The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 168,000. In Scotland, the BMA represents over 16,000 members.

We welcome the opportunity to provide written evidence to the Health and Sport Committee on phase two of their inquiry into NHS Governance looking specifically at clinical governance.

**Are services safe, effective and evidence-based?**

Given the breadth, scale, scope and complexity of NHS activities across Scotland this question is impossible to answer comprehensively or with a simple ‘yes’ or ‘no’. The picture is mixed.

There are some clearly identifiable intrinsic risks and presumptions in the current NHS ‘system’ that are completely ignored and should be addressed.

The arbiters of the service are also the providers of the service in most instances (the health board acts as its own safety and quality controller for the most part) which clearly is a potential conflict of interest and a significant risk when things are going wrong or the system is under tension.

The pressure for ‘only good news’ to be escalated is worryingly prevalent and may mean that areas of concern are not always raised because of a perception they will not be well received by senior management.

Whilst evidence-based practice is a good standard to aspire to, there needs to be an enhanced awareness that we do not have an evidence base for everything we do in the health service that is nevertheless valid.

There are many aspects of care that cannot be proven in a clinical trial but are still valuable activity for the health service to be engaged in. We should be looking for appropriate evidence bases for activities whilst at the same time accepting this is not possible/desirable for everything we do - and we cannot assess effect wholly on (often pseudo-scientific) scores and measured indices.

There is a near complete disconnect between the high-level strategic risk management activities that nationally and regionally dominate management and the 'shop floor/coal face' activities of the service. All too often this results in a
top-down approach with decisions taken at this level being foisted on to the medical workforce without appropriate consultation or consideration of the impact, including unintended consequences for staff and the service they are providing.

Senior management at health boards could improve their processes for involving the people who will be impacted by various changes and initiatives at an earlier stage. Failure to do this can often result in a draconian interpretation and implementation of new ‘rules’ which adversely impact on patient care and staff morale.

Invariably this results in time spent trying to negotiate a ‘reinterpretation’ of what was meant and protracted efforts to find a workable solution – all of which adds to a sense of frustration and confusion for those caught in the crossfire as well as time wasted.

The culture within the NHS in Scotland does not encourage staff at any level to challenge perceived wisdom or ways of doing things to establish if they continue to be effective or could be done differently. This can result in a lack of fresh ideas or willingness to address approaches which are not working well for fear of being seen as ‘non-compliant’.

There is a very variable level of engagement with medical advisory committees as we have previously highlighted in evidence sessions to the health and sport committee. This should be addressed by re-emphasising the importance of health boards adhering to their statutory obligation to consult with Area Medical Committees on clinical issues. There is more detail on our views about the importance of senior medical input into board decisions in the research commissioned by BMA Scotland in 2015 to garner the views of consultants’ changing work experience. ¹

In terms of safety this can depend on a range of issues. In A&E for example, whilst efforts have been made to help improve safety, including increased staffing, emergency departments still get overwhelmed on a regular basis. An influx of patients, particularly a large number of ill people who require a lot of nursing and medical input, and delays in moving patients out of the department due to blockages elsewhere in the service puts immense strain on the system and the staff.

Overnight, ward nurse staffing is often so limited that requests for an extra pairs of hands may go unanswered. Although A&E staff are asked to report such problems and ask for assistance when required, when that help is not forthcoming and the situation is not addressed over long periods of time, it is

very frustrating and demoralising for staff. It is likely that this is replicated in other busy hospital wards outwith A&E.

This experience of being routinely short staffed means that the medical workforce is not able to be consistently confident about the safety and quality of the service which they are able to offer. This undermines morale and is one of the reasons staff leave. Increasing staff numbers is meant to help, but if it’s the experienced staff who leave, there is still a deficit.

In the circumstances we work in currently, safety is hugely dependent on the availability of experienced staff, across all groups, who can make complex judgement calls in challenging operating environments, often in a limited timeframe.

The ongoing issues around recruitment and retention of medical staff mean that those currently working in the system are under more pressure than ever as they deal with the difficulties caused by unfilled posts and the commensurate rise in already unsustainable workloads. Inevitably this will have an impact, not only on patients' safety but also on staff welfare and wellbeing.

Often it does seem that having processes in place for reporting such issues takes precedence over dealing with resolving the problems.

**Are patient and service users’ perspectives taken into account in the planning and delivery of services?**

There is clearly a level of engagement delivered through patient groups, feedback and formal mechanisms for public input to board decisions.

However, the extent to which the average patient is truly engaged is extremely limited. We have almost no capacity as doctors to capture routine feedback on services from patients using the service. This is evidenced by the issues we face in gathering relevant data of this kind for our own medical revalidation.

**Do services treat people with dignity and respect?**

For the most part yes. There is a high level of awareness amongst all health care professionals about the need to deliver a service with dignity and respect and that is what staff strive to achieve, often in very difficult circumstances.

To that end, dignity and respect are maintained as much as possible, but this is difficult to achieve when capacity is overwhelmed and patients who should be receiving treatment in a room are receiving it behind a screen in a corridor.

The capacity to deliver information to, and engage in, useful conversations with non-English speaking patients and families is highly variable. There is
considerable pressure to 'get on with it' and use family members or sub-optimal telephone translation services when an interpreter would clearly enhance the explanation/interaction.

None the less, telephone interpreter services can be helpful for communicating with patients in a way that they would expect and which allows them to understand what is happening. This can be a more dignified and professional option than having to use friends/relatives to interpret, which is generally not appropriate when discussing health issues. But the actual presence of an interpreter would make patient-staff interactions so much better on many occasions.

When capacity is exceeded by demand the dignity/respect aspect of caring for patients often suffers at the expediency of delivering a safe service – one example would be not having enough staff rostered to open teenage specific bays so they may end up sharing with much younger children which is far from ideal. For emergency mental health admissions patients frequently have to wait hours for a bed, and often they have to be sent many miles from home and family at the very time when they are at their most vulnerable. There are numerous other examples across services where lack of capacity means that patients who would benefit from being in a particular ward may not be able to be accommodated at the appropriate time.

**Are staff and the public confident about the safety and quality of NHS services?**

For the most part yes. However some initiatives such as the ‘naming and shaming’ of hand washing performance at ward doors can lead to a profoundly negative impact on ward staff and patients alike without any evidence that these ‘results’ are having any kind of detrimental impact on patient care.

Doctors also receive feedback that the ‘corporate-speak’ used to answer complaints can affect the public’s confidence in the quality of services. Platitudes that fail to answer the concerns raised by the complainant sap confidence in the system and can lead to patients feeling like their concerns have not been truly ‘heard’.

Patient safety should always be the priority in the NHS and staff have a responsibility to raise concerns if they believe that somebody’s safety is in danger. In previous written evidence to the committee on the NHS Scotland Staff Governance Standard we said that it was essential that whistle-blowers have legal protection and have confidence that they will not face any detriment as a result of speaking out.

In particular we highlighted specific issues under current legislation on whistleblowing affecting junior doctors.
Under current legislation on whistleblowing, junior doctors have the right to take their employer to an employment tribunal if they do suffer any detriment as a result of their whistleblowing. However, junior doctors are in a unique position, with the exception of GP trainees, of being employed by a territorial health board while NHS Education Scotland (NES) have overall responsibility for their training.

Given that the majority of junior doctors are not employed by NES, they do not have the equivalent legal protection if they were to suffer detriment from NES as a result of whistleblowing that they would have if they were mistreated by the territorial health board that employs them.

NES play a significant role in the career prospects of junior doctors during the course of their training, including the provision of their national training number without which they cannot progress through their training.

In England, the BMA has reached agreement with Health Education England (HEE) that a junior doctor who whistleblows will now have legal protection from any action taken by HEE that has a detrimental effect on that junior doctor. HEE has agreed to take on legal liability for ensuring that whistleblowing trainees do not suffer detrimental treatment as a result of their action, giving junior doctors the option of legal recourse if any detriment was to take place.

BMA Scotland has asked NES to agree to equivalent protection for junior doctors in Scotland, as we believe that the current whistleblowing policy that NES has in place is not sufficient to give junior doctors the option of legal recourse in the event of mistreatment by NES.

The BMA’s Scottish Junior Doctor Committee representatives have met with NES and have reached a shared agreement to work together to achieve an effective solution to this issue and this work is underway, recognising the different legal positions in England and Scotland and legislation currently going through the Scottish Parliament. We have also shared our legal advice on the matter in a bid to develop a resolution which will provide appropriate legal protection for junior doctors.

Do quality of care, effectiveness and efficiency drive decision making in the NHS?

Yes - and for the most part we work in a service where ‘quality’ still trumps ‘efficiency’ - however the very significant financial stringencies now faced by NHS boards throw that into sharp relief. There are plenty of examples where we are increasingly forced to make difficult decisions that risk compromising the clinical needs of patients because of the pressure on resources. Implicit rationing is all too common and directly opposes the principle of equity for all patients.
Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

Again given the number of systems in place covering a myriad of issues it is hard to give a definitive answer that covers every instance. But we can say that there is clear signposting for where to go with a ‘this is not safe’ issue. That said, when you raise the spectre of a problem you may well face criticism for doing so, or lip-service is paid to addressing it. Furthermore, the systems (such as they are) don’t really ‘detect’ as much as ‘respond to’ issues that are presented.

There is a fundamental problem in the health service that often responses seem capable of going only one of two ways, either a ‘red alert’ full-on response or no palpable response or action at all where no-one listens to any of your concerns and management take no steps to address the issue. If you don’t have the very urgent ‘red alert’ issue to report then there is very limited capacity to feed concerns in and get an answer that goes further than an acknowledgment that you have raised an issue.