HEALTH AND SPORT COMMITTEE

AGENDA

27th Meeting, 2017 (Session 5)

Tuesday 21 November 2017

The Committee will meet at 10.00 am in the James Clerk Maxwell Room (CR4).

1. **Declaration of interests**: Ash Denham and Emma Harper will be invited to declare any relevant interests.

2. **Choice of Deputy Convener**: The Committee will choose a Deputy Convener.

3. **NHS Governance**: The Committee will take evidence on clinical governance from—

   Dr David Chung, Vice President, Royal College of Emergency Medicine Scotland;

   Dr Peter Bennie, Chair, BMA Scotland;

   Sara Conroy, Professional Adviser, Chartered Society of Physiotherapy representing the Allied Health Professions Federation Scotland;

   Lorna Greene, Policy Officer, Royal College of Nursing (Scotland);

   Dr Gordon McDavid, Medicolegal Adviser, The Medical Protection Society.

4. **NHS Governance (in private)**: The Committee will consider the evidence heard earlier in the session.

5. **Sport for Everyone (in private)**: The Committee will consider a revised draft report.

6. **Work Programme (in private)**: The Committee will consider a briefing on preventative spend session.
David Cullum
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: david.cullum@parliament.scot
The papers for this meeting are as follows—

**Agenda item 3**
PRIVATE PAPER HS/S5/17/27/1 (P)
Written Submissions HS/S5/17/27/2

**Agenda item 5**
PRIVATE PAPER HS/S5/17/27/3 (P)

**Agenda item 6**
PRIVATE PAPER HS/S5/17/27/4 (P)
The Royal College of Emergency Medicine Scotland (RCEM Scotland) is the single authoritative body for Emergency Medicine in Scotland. The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Are services safe, effective, and evidence-based?

1. NHS Scotland’s medical workforce faces a significant challenge to meet the health needs of a growing and ageing population. Scotland’s population is projected to rise by 7% in the next 22 years and the number of people aged 75 and over is predicted to grow by 85% by 2039.¹

2. Accompanying this growth is an increasing propensity to access the health and social care services, including Emergency Departments (EDs), which can place more pressure on the system and compromise patient safety.

3. Partly due to this increase in demand, it is noticeable that we have seen a gradual deterioration in 4-hour performance when compared to five years ago. Whilst this might not seem very significant on the face of it, when we look at the 8-hour and 12-hour performance data, we can see that there are still a substantial number of patients left waiting in busy and crowded EDs for eight hours, or more.²

¹ National Records of Scotland, Projected Population of Scotland (2014-based), Published in 2015
² ISD Scotland, Emergency Department Activity
4. Longer waits in Emergency Departments are associated with higher mortality rates, whilst they also highlight the deeper issues of patient flow through the hospital and congestion in hospital wards.³

5. Nevertheless, over the last couple of years, performance in Scottish Emergency Departments has improved and Scotland continues to have the best Emergency Department 4-hour performance among the UK Nations.

6. This enviable performance is due to a number of reasons including support from colleagues in other hospital departments to ensure patient flow and an evidenced based approach to workforce planning. Indeed, the emergency medicine workforce has risen to keep up with demand: in the space of six years, the number of whole time equivalent emergency medicine consultant staff has increased by 68%, from 131.2 WTE in March 2011 to 220.6 WTE in March 2017.⁴

7. This increase in senior staff has been translated directly into providing more cover to the out of hours period, when EDs are busiest. Emergency Medicine is the only specialty which has achieved this. There is a Consultant present on the ‘Shop Floor’ deep into the night in most EDs now. This has improved patient safety, especially when compared to the past. Consultant cover has also been extended during weekends and public holidays which, due to a reduction in staffing elsewhere in the NHS, still pose a significant safety issue, including creating a backlog of work impacting on the ‘normal’ week.

8. The RCEM Scotland believes that this improved performance points to the beginnings of a safety culture in NHS Scotland. However, limits to resources within both the social care and health care communities mean that Exit Block and ED crowding can still be an issue, causing harm and motility to patients and poor patient experiences. Whilst emergency care services are safer and more effective than ever before, we still have a substantial way to go to ensure that the 4-hour standard is constantly met.

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

9. A commitment to deliver high quality, patient centred care should be at the heart of every health care team. However, currently there is insufficient data to understand patient journeys, meaning that the planning and delivery of services are sometimes not well informed.

10. Patient experiences are not robustly collected in Emergency Departments for a variety of reasons. For example, due to the nature of emergency care, patient experience data is hard to collect: the ED is a dynamic place and both patients and staff are in constant motion, making experience data collection difficult and sometimes inappropriate.

11. It is arguable that this lack of research hinders the improvement of patient journeys. When dedicated staff have been involved in shadowing exercises very high-quality feedback is revealed. These exercises are most valuable following the whole patient journey, not just within the walls of the ED.

12. Furthermore, the lack of accessibility to patient care records and variability means that the patient journey is sometimes compromised. If patient records were standardised, health care

³ C. Sullivan, The National Emergency Access Target (NEAT) and the 4-hour rule (2016) and Nuffield Trust, Understanding patient flow in hospitals (2016)
⁴ ISD Scotland, NHS Scotland Workforce Information, Consultant staff in post
plans would be formulated earlier, making the transition from hospital based care to community services more timely and efficient, improving patient outcomes overall.\(^5\)

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

13. Health and social care staff constantly aim to treat patients with care, dignity and respect. However, due to resource constraints and poor patient flow within the health and social care system, this is sometimes difficult to achieve.

14. As already stated, there are still a substantial number of 8-hour and 12-hour breaches in Scottish Emergency Departments.\(^6\) The difficulty of meeting the four-hour standard of 95% has been shown comprehensively to be due to “Exit Block”.\(^7\)

15. Exit Block is symptomatic of other issues. It is directly connected to timely flow into, as well as the timely availability of, appropriate beds in a hospital or social care in the community.\(^8\) Exit Block is particularly pernicious as a reduction in operational capacity leads to crowding. ED crowding is linked categorically to poor patient outcomes, poor patient experience and poor staff morale. Indeed, the issues of Exit Block, ED crowding, and under capacity across the acute care journey as a whole, causes harm and mortality.

16. In cases such as these, patients can be left on a hospital trolley on a corridor or ward waiting for an appropriate bed to become free for a substantial length of time, without regular or appropriate care. In these extreme examples, patients are not treated with dignity, respect or high-quality care. We must ensure that clinical governance activities help to reduce these prevailing issues.

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

17. Both the Organisation for Economic Co-operation and Development (OECD) and the Nuffield Trust recently concluded that “Scotland is home to a unique culture and set of institutions that seek to improve the quality of health care”.\(^9\)

18. To some extent, the reports are correct: NHS Scotland uses clear methods of testing quality improvements which are overseen by a single organisation, unlike the rest of the UK Nations. This means that initiatives are more likely to be implemented and that many decisions are based on quality of care and efficiency.\(^10\)

19. Furthermore, the Scottish Patient Safety Programme’s (SPSP) objective is to “improve the safety and reliability of healthcare and reduce harm, whenever care is delivered” through in-depth data collection and focused programmes.\(^11\)

20. Nevertheless, the College believes that more time and resources injected into clinical governance is required so that Health Boards can deliver a more robust patient safety programme. At present, some Scottish EDs do not have a clear and organised clinical governance framework which is necessary to drive quality of care decision making.


\(^6\) ISD Scotland, [Emergency Department Activity](https://www.isdscotland.org/)<br>
\(^7\) The Royal College of Emergency Medicine, [Exit Block](https://www.rcem.ac.uk/)<br>
\(^8\) Ibid.<br>
\(^11\) [Scottish Patient Safety Programme](https://www.gov.scot/about/organisations/scottish-patient-safety-programme/)
21. There are several benefits of Positive Reporting, and learning systems such as ‘Learning for Excellence’ in England drive quality improvement and sharing best practice. There is an opportunity for Scotland to initiate this on a national scale.

Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

22. Clinical governance has been described as “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. However, the College does not believe that NHS Scotland has optimised these aims.

23. Some of our Members and Fellows working in Scottish EDs have reported that due to funding constraints, organised approaches to clinical governance have been significantly diminished or abandoned altogether. In some cases, clinical governance departments have been closed and the work distributed among other hospital teams. This has resulted in the delivery of much smaller and fewer patient safety programmes. We are also aware of some CG software support contracts not being renewed, with the c.£7000 a year cost being cited as prohibitive when queried by the suppliers.

24. One of our Scottish Fellows commented: “there is little coordinated, recognisable work in this area across our Health Board. We have become reactive and respond only to serious incidents - the feel is that ‘firefighting' has become the new norm”.

25. It is arguable that a ‘Closed Loop’ system remains in NHS Scotland. The ‘Blame Culture’ is still prevalent and prevents learning from a truly open system. Furthermore, the terms of reference of new systems such as ‘Root Cause Analysis’ are limited. Systemic problems such as staffing or reduction in capacity are placed out of their scope meaning that important data can be missed.

26. The DATIX reporting system (a patient safety system that provides web-based incident reporting and risk management software) has, in some cases, hindered rather than helped. It is not easy to use the system of incident reporting required to drive learning and to help shift the culture further to one which seeks out errors to learn ways to prevent them from re-occurring.

27. Although the College recognises that the safety and quality of Emergency Departments has greatly improved, we should not become complacent, nor should we only concentrate on extreme incidents.

28. The Scottish Government and NHS Scotland should ensure that we constantly strive for improvement, clinical governance teams should be established, or re-established, in every Health Board and patient safety and the quality of services should not be compromised.

---

12 BMJ, Clinical governance and the drive for quality improvement in the NHS
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.
AHPF Scotland believes that there are a number of effective means of ensuring safe and effective care in the NHS in Scotland. The three spheres of clinical governance can be viewed as;

1. An individual's professional accountability for the quality of his/her work, in line with the requirements of their professional body.

2. An individual's professional accountability to the requirements of the organisation in which he/she works

3. The accountability of senior members of staff and management for the organisation’s performance & more widely for its provision of services to service users.

**Amongst the allied health professions, clinical governance measures include:**

- HCPC\(^1\) registration regularly checked
- All practitioners get clinical supervision and CPD
- Electronic knowledge and skills framework (EKSF) used for all NHS staff
- Care and care quality is reviewed through capacity management
- Clinical leads and professional managers responsible for evidence based practice
- Care record audit twice a year
- DATIX reporting system for reporting adverse incidents
- Mandatory training on H&S is provided and monitored
- Boards apply Patient Safety and Quality programmes

The above are examples to illustrate that safety, which is of critical importance to practicing allied health professionals, is maintained and monitored throughout the NHS in Scotland.

**Similarly, allied health professionals practice patient centred care**

- At first appointment, the practitioner focuses on and seeks to establish patient/ carer perspective.

---

\(^1\) Health and Care Professions Council [http://www.hcpc-uk.co.uk/](http://www.hcpc-uk.co.uk/)
Clinical assessment focus on what matters to patient.
Care planning is collaborative and person centred goals are formed
Consistent use of the validated tool the ‘CARE measure’
Proactively seek patient feedback re service, service developments

Challenges, however, arise around clinical governance, when conflicting aspects of patient centred care have to be managed. For example,

- Where staff capacity is inadequate to meet demand, resulting in long waiting times, shorter treatment sessions and pressures to reduce patient contact, and compromised outcomes.
- Staff development, such as continuing professional development (CPD) and eKSF\(^2\) are often the first to be deprioritised in response to unmanageable caseloads
- Evidence based approaches to service redesign, often developed with short-term Scottish government funding, are not continued, regardless of proven clinical and cost effectiveness, due to historical practice and silo working/budgeting.
- SIGN\(^3\) and NICE\(^4\) guidelines, which develop evidence based clinically effective care, are not always implemented, because of costs and budgetary challenges rather than clinical outcomes.
- Longer waiting times created to manage patient demand come with risks to patient safety, such as increased chronicity and bio-psycho-social needs.
- Allied health professions often report being under-utilised when their clinical skills and knowledge are not recognised or accounted for in the design and delivery of services, which can prevent the most effective care from the most appropriate health professional.
- Investment in quality improvement, the development of advanced practitioner roles and national clinical strategies can overlook or underestimate the knowledge, skills, autonomy and contribution of the allied professions.

The Allied Health Professions Federation (AHPF) is made up of twelve professional bodies representing Allied Health Professionals in the UK. The Allied Health Professions Federation in Scotland (AHPF Scotland) provides collective leadership for the professional bodies representing the allied health professions in Scotland. Together the AHP professional bodies represent over 14,000 professionals in Scotland, who make an essential contribution to health and social care.

---

\(^3\) Scottish Intercollegiate Guidelines Network [http://www.sign.ac.uk/](http://www.sign.ac.uk/)
\(^4\) National institute for Clinical Excellence [https://www.nice.org.uk/](https://www.nice.org.uk/)
Background
In order to meet the healthcare quality ambitions for the delivery of safe, effective and person-centred health and care, there needs to be clear clinical governance arrangements in place within boards and integration authorities. In this way, clinical governance systems should serve to make organisations accountable for the continuous monitoring and improvement of the quality of care and services, and ensure the safeguarding of high standards.

The Royal College of Nursing (RCN) is clear that, from the outset, clinicians need to be involved to support the development and implementation of clinical governance arrangements in Scotland's emerging health and social care landscape.

The RCN is concerned around the lack of meaningful engagement undertaken by the Scottish Government in relation to some significant policy directives and service redesign, and the impact that this may have on clinical governance. The RCN has, for example, previously flagged concerns regarding the lack of meaningful engagement around development of the clinical strategy. This strategy will, in turn, inform regionalisation and it is crucial that there is an understanding of how robust and transparent clinical governance arrangements will accompany reform plans and then regionalised service delivery.

It is also important that any further nationally directed processes which may be introduced to provide assurance on the quality of care provided, and support improvement and remediation, are in line with existing clinical governance arrangements. The new National Care Standards, for example, are, as a set of outcomes based standards for best practice, aspirational and ambitious and have the potential to help deliver more meaningful, person-centred care. However, the lack of clarity around how they might be monitored and inspected against in health settings is a concern as it is not explicit how they will sit with existing clinical standards. The RCN does not wish to see the duplication of such processes to monitor standards which would add to the burden of assessment and inspection experienced by health care teams to the detriment of improvement activity. To that end the RCN continues to work with HIS to get the balance between inspection and improvement activity right.

Any new standards or national policies must streamline and support an overarching framework for quality of care that will ensure clarity for both staff and people receiving care.
Are services safe, effective, and evidence-based?
The RCN is clear that people across Scotland need to feel assured that they are in receipt of safe, effective, quality care, regardless of the setting.

The RCN understands that the scope of the Committee’s inquiry is NHS Governance, but believes that it is important to consider how services commissioned and delivered by integration authorities are governed, and whether the NHS clinical governance standards which, in theory apply, are working at a practical level.

For people using services, as well as professionals it is crucial that there is a coherent system of clinical and care governance which covers the whole of health and social care, and which works on the ground, rather than separate systems emerging for integrated and non-integrated services. Given that integration is still in its infancy, it is only now beginning to be possible to see how clinical governance arrangements work in practice across the NHS and integrated services.

The different quality improvement and scrutiny landscape of health and social care is complex, with a multitude of standards, inspection methodologies and policy initiatives being led by a diverse range of organisations. This means that professionals are operating in what can sometimes be a confused arena.

Health Improvement Scotland (HIS), for example, has both an inspection and improvement function, but in order to drive up standards the RCN believes that there must be greater clarity in how the two functions work together.

The RCN has been involved in a number of HIS reviews of standards and methodologies, including the inspection of older people’s care and the older people in acute care improvement programme. The RCN believes that this work is valuable and is supportive of HIS’s Quality of Care Approach which has the potential to better support the delivery of safe and effective care.

Are patient and service users’ perspectives taken into account in the planning and delivery of services?
It is crucial that where there are concerns around the ability to provide safe care, for example because of a lack of nursing staff, that timely and appropriate decisions are made by NHS boards on advice from professional leads to ensure safe, effective care for patients.

The RCN has consistently stated that, given the pressures and demand on the NHS in Scotland, tough decisions will have to be made about what to invest in and what to disinvest from. The RCN has said that these decisions will need to be made, in partnership with the public and with staff as well as political decision makers. In its manifesto ahead of the 2016 Scottish Parliament elections the RCN advocated the creation of a set of clear, consistent and transparent criteria to be used when taking any decision on health care funding.
It is, however, important to recognise that public expectations around where and how services are delivered are not always compatible with rigorous clinical governance. In such instances clinical governance arrangements which ensure safe, effective, quality care must not be undermined by public or political pressure.

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

Nursing staff want to treat all patients with dignity and respect. It is a core part of the Nursing and Midwifery Council Code which governs the professional standards for nurses and midwives. Treating people with dignity and respect is at the heart of person-centred care approach, but the culture, governance and leadership of organisations also has an impact on positive patient experience.

The RCN is concerned that nursing staff do not feel that they have adequate time to spend with patients because of staff shortages. The RCN’s centenary survey of its members in 2016 showed that staffing levels were their biggest concern. ISD statistics published in June recorded Scotland’s highest ever nursing and midwifery vacancy rate - 4.5%.

Given that, the RCN does have significant concerns around the impact of workforce pressures and recruitment and retention challenges on the care that nursing staff are able to provide. The RCN responded to the Scottish Government’s consultation on its workforce plan and many of the issues raised in that response are relevant here.

The RCN has supported the development of Excellence in Care which is a nursing quality assurance framework and believes that this work, led by the Chief Nursing Officer, can go a long way to ensuring that services are safe, effective and evidence-based; that patient and service users’ perspectives are taken into account in the planning and delivery of services; and that services treat people with dignity and respect. This approach does, however, depend upon services having an adequate number of nursing staff.

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

A key purpose of clinical governance is to support staff in continuously improving the quality and safety of care. It does also ensure that wherever possible poor performance is identified and addressed.

The lack of time for nursing staff to undertake CPD is therefore a concern to the RCN. Nursing teams must keep their knowledge and skills up-to-date by taking part in appropriate and regular learning and professional development activities that maintain and develop their competence and improve their performance.

From April 2016 registered nurses must undergo revalidation every three years to remain on the NMC register. As part of this they must have undertaken 35 hours of CPD over three years with at least 20 hours being participatory learning, such as study days, workshops and coaching. CPD also features in the NHS Health Care Support Worker Codes of Practice, NHS Scotland Staff Governance Standards and the Scottish Social Services Council Codes of Practice.
But there is a tension between what staff are required to undertake around CPD and what in reality they are able to do. Employers struggle to release staff because of day-to-day service pressures, and the lack of protected study time means staff are not able to access the CPD they want and need.

The 2015 NHS Scotland Staff Survey showed that less than half of staff surveyed felt they could meet all the conflicting demands on their time at work. Time for CPD and development is not prioritised, with over a quarter of staff not even having an appraisal or development review meeting in the last 12 months. The 2015 RCN employment survey found that 37% of members in Scotland reported not receiving any CPD in the last 12 months.

Other regulated professions, such as doctors, have their mandatory CPD time protected and guaranteed. This should be the same for all members of health care teams.

In its response to the Scottish Government’s consultation on legislation for safe and effective care, the RCN called for the legislation to be focused on ensuring safe, effective, quality care through provision of appropriate staffing. This means that far greater emphasis must be placed on the role of care and clinical governance structures within any safe staffing legislation to provide appropriate, and equal, oversight from staff and clinical governance perspectives.

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

*Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?*

The RCN has put on the record many times its concerns around the efficiency savings NHS boards and integration authorities are being asked to make and the impact that this has on the services being delivered, the health professionals delivering those services, and the people using services.
NHS Governance - Clinical governance
The Medical Protection Society

The Medical Protection Society (MPS) would like to take this opportunity to respond to your request for views on the issue of clinical governance as part of the inquiry into the culture within NHS Scotland. Although not all the questions fall directly within our remit, we would like to provide our views on the last question regarding the quality of care and what should happen when things go wrong.

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world and over 11,000 members in Scotland. We are a not-for-profit membership organisation, not an insurance company. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice.

MPS has played an active role in the Scottish Government’s deliberations on proposals for a statutory duty of candour, and a criminal offence of wilful neglect. We have long called for a culture of improved openness in NHS Scotland. From experience we know that cultural and organisational failure to be open when something goes wrong plays a significant role in clinical quality and rates of adverse events.

Healthcare professionals remain fearful of blame or personal recrimination if they report incidents. We believe that the optimal way to change healthcare professionals’ behaviour is through cultural change: creating an environment of normalising reporting errors and engendering an eagerness to report, investigate and learn from adverse events.

MPS has always been of the view that whilst you can mandate disclosure through legislation, it is not an instrument that would appropriately address the attributes of high quality and open communication. MPS remains concerned that the new legal duty of candour on organisations could become a distraction and may inadvertently result in a “tick-box” process when something goes wrong. This may mean that patients do not get the meaningful and sincere explanation and apology they deserve. It must be ensured that new laws and obligations on healthcare professionals do not themselves add to the culture of fear. Staff should be encouraged to act appropriately when something goes wrong and to feel confident to demonstrate individualised empathy, sincerity, and comprehensiveness in subsequent investigation.

MPS wants to continue playing an active role in ensuring that any duty placed upon healthcare professionals is effectively communicated and that any new requirements assist in fostering an open, learning culture. Our Medical Director, Dr Rob Hendry, is a member of the working group that is developing the duty of candour regulations and we are delighted to be involved in this process and to offer our extensive global expertise in such matters.

When things go wrong, an appropriate apology plays a vital role. We welcomed the Apologies (Scotland) Bill in 2015, although we were disappointed to see that some provisions in the Bill regarding the protection of healthcare professionals have been weakened. It is useful for doctors to know that an apology cannot be used as an admission of negligence. We understand the rational that this may mitigate the fear of recrimination, which can stifle an open approach to errors, but would be concerned that legislation will not provide the requisite cultural change within the workforce. A conversation with a patient after an error is one of the most difficult a doctor can face, but a natural apology and truthful
discussion about what happened plays an important part in helping the patient to heal and move on.

Ultimately we believe that a cultural change within healthcare is needed. A culture where the norm is for doctors to feel able to admit errors, apologise, and learn from mistakes. We need an environment where staff are trained and supported to be open about mistakes and to learn from them, and where senior clinicians lead by example. We welcome a wider discussion on how this environment could best be achieved and stand ready to do our part.

We are keen to work with NHS Scotland in the future on issues such as this to assist in improving patient care and safety by supporting our members and the profession. Improved safety will ultimately help reduce errors and will help reduce complaints and claims in the long-term, which will be beneficial to all.