NHS Governance – Clinical Governance
South Lanarkshire Health and Social Care Partnership

1. Are services safe, effective and evidence based?
South Lanarkshire Health and Social Care Partnership (SL H&SCP) aims to provide services that are safe, effective and evidence based. However, it is well recognised that there is a time lag between evidence and therefore, guidelines being agreed and achieving widespread implementation. A historical example of this would be the delay between the role of helicobacter in upper gastro-intestinal symptoms being discovered and its implementation in widespread clinical practice. Therefore some clinical practices are behind the evidence base and this is inevitable. A current example is the delay in changing the use of antibiotics, despite the current guidelines.

There are ever more systems to ensure that safety, effectiveness and evidence base are monitored and improved and these are reflected in high profile data such as hospital standardised mortality ratio, HSMR or rates of hospital acquired infection. These attributes are also reflected in guidelines such as antimicrobial usage guidelines, local formularies and their monitoring. There are many areas of clinical practice which do not receive the same level of scrutiny where the level of assurance is more related to the professional regulation processes than direct monitoring.

General evidence about safety and effectiveness of services comes through the DATIX Incident Management System and our learning and review group. This group looks at all learning opportunities in the HSCP to assist with sharing the learning. Effectiveness is partly a function of the resource used and in the current economic climate there is a substantial drive for effectiveness. There is good evidence of the attributes in the question being taken seriously. However, it is never a finished article and so there will always be the need to work to increase safety with effective and evidence based interventions.

2. Are patients and service users’ perspectives taken into account in the planning and delivery of services?
SL H&SCP takes patient and service user perspectives seriously and many of our groups have patient representatives, specific service users and carers’ representatives contributing to them at high level. However, not all groups have this facility. We actively encourage feedback on a routine basis and this information can be taken in to account in the planning and delivery of services.

Getting appropriate user input is difficult as the numbers of users contributing in this way can be less than the opportunities available. Therefore we need to be very careful to make best use of this potentially scarce resource. As an example, we have recently used feedback from users in improvement in the treatment room services.
3. Do services treat people with dignity and respect?
SL H&SCP within a clinical context (and not addressing the care governance context) aim to treat people with dignity and respect. This forms part of our induction programme and ongoing education and the effectiveness of this is picked up through feedback, complaints and compliments. Within a governance context we continue to develop the easy feedback mechanisms for patients and the direct measurement of compliments as well as complaints. The DATIX system also contributes to governance on such issues.

4. Are staff and the public confident about the safety and quality of NHS services?
Services from time to time do not deliver or are perceived as not delivering to the high quality that we would all aspire to. The current availability of fast news and unregulated dissemination of information which is not necessarily completely accurate via social media and similar, results in members of the public, seeming to be at times inappropriately not confident about the safety and quality of NHS services. There are many people who receive excellent services and are highly satisfied. Periodic national surveys support the high regard in which safety and quality of NHS services are held by staff and public.

There are a few areas in which staff and the public are realistically less confident about the safety and quality of NHS services and broadly speaking these include issues related to:

1. Availability of staff. This is often a national issue
2. Availability of funding. Where a specific service has not reached a priority level sufficient to warrant further funding
3. System challenges relating to the exchange of information across boundaries e.g. medications.

The Scottish Patient Safety programme has demonstrated improvements in safety and effectiveness for many areas throughout the National Health Service with very good international comparisons. This should give confidence to staff and public despite the infrequent episodes of less than ideal care and service.

The continuing work of the Scottish Public Services Ombudsman and continuing evolution of the complaint process should increase confidence.

One of the confidence issues can be exemplified by the use of medication. We are taking on and developing the ideas of Realistic Medicine in terms of realistic prescribing, which is supported by many of our patients and service users. It is recognised that that effective medications all have their downsides for some individuals and the use of extensive polypharmacy regimes are problematical on a number of levels. This is a governance safety and efficacy issue. However there are
also interpreters who suggest this agenda is driven by cost cutting and aiming to get cheaper lower quality medications. This is illustrative of the breadth of views that come in to play in terms of staff and public confidence.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?
In South Lanarkshire Health and Social Care Partnership we recognise that quality care is more effective and more efficient even where short term costs may be incurred. We therefore use these parameters to drive decision making despite the financially challenging environment.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?
The ideal system would make it easy to do the right thing and difficult to do the wrong thing, plus having a mechanism for detecting care which falls below an acceptable standard. In reality this descriptor can only be applied to a very few quite specific pathways of care and these are hard to track within a community and primary care context. In general examples of this kind of system include the specific cancer report regionally or nationally with aligned standards and they have helped to improve processes and data recording.

Moving along the scale of a system, there are audits performed regularly e.g. on case notes which will detect reduced quality of care in terms of recording. Further along the systems spectrum are any multi disciplinary team or uni disciplinary team meetings where cases are discussed. The rise of this culture has helped to ensure that full range of care to an acceptable quality is in place. Finally the professional regulations systems for clinicians are designed to detect unacceptable quality of care but it is impossible to quantify any impact from these systems.

Given the range of mechanisms available the addition of new mechanisms seems unwarranted, but making best use of the existing systems is preferable.