NHS Governance – Clinical Governance

The Royal Society of Edinburgh

Introduction

This paper was prepared using the expertise of a Working Group which consisted of Royal Society of Edinburgh (RSE) Fellows and Young Academy of Scotland members. The Advice Paper has been approved by the General Secretary of the RSE, Professor Alan Alexander.

This paper seeks to make a valuable contribution to the inquiry and to provide a means of informing public debate and awareness on clinical governance in the NHS. The RSE recognises that this call for evidence is part of a more comprehensive inquiry into NHS governance in Scotland. While there are three stages of the calls for evidence, it is clear that there will be clear connections among them. The RSE welcomes the inquiry and notes that to date there has been no significant crisis in the Scottish NHS similar to crises that the NHS in England has experienced. Conducting this type of inquiry before any major crisis occurs in Scotland is encouraging and should be considered as well timed. It would be expected that this inquiry could help the Scottish NHS to become more resilient in the long term.

It should be noted that the questions included in this call for evidence can be viewed as general questions about the overall performance of the NHS; in the context of the inquiry this response will answer on how clinical governance can affect the performance of the NHS. Within this response the RSE has included recommendations within the answers and these are bulleted at the end of each answer for clarity.

Questions

1. Are services safe, effective, and evidence-based?

This question seeks to assess to what extent services are safe, effective and evidence based it does not attempt to determine if services demonstrate any, or more, of these attributes. Services remain relatively safe and effective, as is demonstrated by the fact that in Scotland there has been no significant “patient safety” crisis. However, this does not mean that the service is completely safe as there are clear risks that face services in Scotland mostly relating to workforce numbers. Several professions are stretched, with General Practices in particular facing unsafe workload pressure. This may be down to a mismatch between what is
being required of the frontline clinicians and the level of support provided to deliver the service\(^1\). We believe that workforce numbers are a significant issue and that better workforce planning and skill mix are key to improving the health service in Scotland. However we do not comment on them in detail as we are aware that a separate enquiry is underway on this issue.

Evidence is critical to allowing the patient to make an informed choice and this should be provided in an accessible format and communicated clearly. The more information that is available to the patient outwith the consultation, the better the patient can be informed. Improving the access to reputable evidence could lessen pressure on frontline services. NHS England has effective online portals and these provide a good example of how evidence can be effectively communicated Scotland could learn from this example.

Communication between professionals involved in patient care is also important. Communication could help improve the efficiency of the service and relieve pressures from frontline services. However, there are clear failures in communication within services. For example poor communication between the different teams responsible for patients’ can lead to avoidable errors. Despite having the ability to link almost all health system patient contacts in Scotland, we are not yet doing so. In those areas of care where better communication is enabled, such as in diabetes, the care is more effective and evidence based\(^2\). John Halamka the Chief Information Officer of Beth Deaconess Medical Centre Harvard Medical School is part of group advising how to make better use of Scotland’s Health IT capabilities\(^3\). Some of the recommendations are likely to be similar to the exercise undertaken by the NHS in England\(^4\).

The available evidence on clinical care strategies is poorly used and the care experience is poorly captured, resulting in missed opportunities, wasted resources, and potential harm to patients\(^5\). The Commonwealth Fund recently estimated that there are seventy-five avoidable deaths for every 100K people in the UK’s health system per annum\(^6\). The evidence base does not always effectively inform services. For example randomised trials may not take into consideration those with multiple morbidities who are receiving a range of medication. This is due in part to the stringent Medicines and Healthcare products Regulatory Agency (MHRA) rules governing clinical trials which tightly control patient recruitment strategies for new

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\(^5\) The Path to Continuously Learning Health Care in America (2013) by the National Academy of Sciencesx National Academies Press, Washington, D.C.

\(^6\) C. Schneider, E; Sarnak, D; Squires, D; Shah, A; Doty M. (2017), ‘Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care’. 2
treatment registration. This may require health services to think about how relevant evidence is for people with multiple morbidities. This could become more of a concern as the ageing population dramatically increases. Currently there are good examples of data being brought together which is helping inform the work on multiple morbidities and polypharmacy (patient use of 4 or more medications), a good example of this is the work of Professor Bruce Guthrie of the University of Dundee. Additionally, we recommend that there should be better learning between health boards on effective strategies, and that all interventions, both clinical and managerial, should always be evidenced based.

Evidence from routinely collected patient data is fast becoming a significant resource which can be used to great effective in the NHS. Investigations or research into how routine data could be used to track health care systems in real time should be expanded and could improve the effectiveness of care. There are examples showing the effectiveness of collating data to improve healthcare such as the decrease in diabetes amputations across Tayside Health Board\(^7\) and the role of Scottish research helped identify what caused the C Diff infection problem leading to a reduction in deaths from the infection\(^8\). These are good examples that can generate good publicity over the role of data and could change the perception of sharing data.

It is essential that areas of good practice are effectively disseminated and implemented so that the benefits are available equitably. Provision of more clinical data in real time could help improve the provision of community care allowing it to be more targeted, this data could be used in general practice to improve the efficiency of healthcare. More generally there needs to be a focus on identifying how data can benefit the NHS and raising awareness of this. There are already examples of how collating big data has helped in new treatments and improved services. Therefore collating data across all health boards and across different service providers (e.g. GP, secondary care, social care) should be a priority. There should be discussion with the public to highlight the benefits of increasing appropriate access to identifiable data, and greater sharing of anonymised data with a view to sharing of good practice.

In measuring the efficiency of services, the RSE understands that it is difficult to measure efficiency for although there are surrogate markers which have a correlation with the clinical endpoint, and may help to measure some effects, they do not capture all aspects. Research could identify a range of clinical indicators that could measure efficiency and effectiveness of services and process indicators which might be proxies for or early warning of important issues. For examples, Hospital Acquired Infection (HAI) rates might be relevant clinical indicators; handwashing rates might be proxy/ process indicators. There are already some good examples of this with Health Improvement Scotland (HIS) inspections assessing hospital safety

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and cleanliness, death from sepsis, and management of venous catheters\textsuperscript{9}. These are all significant initiatives which already illustrate improvements in the health service. Consideration should be given to further indicators which could be published in real time, and also to those which might be useful for international comparisons. Examples of the latter might be the health care outcomes used in the Commonwealth fund comparators\textsuperscript{10}.

- The NHS should look into new ways to make reputable and reliable information and evidence more accessible to the public, as this could reduce pressure on frontline services.
- Communication between levels and areas of care should be improved; efforts should be made to better use IT to improve communication. The example in NHS England portals could be followed.
- The NHS should ensure that evidence of good practice with enhanced outcomes is disseminated throughout the service.
- Health services should consider the relevance of evidence especially to patients with multimorbidity.
- Collating data across multiple services and health boards should be a priority.
- There are good examples of data already; these, together with future examples, should be promoted to change perception of the usefulness of data.
- Research should be commissioned that would help identify clinical indicators that could provide a better measurement of effectiveness.
- Consideration should be given to further indicators that could be published in real time.

2. \textit{Are patient and service users' perspectives taken into account in the planning and delivery of services?}

Patient and service users’ views should continue to be taken into account in the planning and delivery of services. However, the RSE notes that this is the subject of a separate consultation\textsuperscript{11}. There are clear barriers to gathering patient and user feedback that could help plan the effective delivery of services. Across a proportion of patients there is a lack of understanding of how the services are provided and the circumstances of what specific treatment they should receive. Clinical governance could help patients and users improve their understanding of service structure but greater improvement will require action in a range of areas particularly education, starting in the schools, about health and how to improve and maintain it. Improving


the knowledge and understanding of patients and users of the service they receive will help to improve the level and quality of the feedback they provide.

Currently there is a lack of mechanisms for gathering the voice of the patient and user (including potential users). This helps create a vacuum in which the voice that is commonly heard is not that of the patient but those of activists and professionals. There needs to be consideration of how to significantly improve mechanisms that will take patient perspectives into account. One method that could be considered is random sampling of patient experiences which could be compared to other areas. This data should be collected independently.

Consideration of the patient and public perspective needs to address the challenge in balancing perspectives and experience of health services users with implementation of radical (but perhaps more effective) solutions. For example, the increase in unscheduled care is placing A&E departments under significant pressure and, a lack of information and evidence available to patients may be driving this increase. As a result, patient feedback may indicate support for extensive boosts to A&E resources rather than an increase in resources for community care. On the other hand, a balance must be achieved. The opinions of patients and users are important, but they should also be weighed against opinions of healthcare professionals, trained in the area, and evidence based research into the future direction of healthcare. For example, an increasing ageing population with multimorbidity and poly-pharmacy indicates that the future of care provision is likely to change. Closing down a district hospital may not be popular within the local community, however the increasing complexity and cost of diagnostic equipment means centralisation of secondary care resource may be necessary. This could also free up resource for better Community Care. Changing the public perception of community care and its effectiveness could help in changing future care provision.

We recommend that patient based measures of care (both health and social care) should be developed and reported in real time, alongside clinical and process indicators, to better ensure that the patient perspective is taken into account in service delivery. Consideration should also be given to measuring the ‘treatment burden’ - for example multiple appointments on different dates – for those with multimorbidity, as a prelude to developing strategies to reduce this.

- Improving education in schools and beyond about health could help to develop patient and user understanding of care.
- New mechanisms should be sought that would significantly improve the gathering of the patient and user concerns. One method could be random sampling of patient experiences.
- There should be consideration of the patient and user perspective and how these align with future priorities in the provision of care.
- The NHS and Scottish Government should look to improve the perception and performance of community care.
- Patient based measures of care (both health and social care) should be developed and reported in real time.
• Consideration should also be given to the treatment burden for those with multimorbidity.

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

Again similarly to the first question, this should ask ‘to what extent’ rather than invite a yes or no answer. Generally complaints data are used to access whether services are treating people with dignity and respect. Most patient surveys suggest services do treat people with dignity and respect though legal cases and more detailed anthropological studies often reveal a more disturbing picture\(^\text{12}\). Scotland has several policies to support dignity and respect for patients and there are organisations which are trying to ensure such dignity and respect. However there seems to be no stream of data from high quality anthropological studies trying to illuminate into this area.

The RSE welcomes the work of HIS around dignity and respect in healthcare, assessed through their inspections. HIS, the Scottish Government and the Care Inspectorate all have a duty to assess services in such a way as to determine this and it is welcome that they are working on revised national care standards for Scotland. This work is at the start of identifying measurable data that will determine if services treat people with dignity and respect. RSE would recommend that satisfaction data need to be monitored more closely. Satisfaction rates may vary dependent on demand particular kind of care, some professionals will be able to spend significantly more time than others, and therefore looking at the specifics should be encouraged. For instance clinicians who manage to spend a significant amount of time with patients will likely receive better satisfaction rates: those working in hard pressed services with inadequate workforce will engender poorer satisfaction scores. There are several other factors that should be considered in assessing patient and user surveys. Generally there is a lack of understanding of resource and staff constraints and of the fact that the culture of the organisation can lead to specific behaviour. Low staff levels in pressed environments lead to poor morale and burn out. Improving resources, organisational culture and staff levels would most likely improve satisfaction rates across NHS users and help identify precisely where services are not treating people with dignity and respect.

• There should be work to improve the data that could help inform whether services treat people with dignity and respect.
• Satisfaction data should be monitored more closely by looking at the specifics that could help identify satisfaction rates relative to area of care taking demand pressures into consideration.
• Improving understanding of resource and staff constraints and how this leads to staff behaviour should be a priority.
• Improving organisation culture and resources would be a quick and effective way of improving the provision of care.

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

Similarly, staff surveys provide a good indication whether the staff are confident in the safety and quality of NHS services. Opinion polling and studies of public opinion also help indicate the level of confidence in NHS services. Currently it appears that the infrequent studies undertaken to monitor this often have low response rates with questionable generalisability. Staff surveys in England have a good indicator in asking staff if they would like their family, friends or relatives to be treated in their hospital. This is an indicator that could be included in future staff surveys in Scotland.

Within the feedback from surveys of staff and the public there will be differences that need to be considered. For example elderly care patients may be more content with their overall safety rather than quality, and it is often the case that they are uninformed about their safety; therefore surveys may not be entirely accurate. Moreover, there may be a difference of opinion between staff and the general public as they have different priorities and knowledge surrounding healthcare. Patients may give more weight to details which could be considered “superficial” (for example, the quality of the food, or reading materials) rather than the quality of the health care. Although most details carry a level of importance, some are more likely to have a direct effect on safety and quality. Hence the sharing of data and evidence could help inform patients and help to properly assess their confidence in the safety and quality of the NHS. Sharing more data and evidence to inform staff and the public should be recommended, and high level data should be used to inform authorities’ future decision making. In addition to quantitative data, the RSE recommend that qualitative data drawn from narrative reviews are useful for understanding the patient experience, and should be considered.

The RSE recognises that it is difficult to capture the overall performance of the NHS due to the complexities of the service. However there could be a benchmarking process which identifies what has been done and what can be done in future to improve performance, an example of where this is already used is in the HIS led inspections, where ‘findings’ have decreased as inspections take place. Professional satisfaction is important to patient wellbeing and safety and the RSE would recommend that staff receive the proper support to speak out if they identify bad practice. Commissioning research into more measurable indicators (including those which measure integration between health and social care) could help to show more clearly the performance of the health service in the opinion of both staff and the public.

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• Studies are infrequent and often have a low response rate; efforts should be made to improve frequency and participation. This may involve targeting surveys.
• The questions asked in surveys should be reviewed and new additional questions that would give a better indication should be considered.
• Data and evidence should be shared more widely with patients and staff to help inform their understanding of care. This could, in turn, lead to better responses to surveys.
• Narrative reviews are useful for understanding the patient experience, and should be considered.
• Staff should receive the proper support to speak out if they identify bad practice.
• Research should be commissioned into identifying more measurable indicators, particularly for measuring the integration between health and social care.

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

The RSE understands that a lot of decisions are driven by cost / benefit efficiency; this is clear in the level of importance authorities place on senior managers within the health service on financial management. The RSE would recommend that quality and effectiveness of care should be prioritised as much as efficiency in driving decision making in the NHS. Placing a higher level of importance on efficiency could increase the risk of major crises that would bring services to media attention and scrutiny.

The RSE would recommend that in considerations of improving healthcare equity is fully considered, as improving quality in certain areas of the system may come at the expense of another area or group of patients. Inequity in healthcare is an important determinant of inequalities in health, and this may result in the NHS becoming part of the problem and not the solution.

A more quantitative approach in measuring what has not been done could help improve the quality of care as it could show what the health care system needs to do to improve. For example, although there may be an overall satisfaction rate with the service, quantitative data would be able to define markers to help identify when poor care occurs. The results could give an indication of what could be done to further improve care and satisfaction rates.

• Quality and effectiveness of care should be prioritised as much as efficiency in driving decision making.
• Equity should be included in the considerations of improving health care.
• Using a quantitative approach could help identify further areas in which provision of care and satisfaction could improve.
6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

The RSE understands that there are several bodies and specialists who can investigate when things go wrong in healthcare. The DATIX systems have been reconciled and are now the main reporting system by which data on incidents are collected with more overlaps with case records and national indicators across all health boards. The RSE would recommend that methods should be explored that would support staff who raise awareness of poor practice.

For England the Department of Health set up in 2017 an independent Healthcare Safety Investigation Branch (www.hsib.org.uk) that will work to investigate safety incidents. This example could be considered for application in Scotland. Currently, there are several bodies which effectively investigate professional malpractice such as the GMC for doctors. However there is not a similar body which independently investigates system failure. The RSE recognises the work of HIS, the Care Inspectorate and the Kings Fund in carrying out investigations into health services in Scotland. This work is useful but it does not cover everything, and the RSE would recommend that these organisations are empowered to expand their remit to support more robust investigations. More support could be provided by the Scottish Government to do this.

Some systems are likely to have significant gaps in areas relating to inequalities e.g. low socioeconomic status in particular\textsuperscript{14}. Defence Union newsletters provide specific advice on issues they wish to highlight but a more proactive approach to learn from all cases that go wrong, as was done with Surgical or asthma deaths would provide the basis for iterative improvements to be developed, implemented and evaluated\textsuperscript{15}.

Data will be crucial for measuring the quality of care, where analyses can show underperforming areas and the development of technologies such as algorithms and artificial intelligence may help to detect unacceptable quality of care. The NHS in Scotland should look to identify any opportunities in which data and technology could improve the quality and safety of future health care provision.

- The DATIX system should continue to be used and collated so as to identify national indicators of poor practice or adverse events.
- Greater support for staff who chose to raise awareness of poor practice through whistle blowing.
- Scotland should look to develop its own independent healthcare safety investigation body similar to that in England.


- The remits of HIS, Care Inspectorate and the Kings Fund should be expanded to allow them to conduct more robust investigations.
- Research should be carried out to identify future use of data and how it can improve healthcare provision.

Additional Information

This Advice Paper has been signed off by the General Secretary of the RSE.

All responses are published on the RSE website (www.rse.org.uk).