A Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire

Findings and Recommendations

December 2013
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
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1 Introduction

Background

1.1 In August 2013, the Cabinet Secretary for Health and Wellbeing commissioned Healthcare Improvement Scotland to undertake a Rapid Review of the safety and quality of care for acute adult patients in NHS Lanarkshire.

1.2 The terms of reference for the review were to:

- provide an independent expert diagnosis of the factors which may underlie the Hospital Standardised Mortality Ratio figures, including a Rapid Review assessment of any systemic factors which may be impacting on the safety and quality of care and treatment being provided to patients in NHS Lanarkshire’s acute hospitals
- consider whether the existing action by NHS Lanarkshire to address any key issues, identified in the diagnostic phase is adequate and whether any additional steps should be taken
- advise if any additional support should be made available to NHS Lanarkshire to help strengthen and accelerate their improvement programme, and
- advise on any areas that may require further action.

1.3 Healthcare Improvement Scotland has undertaken an extensive, independent review of the factors influencing the quality and safety of care in NHS Lanarkshire’s acute hospitals (Wishaw Hospital, Hairmyres Hospital and Monklands Hospital). The review team included a range of experienced healthcare professionals from across NHSScotland and members of the public. It was supported by an expert advisory group.

1.4 This report sets out the principal findings from this review and the recommendations that NHS Lanarkshire should undertake in response to these findings.

Hospital Standardised Mortality Ratio (HSMR)

1.5 The Rapid Review into NHS Lanarkshire was prompted by a higher than predicted level of mortality in the first quarter of 2013 (January to March 2013). This is measured by an indicator called the Hospital Standardised Mortality Ratio or HSMR. The HSMR is based on a complex model that looks at the ratio of observed deaths within 30 days of admission to an acute hospital to the number of predicted deaths.

1.6 NHS Lanarkshire’s HSMR first came into focus in February 2012 when the data for the period July 2011 to September 2011 were published by ISD. This publication highlighted that the HSMR for Monklands Hospital was significantly higher than the Scottish average. The Rapid Review was commissioned following the August 2013 release of HSMR figures based on the provisional values for all hospitals for January to March 2013. Table 1 summarises the data released in February 2012 to

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the initiation of the review in August 2013, with hospitals identified as outliers over that time period.

Table 1: HSMR levels July 2011 to March 2013

<table>
<thead>
<tr>
<th>Publication date</th>
<th>HSMR period</th>
<th>Lanarkshire hospitals significantly higher than the Scottish average</th>
</tr>
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<tbody>
<tr>
<td>February 2012</td>
<td>July - September 2011</td>
<td>Monklands Hospital (this quarter’s figure was later revised down to within the accepted range due to impact of late submission of data)</td>
</tr>
<tr>
<td>May 2012</td>
<td>October - December 2011</td>
<td>Monklands Hospital (this quarter’s figure was later revised down to within the accepted range due to impact of late submission of data)</td>
</tr>
<tr>
<td>August 2012</td>
<td>January - March 2012</td>
<td>All within accepted range</td>
</tr>
<tr>
<td>November 2012</td>
<td>April - June 2012</td>
<td>Monklands Hospital</td>
</tr>
<tr>
<td>February 2013</td>
<td>July - September 2012</td>
<td>Monklands Hospital</td>
</tr>
<tr>
<td>May 2013</td>
<td>October - December 2012</td>
<td>Monklands Hospital Hairmyres Hospital (this quarter’s figure for Hairmyres was later revised down to within the accepted range due to impact of late submission of data)</td>
</tr>
<tr>
<td>August 2013</td>
<td>January - March 2013</td>
<td>Monklands Hospital Wishaw Hospital (this quarter’s figure for Wishaw was later revised down to within the accepted range due to the impact of late submission of data)</td>
</tr>
</tbody>
</table>

1.7 At the point of initiating the Rapid Review in August 2013, each one of the acute hospitals in NHS Lanarkshire had had an HSMR significantly higher than the Scottish average at some point in the preceding 18 months. Therefore, the decision was made to include all three hospitals in this Rapid Review. However, an updated analysis was provided during the course of the review that takes account of inpatient records that were submitted late. This updated analysis moves the Hairmyres Hospital HSMR for October 2012–December 2012 and the Wishaw Hospital HSMR for January 2013–March 2013 from being statistical outliers to within the accepted range. The late submission of data is a matter covered later in this report.

1.8 In December 2011, Healthcare Improvement Scotland published a guide to the HSMR indicator to assist NHS boards to understand and use these data to improve care. The guide explains factors to take into account when interpreting HSMR and its appropriate use.

1.9 The guide reflects the point that ‘Most deaths following admission to hospital are inevitable, because of the patients’ condition when they are admitted. Some deaths can be prevented, however, by improving care and treatment or by avoiding harm.

Death is a ‘hard’ outcome which is recorded accurately and so hospital mortality is a helpful lens through which to view the systems of care. It is important that the health service makes good use of hospital mortality statistics to help get a better understanding of how patient care is delivered. Used wisely, such information can highlight aspects of care that can be improved, to make things better for patients and their families. The Hospital Standardised Mortality Ratio (HSMR) is one such measure.’

1.10 This report explains in more detail the work to better understand the underlying data that has caused the higher than expected HSMR, but more importantly focuses on the safety and quality of acute healthcare afforded to the people of NHS Lanarkshire. In accordance with the Healthcare Improvement Scotland guidance highlighted above, the review takes the HSMR as the starting point for inquiry, but does not base conclusions about the quality of care on the HSMR figure.

Scope of the Rapid Review

1.11 The Rapid Review, has sought to examine two key issues:

- an assessment of the safety and quality of care in NHS Lanarkshire’s acute hospitals, and
- the key causal factors for the higher than average HSMR.

1.12 In looking at the key system issues that may be impacting on the safety and quality of care within the acute hospitals, the review team focused on issues which are known to have a significant impact on the safety and effectiveness of the clinical care provided. These included the following.

- The **patient and carer experience** within the acute hospital setting.
- Current **clinical practice in relation to the safe provision of care** and the effective implementation of the Scottish Patient Safety Programme, particularly timely identification and response to deteriorating patients including the identification and management of sepsis and end of life care.
- **Workforce issues** within the acute hospital setting such as staffing levels and skill mix. The review team did not assess the staffing levels in every single ward and/or team. Rather it used the initial data analysis and information from the focus groups and site visits to identify any areas for more in-depth review.
- The **operational effectiveness** of the acute hospital with a focus on the management of patient flow through accident and emergency and within the hospital.
- The **leadership and governance** of the safety and quality of care within the acute hospital setting.

Principles for the Rapid Review

1.13 In undertaking this Rapid Review, Healthcare Improvement Scotland, NHS Lanarkshire and the Scottish Government signed up to the following principles.

- **Primacy of safety and quality of care**. This work is driven and underpinned by a commitment to improving the safety and quality of care for patients and, as such, patient interests will be placed first at all times.
• **Patient, carer and public participation.** Patients, carers and members of the public will play a central role in the overall review. The views of patients in all three acute hospitals, either directly or through representatives, will be sought by the team and reflected in its report.

• **Listening to the views of staff.** Staff will be supported to provide frank and honest opinions about the safety and quality of care and treatment provided to patients in their hospital. The review team will seek views from a broad range of staff and wherever possible, the review team will seek to triangulate this information with data and observation of practice.

• **Openness and transparency.** Where possible, information and intelligence relating to the review will be made publicly available.

• **Respect.** The review team and NHS Lanarkshire will engage with each other in a tone that is supportive, enabling and constructive. The review team will assume the goodwill and good intentions of all staff unless there is clear evidence to the contrary. Equally, NHS Lanarkshire will assume the goodwill and good intentions of all review team members unless there is clear evidence to the contrary.

• **Balancing partnership working and independent assurance.** The review team will work in partnership with NHS Lanarkshire from an understanding that improving the safety and quality of care is a shared purpose. However, it is understood that the requirement for an independent assessment will impact on the extent to which NHS Lanarkshire staff can be actively involved in some aspects of this process. Healthcare Improvement Scotland will work with NHS Lanarkshire to ensure that there is an appropriate balance between involvement and independence.

• **Systems perspective.** In undertaking its work, the review team will be mindful of the wider system conditions that impact on individual clinicians and managers. A key part of the diagnostic will be considering which system conditions may be impacting negatively on the safe and effective delivery of care.

• **Co-operation between organisations.** The review will be built around strong co-operation between the different organisations that make up the health system, placing the interests of patients first at all times.

**The review team and the expert advisory group**

1.14 The Rapid Review has been conducted by a review team. The review team, chaired by the Director of Scrutiny and Assurance in Healthcare Improvement Scotland, includes a wide range of experienced healthcare professionals from across the NHS in Scotland and members of the public. The clinical lead for the Rapid Review is the Medical Director for Quality Improvement in NHS Lothian. **Therefore, the findings of this review have been endorsed by a team of senior clinicians and managers who have current experience and knowledge of the day to day challenges facing healthcare providers.**

1.15 The review team has also been supported by a separate expert advisory group (EAG) chaired by the Executive Clinical Director of Healthcare Improvement Scotland.

1.16 The review team and EAG memberships are shown on page 8.
### Table 2: Review team

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
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<tbody>
<tr>
<td>Robbie Pearson (Chair)</td>
<td>Director of Scrutiny and Assurance, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>William Arbuckle</td>
<td>Senior Charge Nurse, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Ken Barker</td>
<td>Public Partner</td>
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<tr>
<td>Richard Brewster</td>
<td>Programme Manager, Healthcare Improvement Scotland</td>
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<tr>
<td>Professor Hazel Borland</td>
<td>Executive Nurse Director, NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Dr Malcolm Daniel</td>
<td>Consultant in Anaesthesia &amp; Intensive Care, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Yvonne Ewart</td>
<td>Student Nurse, NHS Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>Norman Gibb</td>
<td>Public Partner</td>
</tr>
<tr>
<td>Ruth Glassborow</td>
<td>Project Director, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Alan Ketchen</td>
<td>Programme Manager, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr Zoeb Jivaji</td>
<td>Junior Doctor, CT2 Anaesthetics, NHS Lothian</td>
</tr>
<tr>
<td>Penny Leggat</td>
<td>Public Partner</td>
</tr>
<tr>
<td>Dr Sheena MacDonald</td>
<td>Medical Director, NHS Borders</td>
</tr>
<tr>
<td>Dr Simon Mackenzie</td>
<td>Medical Director for Quality Improvement, NHS Lothian and Clinical Lead for the review team</td>
</tr>
<tr>
<td>Dr Crawford McGuffie</td>
<td>Associate Medical Director, NHS Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>Lorraine McLafferty</td>
<td>Project Officer, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Lesley McLay</td>
<td>Chief Operating Officer, NHS Tayside</td>
</tr>
<tr>
<td>Irene Robertson</td>
<td>Inspector, Healthcare Improvement Scotland</td>
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<tr>
<td>Ian Smith</td>
<td>Senior Inspector, Healthcare Improvement Scotland</td>
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### Table 3: Expert advisory group

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<tr>
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<tr>
<td>Dr Brian Robson (Chair)</td>
<td>Executive Clinical Director, Healthcare Improvement Scotland</td>
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<tr>
<td>Dr Jennifer Armstrong</td>
<td>Medical Director, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Dr Penny Bridger</td>
<td>Consultant in Public Health Medicine, NHS National Services Scotland</td>
</tr>
<tr>
<td>Duncan Buchanan</td>
<td>Head of Services, Information Services, NHS National Services Scotland</td>
</tr>
<tr>
<td>Fiona Dagge-Bell</td>
<td>Chief Nurse, Midwife and Allied Health Professional Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Alison Hunter</td>
<td>Improvement Advisor, Scottish Patient Safety Programme, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr Steve Kendrick</td>
<td>Information Consultant Strategy and Business Development, ISD Scotland</td>
</tr>
<tr>
<td>Jo Matthews</td>
<td>Head of Patient Safety, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Richard Norris</td>
<td>Director, Scottish Health Council</td>
</tr>
<tr>
<td>Professor Rowan Parks</td>
<td>Deputy Medical Director NHS Education for Scotland</td>
</tr>
<tr>
<td>Professor Angela Wallace</td>
<td>Executive Nurse Director, NHS Forth Valley</td>
</tr>
<tr>
<td>Dr Kevin Stewart</td>
<td>Clinical Director, Clinical Effectiveness and Evaluation Unit (CEEU), Clinical Standards Department. Royal College of Physicians, London</td>
</tr>
<tr>
<td>Susan Went</td>
<td>Director of Evidence and Improvement, Healthcare Improvement Scotland (until 15 November 2013)</td>
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</table>
2 The structure of the Rapid Review

Overall structure

2.1 The Rapid Review was announced on 27 August 2013 by the Cabinet Secretary for Health and Wellbeing.

2.2 This Rapid Review, as the title implies, has been undertaken in an extremely short space of time: just over 100 days from initiation to publication of this report. In producing this report in such a short space of time, Healthcare Improvement Scotland could not have delivered it without the support and co-operation of the members of the review team, the expert advisory group, and, most importantly of all, the patients and staff, including the leadership team, in NHS Lanarkshire.

2.3 This is the first review of its kind carried out by Healthcare Improvement Scotland. The Rapid Review drew on the recent experiences in NHS England in undertaking reviews of NHS trusts by Sir Bruce Keogh, Medical Director of NHS England. Whilst the Rapid Review did not replicate in every instance the elements of Sir Bruce Keogh’s reviews of mortality in NHS England, the review team did take account of opportunities to appropriately apply aspects of the process in undertaking the Rapid Review in NHS Lanarkshire.

2.4 The Rapid Review consisted of three broad phases:

- the gathering of data and intelligence: from 27 August to 26 September 2013
- the assessment of the quality and safety of care: review visits (announced and unannounced) to all three hospitals between 9 and 27 October 2013, and
- the development of the Rapid Review report underpinned by the triangulation of data, intelligence and observation of care.

All three phases have been underpinned by the collection and analysis of patients’ and carers’ experiences of using the three acute hospitals.

2.5 From start to finish of the Rapid Review, the review team has:

- conducted visits to over 40 clinical areas
- spoken to over 200 staff members
- received feedback from over 300 patients and carers about their experience of the care received, and
- reviewed a total of 152 medical records of patients who had died within 30 days of admission across the three hospitals (these were a consecutive sample of around the first 50 deaths from 1 January 2013 onwards per site).

2.6 The review team has also considered the largest amount of data and information ever reviewed and analysed in a Healthcare Improvement Scotland review to date. Several thousand pages of data and intelligence have been received, analysed and generated over the period of the Rapid Review.

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5 http://news.scotland.gov.uk/News/Hospital-mortality-360.aspx
Securing the public perspective

2.7 From the outset, the review team placed the perspective of the public central to the Rapid Review.

2.8 The review team had three public partners (lay members), each with considerable experience in reviewing and inspecting health services. The review team also used a range of mechanisms to hear the voice of patients, their families and their carers. The experiences of those who come into contact with NHS Lanarkshire are woven throughout this report.

Building the data and the intelligence: 27 August–26 September 2013

2.9 In the first phase of the Rapid Review, the review team focused on assembling the data and intelligence on the quality and safety of care in NHS Lanarkshire.

2.10 Over the course of 4 weeks, the data and measurement team and the Information Services Division (ISD) of NHS National Services Scotland built a comprehensive picture about acute services in NHS Lanarkshire. This picture helped to shape the ‘key lines of enquiry’ for the subsequent review visits in October 2013.

2.11 A data and intelligence pack was drawn together and discussed with the review team on 2 October 2013. The pack was used to generate questions which would be used to guide the interviews in the review visits in October. A copy of the data and intelligence pack and the ‘key lines of enquiry’ will be published on Healthcare Improvement Scotland’s website shortly.

2.12 The data and intelligence pack covered safety, quality of care, operational effectiveness, patient experience, leadership and governance and workforce. It includes nationally published data as well as other information produced by the NHS board.

Review visit to NHS Lanarkshire: October 2013

2.13 The review team undertook three intensive visits over 3 days to each of the acute hospitals in NHS Lanarkshire. The hospitals were visited on the following days:

- 9 October 2013 (Wishaw Hospital)
- 10 October 2013 (Monklands Hospital), and
- 11 October 2013 (Hairmyres Hospital).

2.14 The days were structured similarly consisting of:

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

2.15 The first day (9 October 2013) began with a presentation to the review team by the Chief Executive and the executive team of NHS Lanarkshire. A copy of this presentation is at Healthcare Improvement Scotland’s website.6

6http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/nhs_lanarkshire_review.aspx
2.16 The day before the visit to each hospital, the Scottish Health Council had representatives available in the foyer to collect patients’ and carers’ experiences of the quality of care.

2.17 The night before the visit to each hospital, patients and carers were invited to attend a listening surgery to share their experiences of the quality of care.

2.18 At the end of each day, members of the review team fed back areas of concern or escalation to the management team in NHS Lanarkshire. More urgent concerns were escalated immediately.

2.19 The matters identified in the review visits formed the basis for further follow-up unannounced review visits in the following few weeks. These included evening, night time and weekend visits. The onsite review period was concluded on the evening of 27 October 2013. In total, 43 clinical areas were visited on an either announced or unannounced basis between 9 and 27 October 2013.

**Post review visit**

2.20 Following the conclusion of the announced review visit on 11 October 2013, the review team carried out a complex and extensive exercise to follow up on evidence, to better understand areas for improvement and to corroborate observations or written information.

2.21 The post visit period has included a considerable amount of further information gathering. The review team also sought information on matters escalated to NHS Lanarkshire. Throughout this period, the review team received the full co-operation and assistance of the staff and senior management team in NHS Lanarkshire. The review team acknowledges the extra demands that this has placed on staff in NHS Lanarkshire and is grateful for the positive way that they have responded.

2.22 The review team also sought the advice and expertise of members of the expert advisory group. The expert advisory group provided a ready source of support and challenge to the thinking of the review team.

**Safety and quality summit**

2.23 Following the publication of this report, a safety and quality summit will be held, with the aim of agreeing:

- a prioritised action plan in response to the review findings, and
- agreeing any additional support to enable implementation of the priority actions.

2.24 The summit will include representation from NHS Lanarkshire, relevant members of the review team, expert advisory group and representatives from national organisations who are in a position to commit support for the implementation of the agreed action plan.
### 3 Recommendations

**Recommendation 1**: NHS Lanarkshire should take further urgent action to address its late submission of national inpatient data (SMR01). This will ensure that the published HSMR is accurate.

**Recommendation 2**: NHS Lanarkshire should ensure that its existing plan to produce accurate and timely patient discharge summaries is implemented on schedule.

**Recommendation 3**: NHS Lanarkshire should review its current complaints process to ensure it consistently delivers person-centred responses.

**Recommendation 4**: NHS Lanarkshire should review its processes for collecting patient and carer experience data, to ensure that patients and carers feel able to provide honest feedback that is reflective of both the positive and negative aspects of care.

**Recommendation 5**: NHS Lanarkshire must strengthen its ability to:

a) reliably identify patients whose clinical condition is deteriorating, and  
b) deploy an effective, timely and appropriate response to the patient’s needs.

**Recommendation 6**: NHS Lanarkshire should review its overall structure for the delivery of the Scottish Patient Safety Programme, ensuring that:

a) effective senior level leadership is in place to lead and manage the programme, including a planned programme of regular Leadership Safety Walkrounds  
b) a realistic and prioritised plan can actually be implemented and sustained  
c) there are sufficient individuals with quality improvement expertise actually providing practical coaching and support, with the aim of delivering sustained improvements across a prioritised and focused programme of work  
d) there is a clear focus on building improvement skills in all staff, and  
e) the Board actively scrutinises its performance against the key elements of the Scottish Patient Safety Programme and reviews its approach to learning from the data generated.

**Recommendation 7**: NHS Lanarkshire should take prompt action to develop and implement a credible and practical model for medical staffing that meets patient needs. The model needs to be informed by, and inform, the clinical model of care.

a) There needs to be particular attention to the seniority and number of staff out of hours.  
b) There needs to be robust arrangements for when staff are on leave.  
c) The immediate priority areas should be the staffing of orthopaedics, acute/general medicine, care of the elderly and emergency medicine, but the same principles need to be applied to other specialties.  
d) For orthopaedics, the review team believes that this requires a more fundamental review of the distribution of orthopaedic services across NHS Lanarkshire.
e) For the emergency medical patient, the review team believes that they require regular senior medical input throughout the entire patient journey, with as much attention to care on the wards as at the admission units and emergency departments.

**Recommendation 8:** NHS Lanarkshire should take action to simplify the current medical management arrangements and strengthen the site-specific medical leadership.

**Recommendation 9:** NHS Lanarkshire should ensure robust procedures are in place for development and ratification of clinical protocols.

**Recommendation 10:** NHS Lanarkshire should rerun the workload tools, with occupancy levels reflective of the ward’s actual activity and any additional investment in nursing staff should then be prioritised for wards and units which have the most significant gaps against the assessed level of needs.

**Recommendation 11:** NHS Lanarkshire should ensure further review of nurse numbers and/or skill mix is considered in association with work to address vacancy levels, bank usage, support to improve rostering practices (including consideration of the potential benefit from eRostering) and appropriate non-clinical/administrative support for senior charge nurses.

**Recommendation 12:** NHS Lanarkshire should review other non-nursing practices to ensure maximum benefit from any changes to the nursing workforce. These include the timing and number of concurrent consultant ward rounds and timely discharge.

**Recommendation 13:** NHS Lanarkshire should review how often senior charge nurses are required to be on call for the hospital when they are also rostered onto the ward and take appropriate action to ensure that this only happens in exceptional circumstances.

**Recommendations 14:** NHS Lanarkshire should ensure that the new nursing dashboard is developed so that it enables easy identification of any wards where the actual numbers of staff rostered are significantly different to the agreed numbers identified by the workload tools.

**Recommendation 15:** NHS Lanarkshire should ensure that robust internal management and governance arrangements are in place and sufficient skilled local clinical and managerial time is allocated to the work with the National Acute Patient Flow Team to redesign patient pathways with the aim of reducing bed occupancy and improving safety. **The safety and quality summit should be used to agree how this work will effectively interface with programme of support currently being provided by the Scottish Government’s performance support team.**

**Recommendation 16:** NHS Lanarkshire should review its current management arrangements, ensuring there is sufficient senior clinical and operational management on each of the three hospital sites. This needs to include clarity on lines of accountability and decision-making responsibilities which then need to be communicated across the three sites so staff understand how, when and where to escalate issues of concern.

**Recommendation 17:** NHS Lanarkshire should review the number of internal groups and bodies with a view to ensuring a sharper and clearer line of accountability through the corporate management team and to the Board for delivery. This will assist in giving clarity regarding priorities and the progressing of delivery. In particular, the link between the current work to improve patient flow and safety improvements needs to be clear and guide work at all levels.
Recommendation 18: NHS Lanarkshire should review its current approach to developing the organisational capacity for improvement. The focus should be on developing and testing changes that lead to improved patient care and outcomes. A focus on making sustainable improvement to patient outcomes reduces the risk of simply providing training without any subsequent implementation.

Recommendation 19: NHS Lanarkshire should develop its Quality Improvement Hub from a virtual concept to an actual team of experts to accelerate improvement across the organisation. This team should include improvement advisors, practice development leads, clinical governance staff, information analysts and organisational development staff.

Recommendation 20: NHS Lanarkshire should ensure an appropriate balance between generating data and developing the capacity to interpret and challenge it at all levels of the organisation to support improvement, performance management and assurance.

Recommendation 21: NHS Lanarkshire should take action to address the current culture whereby key safety concerns are not routinely escalated. This needs to include systems for taking appropriate action or mitigation measures and for feeding back to staff on the action taken.
4 Understanding the HSMR

Introduction

4.1 As indicated in Section 1, a higher than predicted HSMR cannot be used to make judgements about the quality and safety of health services. Nor can it be used to quantify the number of avoidable deaths. Instead it should be used as a ‘smoke alarm’ which alerts an NHS board to potential problems and leads to a more detailed review of safety and quality issues.

4.2 In recognition of this, Sections 5–10 of this report highlight the findings from the independent review into the safety and quality of care across NHS Lanarkshire’s three acute hospitals. This section summarises the findings from the assessment of any other factors that may be impacting on the higher than average HSMR. A more detailed analysis is available as a separate appendix to this report and can be found on the Healthcare Improvement Scotland website.

HSMR – current position and trends over time

4.3 The Rapid Review was commissioned following the August release of HSMR figures based on the provisional values for all hospitals for January to March 2013 (Figure 1). The figures for this time period have now been updated for the November release (Figure 2) to take account of any records NHS boards have submitted subsequently. The effect is that, whilst Monklands Hospital remains a statistical outlier on the revised figures, Wishaw Hospital is no longer an outlier. Hairmyres Hospital is not an outlier on either the provisional or revised figures. More information on this can be found in the separate HSMR appendix.

Comparison of HSMRs for Monklands Hospital, Hairmyres Hospital and Wishaw Hospital with the Scottish average (January–March 2013)

<table>
<thead>
<tr>
<th>Figure 1: August 2013 release, provisional data</th>
<th>Figure 2: November 2013 release, final data</th>
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<tbody>
<tr>
<td><img src="image1.png" alt="Graph showing HSMR comparison" /></td>
<td><img src="image2.png" alt="Graph showing HSMR comparison" /></td>
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4.4 Since the initiation of the Rapid Review, the data for the quarter April–June 2013 has been published (Figure 3). These highlight that the HSMR for Monklands Hospital

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*www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/nhs_lanarkshire_review.aspx*
remains an outlier and that Hairmyres Hospital and Wishaw Hospital are within the accepted range.

Figure 3: Comparison of HSMRs for Monklands Hospital, Hairmyres Hospital and Wishaw Hospital with the Scottish average (April–June 2013), provisional data

![Graph showing comparison of HSMRs for Monklands, Hairmyres, and Wishaw hospitals with Scottish average.]

4.5 The trend over time for each of the three hospitals is shown in Figure 4. The published overall reduction at Wishaw Hospital (17.6%) is greater than the overall change across Scotland (12.4%), whilst the reduction at Monklands Hospital (4.3%) and Hairmyres Hospital (7.1%) are less.

Figure 4: HSMR for deaths within 30 days of admission to hospital. Data presented for Scotland, Hairmyres Hospital, Monklands Hospital and Wishaw Hospital (October–December 2006 to April–June 2013)

![Graph showing trend of HSMR for 30-day deaths across quarters from Oct-Dec 2006 to Apr-Jun 2013.]

Data Source: ISD (November release).
What factors might be contributing to the higher than predicted HSMR?

4.6 The HSMR is based on a statistical model and can therefore be impacted by both the quality of data feeding the model and the validity of any assumptions which underpin the model. The review team asked ISD to undertake a detailed analysis of factors related to data, the model and the way services are delivered in NHS Lanarkshire that may be contributing to the higher than expected HSMR. This work examined several factors which are detailed in the separate HSMR appendix which accompanies this report. To date, the following factors have been investigated as set out in Table 4.

Table 4: Factors potentially impacting the HSMR

<table>
<thead>
<tr>
<th>Factor potentially impacting HSMR</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of clinical coding</td>
<td>Highly unlikely that impacting on the HSMR</td>
</tr>
<tr>
<td>Accuracy of diagnosis on initial admission</td>
<td>Highly unlikely that impacting on the HSMR</td>
</tr>
<tr>
<td>Quality and timeliness of discharge documentation</td>
<td>May be impacting on the HSMR</td>
</tr>
<tr>
<td>Initiation of Hospital at Home services in Monklands</td>
<td>Highly unlikely that impacting on the HSMR</td>
</tr>
<tr>
<td>Late submission of SMR01 records (national acute inpatient data set)</td>
<td>Is impacting on the HSMR in the provisional data</td>
</tr>
<tr>
<td>Palliative and end of life care</td>
<td>Unlikely that impacting on the HSMR</td>
</tr>
</tbody>
</table>

4.7 The review team noted that, whilst late submission of data or failure to complete discharge summaries, may affect the HSMR value published, it is the responsibility of the NHS board to submit accurate and timely data. NHS boards are expected to submit SMR01 records to ISD within 6 weeks of the end of the month in which the discharge occurred. The team also noted that this revising down of figures due to late submission of data has been an ongoing issue for NHS Lanarkshire and that the July–September 2011 Monklands Hospital data were previously revised from being a statistical outlier to a non statistical outlier on the basis of late returns (this was also the case for the figures for October–December 2011).

4.8 Although the HSMR model attempts to control for case-mix, NHS Lanarkshire has suggested that it may not adequately control for the unique characteristics of the population admitted to Monklands Hospital. Though it is unlikely that this is the case, it is not impossible, and the review team was unable to rule out this possibility.

4.9 NHS Lanarkshire’s Health Profile 2010 was produced by the Scottish Public Health Observatory (ScotPHO) team at ISD [Data Appendix Reference 4a]⁸. The health profile of the population of NHS Lanarkshire is generally worse than the Scottish average, including a significantly higher:

- rate of early deaths from coronary heart disease, cancer and cerebrovascular disease and alcohol conditions
- prevalence of diabetes

⁸ Please note that throughout this report statements are made which reference additional data in the Data Appendix. These are indicated by the use of [Data Appendix Reference xx] referencing.
• number of patients who have been hospitalised with chronic obstructive pulmonary disease (COPD) and coronary heart disease
• number of individuals admitted as an emergency and patients (aged 65+) with multiple hospital admissions
• percentage of patients prescribed drugs for anxiety, depression and psychosis
• percentage of adults claiming incapacity benefit/severe disability allowance
• percentage of the Lanarkshire population that is classed as income deprived, of working age employment deprived or claiming Jobseeker’s Allowance, dependant on out of work benefits or child tax credit or claiming pension credits (aged 60+), and
• crime rate in the NHS Lanarkshire area.

Conclusions and recommendations

4.10 The late submission of records had a notable impact on the HSMR for Monklands for the period January-March 2013. When these figures were first published in August 2013, the HSMR was 1.38. When the figures were updated in November 2013, using a more complete dataset, the HSMR was 1.26. Monkland’s HSMR was significantly higher than the Scottish average for both these analyses.

4.11 The HSMR for Wishaw Hospital and Hairmyres Hospital were also reduced when late submissions were included. These revised figures mean that Wishaw Hospital and Hairmyres Hospital have not been significant outliers at any point over the last 18 months.

4.12 The review team note that late submission of data has previously resulted in an inaccurately elevated HSMR for Monklands Hospital for July 2011–September 2011 and for October 2011–December 2011. NHS Lanarkshire has reported that the underlying cause of the late submission of SMR01 forms to ISD for this time period is different to the reasons for the late submissions observed more recently. The review team note there continue to be issues, and that it is the responsibility of each NHS board to submit complete, accurate and timely data.

4.13 Quality of coding, local admission practice and care at home policies do not appear to contribute markedly to the higher than predicted mortality. There is a component of the high HSMR at Monklands Hospital that remains unexplained and may be a result of one or a combination of the following.

a) **The accuracy of diagnosis recorded in the clinical records.** The case note review found some evidence of issues here, but it has not been possible to quantify the magnitude. Specifically, if hospital discharge summaries in Lanarkshire are routinely less complete or accurate than for other hospitals, then this in theory could artificially inflate the HSMR for Lanarkshire’s hospitals.
b) **Limitations of the HSMR model.** All models are recognised as having limitations, and there are always factors which they cannot take into account. It is unlikely, but not impossible, that there is something about the population of patients admitted to Monklands Hospital that the model does not adequately control for. The review team asked ISD to undertake a review of the effect of including the Scottish Index of Multiple Deprivation\(^9\) in the model and this did not have a significant impact.

c) **Random variation** is unlikely to be an explanation when a hospital, such as Monklands Hospital, is a persistent outlier.

d) **Quality of care.** Whilst it is not possible to draw definitive conclusions about quality of care on the basis of the HSMR, it is possible that issues with the quality of care could cause avoidable deaths and that the HSMR is drawing attention to this.

4.14 **The rest of this report focuses on the issues identified during the Rapid Review into the safety and quality of care for acute adult patients.** Though initiated because of the elevated HSMRs, the findings from the Rapid Review stand in their own right and are not impacted by either revisions to the HSMR data or any questions around the application of the model.

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**Recommendation 1:** NHS Lanarkshire should take further urgent action to address its late submission of national inpatient data (SMR01). This will ensure that the published HSMR is accurate.

**Recommendation 2:** NHS Lanarkshire should ensure that its existing plan to produce accurate and timely discharge summaries is implemented on schedule.

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\(^9\) Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government’s official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index. It divides Scotland into 6,505 small areas, called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,505 (least deprived). By identifying small areas where there are concentrations of multiple deprivation, the SIMD can be used to target policies and resources at the places with greatest need.
5 Patient and carer experience

Introduction

5.1 A vital element of the Rapid Review assessment of NHS Lanarkshire was ensuring that the voices of patients, carers and members of the public in Lanarkshire were heard.

5.2 Members of the public were an integral part of the review team, bringing their own experience and expertise. The review team also considered a wide range of existing data on patient and carer experience and set up a range of mechanisms to obtain direct feedback from patients, carers and public partners.

Direct patient and carer feedback

5.3 Across the different options for submitting an experience, a total of 352 patient or carer experiences were gathered from 327 people. The Data Appendix includes a breakdown of the options for submitting information on the experience of using the acute hospitals and the number of people who used each option [Data Appendix Reference 5a]. Sixty-eight per cent of the patient experiences provided related to 2013, 14% were from 2012, 16.4% were of no specified date, and the remainder pre-dated 2012 [Data Appendix Reference 5bii].

5.4 More detailed information on the wider patient and carer experience submissions can also be found in the Data Appendix [Data Appendix Reference 5b-c]. This includes information received from a constituency MSP, which covers complaints and experiences at Monklands Hospital.

5.5 The publicity requesting patient and carer involvement made clear that the review team could not respond directly to issues raised or 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 visit and the subsequent findings and recommendations of this report.

5.6 The review team received a total of 125 positive experiences, 106 mixed (both positive and negative aspects) and 121 negative experiences. The breakdown across the three sites is highlighted in Chart 1.

Chart 1: Experiences by hospital sites
5.7 Chart 2 highlights the most frequently reported areas of concern for each site (included if there are 15 occurrences or more for one of the sites.) The information appendix provides a breakdown of all the categories [Data Appendix Reference 5b]. The top four concerns mentioned were:

- assisting patients with basic tasks such as eating and toileting was stated in 17% of experiences (23 Hairmyres Hospital, 26 Monklands Hospital, 9 Wishaw Hospital, 2 more than one site)
- lack of staff cover and inappropriate skill mix was stated in 17% of experiences (14 Hairmyres Hospital, 20 Monklands Hospital, 19 Wishaw Hospital, 6 more than one site, 1 not stated)
- poor staff attitude/rudeness was stated in 16.7% of experiences (16 Hairmyres Hospital, 25 Monklands Hospital, 13 Wishaw Hospital, 5 more than one site), and
- not informing carers or respecting/listening to carer views was stated in 14.5% of experiences (11 Hairmyres Hospital, 25 Monklands Hospital, 10 Wishaw Hospital, 4 more than one site, 1 not stated).

Chart 2: Reported areas of concern

Note: While the classification of patient and carer experiences has been consistently classified by one person, the interpretation of experiences can be subjective.

5.8 Specific patient and carer stories that illustrate the review team’s key findings are woven throughout this report. The review team has not investigated any individual experience and is aware that, in some cases, there may be additional information that NHS Lanarkshire could provide that may challenge some of the details. However, the review team made the decision to include actual stories as, whatever the facts of the case, these illustrate how individual patients and carers have experienced services.
Existing patient and carer experience data

5.9 In 2011 and 2012, the Better Together Survey was conducted. This was a national patient experience survey which covered all NHS boards. An overall Healthcare Experience Indicator was developed which was based on the results of the inpatient survey. On the 2012 Better Together Survey, NHS Lanarkshire had the lowest Healthcare Experience Indicator score across Scotland. At a hospital level, Monklands Hospital had the lowest score in Scotland [Data Appendix Reference 5d-e].

5.10 In response to these results, and in recognition of the need to assess and monitor progress on the key issues raised in the Better Together surveys, NHS Lanarkshire developed its own internal patient experience indicator. The locally developed questionnaire prompts discussion with a random sample of five patients in each ward, every month and is conducted by a range of staff describing themselves as volunteers, including the nurse director. This means that approximately 235 patients are interviewed every month.

5.11 Questions were developed in partnership with the public partnership forums and draw on themes identified in key reports such as the older people in acute hospitals inspections and the Francis Report. In June 2013, the questions and frequency of asking them was reviewed in partnership with the public partnership forums.

5.12 In April 2013, in recognition of the links between patient experience and safety issues, the NHS board increased the sample to 10 patients in each ward in Monklands Hospital.

5.13 The internal surveys carried out by NHS Lanarkshire (September 2011–April 2013) show considerable improvement compared to the 2012 Better Together Surveys (relating to hospital stays October 2010–September 2011). When the six questions that scored lowest in the Better Together survey are compared to the internal NHS Lanarkshire survey, there is an average increase in positive scores of 24 percentage points. [Data Appendix Reference 5f].

5.14 The review team noted that NHS Lanarkshire has set a local goal of 95% positive responses to its local patient experience indicator.

5.15 The two surveys use different approaches. The local survey interviews patients currently on the inpatient ward and the national survey contacts individuals post discharge. An acknowledged weakness of the local approach is the potential that current patients may be less willing to highlight problems. During a discussion at the site visit, NHS Lanarkshire cited research indicating the optimum time between discharge and gathering of patient experience as 2 weeks. An acknowledged weakness of the national approach is the time gap between the inpatient experience and the survey and the time gap between survey and publication.

5.16 NHS Lanarkshire also piloted a local carer experience indicator in June and July 2013. The results from this were published in September 2013. The review team was advised that the intention is to roll this out more widely following a review of the questions asked. NHS Lanarkshire is to be commended for this work and encouraged to develop it further.

5.17 NHS Lanarkshire has also tested its own observational audit tools.
5.18 The review team also considered information submitted to the Patient Opinion website. At the point where the website was reviewed (2–4 September 2013), there were 22 posts of which 16 related to negative experiences [Data Appendix Reference 5g].

5.19 Older people in acute hospital inspection reports were also reviewed to identify any key themes where patient care could be improved. Monklands Hospital (June 2012) and Wishaw Hospital (May–June 2012) both had 15 areas for improvement particularly highlighting weaknesses around treating older people with compassion, dignity and respect and issues around the care of individuals with dementia and cognitive impairment. Hairmyres Hospital (March 2012) had eight areas for improvement including efficient discharge of dementia patients, monitoring of their movement between wards, personalised care plans, and management of pressure ulcers. NHS Lanarkshire has developed action plans in response and has stated that it has increased its number of senior nurses for care of the elderly from one to three.

**NHS Lanarkshire’s complaints processes**

5.20 The review team looked at NHS Lanarkshire’s complaints report for 2012–2013, the quarterly report for April–June 2013 and the Scottish Public Services Ombudsman (SPSO) reports for NHS Lanarkshire and conducted a random audit of complaints files during the site visits. Members of the public who telephoned the Patient Advice and Support Service with experiences of using NHS Lanarkshire’s acute hospitals were also asked about their experiences of making a complaint.

**Complaints data and themes**

5.21 From April 2012–March 2013, NHS Lanarkshire received 681 formal complaints and 654 informal concerns across all three acute sites. Nationally, NHS Lanarkshire received 11.3% of all complaints in 2012–2013. This is broadly in line with its percentage of the estimated total Scottish population of 11%.

5.22 Thirty-eight per cent of the complaints related to clinical treatment and 32% of complaints related to staff attitude and behaviour. This is in line with trends nationally across Scotland (38% ‘treatment’ and 32% ‘staff’

5.23 From April 2012–March 2013, NHS Lanarkshire answered 95% of complaints within the target of 20 working days compared to a national performance of 61%.

5.24 NHS Lanarkshire provided the review team with more recent complaints data for the period April–June 2013. This highlighted that Hairmyres Hospital had a 42% increase from the previous quarter (rising from 10 complaints to 17 complaints), almost exclusively related to surgery and critical care.

5.25 The annual and quarterly reports do not list the number of compliments received. NHS Lanarkshire does not currently have a robust method in place for collecting data on compliments that avoids increasing the administrative burden on staff. It is currently looking at systems for this.

**Appeals to the Scottish Public Services Ombudsman (SPSO)**

5.26 A total of 102 complaints relating to NHS Lanarkshire were referred to the SPSO in 2012–2013. This was 8.2% of the health sector total for Scotland (NHS Lanarkshire has around 11% of the population of Scotland).

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10 ISD, NHS Complaints Statistics Scotland 2012-201313
5.27 Sixty-five per cent of complaints to the SPSO relating to NHS Lanarkshire during 2012–2013 were upheld or partly upheld. This compares to an upheld/partly upheld rate across Scotland of 51.9%.

5.28 Thirteen per cent (26 out of 200) of all the upheld/partly upheld cases by SPSO were from NHS Lanarkshire. It should be noted that these were cases that reached resolution in 2012–2013 and do not all relate to patient episodes during that year.

**NHS Lanarkshire’s processes for learning from complaints**

5.29 The review team considered the internal processes for learning from complaints.

- The majority of complaints are signed off by the hospital general manager. In some cases, complaints are signed off by NHS Lanarkshire’s nurse director.
- Responses routinely offer the complainant an opportunity to meet with senior staff if they have outstanding concerns. If the complainant responds affirmatively to this offer then the meeting is chaired by the most appropriate person for that complaint, including clinical managers, medical and nursing directors or other executives.
- For complaints registered in 2012–2013, NHS Lanarkshire held 62 staff debrief meetings (24 at Hairmyres Hospital, 20 at Monklands Hospital and 18 at Wishaw Hospital). Debriefs are initiated at the request of the senior nurses or clinical directors. Any recurrent issues on individual wards are also identified from this process and fed back to the ward concerned. An overview of each debrief and the learning from this is included in the annual complaints report.
- Issues arising from complaints are disseminated to staff by ward safety briefs, and quarterly complaints reports are submitted to the site-based clinical governance committees to consider further action. Issues arising from complaints are discussed at senior charge nurse forums and relevant issues are also discussed at ward level.
- Twice yearly complaints ‘stocktakes’ involving senior staff discuss complaints trends and the general manager for each site is responsible for ensuring any learning is taken forward.
- Findings from complaints upheld by the SPSO are disseminated across the organisation with an anonymised synopsis and action plan. Implementation of the plan is monitored by the patient affairs manager.

**Review team audit of complaints responses**

5.30 Over the course of the site visits, members of the review team randomly sampled 26 complaints files. Findings included the following.

- The reviewers considered that some of the complaints had been dealt with sensitively and sympathetically, whilst other responses gave the impression of being impersonal or defensive.
- There were examples where staff met directly with patients and carers to discuss their concerns and these often helped to resolve issues. It is not clear whether this has been initiated by the patients, carers or by the professionals involved. There were some cases where the nature of the complaint indicated very distressing circumstances and/or poor care, yet no direct conversation seems to have taken place. NHS Lanarkshire’s complaints policy does not provide guidance on the circumstances when direct liaison with the patient or carer should be routinely initiated within the context of formal complaints.
There were examples of people stating they were not satisfied with the way the complaint had been dealt with after NHS Lanarkshire had sent its concluding letter. In one case, correspondence continued for 8–9 months after ‘resolution’. In another, the complainant expressed the view that the response was ‘not person centred’. Other examples of this were evident from respondents who were asked about their experience of complaints when contacting the Patient Advice and Support Service (PASS) information line (see paragraph 5.31). Although there were some positive reports of the way complaints were handled, some people felt that their complaint was not handled well.

- ‘Did not feel that my concerns were taken seriously or listened to. No meetings with consultant, very poor communication.’
- ‘Attended meeting for complaint. Man wasn’t independent. Defended hospital, didn’t want criticism. Approached MSP.’
- ‘Depended who you spoke to. Some nurses were fantastic while others were awful.’

Views received from patients and carers on the complaints process

Members of the public contacting the PASS information line were also asked about their experience of making a complaint. This information was not gathered systematically from the other sources of patient and carer experience. The Data Appendix highlights the comments on individuals’ experiences of the complaints process and the reasons why some individuals did not use it despite being unhappy with their experience of care [Data Appendix Reference 5h].

Conclusions and recommendations

NHS Lanarkshire is clearly committed to learning from patient experience data. It has invested in patient affairs managers for every acute hospital site, developed local patient and carer experience indicators, developed a local observation audit and regularly reports patient experience information at Board level. The Board level reporting includes the patient experience dashboard and the use of patient experience stories.

However, the review team identified ways to improve reliably translating this commitment into action. In particular, NHS Lanarkshire needs to:

- review the current approach to complaints and in doing so consider the views of individuals who have complained. The primary focus of the process must be on responding fully to the issues raised by complaints, rather than on purely meeting the 20-day target. NHS Lanarkshire should consider a more proactive approach to contacting individuals who are making complex formal complaints to ensure clarity on both the issues raised and the desired outcome from the complainant.
- review its approach to complaints sign-off and oversight to ensure that relevant senior leaders are sighted on both the final response and any recurring themes that may require action. The review team noted the importance of senior leaders reading complaints letters and responses as well as seeing a high level analysis of themes.
- review its current processes for collecting patient experience data, to ensure the feedback is not inappropriately influenced by patients’ concerns that any negative comments may impact on their current care. This review needs to
consider whether setting a goal of a 95% positive response rate is creating any unintended negative consequences.

- ensure robust processes are in place for integrating learning from complaints and patient experiences into the overall quality improvement programme. The review team noted that the new general ward dashboard will incorporate patient complaints and experience data which will enable clinicians and managers to consider these data together with a range of other indicators.

**Recommendation 3**: NHS Lanarkshire should review its current complaints process to ensure it consistently delivers person-centred responses.

**Recommendation 4**: NHS Lanarkshire should review its processes for collecting patient and carer experience data, to ensure that patients and carers feel able to provide honest feedback that is reflective of both the positive and negative aspects of care.
6 The safety of patient care

Introduction

6.1 The review team considered several areas in respect of the safe provision of care for patients with a particular focus on how NHS Lanarkshire identifies, and cares for, patients whose clinical condition is deteriorating. The review team also considered the wider delivery of the Scottish Patient Safety Programme in NHS Lanarkshire.

Case note review

6.2 For each hospital, the records of approximately 50 consecutive patients who had died were reviewed using the 3 x 2 matrix tool developed by the NHS Modernisation Agency. This tool is designed to identify possible areas for improvement and 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.’

6.3 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.

6.4 In total, the review team reviewed 152 case notes (Hairmyres Hospital 53, Monklands Hospital 51, Wishaw Hospital 48) and 175 adverse events were identified using the Institute of Healthcare Improvement (IHI) Global Trigger Tool for Measuring Adverse Events (UK version). This needs to be seen in context. The tool defines an adverse event as any harm to a patient, however minor and whether or not it was the result of an error. The Global Trigger Tool excludes any consideration of whether an adverse event was preventable, as the discussion about the preventability of an adverse event is often a barrier to determining the cause of an adverse event. Indeed, some of the adverse events will not be preventable as they will be recognised complications of treatment. The tool used is a highly sensitive one. It is intended to detect as many adverse events as possible with the aim of identifying all possible opportunities for improvement.

6.5 This tool is not designed to identify avoidable deaths or to give a definitive figure that can then be used to compare one organisation’s rate of adverse events to another. However, in the professional view of the members of the review team, the findings from the case note review are not unusual. Similar patterns have been seen elsewhere.

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11 A Matter of Life and Death, improving hospital mortality rates and end of life care, 3x2 matrix tool to identify care issues around patients who die in hospital, NHS Modernisation Agency, July 2004

12 IHI Global Trigger Tool for Measuring Adverse Events (UK version), Institute for Healthcare Improvement, September 2008
6.6 The case note reviews highlighted the need to focus improvement in the following areas.

a) Improve the recognition of patients whose condition is deteriorating.
   - Ensure that each time basic observations are made, a Modified Early Warning Score (MEWS)\(^{13}\) is calculated.
   - Ensure that there is clarity about the frequency of observations required given a patient's condition and any changes in MEWS scores, and ensure that this is consistently applied across the NHS board.

b) Improve the response to patients whose condition is deteriorating.
   - Escalation should be clear, prompt and effective.
   - Reduce variability in delivery of care for patients with sepsis, ensuring reliable delivery of the Sepsis 6 bundle\(^{14}\) within 1 hour of identification of sepsis.

c) Improve the medical review of patients.
   - There is an opportunity to improve senior review, particularly of patients who may be at risk over weekends and public holidays. Medical cover over the weekend period on medical wards is disproportionately reliant on very junior doctors (FY2, GPST and CT1).
   - In general, it was not always clear which consultant was responsible for a patient. In some cases, there was no record in the patient's notes of being seen by a senior decision maker for 5 days, nor was there an entry in the notes of the plans for the medical aspects of care.

d) Improve communication and note keeping.
   - There are opportunities to improve structured communication between staff when patients move between departments and when shifts change.
   - It is important to ensure that there are good entries in the clinical notes at times of critical deterioration.
   - There was variability in the action planning within medical notes. Some showed effective plans, escalation and timescales, but others did not.
   - Discharge summaries were often very delayed and sometimes completed by doctors who were not involved with the care of the patient.

6.7 The findings from the case note review have been used as a source of evidence by the review team and considered as part of its assessment of the safety and quality of care. Therefore the detailed findings are weaved into the remaining sections of this report as relevant.

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\(^{13}\) The MEWS is based on data derived from physiological readings and is used to quickly determine when a patient's condition is deteriorating and therefore requires review.

\(^{14}\) Sepsis 6 is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The following elements are to be completed within 1 hour of the time of presentation with sepsis:
1. Give high flow oxygen
2. Take blood cultures
3. Give IV antibiotics
4. Start IV fluid resuscitation
5. Check lactate, and
Care of the deteriorating patient

Programme of work

6.8 Since 2008, the Scottish Patient Safety Programme has included a focus on the reliable implementation of the MEWS. From 2013, this has developed into a ‘deteriorating patient’ workstream that aims to improve the reliable identification and appropriate response to patients whose condition is deteriorating.

6.9 NHS Lanarkshire identified the care of the deteriorating patient as a major priority within its initial HSMR improvement plan in March 2012. It is currently one of four key workstreams within its HSMR Improvement Programme. The other three are end of life care (including Anticipatory Care Plans), information and quality reviews and clinical change/leadership.

6.10 The review team noted that NHS Lanarkshire took the decision in December 2012 to establish the HSMR Improvement Programme Board. In June 2013, the Board received the HSMR Improvement Programme with a range of actions to be taken forward. This built on the previous improvement plan, which was initiated in March 2012, and continued to highlight the care of the deteriorating patient as a priority.

6.11 The review team noted that, in July 2013, the Healthcare Improvement Scotland HSMR Review Group\(^{15}\) replied to NHS Lanarkshire’s update. This letter indicated that, though broadly satisfied with the response and pleased to see specific development actions outlined for the coming period raised, they had concerns that many of the actions were focused on longer term strategic solutions rather than on immediate process reliability (for example maximising early rescue through ensuring translation of MEWS scores into action by the intervention team and targeted application of the Sepsis 6 bundle to clinical areas with higher sepsis rates).

6.12 The review team noted that the current focus of the deteriorating patient workstream was summarised in a Project Initiation Document (PID) dated 23 September 2013 (v2.2). The first version of the PID was created in August 2013.

6.13 The PID has 6 sub-divisions, including:

- recognition and rescue of deteriorating patients
- sepsis
- condition specific interventions for delirium
- catheter associated urinary tract infection (CAUTI)

\(^{15}\) If a hospital is identified as having a relatively high HSMR, then Healthcare Improvement Scotland has a structured dialogue with the NHS Board in question. This dialogue is overseen by the HSMR Review Group. The group seeks reassurance that the NHS Board is taking appropriate action to understand and respond to the HSMR data, and also aims to provide advice to the NHS Board in this regard. Membership of the group is drawn from some NHS Boards, the Information Services Division, and Healthcare Improvement Scotland.
• introduction of intentional rounding\textsuperscript{16}, and
• introduction of electronic recording of observations (TrakCare) in five wards at Monklands Hospital.

6.14 The review team received a detailed Gantt chart for the deteriorating patient workstream that was dated 15 September 2013. Some actions in the Gantt chart had demanding timescales, whilst others had no timescales at all. NHS Lanarkshire highlighted that the Gantt chart is updated regularly in line with output from project team meetings so it was described as a dynamic document.

6.15 The review team noted that the PID for the deteriorating patient workstream included a list of project deliverables with longer timescales than the pre-dated Gantt chart. Both documents indicate diverse and substantial programmes of work.

6.16 The review team noted that in May 2013, NHS Lanarkshire’s Board decided to prioritise the use of operational and quality improvement capability and capacity for the HSMR work. At the time of the review visit, the following improvement resources were allocated to support the deteriorating patient workstream:

• one WTE improvement advisor per site with 90\% of time focused on the workstream
• approximately 0.6 practice development practitioner on each site supporting HSMR (with other 0.4 per site focused on other related improvement work including pressure area care and falls)
• across the three sites 3.9 WTE practice scholars are also allocated to supporting the work, and
• across the three sites, half day each week on deteriorating patient and sepsis improvement work provided by NHS Lanarkshire’s critical care nurse consultant and half day each week provided by a consultant anaesthetist (Scottish Patient Safety Programme Fellow) which was planned to increase to a day a week from 18 November 2013.

6.17 However, the review team noted a disconnect between the detailed Improvement Programme and the actions identified in the PID, and therefore found it difficult to understand the exact programme of work planned and the timescales associated with it. Although it appears to be diverse and substantial and, even with the additional resources allocated, the review team questioned NHS Lanarkshire’s current ability to secure meaningful and sustainable implementation in the timeframes outlined.

Measurement for improvement

6.18 The review team noted the associated measurement plan includes:

• cardiac arrest count each month
• cardiac arrest rate per 1000 discharges or days between cardiac arrests
• percentage compliance with early warning score assessment
• percentage of observations for which respiratory rate is recorded
• percentage of observations identified as at risk that have appropriate intervention

\textsuperscript{16} Intentional (or Care) rounding is a structured process whereby the nursing team visit patients at regular intervals as defined by their care needs. The purpose is to regularly address all their requirements during these visits including physiological observations, pressure care, food and nutrition requirements and pain control. It offers an opportunity to address a wide range of patients needs and has been evidenced to improve outcomes for patients such as a reduction in falls and pressure ulcers
• Scottish structured response count or rate
• structured review rate, and
• MEWS compliance, and number of emergency admissions to Intensive Care Unit.

6.19 NHS Lanarkshire is monitoring the measures that it is putting in place. The review team saw a deteriorating patient dashboard which included a range of measures from July 2012 through to August 2013 [Data Appendix Reference 6a]. The dashboard shows consistently strong and exceptionally high compliance with MEWS assessment based on self reporting from wards (greater than 95% across all three measures since July 2012).

6.20 The MEWS process and outcome measures were also being reported to the Board as part of the quality dashboard.

6.21 A recent audit of MEWS compliance initiated by NHS Lanarkshire and conducted in the week beginning 16 September 2013, found a measured compliance of 17% at Hairmyres Hospital, 28% at Wishaw Hospital and 40% at Monklands Hospital [Data Appendix Reference 6aii]. NHS Lanarkshire confirmed the MEWS performance reported to the Board had been self-monitored by ward staff themselves and reviewed locally through the Scottish Patient Safety Programme. NHS Lanarkshire added that variability in outcome results had resulted in random checks by the hospital emergency care team to establish the accuracy of MEWS and it was identified that these were not as accurate as the ward staff themselves considered. This led to the establishment of ALERT and CRASH courses.

6.22 The case note review (6.6) also highlighted that compliance with MEWS scoring was highly variable and reflects the results of the recent local audit. Issues identified included failure to carry out some observations, failure to change the frequency of observations in response to patients’ needs and that the MEWS form did not give guidance on the frequency of observation. The case note review relates to practice in January 2013 and therefore predates some of the changes made since then by NHS Lanarkshire including the introduction of the new clinical observation policy.

6.23 As part of their HSMR improvement work, NHS Lanarkshire initiated a programme of training to ensure clinical staff have the skills to identify patients who are deteriorating. Two courses were put in place: CRASH which is aimed at Clinical Support Workers and ALERT which is aimed at registered nurses. By February 2013, approximately 100 Clinical Support Workers and 700 registered nurses had attended this training (HSMR Progress Report to Healthcare Improvement Scotland, February 2013). The data appendix highlights the percentage of staff trained per ward by November 2013 [Data Appendix Reference 6b]. The review team heard consistently good feedback about both the courses from a range of staff.

6.24 A clinical observation policy was introduced in August 2013. This includes clear guidance on how to tailor frequency of MEWS when scores are elevated and when and who to escalate to.

6.25 However, the review team heard that staff did not always have time to do observations as often as indicated and the case note review reinforced this. Staff also raised concerns about the implementation of the new clinical observation policy. The review team heard that, in some areas, the focus was on instructing staff to comply without taking the necessary action to address the system issues which are getting in the way of compliance.
6.26 The nurse director, in a report drafted September 2013 on nursing workforce numbers, recognised the importance of adequate numbers of nursing staff for the identification of the deteriorating patient:

- ‘Registered nurses constitute an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. The effectiveness of nurse surveillance is influenced by the number of registered nurses available to assess patients on an ongoing basis.’

6.27 The review team was repeatedly told by staff that the response to deteriorating patient during the day was good, but that out of hours it was less reliable. The case note review identified the need to improve the medical response when patients become more seriously ill.

6.28 The review team observed good work by hospital emergency care team in the provision of care in the out of hours period in all three hospitals. The core team consists of 27 WTE advanced nurse practitioners, nine on each hospital site, managed and led by the consultant nurse from critical care. Two advanced nurse practitioners support the hospital at night medical team by being first responders to the deteriorating ward patient. They use advanced assessment skills and non-medical prescribing to support immediate treatment planning.

6.29 The review team observed a service delivered by committed and motivated individuals that is making a significant contribution to ensuring good quality patient care out of hours. However, the hospital emergency care team still needs to have access to appropriately skilled and accessible medical advice. Given their lead role around the rescue of the deteriorating patient, this team also needs to be skilled in improvement methods which support the testing and reliable implementation of evidence-based practice.

6.30 The review team observed excellent handovers between daytime teams and the hospital emergency care team teams. However, the review team observed a lack of surgical and orthopaedic attendance at hospital emergency care team handover meetings, although attendance is expected. This was also reported as a key issue by staff across all three sites.

6.31 Patients and carers told the review team about issues with communication between staff (handovers) and staff not checking notes. In total, 50 experiences (14%) mentioned these issues (17 examples at Hairmyres, 18 at Monklands, 9 at Wishaw, 3 more than one site, and 3 with site not stated).

6.32 Examples of experiences shared with the review team included:

- ‘The patient has to constantly update nursing staff on what meds they’ve had and what they are due. Communication needs to be reviewed. Nurses and doctors need to speak to one another. It’s frightening to realise that the nurse or doctor doesn’t know what’s happening to you and what’s planned.’

- ‘In the case of some staff information was handled efficiently…..in other occasions however we were repeatedly asked questions which had previously been answered fully. We were also constantly correcting errors and misconceptions.’

6.33 However, the review team were also told about positive experiences and examples included:
• ‘The communication was spot on, we were kept up to date continually on her condition. Her pain was managed and she was made comfortable. As a family we felt that the way she was treated helped us to deal with our loss.’

• ‘The level of care I have received in all wards has been excellent. Communication between professionals and patients is good.’

6.34 In terms of identifying and responding to patients whose condition is deteriorating, the review team noted that it is not sufficient for members of staff to know what to do, they also need to be able to do it in the clinical environment. It seems unlikely that this can be achieved without attending to the issues surrounding nursing and medical staffing that are highlighted in Section 7 and 8 of this report.

6.35 The review team observed that there needs to be a stronger focus on the application of improvement methodology at the front line to ensure that patient observation happens reliably and is accompanied by an appropriate response, even within a busy clinical environment.

6.36 Ensuring reliable implementation of early warning scores and appropriate escalation is complex and is a challenge facing NHS boards across Scotland. Whilst the intentions in NHS Lanarkshire’s current plan are commendable, it needs to ensure a clearer focus on the priority actions that will deliver improvements and develop a realistic plan for implementation that supports key staff to focus attention on reliable implementation in priority areas before spreading changes more widely.

Improvement work focused on response to Sepsis

6.37 The case note reviews identified that the implementation of the Sepsis 6 bundle was variable and in some cases there was significant delay in providing appropriate care.

6.38 Improving the care of patients with sepsis is a part of NHS Lanarkshire’s HSMR deteriorating patient workstream and was included in the initial action plan in March 2012. The current work plan includes a focus on reducing the delay between recognising sepsis and the implementation of the 6 key evidence-based interventions. This is known as the Sepsis 6 bundle and includes initiation of intravenous (IV) antibiotics within 1 hour.

6.39 The initial focus has been on three pilot areas: Monklands Hospital emergency receiving unit, Hairmyres Hospital accident and emergency and Wishaw Hospital accident and emergency. The review team noted that these were appropriate areas to focus initial work.

6.40 The data related to delivery of the Sepsis 6 bundle reported by NHS Lanarkshire to the Scottish Patient Safety Programme extranet were reviewed for the three pilot areas. These data show signs of improvements in the percentage of patients with the Sepsis 6 bundle performed within 1 hour at both Wishaw and Hairmyres Hospital accident and emergency, but no change at Monklands Hospital emergency receiving unit, where this site had a higher original baseline [Data Appendix Reference 6c].

6.41 The review team also noted an improvement in the time to administer antibiotics across all three areas reviewed (Source: NHS Lanarkshire Extranet Scottish Patient Safety Programme Data [Data Appendix Reference 6c]).

6.42 The national Scottish Patient Safety Programme team advised that NHS Lanarkshire’s existing level of improvement is in line with other NHS boards.
6.43 The review team also noted that NHS Lanarkshire has actively participated in and contributed to the national Sepsis Collaborative since its launch in January 2012. This includes:

- regular participation and presentation of their work on conference calls and at Learning Sessions
- regular uploading of data, resources and tests of change to the extranet sepsis community site, and
- innovative use of the sepsis training video with doctors in training.

6.44 The review team noted that the sepsis work has been focused on the priority actions that will deliver improvements and that there are signs of improvement in the time to delivery of the Sepsis 6 bundle on two of the three pilot sites and improvement in the time to administer antibiotics across all three of the pilot sites. It also noted the innovative use of the sepsis training video and the positive and proactive engagement with this workstream nationally.

Scottish Patient Safety Programme

6.45 The Scottish Patient Safety Programme was launched in January 2008 with the aim of reducing mortality in Scotland’s hospitals by 15% by December 2012. The original focus of SPSP was on acute adult inpatients. However, this has now expanded to include maternal, paediatrics, neonates, primary care and mental health.

6.46 The review team found that the awareness of the Scottish Patient Safety Programme was low in the majority of areas they visited with no obvious improvement methods being systematically applied. The exceptions included the intensive care unit at Monklands Hospital which has a Scottish Patient Safety Programme Fellow attached to it and ward 3 at Hairmyres Hospital where the charge nurse had developed her own safety board and had allocated lead roles for patient safety to her senior nursing team.

6.47 The review team noted the absence of improvement data being displayed in the majority of the ward areas visited. The review team was advised that this was due to an instruction to take down the data in January 2013, as there were concerns that it had lost its meaning. NHS Lanarkshire advised that it was in the process of revising the information with the aim of re-instating the ward data displays. However, the review team found a number of senior managers who were not aware that this instruction had been issued. This included the nurse director who advised that the initial request was to review the data on display, not to take it down.

6.48 No member of staff the review team spoke with could recall a recent Scottish Patient Safety Programme Leadership Walkround. It was subsequently confirmed that these were not happening. The review team observed a lack of senior level leadership for the safety programme in NHS Lanarkshire. It is recognised that the appointment of the new Medical Director offers an opportunity to refocus work on improving the safety of patient care and to reinstate the Scottish Patient Safety Programme Leadership Walkrounds.

6.49 The Board receives regular performance reports. The clinical governance report to the Board in November 2012 reported very significant progress against key compliance elements of the Scottish Patient Safety Programme. It stated:
Some notable reported successes are:

- 100% spread of reliable hand hygiene techniques in all clinical and general ward areas in the three acute hospitals.
- 100% spread of PVC bundle\(^{17}\) in general ward areas in the three acute hospitals.
- 100% spread of Early Warning Score (EWS) bundle in general ward areas in the three acute hospitals'.

6.50 The review team noted the importance of ensuring reliable implementation of patient safety work in pilot areas before spread to other areas.

6.51 The most recent report to the Board on the quality dashboard (Board meeting, October 2013) reported high levels of performance against key safety process measures including the MEWS and PVC maintenance compliance.

6.52 Paragraphs 6.19 to 6.22 highlight concerns about the reliable implementation of MEWS. The case note review identified that PVC care was found to be either ‘Fully’ or ‘Good’ on 59% of occasions at Monklands, 74% at Hairmyres and 78% at Wishaw.

6.53 **The review team did not believe that there was sufficient and robust evidence to support the statements made about the level of compliance elements of the safety programme as reported to the Board.** The review team noted that the measures were self-reported by wards, but it also noted the lack of active challenge of the high reported compliance rates at Board level, even when related outcome measures were not improving.

6.54 The review team noted the need for leaders to recognise when process measures that have apparently achieved high reliability are not matched by improvement in outcome measures. In these situations, leaders should initiate more detailed work to understand the cause of the mismatch. This is a critical element of improvement work which has been highlighted extensively throughout the life of Scottish Patient Safety Programme and discussed at the SPSP learning sessions with a suggested approach included in the Scottish Government circular, CEL (2013) 19: Next Steps for Acute Adult Safety\(^{18}\) and the recently circulated measurement plan.

**Conclusions and recommendations**

6.55 The review team identified a need to ensure that the experience of patients and the safety of patient care are subject to close scrutiny. NHS Lanarkshire must develop a culture of constructively challenging itself on the data, the pace and the extent of progress. In particular, when apparently good compliance with self-reported process measures is not associated with improved outcomes, questions should be asked. NHS Lanarkshire should review its performance in the context of the Scottish Government CEL (2013) 19.

6.56 NHS Lanarkshire needs to strengthen the leadership of the Scottish Patient Safety Programme in the NHS board.

6.57 The review team considers that, whilst knowledge about recognising and rescuing the deteriorating patient is a pre-requisite for success, other aspects are equally important. In particular:

\(^{17}\) The PVC bundle is a series of steps to prevent bloodstream infections when inserting and maintaining a catheter inserted into a vein in the hand or the arm, in order to give fluids or medication.

• staff need to be able to perform the observations required in a timely manner. Given the issues identified around nursing staff’s availability to do observations as frequently as needed, and medical staff’s availability to respond when required, this is inextricably linked to staffing levels (see Sections 7 and 8), bed occupancy, and the numbers of patients being boarded (Section 9).
• clinical teams must be supported to implement the new clinical observation policy through the local testing of changes to translate policy into action. When a deteriorating patient is identified, a reliable mechanism for escalating and communicating this to relevant members of the clinical team needs to be tested and implemented.

6.58 The review team identified a lack of systematic application of improvement methods at ward level. The rate of spread of SPSP locally, together with the findings of this review, indicate a need to focus on reliable implementation of key actions in priority areas before rolling out system wide. The review team noted that this more focused approach has been taken with the sepsis work and recommends that NHS Lanarkshire continues to focus on delivering reliable implementation in key areas before spreading more widely.

**Recommendation 5:** NHS Lanarkshire must strengthen its ability to:

a) reliably identify patients whose clinical condition is deteriorating, and
b) deploy an effective, timely and appropriate response to the patients’ needs.

**Recommendation 6:** NHS Lanarkshire should review its overall structure for the delivery of the Scottish Patient Safety Programme, ensuring that:

a) effective senior level leadership is in place to lead and manage the programme, including a planned programme of regular Leadership Safety Walkrounds
b) a realistic and prioritised plan can actually be implemented and sustained
c) there are sufficient individuals with quality improvement expertise actually provide practical coaching and support, with the aim of delivering sustained improvements across a prioritised and focused programme of work
d) there is a clear focus on building improvement skills in all staff, and
e) the Board actively scrutinises its performance against the key elements of Scottish Patient Safety Programme and reviews its approach to learning from the data generated.
7 Workforce – Medical staffing

Introduction

7.1 The review team considered whether there were issues relating to the numbers, availability and seniority of medical staff that were affecting the quality of care in NHS Lanarkshire.

7.2 This aspect of the review needs to be seen in the context of challenges across Scotland in relation to national workforce planning. Traditionally, the NHS has relied heavily on trainee doctors to provide the clinical service, particularly the emergency service out of hours. The Scottish Government policy direction for the last several years has been to move towards a service provided by trained doctors (consultants and specialty doctors) and the number of training posts has been reduced.

7.3 Specialty doctors must have a minimum of four years post-graduate training, of which two must have been in a relevant specialty. Specialty doctor posts are not always seen as attractive and recruitment can be difficult.

7.4 The allocation of trainees by NHS Education for Scotland is a national issue driven primarily by the clinical experience required by the trainee and the quality of the training.

7.5 Figure 5 summarises the different grades of doctor and may help with interpretation of this section. This is a simplification of the medical career for the purposes of helping the reader of this document. All doctors in training contribute to patient care, but they are not interchangeable. As they progress through their training, they are able to take greater responsibility.

Figure 5: Medical career structure
Composition of NHS Lanarkshire medical workforce

7.6 The ratio of consultant staff to inpatient beds in Lanarkshire (0.271) is close to the Scottish average (0.273) (April–June 2013) [Data Appendix Reference 7a]. Compared to the Scottish average, NHS Lanarkshire has fewer trainees and more specialty doctors; similar patterns exist in other NHS boards [Data Appendix Reference 7b].

Consultant and specialty doctors

7.7 Since January 2011, NHS Lanarkshire has expanded its acute medical workforce by 43.45 WTE consultants (10.9%) and 18 WTE specialty doctors (13.7%). Fifty-three per cent of this increase has been focused on emergency medicine and general medicine including care of the elderly [Data Appendix Reference 7c].

7.8 However, recruitment and retention have been challenging and, despite efforts by NHS Lanarkshire to recruit staff, the vacancy rates at August 2013 were 16% for consultants and 14% for specialty doctors (source: NHS Lanarkshire, Healthcare Improvement Scotland Rapid Review team; medical staffing narrative).

7.9 In 2012–2013, NHS Lanarkshire spent a total of £3.84m on medical locums, £1m more than 2011–2012. During 2012–2013, the highest spend on locums has been in the Emergency and Medical Directorate (£1.6m). Between September 2012 and August 2013, locums typically covered 8% of general medicine and care of the elderly posts at Monklands Hospital, 3% at Wishaw Hospital and around 1% at Hairmyres Hospital. For emergency medicine, the percentages were 5% Monklands Hospital, 5% Hairmyres Hospital and 15% Wishaw Hospital. These figures relate almost entirely to middle grade and consultant medical staff and exclude short-term locums (source: NHS Lanarkshire).

7.10 For the year April 2012 to March 2013, medical sickness absence rates of 1.44% for Wishaw Hospital, 1.07% for Monklands Hospital and 1.20% for Hairmyres Hospital are not high, and are not different from Scotland generally (1.23%) [Data Appendix Reference 7d]. The causes for the high locum use are principally gaps from difficulties filling posts, maternity leave and out of programme experience for trainees.

7.11 NHS Lanarkshire identifies that locums are often difficult to obtain for middle grade and consultant medical staff. The locums who are appointed are often less senior than is optimal for the post they are covering. This means they are less able to function independently and require greater supervision initially, which adds to the work of existing staff.

Doctors in training

7.12 NHS Lanarkshire has 7.4% of the trainee doctors in Scotland and 10.8% of the Scottish population (source: NHS Education for Scotland). However, this does not necessarily mean that their allocation is inappropriate. All NHS boards except the teaching boards of NHS Greater Glasgow and Clyde, NHS Grampian, NHS Lothian and NHS Tayside have fewer trainees than would be expected on a population basis. The four teaching NHS boards provide a range of specialist services to other NHS boards, in which trainee doctors require training experience. As indicated in paragraph 7.4, the distribution of trainees is determined primarily to meet training needs, although it does also take account of service pressures. Whilst NHS Lanarkshire believes that it is disadvantaged in terms of trainee allocation, it is not evident that this is the case compared to similar NHS boards. However, NHS
Lanarkshire is particularly challenged as it needs to provide sufficient staffing across its three acute district general hospital sites.

7.13 The recruitment of doctors to training posts is led by NHS Education for Scotland. Recruitment in some specialties at some levels is difficult throughout the UK. In 2013, 92% of posts were filled, but only 81% at ST level. Notably, in terms of higher training posts, 81% were filled in medicine, 58% in anaesthetics and 31% in emergency medicine. These are the trainees who are able to act as independent decision makers and who are required as the next generation of consultants. There are also pressures because of the number of posts temporarily vacated by out of programme training or maternity and paternity leave. In August 2013, the number of training posts in NHS Lanarkshire that were not filled was 17% (source: NHS Lanarkshire). The inability to fill posts can have a severe effect on service delivery, as trainee doctor rotas must meet stringent requirements for training, and for both European Working Time Regulation and New Deal contractual requirements. In general, rotas have little or no capacity to accommodate gaps.

7.14 Given the complexity of issues associated with medical trainee distributions, the review team is not in a position to comment on whether the number of trainees that NHS Lanarkshire has is appropriate and fair.

7.15 However, it is clear from the data that NHS Lanarkshire is experiencing service pressures resulting from changes in the service contribution of the trainee medical workforce. It is relevant that emergency medicine and general medicine are two areas where recruitment is very difficult.

Attitudes of medical staff

7.16 Patients and carers painted a mixed picture of medical staff attitudes. Examples of positive comments included:

- ‘Registrar and consultant were both excellent.’
- ‘Doctor talked to me as an equal, kept informed’
- ‘One doctor returned after his shift had finished and took the opportunity to actually involve the patient and his wife in their care...his compassion and dedication to providing patient centred care and the highest standard of medical care is a shining example.’

7.17 Others told us about less positive experiences including:

- ‘The junior doctor was observed at one point very shortly after the failed resuscitation attempt to be chatting, joking and laughing with consultant about matters entirely unrelated to medicine whilst standing outside room within the near presence of the family in the adjoining waiting room’
- ‘Doctor and nurse unsympathetic and quite rude. Felt it was a bit like a production line. Nothing much explained to me’

Overall management of medical staff

7.18 In attempting to manage the medical staffing issues, NHS Lanarkshire identifies a number of constraints, many of which it has highlighted as outwith its control:

- reduced numbers and seniority of junior doctors (see 7.11–7.15)
- UK wide issues with recruitment of doctors to certain specialties at both trainee and career grade level
- the difficulties running three out of hours rotas across each of the three acute hospitals
- consultant posts in other surrounding NHS boards may be more attractive, in terms of specialist focus and less frequent out of hours duties, and
- the need to balance medical staffing across three key priorities: emergency response, elective waiting times targets and routine ward cover to ensure safe and effective care.

7.19 The review team noted that most of these issues are faced by all NHS boards and that, whilst some are outside the direct and sole control of NHS Lanarkshire, others can be influenced.

7.20 The review team found the management structures for medical staffing particularly difficult to navigate with a complex mix of site and specialty management [Data Appendix Reference 7e].

7.21 In particular the review team noted that, for each of the emergency departments, there are two individuals who share responsibility for directly managing the medical input: the site-based clinical director for emergency medicine; and the divisional-based clinical director for emergency departments. A separate site-based clinical governance lead also has a remit for clinical governance across all specialisms including emergency departments. This means that, in total, there are seven senior doctors sharing responsibility for the effective medical care across NHS Lanarkshire’s three emergency departments.

7.22 The review team noted that, across all three hospitals, the junior doctors reported good relationships with consultants and a “positive open no-blame culture”.

7.23 The monitoring of doctors in training hours is reported as New Deal and European Working Time Directive compliant, but several rotas have not been successfully monitored for over a year. Regular monitoring is a contractual obligation on both employer and employee. Failure to monitor successfully places the NHS board at financial risk if subsequent monitoring is not New Deal compliant.

7.24 NHS Lanarkshire has been innovative in developing alternative roles to help address some of the medical recruitment difficulties. In particular, it has adopted the physician assistant role in general surgery, trauma and orthopaedics, and anaesthesia. It has also developed a range of senior nursing posts who are able to take on duties that were historically undertaken by junior doctors including:

- the minor injury nurse treatment service in the emergency department
- the hospital emergency care team which provides nurse practitioners 24 hours per day to support care on wards
- advanced nurse practitioners in critical are who are trained as prescribers and in practical clinical procedures such as central venous catheters (CVC), A lines and chest drains
- acute care of the elderly (ACE) nurse practitioners and nurse and
- advanced neonatal nurse practitioners, one of whom is now competent to fill a middle grade doctor slot.

It has also developed allied health care consultants in the care of the elderly.
Availability of medical staff

7.25 The review team heard widespread concern about availability of medical staffing, in terms of both numbers and seniority. The concerns expressed related particularly to cover out of hours, both during the week and at weekends including:

- not enough medical cover out of hours which means delays in responding to patient need
- not enough senior doctors (more senior trainees, specialty doctors or consultants) out of hours and a lack of consultant review on wards at weekends, during leave and during other absences
- middle grade rotas are a challenge to populate, and
- pressure of rotas on three sites.

7.26 The areas that were most repeatedly highlighted were emergency medicine, general medicine (including acute medicine and care of the elderly), and orthopaedic surgery. Each of these is considered in more detail below.

Emergency medicine

7.27 At the Board meeting in January 2011, NHS Lanarkshire approved a proposal to invest £1.246m in additional staffing for the emergency departments. Part of this funding has been used to employ 13 additional consultants. On all three sites, consultants are scheduled to be on duty throughout the weekend until late evening. This is good practice as this is often the busiest time for emergency departments.

7.28 The additional investment has also allowed the expansion of the existing minor injury nurse treatment service. This advanced practice in minor injury or illness is now well embedded into the emergency departments on all three sites, with 80% of see and treat activity now nurse led (source: NHS Lanarkshire).

7.29 However, there have been difficulties with recruitment and retention, and emergency medicine remains heavily dependent on locum middle grade and consultant medical staff. Between September 2012 and August 2013, locums covered 5% of posts at Monklands Hospital, 5% at Hairmyres Hospital and 15% at Wishaw Hospital. These figures exclude short term locums (source: NHS Lanarkshire).

7.30 The review team heard that, despite the expansion of the consultant workforce referred to above, emergency department consultants are experiencing significant workload and rota pressures. The update on medical staffing Board paper of June 2013 recognises that they will be unable to continue working under this pressure for more than a 12-month period. As an example, consultants at Hairmyres Hospital and Monklands Hospital are often having to sleep in the hospital overnight because of the lack of a suitable middle grade trainee or specialty doctor to support more junior staff. This has been less of an issue at Wishaw Hospital where there are historically more specialty doctors and fewer trainees.

7.31 Consultants in emergency medicine expressed the view that a new model of care is required as they cannot sustainably staff a 24-hour, 7-day a week emergency medicine response in each of the three sites.

7.32 Staff reported that the out of hours GP service is not integrated with the acute hospital's front door. It has been noted that there are increasing difficulties in finding GPs to fill weekend and public holiday shifts in the out of hours service.
General medicine including acute medicine and care of the elderly (COTE)

7.33 The review team identified concerns around the medical staffing availability for both the front door receiving units (emergency receiving unit at Monklands Hospital, acute medical receiving unit at Hairmyres Hospital, emergency care unit at Wishaw Hospital) and for the general medical wards.

7.34 The working patterns and hours for consultants in acute and general medicine are different across the three sites. Table 5 briefly summarises the pattern for Monday to Friday. Essentially similar arrangements are seen at the weekend with varying patterns of cover for both admission units and wards which are reviewed in subsequent sections.

Table 5: Working patterns

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Consultants rostered to be on site until:</th>
<th>Responsibilities of consultants rostered to see new emergency admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wishaw</td>
<td>11pm</td>
<td>No other duties</td>
</tr>
<tr>
<td>Hairmyres</td>
<td>6.30pm</td>
<td>No other duties</td>
</tr>
<tr>
<td>Monklands</td>
<td>7pm*</td>
<td>May have other duties relating to ward or specialty</td>
</tr>
</tbody>
</table>

*Consultants at Monklands Hospital report that, in practice, they are often on site until between 7–10pm. Consultants at Hairmyres Hospital may also stay later when required.

7.35 The review team heard from staff that they believe that providing out of hours emergency medical cover across all three sites is unsustainable as it leaves rotas too thinly stretched and also creates onerous on-call rotas for consultants which impacts on recruitment.

7.36 Feedback from medical trainees raised concerns about workload in medicine on all three sites. The review team is aware that there are similar issues nationally and that this is making recruitment into acute medical specialties difficult.

7.37 In addition to the medical staff outlined below, two hospital emergency care team nurse practitioners are on each site overnight. These posts have been developed to support the hospital at night medical team and use advanced assessment skills and non-medical prescribing to support immediate treatment planning. The review team heard positive feedback from a range of staff about this development. However, it was identified that there were still occasions when medical input was required.

General medicine - Monklands Hospital

7.38 Consultant cover for the emergency receiving unit is variable. There is an acute physician who focuses on the assessment areas and the clinical decision unit and works with the minor injury nurse treatment service staff, prioritising admission avoidance and same day discharges. This is inconsistent (only in place Sunday to Thursday and no cover for leave). The principal consultant for the emergency receiving unit undertakes two ward rounds, one at 8am and a second at 2pm. This consultant changes each day so there is no continuity of care for those patients who remain in the emergency receiving unit for another day. This was identified as an issue by the emergency access support team in 2011. The Royal College of Physicians recommends that consultant duties are for a minimum of two consecutive days. Staff told the review team that consultants regularly arrive late for the
emergency receiving unit ward rounds, and on the day of the visit, the review team observed a consultant arriving 30 minutes late for the morning ward round. The review team noted that consultants covering the emergency receiving unit may have other expectations on them during that time that impact on their ability to meet their emergency receiving unit commitments. It is also clear that consultants are finding the workload excessive.

7.39 Although most patients do not stay more than 1 day in the emergency receiving unit, some do. It was reported to the review team that, a patient who had been reviewed by a consultant, and remained in the emergency receiving unit, would not routinely be seen in subsequent days by a consultant although NHS Lanarkshire advised that the consultant from the previous day would re-visit them.

7.40 Issues around consultant cover for the emergency receiving unit were identified in March 2008. The emergency access support team made recommendations to change the pattern of working in August 2011 and again in January 2013.

7.41 A proposal to create a department of acute medicine was developed by the emergency medicine directorate team in January 2013, based on guidance from the Royal College of Physicians and the Society of Acute Medicine. The proposal identifies significant unmet need and includes phrases such as ‘admissions frequently exceed safe capacity for one consultant’, ‘fairly chaotic’, and ‘patchy/poor’ in relation to the ability of the workforce to meet the needs of patients. The paper describes a new model requiring recruitment and investment to ensure consultants covering the emergency receiving unit have no other duties and are available into the evening. There is no evidence that this model has been formally presented to NHS Lanarkshire’s Board.

7.42 The review team heard from both management and consultants that an attempt to recruit a further acute physician had been unsuccessful. However a long-term locum appointment has been secured.

7.43 The review team also identified concerns with medical cover on the wards. Staff told the review team about delays in securing a doctor to respond to patients whose condition is deteriorating. The case note review identified that some patients went a number of days without any record of them being reviewed by a senior member of medical staff.

7.44 There are consultant-led ward rounds at weekends on the emergency receiving unit, on the communicable disease, renal and haematology wards, and the care of the elderly wards.

7.45 There are no consultant-led ward rounds on the general medical wards at weekends, so patients admitted to these wards from the emergency receiving unit may not be reviewed by a consultant until the Monday. The review team also heard that patients who were already on the general medical wards would not be routinely reviewed by a doctor of any grade over the weekend unless identified as ‘at risk’ by the ward team on Friday afternoon.

7.46 This is supported by the case note review which found that, at weekends, it is not uncommon for patients on medical wards identified as ‘at risk’ to be reviewed solely by a medical trainee (general medicine) in the early stages of training (FY2-ST2).

7.47 The case note review also found that involvement of consultants in decision-making for individuals with critical illness was not always documented within the case notes.
or did not happen. This was noted both in the out of hours period and during the day. In one instance, there was only documented evidence that the patient had been seen by a consultant once in their 9 day admission; another had no record of a consultant review within the last 3 days of life; and another had gaps of 4 days between recorded reviews.

7.48 The review team heard that levels of cover for emergency duties may be affected by leave. An example given was that when the acute physician who normally covers the medical high dependency unit is on leave, the session is not covered. NHS Lanarkshire advised that named consultants are always responsible for the care of patients on the medical high dependency unit. The review team noted that robust cover of this unit is one of the proposed benefits of the proposed new medical staffing model.

General medicine – Hairmyres Hospital

7.49 The most senior doctor overnight may be at CT1 level.

7.50 The review team heard that, when consultants were on leave or on emergency duties, patients under their care on the medical wards are not routinely seen by another consultant. This means a patient could go up to 2 weeks without seeing a senior doctor. This was escalated to NHS Lanarkshire during the visit as an issue for immediate attention as the lack of regular consultant review is likely to impact adversely on both patient safety and on operational efficiency.

7.51 The initial response from senior management in NHS Lanarkshire was that they expressed concern and added that they were not aware of this practice happening. They committed to undertake an investigation. Their investigation confirmed that the practice does happen.

7.52 NHS Lanarkshire told the review team that when a consultant is away, trainee doctors will see the patient and report any issues to another consultant. The other consultants on the ward will also do a ‘Board Round’ with trainee doctors. This means that all patients on the ward are discussed in the doctors’ office and the trainees can raise concerns with consultants who will review a patient if requested.

7.53 Though acknowledging the situation as far from ideal, NHS Lanarkshire advised the review team that the consultants do not have the capacity to routinely review the patients of colleagues who are on leave.

7.54 The review team expressed concern about this practice which requires junior staff to recognise the need for escalation. It recommends that NHS Lanarkshire needs to urgently resolve this to ensure safe and effective patient care.

7.55 To ensure all patients admitted from assessment units to a ward are seen within 24 hours, it is recommended that a consultant spends the first hour of each day reviewing any new admissions and ensuring that they have a plan for their care. This is referred to as ‘golden hour’ rounds. NHS Lanarkshire highlighted that funding had been agreed for an additional locum consultant to pilot ‘golden hour’ rounds on medical wards, but had not been able to recruit for this post.

7.56 The review team was advised that the care of the elderly consultants review patients on the acute medical receiving unit who meet referral criteria each morning, but limit the number that they will see to eight patients per day, irrespective of the number who meet the criteria. Any additional patients remain under general medicine. Whilst this is intended to ensure good care for the patients who are seen, and to give the
geriatricians a manageable workload, it is inequitable and leaves patients without timely specialist review and input.

**General Medicine – Wishaw Hospital**

7.57 At Wishaw Hospital, the consultant on duty for the emergency care unit is present until 11pm, supervises the hospital emergency care team handover to the night team and will see patients who are causing concern on the wards. This represents good practice in terms of care for patients and support for doctors in training.

7.58 During the visit, the review team raised concerns about acute medicine cover at weekends as there was only one FY1 and one ST3 doctor for five wards. The review team was concerned about the impact of this on the ability to respond to deteriorating patients. NHS Lanarkshire confirmed that this issue had already been picked up through their normal processes and that a FY2/GPST would be starting in November working from 9am–1pm.

**Orthopaedic surgery**

7.59 Elective and trauma services are delivered at each site. Elective patients are also sent to the Golden Jubilee National Hospital (approximately 10% of elective activity) and patients requiring spinal surgery are referred to NHS Greater Glasgow and Clyde.

7.60 The review team heard from consultant medical staff that they believe the current provision, where elective and trauma services are delivered at each site, is not sustainable as it leaves medical out of hours rotas stretched and also creates onerous on call rotas for consultants which impacts on recruitment. NHS Lanarkshire advised the review team that their previous outline and exploratory proposals for the future shape of these services had not been accepted by the Scottish Government at that time. The review team believes that NHS Lanarkshire needs to continue to refine and develop proposals for the safe and appropriate configuration of the orthopaedic service.

7.61 Staff highlighted to the review team that the orthopaedic and surgical teams do not regularly attend the hospital emergency care team handover on any of the three sites. Attendance at handover is good practice and is expected by NHS Lanarkshire. This requires resolution by NHS Lanarkshire.

7.62 At Hairmyres Hospital, there is no on site medical cover out of hours for orthopaedic patients. There is a protocol that requires the emergency department to assess the patients and arrange transfer to the orthopaedic wards. Staff raised the lack of cover from 6-8pm onwards as a concern with the review team, who escalated the issue to NHS Lanarkshire management.

7.63 NHS Lanarkshire confirmed that there is no on-site orthopaedic cover out of hours, but that a protocol exists for immediate management of patients admitted after 10pm. The NHS board also advised that, following discussion with staff, they had uncovered an issue with compliance with the protocol that remained unresolved and was impacting on approximately 50% of overnight admissions. On average, one orthopaedic patient is admitted every night. The review team was advised that the local clinical lead was aware of the compliance issue. The NHS board advised that, with immediate effect, it had issued an instruction that the protocol must be followed and any failure to do so should be escalated immediately to senior management. A
copy of the protocol was forwarded to the review team and the review team was advised that there was no knowledge of it starting at 6pm or 8pm.

7.64 The review team asked NHS Lanarkshire to confirm that in practice the protocol did not start before 10pm. The team also raised concerns about the status of the protocol as it did not indicate the author or the governance routes that it had been through. Further concerns were raised about the content of the protocol and whether it represented a safe level of practice.

7.65 On further investigation, NHS Lanarkshire reported that, in practice, this protocol for the management of orthopaedic patients overnight, starts at around 8pm, rather than 10pm. They also advised that an urgent review of the protocol was being initiated and that it would ensure that the revised version was approved by the acute clinical governance group.

7.66 The review team noted that, even if the protocol was fully implemented, it was unsatisfactory, as it allowed patients to be in hospital overnight without formal clerking and at serious risk of medications being omitted. The review team was concerned to find unacceptable practice being formalised in a protocol.

7.67 NHS Lanarkshire has subsequently advised that a revised protocol has been developed and ratified by all clinical teams and the acute clinical governance group and that it is seeking an independent external orthopaedic opinion on the revised protocol.

7.68 During the visit, the review team was advised that the orthopaedic wards at Wishaw Hospital do not have an FY1. Staff highlighted that, if there is a deteriorating patient on the ward, it is difficult for them to get a response. Language used with the review team included “things are getting missed, things are not getting done” in relation to patient care.

7.69 NHS Lanarkshire reported that, as requested by the review team, a risk assessment had been conducted and it found no evidence that the level of medical support for safe inpatient care was compromised. The NHS board confirmed that work is in place to improve availability of medical staff, including the development of a business case to restore the FY1 to the orthopaedic team.

General surgery

7.70 Consultant and ST doctors raised concerns about staffing levels in general surgery on all three sites, particularly in relation to emergency duties. The ST doctors in surgery reported having to undertake duties overnight previously undertaken by FY1 doctors (this group no longer work overnight). At Wishaw Hospital, working patterns have been altered so that a second consultant is available for emergencies in the morning which has improved care, but this does not happen at weekends or public holidays. The review team heard that ward rounds are conducted at unpredictable times.

Conclusions and recommendations

7.71 There is no doubt that NHS Lanarkshire has attempted to address medical workforce issues. Since January 2011, NHS Lanarkshire has undertaken a significant expansion of its acute medical workforce. It has also focused on developing alternative roles to help address some of the medical staffing recruitment challenges, including developing a number of advanced nurse practitioner posts.
7.72 Whilst acknowledging the range of actions taken by NHS Lanarkshire, the review team noted that many members of the medical staff are working in excess of their job plans to provide good care. They heard that many feel under considerable strain as a result. The challenge of providing services on three sites was a recurrent theme.

7.73 However, the management actions taken have not yet been sufficient to support safe, person-centred and effective care. The concerns around emergency medicine, acute/general medicine, care of the elderly medicine and orthopaedic surgery are supported by multiple sources of evidence. These are significant and persistent issues for which effective actions are not yet in place.

7.74 The review team is concerned about the persistence of practices which represent an unacceptable risk to safe patient care. The review team escalated some issues to NHS Lanarkshire. In highlighting particular areas requiring urgent action, the review team noted that the list is not exhaustive and it is important to apply the principle that care is consistent across all areas. The following practices require urgent attention.

- Monklands Hospital emergency receiving unit: variability of consultant cover, consultants having other duties and lack of daily consultant review if patients remain in the unit.
- Lack of consultant involvement in medical admission during the busy evening period at Monklands Hospital and Hairmyres Hospital.
- Lack of guaranteed consultant review of patients within 24 hours of admission to general medical wards, particularly at weekends.
- Lack of prospective cover for consultants’ annual leave. This was identified in certain specialties at both Monklands Hospital and Hairmyres Hospital and may be more widespread.
- Out of hours admission procedure for orthopaedic patients at Hairmyres Hospital.
- Ward cover given lack of FY1 within orthopaedics at Wishaw Hospital.

7.75 There is a need for NHS Lanarkshire to have plans that recognise the entire patient journey. The review team heard repeatedly that doctors were limiting the number of patients they would see, irrespective of need. Examples include the out of hours service, general medicine and the care of the elderly service. Whilst these are well intentioned in seeking to ensure that standards of care for those seen are maintained, they may have adverse effects on those not seen.

7.76 Despite significant investment, emergency medicine clearly remains problematic. The most recent Board paper on medical staffing (June 2013) states a need to work on short-term solutions, but does not identify who will lead this and gives no detail on the actions, or any indication of long-term solutions. The consultants in emergency medicine have proposed a solution which should be examined to assess whether it can balance the requirement to maintain three emergency departments with sustainable overnight cover by senior medical staff.

7.77 General medicine and care of the elderly are also challenging areas. There are three different models across the three acute hospitals which are historical and have not been reconfigured to meet patient needs. This is in the context of the associated clinical risks identified, particularly at Monklands Hospital, by both the emergency access support team and internal assessments.
7.78 Ensuring appropriate cover for the wards at weekends and overnight will improve both the safe delivery of care, and the length of time individuals stay in hospital. This should also produce benefits in terms of reduced bed occupancy rates and nursing workload.

7.79 The review team is fully aware that these are difficult issues that NHS Lanarkshire is addressing within a challenging national workforce context. It also acknowledges the efforts made by NHS Lanarkshire to date and that, in some cases, difficulties in recruitment are such that they cannot be solved simply by additional financial investment. However, the inescapable conclusion is that the actions taken to date are inadequate. A recurrent theme was that problems were regarded as insoluble and so sub-optimal, and variable care was tolerated. The solutions will require that models of care are built around patients but take account of the workforce that is available.

**Recommendation 7**: NHS Lanarkshire should take prompt action to develop and implement a credible and practical model for medical staffing that meets patient needs. The model needs to be informed by, and inform, the clinical model of care. There needs to be particular attention to the seniority and number of staff out of hours.

a) There needs to be particular attention to the seniority and number of staff out of hours.

b) There needs to be robust arrangements for when staff are on leave.

c) The immediate priority areas should be the staffing of orthopaedics, acute/general medicine, care of the elderly and emergency medicine, but the same principles need to be applied to other specialties.

d) For orthopaedics, the review team believes that this requires a more fundamental review of the distribution of orthopaedic services across NHS Lanarkshire.

e) For the emergency medical patient the review team believes that they require regular senior medical input throughout the entire patient journey, with as much attention to care on the wards as at the admission units and emergency departments.

**Recommendation 8**: NHS Lanarkshire should take action to simplify the current medical management arrangements and strengthen the site-specific medical leadership.

**Recommendation 9**: NHS Lanarkshire should ensure robust procedures are in place for the developing and ratification of clinical protocols.
8 Workforce – Nurse staffing

Introduction

8.1 The review team considered whether the numbers of nursing staff on duty and the balance between registered and unregistered staff was impacting on the person-centred and safe delivery of care.

8.2 The associate nurse director posts on each site are providing clear site-based leadership.

8.3 On each site, the management of nursing is divided between three senior nurses who report directly to the associate nurse director. They spend 2 days a week working on the wards. This is an example of good practice, providing visible senior nurse leadership on the wards, whilst also ensuring that the senior nurses remain connected to the day to day realities of delivering care within the acute environment.

8.4 In addition to the associate nurse director and the three senior nurses, each ward or unit has a senior charge nurse who is responsible for the overall delivery of nursing care in that ward or unit.

8.5 NHS Lanarkshire has also made significant investments in the development of nurse, consultant and advanced nurse practitioner posts. Please see paragraph 7.24 for more information.

Basic nursing care

8.6 Patients and carers described a mixed picture of nursing care. Out of a total of 352 experiences shared, 60 patients or carers (17%) raised concerns about the help given to patients with basic tasks, such as eating or toileting (23 Hairmyres, 26 Monklands, 9 Wishaw and 2 not identified to a particular hospital).

8.7 Examples of positive comments included:

- ‘Excellent care...nurses make patient feel special.’
- ‘Post-op I was very sick, and was again dealt with swiftly and with compassion and dignity. This attitude continued in the ward, both day and night shift, nursing, medical and support staff. I have nothing but praise for all staff I came into contact with.’
- ‘My sister was admitted to Wishaw Hospital. The treatment she received there was extraordinary; she was treated with respect and was able to maintain her dignity until the end of her life.’

8.8 Examples of negative experiences included:

- ‘Buzzed as catheter had come off. One and half hours to come. Was in great pain. Only emptied half of catheter bag. Had spilled over sheets. Told to pull them over.’
- ‘Mother had terminal cancer and was suffering from chronic diarrhoea. Nursing staff changed the patient but left the soiled clothes on the patient’s locker. Carer claims not even in a bag. Carer claims the smell in the room was awful. Carer claims that her mother’s bottom was raw and she repeatedly asked for cream (such as sudocrem) but this was not applied. Therefore, family members
resorted to cleaning the room daily with wipes, leaving bin bags for soiled clothes, and applied sudocrem themselves.’

8.9 At Hairmyres, staff raised concerns with the review team about the availability of snacks for patients outside meal times. In particular, issues were raised that, at times, staff were having to use their own supplies to make hot drinks for patients.

**Nurse staffing levels**

8.10 During the site visit, nursing staff consistently raised concerns that the number and grade of staff on duty was not always sufficient to respond to the workload, particularly out of hours. There were some notable exceptions to this including the accident and emergency at Monklands Hospital, the renal unit at Monklands Hospital and the emergency care unit at Wishaw Hospital.

8.11 Patients and carers also highlighted concerns about nurse staffing levels with comments such as:

- ‘Staff very busy/overworked.’
- ‘There’s not enough caring being done because staff don’t have enough time. I suppose they should see what staffing levels are.’
- ‘The staff were run off their feet. They advised me this was a quieter day but it seemed extremely busy to me. The staff were excellent, caring and attentive.’

8.12 NHS Lanarkshire’s ratio of nursing staff (registered and unregistered) to staffed beds was the third lowest in Scotland at a ratio of 1.76 compared to the Scottish average of 1.88. However, due to investment over the last 6 months, this has now increased to a ratio of 1.79 compared with a Scottish average of 1.82 [Data Appendix Reference 8a]. However, care needs to be taken with drawing conclusions from this as there may be discrepancies between NHS boards around which nurse groups are included under the acute adult category.

8.13 The review team observed a mixed picture of care across the three hospitals. It found some wards with good staffing levels (based on staff comment and against their funded establishment and national workforce tools). The team also spoke to a number of charge nurses who had robust systems in place to ensure high quality care is provided on their wards to every patient every time, even under challenging circumstances.

8.14 However, the review team also found some wards where it was concerned by the routine levels of staffing. This included the rostered skill mix and the routine level of reliance on bank nursing. Where concerns were noted, there appeared to be a mismatch between the funded nursing establishment in the budgets and how these translated into practice.

8.15 For a subset of clinical areas, the funded establishments were reviewed against the actual numbers of staff rostered to work. The majority of establishments are currently funded on the basis of 60% registered and 40% unregistered in line with national recommendations. However, for some wards, the funded skill mix between registered and unregistered nursing staff was not translating into day to day practice, with one ward where some shifts where staffed at 40% registered and 60% unregistered despite the establishment being 60% registered and 40% unregistered and another ward with routine 50% skill mix on early and late shifts.
8.16 In a small number of wards reviewed, there was a regular mismatch between the actual number of staff on shift and the funded levels. It was not within the remit of this review to establish the exact reasons for this, but they are likely to be a mixture of:

- how the total staffing is rostered over the 24-hour period and over the week, so as to ensure that most of the staff are available at the point where the patient needs are the greatest
- impact of sickness rates
- impact of vacancies, and
- difficulties in obtaining bank cover.

8.17 During the site visits, the review team visited 43 clinical areas. The majority of care observed was satisfactory. However, on one ward visited, the review team found inadequate staffing that was clearly impacting on the safety and dignity of patients. The issue was escalated at the time to the hospital management team who addressed the immediate staffing concerns. A briefing was also provided for the review team identifying the action that had been taken. The review team was concerned that the initial response had only focused on the specific issues around the number of staff working on the ward that morning. It did not address the underlying staffing levels which were also of concern. Following further discussion, the review team was then provided with a copy of the revised rota for the next 2 weeks. The review team was content with the immediate action taken. However, NHS Lanarkshire needs to assure itself that ongoing nurse staffing levels in this ward are adequate to meet the level of patient need.

8.18 During the site visits, staff reported to the review team that they do not receive any feedback when they submit incident reports, including submissions which highlight issues around staffing levels.

8.19 A number of senior charge nurses highlighted to the review team that they are on duty for the hospital during ‘office hours’ as well as being included in the numbers on duty for their ward. NHS Lanarkshire has advised that this should only happen when nursing staff had requested it for developmental purposes.

8.20 Nursing staff across all three hospitals raised concerns with the review team about the timing and number of consultant ward rounds impacting on the availability of nursing staff to join them. This impacts on the effective communication of key patient information and is detrimental to multidisciplinary team working for the benefit of patients and their families and carers.

**Sickness, vacancies and bank use**

8.21 Data for April 2012–March 2013 show that the non-medical acute staff sickness rates are in line with the Scottish average [Data Appendix Reference 8b]. Local data show average sickness rates of 6.5% for emergency and medical services and 6.1% for surgical and critical [Data Appendix Reference 8c]. These averages may hide higher rates in particular hospitals or wards.

8.22 Data from June 2013 show that NHS Lanarkshire is carrying less nurse vacancies than the Scottish average, though both rates are increasing [Data Appendix Reference 8d]. However, local data show relatively high vacancy levels (over 8%) in the acute receiving units (Business Case for Acute Nursing Workforce, November 2013). The paper states that these high vacancy levels ‘may reflect particularly high staff turnover levels or recruitment difficulties.’
8.23 Staff reported a high reliance on bank staff and raised concerns that bank staff do not always have the necessary skills and experience for the specialty they are working in. The findings, from the organisational development review conducted by NHS Lanarkshire in November 2012, highlighted that a lack of permanent dedicated staff is perceived by staff to have a detrimental impact on services and care.

8.24 NHS Lanarkshire has the second highest reported use of nurse bank staffing across Scotland with 9.3% of posts on wards filled by bank staff. This compares with a Scottish average of 6.4% (source ISD April 2012–March 2013) [Data Appendix Reference 8e]. NHS Lanarkshire reported that the bank average was 11.85% over September 2012–September 2013.

8.25 There was a 13% increase in the use of bank nursing in the acute sector from 351 WTE in March 2012 to 396 WTE March 2013. This includes registered and unregistered nursing staff [Data Appendix Reference 8f].

8.26 NHS Lanarkshire highlighted that 70% of their nurse bank workforce are already employed by NHS Lanarkshire as nurses.

8.27 At Hairmyres Hospital, concerns were raised that, to cover nursing shortages on wards, staff were being moved into areas where they lack the experience and skills. Specifically, it was reported that intensive care unit nurses are being regularly moved to cover shortages on other wards.

Work already initiated by NHS Lanarkshire to address nurse workforce issues

8.28 NHS Lanarkshire has already identified acute nurse staffing levels as a key issue. In November 2012, the NHS board received a paper summarising a comprehensive review of the acute nurse workforce levels as evidenced through the application and analysis of Scottish Government Health Department Nursing and Midwifery Workload and Workforce Planning Tools. This paper highlighted the following.

- Although there was no empirical or substantive evidence suggesting that current acute nursing workforce levels were not adequate to provide safe and effective care, the review had highlighted that increases in staffing over recent years had not kept up with increases in workload. It also highlighted an increase in Datix reports relating to nursing staffing levels which, on investigation, were related to either sickness absence or surges in clinical activity. The minutes of the Board meeting indicate that the Board was advised that investment was needed to maintain safe patient care and improved patient experience.

- A gap of 171 WTE using the national workload measurement tool which would cost £5.3 million to address. However, applying in-house senior professional judgement, this reduced to 87 posts at a cost of £2.7 million. The in-house modifications were made to take account of local contextual differences around the dependency of patients. £968,000 of the funding had also been identified through redesign leaving a gap of £1.7 million.

8.29 The Board passed a proposal to phase implementation of the additional posts and a decision was made, in January 2013, to invest £802,000 to fund 26.8 WTE additional nursing posts to enable senior charge nurses across NHS Lanarkshire’s acute hospitals to increase their supernumerary time from 1 day a week to 3 days a week. These 15 hours were provided at a 60:40 skill mix split.

8.30 The review team noted that the paper states ‘For this exercise, a 90% bed occupancy level is assumed across all areas.’ From November 2012–June 2013, monthly
average bed occupancy rates varied between 92–98% at Hairmyres Hospital. This means the analysis will have underestimated the number of nursing staff needed in at least some of the Hairmyres Hospital wards. Monthly average bed occupancies across a hospital can also mask wards whose occupancy is regularly above the average. Therefore, the analysis may also have underestimated staffing levels in units in Monklands Hospital and Wishaw Hospital, whilst overestimating numbers needed in other wards on all three hospital sites. The review team did not have access to bed occupancy data prior to November 2012 to assess whether the 90% rate was appropriate at the time the review was undertaken. However, NHS Lanarkshire has advised that it was.

8.31 In September 2013, NHS Lanarkshire produced a paper which proposed an additional investment in 31.31 WTE nurses for emergency medicine and medical admissions at a cost of £1.07 million. This paper highlighted that the initial analysis contained in the paper dated November 2012 has been revised upward from an additional 10.96 WTE to an additional 31.31 WTE. Table 6 highlights the differences between the November 2012 increase and the September 2013 increase.

Table 6: NHS Lanarkshire nurse staffing proposals

<table>
<thead>
<tr>
<th></th>
<th>November 2012 proposed increase</th>
<th>September 2013 revised proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical receiving wards</td>
<td>5.96 WTE</td>
<td>16.37 WTE</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>5 WTE</td>
<td>14.94 WTE</td>
</tr>
<tr>
<td>Total</td>
<td>10.96 WTE</td>
<td>31.31 WTE</td>
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</tbody>
</table>

8.32 The paper identifies the following reasons for the increase from the November 2012 figures to the September 2013 figures.

- For the medical receiving wards, the original analysis was based on an occupancy level of 90% whereas the revised analysis uses an occupancy level of 95% in recognition that this more accurately represents the experiences across the medical receiving units.
- For emergency medicine, the report notes that the GRASP analysis used in the November 2012 paper is out of date and instead applies a different approach to recognise the current context around numbers and case mix.

8.33 The paper dated 23 September 2013 also highlighted that the staffing pressures experienced by these units are a mixture of:

- issues around establishments that require additional funding
- high vacancy levels (over 8%)
- high supplementary staffing levels (such as bank and overtime) to cover gaps in rotas, and
- inefficiencies in current rostering.

8.34 It highlighted that a short-life working group is in place to address the last issue. There is no indication what action is in place to address the vacancy levels.

Skills of nursing workforce

8.35 The findings from the organisational development review, conducted by NHS Lanarkshire in November 2012, highlighted that staff feel that having the right staff
with the right skills in place is (generally) more important than having a specific number of staff.

8.36 The review team heard that, even when there are enough nurses on duty, those individuals did not always have the necessary skills to deliver key tasks. One of the issues highlighted by staff to the review team was the ability to administer intravenous medication.

8.37 Table 7 shows an analysis of the percentage of registered nurses currently competent to administer intravenous medication conducted by NHS Lanarkshire in September 2013.

Table 7: Nurses competent to administer IV medication by hospital and service

<table>
<thead>
<tr>
<th></th>
<th>Hairmyres Hospital</th>
<th>Monklands Hospital</th>
<th>Wishaw Hospital</th>
</tr>
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<tbody>
<tr>
<td>Medical Directorate</td>
<td>80%</td>
<td>73%</td>
<td>82%</td>
</tr>
<tr>
<td>Surgical Directorate</td>
<td>79%</td>
<td>69%</td>
<td>61%</td>
</tr>
<tr>
<td>Department of Medicine for the Elderly</td>
<td>58%</td>
<td>36%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Using data to drive improvement

8.38 The review team noted that a new nursing dashboard is being developed which aims to align a range of key data at ward level to inform both day to day delivery of care and work to improve the quality of care provided. This dashboard will include data under the following domains:

- safe and effective
- workforce
- person-centred, and
- organisational objectives

Conclusions and findings

8.39 The safe, person-centred delivery of care and timely progression of patients from admission to discharge is being adversely impacted by both the numbers of nursing staff on duty and the balance between registered and unregistered staff. There are particular challenges out of hours and at weekends, though the review team also saw evidence of times during week days where there were not enough nurses to respond to patients’ needs in a timely way.

8.40 NHS Lanarkshire had already identified acute nurse staffing levels as a key issue in January 2013. The NHS board invested £802k as part of a phased plan to address the shortfall. The focus of this investment was increasing the senior charge nurses supernumerary time from 1 day a week to 3 days a week.

8.41 The decision to prioritise investment in supernumerary time was made on the basis that this would free up senior charge nurses to address a range of issues that would improve the quality and efficiency of care in acute wards.

8.42 This is a difficult and subjective decision as there are positives and negatives attached to taking either option. If basic staffing levels are not adequate, then it can
be difficult for senior charge nurses to maintain their supernumerary status and we heard examples of exactly this happening from senior charge nurses. In these situations, making the charge nurse supernumerary is unlikely to deliver the benefits anticipated. However, inadequate staffing levels can be associated with a multitude of other factors including increases or changes in ward activity, sickness levels, vacancy levels and effective rostering. In these situations, senior charge nurses need dedicated time to manage these types of issue and prioritising supernumerary time may prove more effective and efficient in the longer term.

8.43 The review team also noted that the initial analysis in November 2012 assumed a 90% bed occupancy across all areas. The subsequent paper in September 2013 highlights the impact of changing this assumption to 95% for the emergency receiving units. The review team noted the need to ensure that the bed occupancy rate used is reflective of the individual specialties’ actual activity.

8.44 The review team heard from a number of senior charge nurses that they are regularly on duty for the hospital during ‘office hours’ as well as being included in the number of nurses allocated to their ward. Nationally, through Leading Better Care, it was agreed that senior charge nurses would not be asked to do this routinely so that they can focus on their ward or unit. They should only perform the manager on call duty out of hours.

8.45 The new nursing dashboard is an important development that seeks to pull together a range of key information at ward level, including data on the effectiveness and safety of care delivered, information on patient experience and information on workforce issues. NHS Lanarkshire is to be commended for its work here. If NHS Lanarkshire can present the data in a format that shows the actual staffing levels in place day to day once the impact of sickness, annual leave, maternity leave, study leave and bank staffing are accounted for then this will also enable senior managers to quickly identify any key differences between actual and planned staffing levels without relying on Datix reporting. The proposed alignment at ward level of workforce data alongside information on the quality of care will also enable the organisation to more easily identify when workforce issues may be impacting on the quality of care.

**Recommendation 10:** NHS Lanarkshire should rerun the workload tools, with occupancy levels reflective of the ward’s actual activity and any additional investment in nursing staff should then be prioritised for wards and units which have the most significant gaps against the assessed level of needs.

**Recommendation 11:** NHS Lanarkshire should ensure further review of nurse numbers and/or skill mix is considered in association with work to address vacancy levels, bank usage, support to improve rostering practices (including consideration of the potential benefit from eRostering) and appropriate non-clinical/administrative support for senior charge nurses.

**Recommendation 12:** NHS Lanarkshire should review should other non-nursing practices to ensure maximum benefit from any changes to the nursing workforce. These include timing and number of concurrent consultant ward rounds and timely discharge.

**Recommendation 13:** NHS Lanarkshire should review how often senior charge nurses are required to be on call for the hospital when they are also rostered onto the ward and take appropriate action to ensure that this only happens in exceptional circumstances.

**Recommendations 14:** NHS Lanarkshire should ensure that the new nursing dashboard is developed so that it enables easy identification of any wards where the actual numbers
of staff rostered are significantly different to the agreed numbers identified by the workload tools.
9 Operational effectiveness

Introduction

9.1 The review team considered whether patients attending as an emergency are treated in a timely and effective way. This included, for those who are admitted, whether care continues to be timely and effective throughout their stay in hospital including appropriate discharge arrangements. This is known as effective patient flow.

9.2 Ensuring effective patient flow is complicated and multi-factorial and is a challenge being faced by acute hospitals around the world. In summary, it involves ensuring that:

- the right community infrastructures are in place to prevent unnecessary presentation and admission to hospital. Over recent years, NHS Lanarkshire and its respective local authority partners, have developed a range of services to improve the community infrastructure, examples of which can be found below.

- effective assessment processes at the front door to reduce inappropriate admissions. A necessary, but not sufficient condition, is the availability of senior medical staff who can make informed decisions on whether to admit or discharge. The medical workforce section of this document identifies some of the key challenges faced here by NHS Lanarkshire.

- active management of the inpatient journey for those who need to be in hospital. Delivering this includes matching appropriately staffed beds to the presenting needs and ensuring effective handover arrangements are in place. Again, the proactive and timely involvement of senior medical staff is one of the necessary conditions as is ensuring the right numbers of nursing staff with the right skills.

- effective and proactive discharge processes are in place with sufficient support in the community to ensure that individuals do not stay any longer than they have to in hospital. This requires effective multidisciplinary working across health and social care, particularly for individuals with complex health and social needs.

9.3 NHS Lanarkshire must ensure that there are sufficient doctors, nurses, midwives and allied health professionals to provide timely and high quality care for individuals ill enough to require an inpatient stay. Like many NHS boards, NHS Lanarkshire needs to address the immediate and presenting needs in acute care whilst at the same time continuing to build a primary and community infrastructure that works effectively with individuals and their families to maintain wellbeing and independence. Meeting this challenge is not easy and requires all NHS boards to balance a range of competing priorities.

9.4 The national Change Fund was set up in recognition that significant shifts to anticipatory and preventative approaches are required to achieve and sustain better outcomes for older people. The Scottish Government established the Change Fund for older people’s services to enable health, social care, housing, independent and third sector partners to implement local plans for making better use of their combined resources to improve outcomes for older people. The combined allocation for North and South Lanarkshire in 2013–2014 was £8 million. It is expected that work progressing under this agenda will begin to ease the pressures on acute hospitals resulting from the growing elderly population. This is a transition fund that was put in place to enable significant redesign of services. Permanent funding for the redesign will need to come through changes to service provision such as the closure of beds.
Examples of recent service developments which are preventing unnecessary presentation, admissions and stays in NHS Lanarkshire’s acute hospitals.

NHS Lanarkshire’s Age Specialist Service Emergency Team (ASSET) is a pilot project allowing older people in North Lanarkshire to remain at home rather than being taken to hospital. It allows GPs to refer older people to ASSET instead of admitting them to hospital and works closely with North Lanarkshire Council Social Work Department. Approximately 20 patients a day are now being managed at home via ASSET. This service recently won the Health and Social Care Integration category of The Herald Society Awards 2013.

In South Lanarkshire, the Integrated Community Support Team pilot is focused on providing earlier supported discharge and maintenance within the community of patients with long term conditions and increasing frailty. The team currently covers the East Kilbride locality and will be rolled out to the Hamilton locality in 2014.

Accident and emergency waiting times and emergency admissions

9.5 The waiting time at accident and emergency is a key indicator of the effectiveness of the wider acute care system. Lengthy waits in accident and emergency often signals issues across the hospital system such as availability of inpatient beds and linked to this, effectiveness of hospital discharge processes.

9.6 The data showing performance against the 4-hour accident and emergency standard highlight that, between January–July 2013, all three hospitals experienced significant performance challenges with Hairmyres Hospital’s performance consistently the worst. [Data Appendix Reference 9a]. All NHS boards across Scotland struggled to sustain the 4-hour target across this time period. However NHS Lanarkshire’s reduction was greater than the Scottish average [Data Appendix Reference 9b].

9.7 If a patient is in accident and emergency for 4 hours or more, the reason for the breach of the 4-hour point is recorded. The most common breach reason recorded at Hairmyres Hospital has been ‘wait for bed’, at Wishaw Hospital ‘wait for first assessment’ and at Monklands Hospital either ‘wait for bed’ or ‘wait for first assessment’.

9.8 Hospitals also monitor the number of patients whose stay in the emergency department exceeds 12 hours. Patients waiting more than 12 hours are a recognised problem across Lanarkshire with rates of up to 1.5% of accident and emergency attendances exceeding 12 hours [Data Appendix Reference 9a]. However, the review team noted that performance so far this winter (2013–2014) has been substantially better to date than last winter.

9.9 Staff told the review team that, due to pressures around the front door of the hospital:

- a trolleyed GP assessment area in Monklands Hospital is regularly converted to beds
- an attempt to improve the emergency assessment processes at Monklands Hospital by developing a four bedded medical assessment unit within the existing emergency receiving unit did not work due to a lack of availability of senior medical time and the ongoing admission of patients into the beds due to pressures on ‘downstream’ medical wards, and
• the GP unit in Hairmyres Hospital was frequently converted to acute medical beds due to capacity pressures.

9.10 The review team also heard concerns from a range of staff that, at times, actions to enable delivery of the 4-hour accident and emergency target are taking precedence over person-centred care. NHS Lanarkshire should be focused on delivering the intent of the targets as well as the specific number.

9.11 For 7 days from Monday 4 February 2013, NHS Lanarkshire audited all admissions for emergency medical and medicine for elderly patients over 65 years. The audit aimed to explore the background and context of these admissions and to seek areas for improvements which will enhance the quality of care, services and experiences for older people in Lanarkshire. The review team commends NHS Lanarkshire for this work and is aware that a number of other NHS boards are looking at the audit framework and considering a similar approach in their areas.

9.12 This audit looked at 158 individuals and included case note reviews to assess whether, with appropriate community support, any of the admissions were preventable. On the basis of this assessment, local clinicians concluded that, with extended community support, 27 individuals (17%) would not have needed to attend hospital and a further 19 individuals (12%) who may not have needed to attend hospital. This highlights the importance of improvement work focusing on the whole patient pathway.

9.13 Staff in NHS Lanarkshire told the review team about increasing workload pressures attached to increased emergency admissions of patients with complex needs. Since April 2010, the number of emergency admissions for patients aged 85 years and over have increased at Hairmyres Hospital and Wishaw Hospital, but have remained static at Monklands Hospital [Data Appendix Reference 9c-d].

**Boarding of patients**

9.14 When the level of admissions exceeds a specialty’s available beds, patients are transferred or ‘boarded out’ to other wards. The medical care remains with the specialty team, but the nursing care is assumed by the new ward. This occurs widely in hospitals and is an understandable, indeed inevitable, response to pressures. However, it has severe drawbacks. Boarding is, at best, undesirable for patients and may be distressing, particularly when the patient is confused or the move takes place at night. There is also some evidence that boarding can have a negative impact on quality of care and patient safety, and increases the risk of breakdown in communication. It is certainly clear that boarding increases patients’ length of stay, therefore exacerbating the pressures on beds. It also creates additional work for a range of staff involved in the patients’ care.

9.15 The review team heard from staff and members of the public that boarding of patients happens regularly. It also heard about the impact of bed pressures on individuals including: ‘My procedure finished around midday but was left on a trolley for next 8 hours. Heard staff constantly phoning for a bed. Was told I was going to a mixed ward which my husband complained about as my procedure was being checked hourly’.

9.16 Nursing staff told the review team that, at times, they experienced difficulty getting the appropriate medical response for patients boarded in their wards.
9.17 The data showed that all three hospitals experienced significant levels of boarding. For the period January–March 2013, 4,044 patients were boarded at Hairmyres Hospital, 3,066 patients boarded at Monklands Hospital, and 1,883 patients boarded at Wishaw Hospital (source: NHS Lanarkshire).

9.18 In addition to boarding between specialties, patients may also be diverted to other hospitals. NHS Lanarkshire operates an emergency response centre that ensures that, when beds are not available at one of the three hospitals, ambulance and GP referrals are diverted to one of the other two. The review team noted that NHS Lanarkshire has procedures in place to identify patients who should attend a particular hospital due to the complexity of their care or because an individual is known to services at a particular hospital. All three hospitals divert patients, but an analysis of the data highlighted that Hairmyres Hospital diverts significantly more patients from its catchment area to other hospitals [Data Appendix Reference 9e].

Bed occupancy, length of stay and delayed discharges

9.19 Bed occupancy is an important factor in a hospital's ability to deliver effective care. The safe level of bed occupancy will depend to some extent on variation in demand. Hospitals admit patients for scheduled and unscheduled care. Scheduled admissions should be highly predictable but if poor planning causes fluctuation then pressure on the hospital will occur. The situation with unscheduled admissions is different. The pattern is highly unpredictable, but there will be inevitable variation around the average. The greater this variation, the lower the occupancy level needs to be to ensure timely and effective care. Average bed occupancy figures can be falsely reassuring because they can conceal times of dangerously high occupancy. Many hospitals have highly predictable patterns of bed occupancy through the week, and throughout each day.

9.20 From April 2012–March 2013 NHS, Lanarkshire’s average bed occupancy for acute specialties was 87.9%. This compares to a Scottish average of 83.5%.

9.21 Monthly average bed occupancy rates between November 2012–June 2013 varied between 92–98% at Hairmyres Hospital; 83–90% at Monklands Hospital and 79–88% at Wishaw Hospital (source: NHS Lanarkshire). Given this is a monthly average at hospital level, Hairmyres Hospital bed occupancy rates are particularly high and are likely to indicate times or wards where occupancy is over 100%. However, the monthly averages for Monklands Hospital and Wishaw Hospital may also conceal days and wards where bed occupancy is running at over 100%.

9.22 Another issue that impacts on bed occupancy is the effectiveness of discharge processes. The review team heard from staff that there are consistent problems finding beds on Monday mornings due to a build up of pressure in the system because of the limited ability to discharge at weekends. For systems, such as Hairmyres Hospital, which are already operating at high bed occupancy rates, this can quickly result in too many patients for the beds available. Data looking at the day of discharge (April 2012–March 2013) were considered for each hospital and highlight that discharge rates do drop significantly at weekends [Data Appendix Reference 9f].

9.23 The review team wanted to know whether NHS Lanarkshire is a significant outlier and discharges a smaller percentage of individuals at weekends than the rest of Scotland. Therefore, data looking at the day of discharge (April 2012–March 2013) were considered for each hospital and compared to the Scottish average [Data Appendix Reference 9f]. This showed that the practice at Monklands Hospital is to
discharge a significantly smaller percentage of patients than the Scottish average on Thursday and Friday, but a higher percentage on a Sunday. Practice at Wishaw Hospital is to discharge a significantly smaller percentage of patients than the Scottish average on Friday, Saturday and Sunday. The percentage of patients discharged on a Friday, Saturday and Sunday at Hairmyres Hospital is similar to the rest of Scotland.

9.24 In recognition of the importance of timely discharge, the review team was advised that each of the three acute hospitals has an Integrated Discharge Hub which is made up of discharge co-ordinators, social workers and a carers co-ordinator. They act as a single point of interface between ward staff and social services. These provided cover from Monday to Friday until 2 November 2013, when they were extended to cover Saturdays. From 16 November 2013, they extended their remit to also cover Sundays. The review team noted that this action should help to improve the persistent problems finding beds on a Monday.

9.25 The review team was advised that multidisciplinary care planning, including allied health professionals, does not happen until later on in the patient’s inpatient journey. Staff also highlighted that a lack of physiotherapy and pharmacy input across the whole patient pathway can impact on length of stay and discharge planning.

9.26 Members of the public and staff also highlighted that patients ready for discharge in the morning may not leave the hospital till the afternoon or evening due to delays in receiving their medication. Addressing this problem would ensure patients are not left waiting around unnecessarily and, by freeing up beds earlier in the day, would ease the pressures on beds. The review team noted that in October 2013, NHS Lanarkshire initiated work to improve the number of patients able to leave earlier in the day.

9.27 Another factor impacting on acute hospital bed use is the number of ‘delayed discharges’. A delayed discharge is defined as a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning the patient’s discharge, but who continues to occupy a bed beyond the ready for discharge date. There are a variety of reasons why individuals may have their discharge delayed, including availability of support in the community. Unnecessarily long stays in acute hospitals are detrimental for individual patients and increase pressure on the existing supply of inpatient beds.

9.28 One of the challenges with looking at delayed discharge data is the potential impact of variability in the accuracy of the data recording, the effect of census reports and the definitions used. It is a well-recognised phenomenon that the figures are lower at the time of the census. Another approach to identifying patients who may be staying longer in an acute bed than necessary or even desirable is looking at acute hospital stays longer than 28 days. Table 8 shows that Hairmyres Hospital has a greater percentage of stays over 28 days than either Monklands Hospital or Wishaw Hospital (source: ISD Scotland)
Table 8: Patients with long stays in acute hospital beds

<table>
<thead>
<tr>
<th>Current average monthly percentage of stays over 28 days</th>
<th>Monklands Hospital</th>
<th>Hairmyres Hospital</th>
<th>Wishaw Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend over last 3 years</td>
<td>Decreased</td>
<td>No evidence of statistical reduction</td>
<td>No evidence of statistical reduction</td>
</tr>
<tr>
<td>Delayed discharges from over 65 audit</td>
<td>18%</td>
<td>22%</td>
<td>24%</td>
</tr>
</tbody>
</table>

9.29 The over 65 audit data highlighted that the underpinning reason for the delayed discharges varied between sites. However, consultant decision-making for discharge and home care delays were the most prominent reasons given. There is an opportunity here to align consultant work to support flow and discharge.

9.30 Average length of stay (October–December 2012 and January–March 2013) for medical and surgical specialties across all three hospitals, whether adjusted or unadjusted, has not been significantly different from the Scottish average for the two most recent quarters (October–December 2012 and January–March 2013). This indicates that patients in Lanarkshire are not staying significantly longer in hospital than the Scottish average [Data Appendix Reference 9g–h].

Emergency readmissions

9.31 Emergency readmissions rates are routinely monitored locally and nationally as high or increasing levels can be an indication of either poor discharge planning or ineffective support in the community.

9.32 Out of a total of 352 patient and carer experiences shared, 30 experiences (9%) raised concerns about inappropriate or inefficient discharge arrangements (6 Hairmyres Hospital, 15 Monklands Hospital, 6 Wishaw Hospital and 3 not identified to a particular hospital).

9.33 Emergency readmissions to NHS Lanarkshire’s acute hospitals within 7 and 28 days of discharge have varied since the baseline period, but none of the shifts have been permanent. During the two most recent quarters (October–December 2012 and January–March 2013), the rate of emergency readmissions for all three NHS Lanarkshire hospitals has not been significantly different from the Scottish average [Data Appendix Reference 9i].

9.34 NHS Lanarkshire has a higher than expected rate of multiple emergency admissions (more than four in one year) compared to Scotland [Data Appendix Reference 9j]. These rates have been standardised for age, sex and deprivation so should somewhat account for the wider health issues apparent in Lanarkshire. This analysis is not available at a hospital level.

9.35 Staff told us about significant delays producing final discharge summaries for patients who have been admitted to acute hospitals, though all patients leave with an interim discharge summary that should enable accurate follow-up in the community. The review team did not look at the quality of the interim discharge summaries. However, the case note review highlighted delays in producing the final discharge summary as an issue in all three hospitals. In some cases, no final discharge letter was filed in the
medical record, some discharge letters were written 3–4 months after death, and in some cases the letter had been completed by a doctor not directly involved in the patient’s care. The review team considered this to reflect challenges in the clarity of who is responsible for a patient’s care and how inpatient care is organised. It may also impact on the quality of the data recording that feeds models such as the HSMR.

9.36 Patients and carers also raised issues around discharge processes with 8% of experiences including this as an issue (6 Hairmyres Hospital, 15 Monklands Hospital, 6 Wishaw Hospital and 3 more than one site).

9.37 Examples of issues raised included:

- ‘Mother has had multiple readmissions over last year. No effective discharge planning and never any follow-up in the community, despite the fact that she is clearly a high risk for readmission.’
- ‘Dietician was supposed to refer to community not done. Discharge procedures and follow-up procedure were shocking.’
- ‘My husband was diagnosed with cancer. He was then discharged on with a limited supply of medication. He had received verbal instructions on his own as to dosage and use, none of this information was conveyed to any other family member. The discharge sheet said ‘no G.P. follow up’ and no mention at all of the fact that he was suffering from cancer...as my husband was increasingly becoming seriously ill day by day I contacted our own GP surgery to request a home visit. I explained to the doctor that he had only been given seven tablets and the only advice given upon the hospital discharge was to take one tablet a day. My husband and I were both unaware that the tablets were in fact morphine and he could have been taking more each day to ease the extreme pain and suffering that he had been enduring.’

9.38 However, we also heard some examples of good discharge planning, including: ‘Speech therapist at Wishaw very good and actually joined up the care with Macmillan nurse team.’

9.39 The review team also noted that the NHS board’s local unscheduled care action plan included a range of planned initiatives to support timely discharge including extension of allied health professional working, palliative care support at weekends and increases to the level of care management in the community.

9.40 NHS Lanarkshire has already identified the quality and timeliness of discharge summaries as a key issue under their Hospital Standardised Mortality Ratio (HSMR) improvement programme and has initiated action to deliver 90% of discharge letters dictated within 10 working days after discharge and verified within 15 working days by the end of March 2014. Actual actions to deliver this include:

- a standard proforma for discharge letter with agreed dataset (NHS Lanarkshire report this action as completed)
- Developing an electronic system to highlight incomplete discharges, and
- training for clinicians on how to complete discharge letter and summary for coding.

**Linking acute patient flow work to patient safety work**

9.41 Internationally, there is a growing evidence base linking poor flow and sub-optimal scheduling in healthcare to an increase in mortality, adverse events, readmissions
and poor financial performance. In particular, there is evidence that congestion in the accident and emergency department and the hospital increases the risk of death for patients admitted to hospital. The Royal College of Physicians of Edinburgh has highlighted the links between poor patient flow and safety, particularly when patients are boarded (RCPEd 2013). The review team is aware that NHS Lanarkshire is working to understand if this is an issue locally [Data Appendix Reference 9k].

9.42 At a senior level, the links between the HSMR Programme Board and the work to improve acute patient flow are recognised (Clinical Governance Committee minutes, July 2013). However, the review team observed the need to strengthen the day to day links between the acute patient flow work and the work to address the higher than average HSMR.

Conclusions and recommendations

9.43 In summary, there are significant challenges across all three hospitals with ensuring that emergency patients are admitted in a timely manner to the ward most appropriate to their needs and, once treated, are then discharged in a timely manner with appropriate support.

9.44 NHS Lanarkshire has already recognised these issues as a key and significant problem. Following renewed concerns about current performance, NHS Lanarkshire has engaged with the Scottish Government performance support team and since October 2013 has been accessing additional external advice and support to help address their difficulties in meeting the 4-hour accident and emergency target.

9.45 The review team also noted that NHS Lanarkshire has recently agreed to work with the national acute patient flow team to pilot work to redesign patient pathways with the aim of reducing bed occupancy and improving safety. Through this initiative, the Scottish Government is funding an international expert in clinical systems redesign to work with NHS Lanarkshire to test approaches that may then be used across Scottish health and social care systems.

9.46 The current level of focus, combined with the external support, means that this situation is extremely fluid with new actions being initiated even during the course of the review team site visits.

9.47 However, it was clear to the review team that the action taken up to the time of the site visits had not been adequate and that previous interventions to support NHS Lanarkshire to achieve the 4-hour standard have not resulted in sustained delivery. The review team acknowledges the impact of changing demographics on NHS Lanarkshire’s ability to sustain improvements. However, the lack of sustained delivery also appears to be associated to difficulties implementing some of the previous recommendations. Though understanding the historical reasons for the lack of progress against key recommendations is beyond the remit of the review, the review team noted a consistent theme around the challenges NHS Lanarkshire faces translating policies and plans into sustained improvement in practice.

9.48 The provision of expert external advice, though helpful, will not be sufficient to address the issues being faced. NHS Lanarkshire must ensure that robust management and governance arrangements are in place and sufficient skilled clinical and managerial time is allocated locally to ensure recommendations are translated into meaningful improvement. The management team and clinical leaders will need to develop strategic as well as tactical solutions to a longstanding problem.
9.49 The review team also noted significant interdependencies between the workforce issues highlighted in previous sections and the challenges that NHS Lanarkshire currently faces in ensuring that emergency patients receive the right care at the right time.

**Recommendation 15: NHS Lanarkshire should ensure that robust internal management and governance arrangements are in place and sufficient skilled local clinical and managerial time is allocated to the work with the National Acute Patient Flow Team to redesign patient pathways with the aim of reducing bed occupancy and improving safety. The safety and quality summit should be used to agree how this work will effectively interface with programme of support currently being provided by the Scottish Government’s performance support team.**
10 Leadership and governance for safety and quality

Introduction

10.1 The review team considered a range of factors when reviewing the leadership and governance to support the effective management of the quality and safety of healthcare in NHS Lanarkshire.

Management structures

10.2 The review team noted the matrix management structures which have a general manager, and associate nurse director responsible for the operational management of an acute hospital site combined with pan-NHS Lanarkshire responsibilities for an acute directorate. The review team noted that NHS Lanarkshire had recently decided to allocate an executive director to support the site management team responsible for delivering unscheduled care on each of the individual sites.

10.3 The review team found that the combined pan-NHS Lanarkshire and site management structure was not widely understood with a consequential lack of clarity about accountability lines and decision-making responsibilities. In the absence of this understanding, individuals who spoke to the review team were left uncertain as to how or where to raise issues. In turn, this may contribute to a culture where risks to patient safety are not appropriately escalated or recorded.

10.4 The review team found that there was greater clarity around the nurse leadership structures than the medical leadership structures.

10.5 The review team noted the need to review existing organisational structures to ensure sharper focus on accountability for clinical leadership and operational delivery within each of the three hospitals. Any revisions to the design of the structure need to take full account of the fundamental importance of strengthening relationships with primary and social care partners. The flow of patients into the hospitals and the earliest possible safe discharge from the hospital needs a close partnership with colleagues in primary care teams and in the two local authorities.

10.6 Specifically, the review team believes that there is a need to urgently strengthen the site-specific medical leadership. It was noted, from a number of concerns expressed, that the current structure does not ensure sufficient time and attention are devoted to providing visible and active medical leadership in each of the three hospitals.

Governance structures

10.7 The review team also considered the range of groups and committees that were in place to oversee the governance and management of NHS Lanarkshire. The review team is not in a position to determine the effectiveness of each group or committee, but has considered the extent to which the infrastructure is aligned and contributing to the overall approach to improving the quality and safety of care for acute adult patients in NHS Lanarkshire.

10.8 The review team noted that there was considerable scope for a range of potentially overlapping group remits including:

- care assurance programme board
- HSMR improvement programme board
- modernisation board
- local unscheduled care management board
- acute strategy programme board
- acute services operating committee
- acute services divisional management team, and
- acute clinical governance and risk management committee.

10.9 The review team acknowledged that over-sight was exercised by the corporate management team and the NHS Lanarkshire Board. However, there is a risk that the currently complex infrastructure and organisational arrangements impede the delivery of the necessary actions, within the required timescales. In particular, the existence of such a range of bodies can inhibit decision-making. They run the risk of a lack of focus, drive and effort to overcome substantial challenges.

10.10 The review team believed that there was a need to secure a better connect between the work to improve the flow of patients through the hospital that reports up through the acute divisional management team to the corporate management team and acute services operating committee and the work to reduce the HSMR which reports through the HSMR improvement programme board to NHS Lanarkshire’s clinical governance steering group. The safety and flow of patients are inherently interconnected and, though this was clearly recognised at a senior level, the review team was concerned that the connection had not been sufficiently made at an operational level. For instance, the HSMR workstream to improve the response to the deteriorating patient does not make reference to the significant challenges around staff capacity to identify deteriorating patients and to respond in a timely manner.

Figure 6: Groups and committees in NHS Lanarkshire for HSMR and patient flow

10.11 The combination of complex management and governance structures led the review team to conclude that there is a significant risk of management effort becoming dissipated in NHS Lanarkshire, with an inevitable concentration on the immediate difficulties over the delivery of less pressing medium or longer term objectives. The
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review team heard staff at all levels indicate that there was a state of perpetual crisis in NHS Lanarkshire regarding unscheduled care.

Developing the capacity and capability for quality improvement

10.12 NHS Lanarkshire’s strategic framework, A Healthier Future (June 2012), includes an aim to deliver a continuous quality improving organisational culture.

10.13 The Quality and Clinical Governance Strategy (2011–2014) recognises the need to develop a shared vision for quality improvement work across NHS Lanarkshire including the need to assist frontline staff to improve quality. Actions taken include:

- Developing the NHS board’s Quality Improvement Hub to provide leadership, strategic direction and drive implementation of quality improvement work across NHS Lanarkshire. However, the review team heard from a range of staff that they do not understand the role of the Quality Improvement Hub or what it is doing to support improvement work.
- Piloting the NHSScotland Quality Improvement Register.
- Piloting a 1-day quality improving course with the national Quality Improvement Hub and had developing and testing a 3-day training course with NHS Education for Scotland.
- Promoting access to the NHS Education for Scotland eLearning modules through FirstPORT.

10.14 There has been extensive training in quality improvement techniques including 752 staff trained in Lean awareness, 280 trained in Lean basic, 86 trained in Lean foundation, 13 trained in Lean intermediate, 16 trained as Lean process owners, 10 Lean black belts in training, 18 trained in Workout (c), 131 trained in project management, three Scottish Patient Safety Programme fellows, one improvement advisor (with a further two in training) and seven improvement science practitioners (NHS Lanarkshire provided data, alumni as of November 2012, draft 1). An additional Scottish Patient Safety Programme fellow graduated in June 2013, bringing the total number to four.

10.15 This is a significant potential resource. However, staff reported a lack of practical support for improvement work and a lack of a common approach to improvement across NHS Lanarkshire. NHS Lanarkshire’s quality improvement leads also highlighted the vital importance of coaching to translate theoretical learning in quality improvement techniques into actual practice. They also highlighted insufficient organisational capacity to provide this coaching.

10.16 In addition to ongoing coaching and support to enable staff to translate training into practice, the review team also noted the need for dedicated time to undertake quality improvement work.

10.17 The review team observed examples of a reliance on writing policies and then instructing staff to follow them (such as in the management of orthopaedic admissions and clinical observations). There needs to be an increased focus on understanding the system conditions which are preventing staff from reliably implementing agreed policies, and supporting staff by changing the system where required. This was particularly notable around the concerns escalated during the site visits, but is also evidenced within the HSMR deteriorating patient workstream where, as identified under the safety section of this report, staffing and workload pressures
are impacting on the reliable identification and timely response to patients whose clinical condition is deteriorating.

10.18 The Scottish Patient Safety Programme advised the review team that NHS Lanarkshire is the only NHS board who has a Scottish Patient Safety Programme Fellow with job planned time to support sepsis and the deteriorating patient work. The team were also advised that NHS Lanarkshire has engaged strongly with the national programme of work focused on sepsis and deteriorating patients.

10.19 The review team noted that the Learning Strategy (2012–2015) does not include a focus on developing the skills of staff to appropriately use and apply quality improvement techniques.

10.20 The Organisational Development Plan (August 2013) highlighted work to develop a common set of values that will drive ongoing improvement in the quality of care delivered, and a common understanding of how these translate into day to day behaviours.

10.21 The review team also heard a view that there are currently too many national improvement initiatives and that there is not the capacity locally to engage with them all.

Using data to drive improvement

10.22 Historically, NHS Lanarkshire has been at the leading edge across Scotland in developing approaches for collecting and reporting ward level data that have the potential to support work to improve quality. In particular, the Lanarkshire Quality Improvement Portal (LanQIP) IT system has been adopted by seven NHS boards across Scotland.

10.23 However, the review team found limited evidence of data actually being used to inform and drive improvement. The ward level issues are highlighted in Section 6 of this report.

10.24 The review team noted key issues around the presentation and understanding of the data at an NHS board level including the following:

- The NHS board’s clinical governance quality dashboard includes a summary which uses trend arrows to show the change from the previous month (Data Appendix Reference 10a). With data which include normal variation, meaningful conclusions cannot be drawn by simply looking at movement from the previous month.

- The main section of the NHS board’s clinical governance quality dashboard presents time series data (Data Appendix Reference 10b). It is positive to see time series data going to the Board. However, this could be strengthened by the inclusion of medians which would aid interpretation and may also help with ensuring the appropriate rigour is applied to the statements made in the narrative section.

- The review team received a number of reports where the data were appropriately shown as a run chart, but were inappropriately broken down into yearly plots. This, combined with the lack of a median, made it difficult to assess trends over time and therefore difficult for managers and clinicians to assess whether significant shifts had happened that may then need responding actions (Data Appendix Reference 10c).
Historically, the Board has been receiving process measures showing high levels of compliance with no movement in outcomes. In particular, the review team noted high reported compliance with pressure ulcer prevention contrasting with a rise in pressure ulcer rates and high reported compliance with MEWS which was not associated with improvement in the deteriorating patient outcome measures (Data Appendix Reference 10b and 10d). There is no evidence from the Board minutes that it has questioned this apparent anomaly. Had it done so then the issues with compliance might have been discovered earlier.

The review team did not believe that there was sufficient and robust evidence to support the statements made about the reliability and spread of the elements of the safety programme as reported to the Board (see Section 6).

10.25 In August 2013, two non executives on the clinical governance committee identified a development need to better understand the information presented in the quality dashboard (Clinical Governance Committee Minutes, August 2013).

Service redesign

10.26 The review team noted the extensive work that had been undertaken in recent years to redesign the delivery of care. However, the review team also heard staff express concern about the insufficient pace and follow through in delivery in the most pressing and difficult areas.

10.27 The reality for healthcare leaders is that they work within a complex and multifaceted landscape where senior teams have to constantly balance a range of competing priorities and demands. NHS Lanarkshire is no different in that regard, and the review team acknowledges that the Board and the corporate management team have a complex environment in which to exercise change. Set against this background, the review team noted that the Board and corporate management team had difficulty in identifying sustainable and acceptable solutions to some of their most pressing and important safety and quality of healthcare challenges including the following.

- As highlighted in Section 7, there is no clearly agreed plan to address the medical staffing shortages across the acute hospitals and ensure safe and effective patient care.
- In September 2011, the emergency access support team report highlighted the priority need to review the model of care for consultant input to the emergency receiving unit at Monklands Hospital with a recommended move to a consultant of several days model. At the time of the review visit, the recommended consultant of several days model had not yet been implemented and it is understood the target date for implementation is January 2014. The review team heard from consultant medical staff in both general medicine and emergency medicine at Monklands Hospital that meetings with senior management had not led to any action.
- The review team found significant issues around the out of hours orthopaedic cover across the three hospitals. It heard from clinicians that there is an urgent need to redesign orthopaedic services to enable sustainable and safe delivery of care. However, there was no evidence that work had taken place to develop sustainable solutions to the challenges faced.

10.28 Together, the examples above point to difficulties in making progress on key issues, under the scope of the review. The review team saw ample material about plans and proposals for the redesign of services, but there was consistent feedback about the difficulties and delays implementing practical change across the acute hospital.
environment. The review team also noted the absence of an agreed focused plan that joins the multiple strands of work of the acute hospitals together into one clear and prioritised set of actions. Whatever the reasons, this Rapid Review provides an opportunity for NHS Lanarkshire to regain focus on priorities for the future.

10.29 In August 2013, the NHS Lanarkshire Board passed a proposal to start a process to develop an NHS Lanarkshire wide acute clinical strategy. In taking this work forward, all the key stakeholders will need to work together to develop a sustainable solution for the provision of acute services across NHS Lanarkshire. This is likely to involve some difficult and challenging discussions and decisions which will require everyone involved to engage in the process with a mindset of working together to find the optimal solution for improving the safety and quality of healthcare for the people of Lanarkshire.

10.30 However, given the timelines attached to the acute clinical strategy development and the pressing nature of some of the issues identified, particularly around the sustainability of out of hours medical cover for the emergency medical and orthopaedic pathways, work needs to progress now to look at potential shorter term solutions in advance of any wider system redesign. As a minimum, solutions must be found to address the out of hours medical input for orthopaedics, acute medicine and emergency medicine. The relevant Colleges, Specialist Societies and Chief Medical Officer Specialty Advisers could be used as sources of expert advice.

Identification and management of risk

10.31 The review team observed a leadership team where there was, at times, a significant disconnect between what they thought was happening and what was actually happening. NHS Lanarkshire is a large, and complex organisation, and it would not be reasonable to expect senior leaders to be aware of every issue. However, the review team noted several occasions (such as those concerns escalated by the review team to management), where there was a lack of awareness about issues that senior leaders might reasonably have been sighted on due to the risks associated with the practice.

10.32 The review team heard of examples of clinicians not escalating their concerns around the safe provision of care due to an apparent belief that it is not worth highlighting the problem as nothing will change in response. This is linked to the under-reporting in Datix of risks (see paragraph 10.34).

10.33 The review team noted an under-reporting of risk within the formal risk management governance arrangements:

a) NHS Lanarkshire’s corporate risk register highlights: ‘There is a risk that NHSL may be unable to sustain viable clinical services if the proposal for the Reshaping of Medical Services becomes live as there will be reduction in the number of doctors in training with restricted affordable models that would maintain medical services across the three level 2 hospitals, with the potential to adversely impact on the sustainability of clinical services, and the potential that recruitment and retention of medical staff will not be achievable.’ The risk is assessed as high but with acceptable controls and a residual risk. There are no risks noted around the availability of sufficiently senior doctors present to plan and deliver safe and effective care. (Risk Register supplied by NHS Lanarkshire and dated April 2013 – Data Appendix Reference 10e).
b) NHS Lanarkshire’s Acute Risk Register does not highlight any direct risks around the availability of medical or nursing staff. There are risks associated to the delivery of the 4-hour Accident and Emergency Target and the Treatment Time Guarantee (risk register supplied by NHS Lanarkshire and dated April 2013 – Data Appendix Reference 10f).

c) The review team could not identify any risks recorded about the nursing workforce issues.

10.34 The review team heard from a range of staff that the incident reporting system (Datix) is not being routinely used to record incidents and safety concerns. Therefore, the incident reporting at Board level is likely to be under-reporting current risks.

10.35 Based on the issues escalated to NHS Lanarkshire, the review team considered that there is a risk that certain operational practices which the review team regard as unacceptable have become an accepted norm in some areas. The review team was particularly concerned about the continuity of medical care for medical wards when consultants are on leave and arrangements for the management of overnight orthopaedic admissions.

Conclusions and recommendations

10.36 Those spoken to by the review team did not doubt the senior leadership team’s commitment. Indeed, a number of senior clinicians commented positively on their accessibility. However, there was a consistent message of a need to demonstrate stronger follow through on proposals and in the resolution of difficult issues. The review team acknowledges the complex operating context for NHS Lanarkshire in delivering care across its acute services.

10.37 NHS Lanarkshire has complex organisational arrangements. It has a blend of on-site and pan-NHS Lanarkshire management arrangements. It should review its current management and organisational arrangements to ensure adequate focused leadership to the day-to-day management of services on each of the three sites. Any review must take into account the need to strengthen medical leadership and the need to take full account of the fundamental importance of strengthening relationships with primary and social care partners.

10.38 Similarly, there is scope to simplify the array of groups and bodies in the NHS Lanarkshire system. There is a need to ensure a sharper and clearer line of accountability through the corporate management team and to the Board for delivery. This will help give clarity to priorities and the progressing of delivery.

10.39 The challenges of embedding a culture of continuous quality improvement across an organisation are considerable and not to be underestimated. It is not possible to say whether NHS Lanarkshire is less advanced, the same, or more advanced than other NHS boards in Scotland. What is clear is that there are, and will remain, considerable challenges in moving from a situation of individual pockets of excellent practice to one where a focus on improving the quality of care is seen and supported to be everyone’s responsibility.

10.40 The current organisational resources for improvement are spread across different departments and directorates. The review team recommends bringing these together into one team, developing the NHS board’s Quality Improvement Hub from a virtual concept to a team of expert improvement resources, which will enable communication, co-ordination and effective prioritisation. This team should include
improvement advisors, practice development leads, clinical governance staff, information analysts and organisational development staff.

10.41 There is a need to review the current approach to developing the organisational capacity for improvement. In particular, there is a need for an overall strategy that includes recognition of the vital role that ongoing coaching and support have in translating classroom learning into actual practice.

10.42 There is also a need to further develop the organisational capacity to understand and use real-time data for improvement, performance management and assurance. This applies to every level of the organisation.

10.43 As referenced in other sections of this report, there are complex staffing issues to be addressed. The issues of out of hours medical input for orthopaedics, acute medicine and emergency medicine need to be tackled in a meaningful way and as a priority. The model of care and the staffing arrangements need to be focused on the needs of patients. The timely provision of care will enhance safety and operational effectiveness.
Recommendation 16: NHS Lanarkshire should review its current management arrangements, ensuring there is sufficient senior clinical and operational management on each of the three hospital sites. This needs to include clarity on lines of accountability and decision-making responsibilities which then need to be communicated across the three sites so staff understand how, when and where to escalate issues of concern.

Recommendation 17: NHS Lanarkshire should review the number of internal groups and bodies with a view to ensuring a sharper and clearer line of accountability through the corporate management team and to the Board for delivery. This will help give clarity to priorities and the progressing of delivery. In particular, the link between current work to improve patient flow and safety improvement needs to be clear and guide work at all levels.

Recommendation 18: NHS Lanarkshire should review its current approach to developing the organisational capacity for improvement. The focus should be on developing and testing changes that lead to improved patient care and outcomes. A focus on making sustainable improvement to patient outcomes reduces the risk of simply providing training without any subsequent implementation.

Recommendation 19: NHS Lanarkshire should develop its Quality Improvement Hub from a virtual concept to an actual team of experts to accelerate improvement across the organisation. This team should include improvement advisors, practice development leads, clinical governance staff, information analysts and organisational development staff.

Recommendation 20: NHS Lanarkshire should ensure an appropriate balance between generating data and developing the capacity to interpret and challenge it at all levels of the organisation to support improvement, performance management and assurance.

Recommendation 21: NHS Lanarkshire should take action to address the current culture whereby key safety concerns are not routinely escalated. This needs to include systems for taking appropriate action or mitigation measures and for feeding back to staff on the action taken.
Appendix 1: Key lines of enquiry

<table>
<thead>
<tr>
<th>Focus</th>
<th>Key lines of enquiry</th>
</tr>
</thead>
</table>
| Leadership and governance      | • Can the Board articulate its governance processes for assuring the quality of treatment and patient care?  
                                | • Can staff at all levels of the organisation describe the key elements of the quality governance processes?  
                                | • Are leadership roles and responsibilities clearly defined for safety and quality?  
                                | • Are risks to the delivery of safe and high quality care identified and managed?  
                                | • Is the organisation able to effectively prioritise actions associated with the quality and safety of care in acute hospitals and to then implement improvement? |
| Operational effectiveness      | • How does the NHS board manage patient admissions and flow through the three hospitals?  
                                | • What does it think are the key issues hindering effective flow and what actions are being taken to address them? |
| Safety                         | • How does the organisation manage deteriorating patients?  
                                | • What are the key issues faced with effectively identifying and managing deteriorating patients and how are they responding?  
                                | • Are other specific interventions relating to areas of higher than average HSMR being effectively implemented? |
| Workforce                      | • How does the organisation approach workforce planning to ensure that patient safety is managed effectively including skill mix?  
                                | • How does the organisation ensure staff have the skills and knowledge to delivery safe and effective care? |
| Patient experience             | • Is there a culture of proactively engaging with patients to obtain their views?  
                                | • How does the organisation use patient experience data including complaints? |
### Appendix 2: Interviews held on announced visits

#### Held at Wishaw Hospital – 9 October 2013

<table>
<thead>
<tr>
<th>Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Ross, NHS Lanarkshire Chief Executive</td>
</tr>
<tr>
<td>Dr Iain Wallace, NHS Lanarkshire Medical Director</td>
</tr>
<tr>
<td>Shona Welton, Head of Patient Affairs</td>
</tr>
<tr>
<td>Dr Alistair Cook, Director of Medical Education</td>
</tr>
<tr>
<td>Alan Lawrie, Director of Acute Services</td>
</tr>
<tr>
<td>Hospital emergency care team nurse</td>
</tr>
</tbody>
</table>

#### Held at Monklands Hospital – 10 October 2013

<table>
<thead>
<tr>
<th>Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neena Mahal, NHS Lanarkshire Chair</td>
</tr>
<tr>
<td>Joan James on behalf of Director of NMAHPs</td>
</tr>
<tr>
<td>Jane Burns, Divisional Medical Director</td>
</tr>
<tr>
<td>Hospital emergency care team nurse</td>
</tr>
<tr>
<td>Laura Ace, Director of Finance</td>
</tr>
</tbody>
</table>

#### Held at Hairmyres Hospital – 11 October 2013

<table>
<thead>
<tr>
<th>Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilian Macer, Chair of Partnership Forum</td>
</tr>
<tr>
<td>Gregor Smith, CHP Divisional Director, Craig Cunningham, Director South CHP,</td>
</tr>
<tr>
<td>Anne Armstrong, Divisional Director Nurse</td>
</tr>
<tr>
<td>Kenny Small, HR Director</td>
</tr>
</tbody>
</table>

#### Other: Held at Kirklands Hospital (due to annual leave during site visit) – 15 October 2013

<table>
<thead>
<tr>
<th>Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosemary Lyness, Director of Nursing, Midwifery and AHPs</td>
</tr>
</tbody>
</table>
Appendix 3: Focus groups and group interviews held on announced visits

### Wishaw Hospital – 9 October 2013

<table>
<thead>
<tr>
<th>Focus group invitees</th>
<th>Number of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 5 Nurses and AHPs</td>
<td>11 registered</td>
</tr>
<tr>
<td>Charge Nurses</td>
<td>9 registered</td>
</tr>
<tr>
<td>Foundation/Specialist Trainee Doctors</td>
<td>5 registered</td>
</tr>
<tr>
<td>Student Nurses</td>
<td>8 registered</td>
</tr>
<tr>
<td>Clinical Support Workers</td>
<td>9 registered</td>
</tr>
<tr>
<td>Emergency Department Consultants</td>
<td>3 registered</td>
</tr>
<tr>
<td>General Medicine Consultants</td>
<td>3 registered</td>
</tr>
<tr>
<td>ICU consultants and charge nurse</td>
<td>3 registered</td>
</tr>
<tr>
<td>Care of the Elderly Consultants</td>
<td>4 registered</td>
</tr>
<tr>
<td>Management Team – Wishaw/Women’s and Cancer Division</td>
<td>5 registered</td>
</tr>
<tr>
<td>HSMR Workstream – Deteriorating Patient/Sepsis</td>
<td>4 registered</td>
</tr>
<tr>
<td>HSMR Workstream – End of Life Care</td>
<td>3 registered</td>
</tr>
<tr>
<td>Staff Drop-in Session</td>
<td>7</td>
</tr>
<tr>
<td>Patient and Public Listening Event</td>
<td>2</td>
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</table>

### Monklands Hospital – 10 October 2013

<table>
<thead>
<tr>
<th>Focus group invitees</th>
<th>Number of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 5 Nurses and AHPs</td>
<td>11 registered</td>
</tr>
<tr>
<td>Charge Nurses</td>
<td>9 registered</td>
</tr>
<tr>
<td>Foundation/Specialist Trainee doctors</td>
<td>8 registered</td>
</tr>
<tr>
<td>Student Nurses</td>
<td>8 registered</td>
</tr>
<tr>
<td>Clinical Support Workers</td>
<td>9 registered</td>
</tr>
<tr>
<td>General Medicine Consultants</td>
<td>4 registered</td>
</tr>
<tr>
<td>ICU Consultants and Charge Nurse</td>
<td>5 registered</td>
</tr>
<tr>
<td>Emergency Department Consultants</td>
<td>3 registered</td>
</tr>
<tr>
<td>Medical Leadership for Monklands Hospital</td>
<td>3 registered</td>
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<tr>
<td>Care of the Elderly Consultants</td>
<td>5 registered</td>
</tr>
<tr>
<td>Management Team – Monklands/Emergency and Medical Division</td>
<td>7 registered</td>
</tr>
<tr>
<td>Management Team - Older People’s and Acute Reshaping Care Division</td>
<td>3 registered</td>
</tr>
<tr>
<td>Clinical Governance &amp; Improvement</td>
<td>5 registered</td>
</tr>
<tr>
<td>Non Executives</td>
<td>7 registered</td>
</tr>
<tr>
<td>GP Session</td>
<td>5</td>
</tr>
<tr>
<td>Staff Drop-in Session</td>
<td>2</td>
</tr>
<tr>
<td>Patient and Public Listening Event</td>
<td>12</td>
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</tbody>
</table>
### Hairmyres Hospital – 11 October 2013

<table>
<thead>
<tr>
<th>Focus group invites</th>
<th>Number of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 5 Nurses and AHPs</td>
<td>11 registered</td>
</tr>
<tr>
<td>Charge Nurses</td>
<td>9 registered</td>
</tr>
<tr>
<td>Student Nurses</td>
<td>8 registered</td>
</tr>
<tr>
<td>Foundation/Specialist Trainee Doctors</td>
<td>8 registered</td>
</tr>
<tr>
<td>Clinical Support Workers</td>
<td>9 registered</td>
</tr>
<tr>
<td>ICU nurse consultant and HECT team nurse</td>
<td>2 registered</td>
</tr>
<tr>
<td>General Medicine Consultants</td>
<td>4 registered</td>
</tr>
<tr>
<td>Emergency Department Consultants</td>
<td>4 registered</td>
</tr>
<tr>
<td>ICU Consultants/Charge Nurse</td>
<td>5 registered</td>
</tr>
<tr>
<td>Care of the Elderly Consultants</td>
<td>7 registered</td>
</tr>
<tr>
<td>Management Team – Hairmyres/Surgical Division</td>
<td>4 registered</td>
</tr>
<tr>
<td>HSMR workstream: Information and Quality</td>
<td>6 registered</td>
</tr>
<tr>
<td>Staff Drop-in Session</td>
<td>12</td>
</tr>
<tr>
<td>Patient and Public Listening Event</td>
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Appendix 4: Clinical areas visited on announced visits

<table>
<thead>
<tr>
<th>Wishaw Hospital – date of observation 9 October 2013</th>
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</thead>
<tbody>
<tr>
<td>Clinical area</td>
</tr>
<tr>
<td>Emergency Care Unit</td>
</tr>
<tr>
<td>Medical/Respiratory</td>
</tr>
<tr>
<td>Orthopaedic</td>
</tr>
<tr>
<td>Surgical Receiving</td>
</tr>
<tr>
<td>Surgical</td>
</tr>
<tr>
<td>Medical/Endocrinology</td>
</tr>
<tr>
<td>Admission and Assessment</td>
</tr>
<tr>
<td>Medical/Cardiology</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>Acute Assessment and Rehabilitation</td>
</tr>
<tr>
<td>Orthopaedic/Rehabilitation</td>
</tr>
<tr>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>Medical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monklands Hospital – date of observation 10 October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical area</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Geriatric/Orthopaedic/Rehabilitation</td>
</tr>
<tr>
<td>Acute Medical Receiving Unit</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>Critical Care Unit/Intensive Care Unit</td>
</tr>
<tr>
<td>Care of the Elderly (wards 21 and 22)</td>
</tr>
<tr>
<td>Surgical (wards 4 and 6)</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Renal</td>
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</table>

<table>
<thead>
<tr>
<th>Hairmyres Hospital – date of observation 11 October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical area</td>
</tr>
<tr>
<td>Acute Assessment Medicine</td>
</tr>
<tr>
<td>Medical/Gastroenterology</td>
</tr>
<tr>
<td>Acute Stroke Unit</td>
</tr>
<tr>
<td>Acute Surgical</td>
</tr>
<tr>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>Acute Medical Receiving Unit</td>
</tr>
<tr>
<td>Continuing Care/Rehabilitation</td>
</tr>
<tr>
<td>Cardiac Care Unit</td>
</tr>
<tr>
<td>Intensive Therapy Unit/High Dependency Unit</td>
</tr>
<tr>
<td>Surgical (wards 5 and 6)</td>
</tr>
<tr>
<td>Orthopaedic</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Diabetes/Endocrinology</td>
</tr>
<tr>
<td>Joint Assessment Unit</td>
</tr>
<tr>
<td>Medical/Cardiology</td>
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</table>
## Appendix 5: Unannounced site visits

<table>
<thead>
<tr>
<th>Site details</th>
<th>Areas visited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hairmyres Hospital</strong></td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>Sunday 20 October 2013</td>
<td>Acute Medical Receiving (ward 2)</td>
</tr>
<tr>
<td>From: 8–11.30pm</td>
<td>Surgical Receiving (ward 4)</td>
</tr>
<tr>
<td></td>
<td>Surgical (ward 6)</td>
</tr>
<tr>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td><strong>Monklands Hospital</strong></td>
<td>Acute Medical Receiving Unit</td>
</tr>
<tr>
<td>Monday 21 October 2013</td>
<td>Orthopaedic (ward 10)</td>
</tr>
<tr>
<td>From 8am–12.30pm</td>
<td>Medical (ward 14)</td>
</tr>
<tr>
<td><strong>Monklands Hospital</strong></td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>Sunday 27 October 2013</td>
<td>Emergency Receiving Unit</td>
</tr>
<tr>
<td>From: 8–10.30pm</td>
<td>Surgical Receiving Unit (ward 4)</td>
</tr>
<tr>
<td></td>
<td>Hospital at night handover</td>
</tr>
</tbody>
</table>
Appendix 6: Information available to the review team

The following documents were accessed by or provided to the review team. Not all of the documents were reviewed in detail. However, a considerable number of them were reviewed and used to validate findings. Documents with an asterisk are quoted in the main report.

Leadership and Governance

- NHS Lanarkshire Board Minutes from September 12 to August 2013*
- NHS Lanarkshire Quality Dashboard/Clinical Governance Corporate Report – September 2013 and October 2013*
- NHS Lanarkshire Quality Dashboard – Person Centred and Patient Experience – May 2013
- NHS Lanarkshire Board Quarterly Corporate Performance report summary – 30 June 2013
- NHS Lanarkshire Clinical Governance Report – November 2012*
- Waiting Times Update to Board – 25 September
- Healthcare Associated Infection Control and Prevention Report to NHS Lanarkshire Board Meeting – August 2013
- Primary Care Out of Hours Bi-Monthly Report covering period June and July 2013
- Patient Focus and Public Involvement (PFPI) Improvement Plan – 2013–2014
- Report on the high level review of the findings and recommendations of the public inquiry into the Mid-Staffordshire NHS Foundation Trust and potential relevance to NHS Lanarkshire – August 2013
- Board update on Improving Care for Older People in Acute Care – July 2013
- Shaping NHS Lanarkshire’s Acute Clinical Strategy – August 2013*
- Palliative Care Strategy – August 2013
- Finance Board Reports – August 2013 and September 2013
- Acute Division Cash Releasing Efficiency Savings 2013–2014
- Board subcommittee structures, terms of reference and membership
  - Audit Committee Terms of Reference March 2013 (members includes Non-Executive Director of the NHS board, at least 4 Non Exec Director members from the Audit Committee)
  - Staff Governance Committee Terms of Reference March 2011 (members include 4 Non Exec Directors one of which is the Employee Director, and 4 staff side Chairs of Operating Divisions (Acute, CHPs and PSSD)
  - Clinical Governance Committee Terms of Reference February 2012 (members include a Non-Executive Director (Chair), plus 3 Non-Executive Directors one of whom is the Chair of the Area Clinical Forum)
  - Remuneration Committee Terms of Reference July 2011 (members include Chairman of NHS Lanarkshire, 3 Chairs of the Operating Committees)
  - North Lanarkshire CHP Operating Management Committee Terms of Reference September 2011
  - South Lanarkshire Partnership Operating Management Committee/Health and Care Partnership Terms of Reference 20 May 2013
  - Area Clinical Forum Constitution and Remit 30 October 2010
- Acute Operating Management Committee Terms of Reference – Role and Remit – May 2013 (members include 3 Non-Executive Directors)
- Acute Operating Management Committee minutes of meetings for – 28 May and 21 August
- Board management structure diagram
- Acute management structure diagram
- Job Descriptions for Executive Team members and Acute Management Team members
- Copy of Directors objectives relating to quality and safety – 2013–2014
- Strengthening Quality in Lanarkshire Strategy 2011–2014*
- Quality Improvement Hub Driver Diagram
- Understanding our current Quality Improvement capability presentation – 15 February 2013
- A Healthier Future OD Plan Summary Report – November 2012*
- A Healthier Future OD Plan 2013–2016*
A Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire: Findings and Recommendations – December 2013

- A Healthier Future OD Plan – presentation updated 16 August 2013
- Learning Strategy – 2012–2015*
- Clinical Governance Board Papers – September 2013, August 2013 and June 2013
- Clinical Governance Committee Minutes – 1 July 2013 and 26 August 2013*
- Risk committee agenda and minutes for two most recent meetings – 10 June 2013 and 12 August 2013
- Board Risk Register – April 2013*
- Acute Division Risk Register – April 2013*

Operational effectiveness
- Local Unscheduled Care Action Plan – June 2013
- Site level Unscheduled Care Action Plans – June 2013
- NHS Lanarkshire Review meeting on Emergency Flow report by Professor Derek Bell and Dr John Riordan – January 2013
- Emergency Access Support Team Reports – August 2011
- Agenda and minutes of Emergency and Medical Directorate meetings
  - Hairmyres Hospital – 21 March, 17 May and 12 July 2013
  - Wishaw Hospital – 13 March, 21 May and 17 September 2013
  - Monklands Hospital – 28 March, 30 May and 18 July 2013
- Agenda and Minutes of Site Flow Groups
  - Hairmyres Hospital – 6 September, 13 September and 20 September 2013
  - Wishaw Hospital – 10 September, 24 September and 31 October 2013
  - Monklands Hospital – 2 September, 9 September, 16 September and 23 September 2013
- Standard Operating Procedure for risk assessing medical patients for potential boarding
- Adult Acute Care Commissioning Standards – NHS London
- Adult Acute Care Clinical Standards Self Assessment
- Over 65 Pathway Report – June 2013*
- Bed Management procedures and responsibilities of clinicians and managers
- Emergency Department Contingency Guidance (Senior Decision Maker Cover)

Patient experience
- NHS Lanarkshire complaints report for 2012–2013 and quarterly report for April–June 2013*
- Scottish Public Services Ombudsman Annual Letter (April 2012–March 2013)*
- Older People in Acute Hospitals – announced inspection – Wishaw – May 2012
- HEI - unannounced inspection report – Wishaw Hospital – June 2013
- Older People in Acute Hospitals – announced inspection – Hairmyres – March 2012
- HEI - unannounced inspection report – Monklands – January 2013
- Older People in Acute Hospitals – announced inspection – Monklands – June 2012
- HEI - unannounced inspection report – Hairmyres – November 2012

Safety
- HSMR Programme Board Terms of Reference 21 January 2013 (membership includes Chief Executive, Medical Directors, Directors of Nursing, HSMR programme manager, Head of Clinical Governance, Employee Director, SPSP Manager)
- HSMR Programme Board minutes - 11 March, 24 June and 13 September 2013
- HSMR workstream Project Initiation Documents
  - Deteriorating Patient/Sepsis – September 2013
  - Information and Quality Reviews – October 2013
  - Anticipatory Care Planning project (Phase 2) – September 2013
  - Palliative Care – September 2013
- HSMR Programme Plan June 2013
- HSMR Gantt chart – September 2013*
- HSMR Progress Report – June 2013, February 2013, April 2012 with supplementary paper (original and revised papers)
- NHS Lanarkshire Case Note Review Reports – July 2013 and April 2012 and summary of review process in email from NHS Lanarkshire on 28 August 2013
• Deteriorating patient dashboard 2012–2013
• Handover weekend meeting document – Monklands
• Report to Deteriorating Patients/Sepsis Workstream – October 2013
• Clinical Observation Policy – September 2013
• Coding – Data Quality Assurance report ISD September 2013 – Monklands
• Copy of coding sticker used for Emergency Admissions at Hairmyres
• Audit data on anti-microbial prescribing – 2013–2014
• Safety Briefs in NHS Lanarkshire briefing
• An audit of the recognition and management of early bloodstream infection at Monklands DGH – 2009
• Peri-arrest audit report – January 2012–August 2013

Workforce
• Proposal for investment in emergency services – January 2011
• Establishing a department of acute medicine at Monklands Hospital – January 2013
• Rapid Review Team Medical Staffing Narrative – September 2013
• Range of additional information on consultant staffing provided by NHS Lanarkshire
• Medical Revalidation Self Assessment 2012–2013
• Update on medical staff paper to NHS Board – May 2012 and June 2013
• Review of Medical Staffing in Lanarkshire Emergency Departments – SBAR May 2013
• West of Scotland Regional Medical Workforce Group Minutes June 2012
• Information on medical shift patterns on wards across acute hospitals
• Strategic Framework for the Development of Clinical Advanced Practice Roles in NHS Lanarkshire
• Acute Nursing Workforce Review – November 2012
• Acute Nursing Workforce Review – report on pilots
• Draft business case for Acute Nursing Workforce – Medical Receiving/Emergency Medicine – September 2013
• Nursing establishment by ward – funded and in post
• Nurse Bank Policy and Procedures
• Leading Better Care, Workforce Integration Subgroup Terms of Reference
• NMAHP Senior Leaders Group Terms of Reference
• NMAHP Leadership Map
• Steps to Achieve the NHS Lanarkshire Vision of Nursing: Strategic Actions 2012–2015 and joint declaration of themes
• Whistle blowing policy
• Capability policy
• NHS Lanarkshire Workforce Plan 2013–2014
• Development programme for clinical leaders in Emergency Medicine
• eKSF performance by ward
• NES 2013 GMC National Trainee Survey data for NHS Lanarkshire
• NES GMC NTS patient safety issues
• NES post assessment questionnaires
### Appendix 7: Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td><strong>ACE nurse</strong></td>
<td>Acute Care of the Elderly Nurse</td>
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<tr>
<td><strong>age specialist service emergency team (ASSET)</strong></td>
<td>A pilot project allowing older people in North Lanarkshire to remain at home rather than being taken to hospital. GPs can refer older people to ASSET instead of admitting them to hospital. Approximately 80% of people referred to the scheme are able to remain at home.</td>
</tr>
<tr>
<td><strong>dashboards</strong></td>
<td>A dashboard is an information tool that summarises key indicators (for example data), to allow managers to gauge the performance of, for example, an organisation or department. A dashboard typically presents data on the current status, providing a snapshot of performance, as well as enabling access to trends in the data over time.</td>
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<td><strong>FY</strong></td>
<td>Foundation year for junior doctor, for example FY1 Foundation Year 1 – all medical graduates in the UK must enter a foundation programme. This is a 2-year planned programme of training where doctors learn about working in the teams that deliver care in the NHS as well as the clinical aspects of caring for sick patients.</td>
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<td><strong>hospital emergency care team</strong></td>
<td>In NHS Lanarkshire, the hospital emergency care team comprises a team of senior nurses and doctors in training who should work in a multidisciplinary way during the hours of 9pm–9am to support the clinical activity on the wards and for emergency admissions as they present through the emergency department.</td>
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<tr>
<td><strong>HSMR</strong></td>
<td>The Hospital Standardised Mortality Ratio (HSMR) is a measurement tool where crude mortality data are adjusted to take account of some of the factors known to affect the underlying risk of death. The HSMR is calculated as the ratio of the actual number of deaths within 30 days of admission to hospital (irrespective of place of death) to the predicted number of deaths (as calculated by a statistical model). Many countries are now using the HSMR (or an equivalent).</td>
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<td><strong>intentional rounding</strong></td>
<td>Intentional (or care) rounding is a structured process whereby the nursing team visits patients at regular intervals as defined by their care needs. The purpose is to regularly address all their requirements during these visits including physiological observations, pressure area care, food and nutrition and pain control. It offers an opportunity to address a wide range of patients’ needs and has been evidenced to improve outcomes for patients such as falls and pressure ulcers.</td>
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<tr>
<td><strong>ISD</strong></td>
<td>Information Services Division (ISD) is a division of NHS National Services Scotland, part of NHSScotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care and facilitates robust planning and decision-making.</td>
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<td><strong>LanQIP</strong></td>
<td>Lanarkshire Quality Improvement Portal (LanQIP) measures a range of quality processes for SPSP and the Leading Better Care (LBC) programme nursing measures. Seven NHS boards across Scotland are also adopting LanQIP to demonstrate their quality improvement data are collected, assured and drives local improvements.</td>
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<td><strong>minor injury nurse treatment service (MINTS)</strong></td>
<td>Minor injury nurse treatment service is a programme which was launched in NHS Lanarkshire in 2007. It consists of nurses with the skills to deal with minor and major injuries and illnesses and helps reduce the time patients have to wait for treatment at accident and emergency.</td>
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<td><strong>modified early warning score (MEWS)</strong></td>
<td>Modified early warning score is based on data derived from physiological readings and is used to quickly determine when a patient’s condition is deteriorating and therefore requires review. From 2013, this has developed into the ‘deteriorating patient’ workstream of the Scottish Patient Safety Programme that aims to improve the reliable identification and appropriate response to patients whose condition is deteriorating.</td>
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<tr>
<td><strong>NES</strong></td>
<td>NHS Education for Scotland (NES) is 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>
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<tr>
<td><strong>PASS</strong></td>
<td>Patient Advice and Support Service (PASS) is 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>
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<td><strong>PID</strong></td>
<td>A Project Initiation Document (PID) defines a range of key issues for a project such as deliverables and governance structures</td>
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<td><strong>Quality Improvement Hub</strong></td>
<td>The NHS Lanarkshire Quality Improvement Hub provides leadership, strategic direction and drives implementation of quality improvement and NHS Lanarkshire’s Strengthening Quality Strategy, as well as demonstrating the impact of quality improvement initiatives.</td>
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<td><strong>Scottish Index of Multiple Deprivation (SIMD)</strong></td>
<td>Scottish Index of Multiple Deprivation is the Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index. It divides Scotland into 6,505 small areas, called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,505 (least deprived). By identifying small areas where there are concentrations of multiple deprivation, it can be used to target policies and resources at the places with greatest need.</td>
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<td><strong>Sepsis 6</strong></td>
<td>Sepsis 6 is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The following elements are to be completed within 1 hour of the time of presentation with sepsis: 1. Give high flow oxygen</td>
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2. Take blood cultures  
3. Give IV antibiotics  
4. Start IV fluid resuscitation  
5. Check lactate, and  

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<th>SMR01</th>
<th>All NHS acute hospitals in Scotland submit an SMR01 for every inpatient or daycase episode of care. SMR stands for Scottish Morbidity Record, and an SMR01 provides information about the patient's episode of care including the primary diagnosis and procedures carried out. All SMR01 records are submitted to ISD where they are held on a central database.</th>
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<tr>
<td>Scottish Public Services Ombudsman (SPSO)</td>
<td>The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about most organisations that provide public services in Scotland. Their service is independent, free and confidential.</td>
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<tr>
<td>ST</td>
<td>Specialty training (ST) doctors have completed the equivalent of at least 4 years of postgraduate training and who are neither in deanery-approved training posts nor hold a consultant appointment. Specialty doctors work in a specialty area with specific skills for the role to which they are appointed.</td>
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<tr>
<td>WTE</td>
<td>Whole-time equivalent (WTE) is an estimated measurement of the staff resource available, taking into account full and part-time working, for example a staff member working fulltime would be counted as 1 WTE and someone working half the amount of contracted hours per week would be a 0.5 WTE.</td>
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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.