Specialist Registrar, Geriatric &amp; General Internal Medicine</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>Professor James Walker</td>
<td>Consultant Obstetrician and Gynaecologist</td>
<td>St James’s University Hospital, Leeds</td>
</tr>
<tr>
<td>Mr George Welch</td>
<td>Associate Medical Director for Surgery &amp; Anaesthetics</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
</tbody>
</table>
## Healthcare Improvement Scotland staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Mark Aggleton</td>
<td>Senior Programme Manager</td>
</tr>
<tr>
<td>Ms Tracy Birch</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>Ms Claire Blackwood</td>
<td>Inspector</td>
</tr>
<tr>
<td>Ms Aileen Bradford</td>
<td>Administrative Officer</td>
</tr>
<tr>
<td>Ms Pamela Campbell</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Ms Sara Jones</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Ms Morag Kasmi</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>Ms Jacqui Macrae</td>
<td>Head of Quality of Care</td>
</tr>
<tr>
<td>Mr Gareth Marr</td>
<td>Inspector</td>
</tr>
<tr>
<td>Dr Simon Mackenzie</td>
<td>Clinical Lead for Business Intelligence</td>
</tr>
<tr>
<td>Mr Donald Morrison</td>
<td>Head of Data, Measurement &amp; Business Intelligence</td>
</tr>
<tr>
<td>Mr Tim Norwood</td>
<td>Data &amp; Measurement Advisor</td>
</tr>
<tr>
<td>Ms Irene Robertson</td>
<td>Inspector</td>
</tr>
<tr>
<td>Ms Edel Sheridan</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Mr Ian Smith</td>
<td>Senior Inspector</td>
</tr>
<tr>
<td>Ms Jane Walker</td>
<td>Inspector</td>
</tr>
</tbody>
</table>
### Appendix 5 – Expert advisory group

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Brian Robson (Chair)</td>
<td>Executive Clinical Director</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Ms Sarah Ballard-Smith</td>
<td>Nurse Director</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Professor Derek Bell</td>
<td>President</td>
<td>Royal College of Physicians of Edinburgh</td>
</tr>
<tr>
<td>Dr Gordon Birnie</td>
<td>Medical Director – Acute Services</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Mr Duncan Buchanan</td>
<td>Head of Service</td>
<td>Public Health and Intelligence, National Services Scotland</td>
</tr>
<tr>
<td>Ms Rosslyn Crocket</td>
<td>Director of Nursing</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Ms Fiona Dagge-Bell</td>
<td>Chief Nurse, Midwife &amp; Allied Health Professional</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr John Dean</td>
<td>Director of Service Integration/ Associate Medical Director</td>
<td>East Lancashire Hospitals NHS Trust</td>
</tr>
<tr>
<td>Dr David Farquharson</td>
<td>Medical Director</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Ms Theresa Fyffe</td>
<td>Director</td>
<td>Royal College of Nursing in Scotland</td>
</tr>
<tr>
<td>Ms Christine Gilmour</td>
<td>Director of Pharmacy</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Ms Ruth Glassborow</td>
<td>Director of Safety &amp; Improvement</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Professor Stewart Irvine</td>
<td>Medical Director</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>Ms Fiona Murphy</td>
<td>Associate Director</td>
<td>Public Health and Intelligence, National Services Scotland</td>
</tr>
<tr>
<td>Mr Richard Norris</td>
<td>Director</td>
<td>Scottish Health Council</td>
</tr>
<tr>
<td>Professor Rowan Parks</td>
<td>Deputy Medical Director</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>Mr Tom Woodcock</td>
<td>Health Foundation Improvement Science Fellow</td>
<td>Northwest London CLAHRC Imperial College London</td>
</tr>
</tbody>
</table>
Areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action.

**Treating older people with compassion, dignity and respect**

**NHS Grampian:**

1. must ensure clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR).
   
   This is to comply with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy – Decision Making and Communication (Scottish Government, May 2010) and SGHD/CMO(2014)17.

2. must ensure all documentation, both nursing and medical, is legible, dated, timed and signed. It should provide details of any assessments and reviews undertaken, and provide clear evidence of the arrangements that have been made for future and ongoing care. It should also include details of information given about care and treatment.
   
   This is to comply with Nursing & Midwifery Council, Record keeping: Guidance for nurses and midwives (2009) and the Generic Standards of Record keeping Royal College of Physicians 2009.

3. must ensure effective discharge planning begins on, or shortly after admission, and is a continual process.
   
   This is to comply with Clinical Standards for Older People in Acute Care Standard 5c.

4. must ensure that all patients, where clinically appropriate, are treated in accordance with the standards set out in the Clinical Standards for Older People in Acute Care.
   
   This is to comply with Clinical Standards for Older People in Acute Care Standards.

5. should ensure that senior management is aware of the need to support clinical staff, and is able to support them.

6. should ensure that staffing levels are maintained to the levels determined by its own workforce planning analysis. This should also consider the impact of skill mix and workload.

7. should ensure bedrail assessments are carried out consistently. This will make sure that no patients are at risk of falling out of bed or that bedrails are not used unnecessarily.
on patients.

8 should ensure alternative equipment is available for use where it is identified that bedrails should not be used in line with NHS Grampian protocol. This is to ensure that patients at risk of falls are managed in a way that respects their dignity and rights.

9 should ensure the management of patient flow in the hospital is fit for purpose, and maintains patient safety, care and dignity.

### Dementia and cognitive impairment

**NHS Grampian:**

10 must ensure all older people who are being treated in accident and emergency or are admitted to hospital are assessed for cognitive impairment.

This is to comply with Clinical Standards for Older People in Acute Care, Standard 2.3.

11 must ensure guidelines on the management of delirium are available to all staff that care for acutely unwell people.

This is to comply with Standards of Care for Dementia in Scotland.

12 must ensure current legislation to protect the rights of patients who lack capacity is fully and appropriately implemented. In order to do so, all staff who have a professional role in the implementation of the legislation must receive training appropriate to their role.

This is to comply with the Adults with Incapacity (Scotland) Act 2000 Part 5 – Medical treatment and research.

13 must ensure patients identified as having cognitive impairment have a personalised care plan in place. This should identify the specific needs of the patient and how the staff will meet them.

This is to comply with Standards of Care for Dementia in Scotland.

14 must ensure systems are in place to record key personal information about people with dementia or other cognitive impairments. This information should be used and be shared with staff involved in the care of the patient.

This is to comply with Standards of Care for Dementia in Scotland.

15 should ensure that where a welfare power of attorney is identified, the document is checked to establish what powers are held. This will ensure that the decisions being made are within a legal framework.

16 should carry out an assessment to help them identify how way finding around the wards within Aberdeen Royal Infirmary can be made clearer. In order to do this the board should involve patient groups and other interested parties.
## Nutritional care and hydration

**NHS Grampian:**

17. **must ensure all patients have their height and weight recorded, and are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital and on an ongoing basis.**

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.

18. **must ensure personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any help the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients.**

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7.

19. **must ensure patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate.**

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6.

20. **should ensure mealtimes are managed in a manner that ensure that patients are prepared for meals and get assistance in a timely manner.**

## Preventing and managing pressure ulcers

**NHS Grampian:**

21. **must ensure patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks.**

   This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, section 2.

22. **must ensure care planning documentation is improved to provide a clear record of the care required and given to a patient and to show evaluation of that care. This documentation should also demonstrate person-centred and personalised care to meet the needs of individual patients dependent on each patient’s level of risk of developing a pressure ulcer.**

   This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, section 1.
### Appendix 7 – Glossary

<table>
<thead>
<tr>
<th><strong>CEL</strong></th>
<th>Chief Executive Letter. A Scottish Government letter to NHS board chief executives.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Datix</strong></td>
<td>Electronic risk management system.</td>
</tr>
<tr>
<td><strong>fully upheld, partially upheld, not upheld</strong></td>
<td>A classification used for the outcome of a complaint.</td>
</tr>
<tr>
<td><strong>General Medical Council (GMC)</strong></td>
<td>Organisation with statutory responsibility for the regulation of doctors (<a href="http://www.gmc-uk.org/index.asp">http://www.gmc-uk.org/index.asp</a>).</td>
</tr>
<tr>
<td><strong>Hospital Standardised Mortality Ratio (HSMR)</strong></td>
<td>A measurement tool where mortality data are adjusted to take account of some of the factors known to affect the underlying risk of death. It is calculated as the ratio of the actual number of deaths within 30 days of admission to hospital to the expected number of deaths.</td>
</tr>
<tr>
<td><strong>key lines of enquiry</strong></td>
<td>Detailed questions that help assessors inform their review judgements.</td>
</tr>
<tr>
<td><strong>Lanarkshire Quality Improvement Portal (LanQIP)</strong></td>
<td>An electronic performance management recording system.</td>
</tr>
<tr>
<td><strong>Medical Engagement Scale (MES)</strong></td>
<td>A tool used to assess medical engagement in management and leadership in NHS organisations.</td>
</tr>
<tr>
<td><strong>NHS Education for Scotland (NES)</strong></td>
<td>A special health board responsible for supporting NHS services in Scotland by developing and delivering education and training for those who work in NHSScotland.</td>
</tr>
<tr>
<td><strong>Patient Advice and Support Service (PASS)</strong></td>
<td>A service delivered by the Scottish Citizens Advice Bureau Service. The service is independent and provides free, confidential information, advice and support to anyone who uses the NHS in Scotland. It aims to support patients, their carers and families in their dealings with the NHS and in other matters affecting their health.</td>
</tr>
<tr>
<td><strong>PricewaterhouseCooper (PwC)</strong></td>
<td>A company providing independent audit services.</td>
</tr>
<tr>
<td><strong>probit</strong></td>
<td>Being honest and trustworthy, and acting with integrity.</td>
</tr>
<tr>
<td><strong>Royal College of Surgeons of England (RCS)</strong></td>
<td>A professional membership organisation and registered charity, representing surgeons in the UK and abroad who advance surgical standards and improve care for patients.</td>
</tr>
<tr>
<td><strong>Scottish Patient Safety Programme (SPSP)</strong></td>
<td>A national initiative that aims to improve the safety and reliability of healthcare and reduce harm, whenever care is delivered.</td>
</tr>
<tr>
<td><strong>Scottish Public Services Ombudsman (SPSO)</strong></td>
<td>The ombudsman is the final stage for complaints regarding most organisations that provide public services in Scotland. The ombudsman service is independent, free and confidential.</td>
</tr>
<tr>
<td><strong>whole-time equivalent (WTE)</strong></td>
<td>An estimated measurement of the staff resource available, taking into account full and part-time working, for example a staff member working full-time would be counted as 1 WTE and someone working half the amount of contracted hours per week would be a 0.5 WTE.</td>
</tr>
</tbody>
</table>