OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 21 November 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 November 2017

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HEALTH AND SPORT COMMITTEE
27th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Peter Bennie (British Medical Association)
Dr David Chung (Royal College of Emergency Medicine Scotland)
Sara Conroy (Allied Health Professions Federation Scotland)
Lorna Greene (Royal College of Nursing)
Dr Gordon McDavid (The Medical Protection Society)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 21 November 2017

[The Convener opened the meeting at 10:00]

Interests

The Convener (Neil Findlay): Good morning and welcome to the 27th meeting of the Health and Sport Committee in 2017.

I ask everyone to ensure that mobile phones are switched off or on silent. It is acceptable to use mobile devices for social media, but do not take photographs or record proceedings.

We have received apologies from Sandra White. I welcome Ash Denholm and Emma Harper to the committee.

The first item is for Ash Denholm and Emma Harper to make a declaration of interests. In accordance with section 3 of the code of conduct, any interests that are relevant to the remit of the committee have to be declared. Any declaration should be brief but sufficiently detailed to make clear to a listener the nature of the interest.

Ash Denham (Edinburgh Eastern) (SNP): I have no relevant interests to declare.

Emma Harper (South Scotland) (SNP): I have relevant interests to declare; I am a registered nurse, currently not practising, and I am a former employee of NHS Dumfries and Galloway. I am seeking opportunities to volunteer to maintain my licence.

The Convener: Thank you very much. I put on the record our thanks to Maree Todd, Tom Arthur and Clare Haughey for their work while they were members of the committee.

Deputy Convener

10:01

The Convener: Agenda item 2 is to choose a deputy convener of the committee. The Parliament has agreed that only members of the Scottish National Party are eligible for nomination. That being the case, I invite nominations for the position.

Ivan McKee (Glasgow Provan) (SNP): I nominate Ash Denham.

Ash Denham was chosen as deputy convener.

The Convener: I congratulate Ash Denham on her appointment, and I look forward to working with her over the next few months and years.

NHS Governance

10:01

The Convener: Agenda item 3 is an evidence session on national health service clinical governance.

We welcome Dr David Chung, vice president, Royal College of Emergency Medicine Scotland; Dr Peter Bennie, chair, British Medical Association Scotland; Sara Conroy, professional adviser, Chartered Society of Physiotherapy, representing Allied Health Professions Federation Scotland; Lorna Greene, policy officer, Royal College of Nursing Scotland; and Dr Gordon McDavid, medicolegal adviser, Medical Protection Society.

Thank you all for coming in this morning. We will move straight to questions, and the first one is from Emma Harper.

Emma Harper: As a new member of the committee, I have read the *Official Report* of last week's evidence session. Members explored the implementation of standards and guidelines and how they are transferred from patient groups to practice. What are the witnesses' views on whether there is adequate knowledge of the standards that are relevant to the work across the sectors? How do we transcribe that information and educate the educators?

The Convener: Who would like to start? Peter Bennie looks ready to go for it.

Peter Bennie (British Medical Association): I was looking about for someone else to answer.

Whenever there is a new guideline, it is usually promulgated fairly well across the health service. My email inbox is filled with notifications of new guidelines and standards that are being put in place. It is also fair to say that it is difficult to keep up to date with everything that comes through. Members will have seen a theme running through quite a few of the written submissions—the pressure of work in the health service means that we are doing crisis management rather than having enough time to step back and consider new guidelines properly and to concentrate on the continuing professional development that is essential to good practice.

Lorna Greene (Royal College of Nursing): From a nursing point of view, leadership within nursing teams is important for communicating any new standards or updates to the wider nursing team. Senior charge nurses and team leaders are a linchpin between standards that have been developed and how they are delivered as part of a patient-facing service. We see them as an integral part of that system. I echo the comment about CPD. It is critical that our members have time to undertake CPD, training and revalidation with the Nursing and Midwifery Council so that their practice remains in line with the most current standards and best practice.

Dr Gordon McDavid (The Medical Protection Society): We are a defence organisation, so we represent our members. We are a mutual and a not-for-profit organisation. Doctors and other health care professionals in our membership come to us when they find themselves in difficulty or when they are seeking advice and support on a medical, legal, or ethical issue. As the largest defence organisation in the world, we have built up a lot of experience of issues where adverse events have happened.

That ties us nicely into the good work that the inquiry is looking into. Education and implementation of guidelines is difficult to achieve, and there is no easy answer. It is not just about setting aside time, or ensuring that people have protected CPD, although that is absolutely vital. We need an overall change in culture within the NHS in Scotland, starting perhaps with the leadership of NHS Scotland moving towards a willingness to allow staff to learn about and develop guidelines, and to be much more open about procedures when they go wrong so that they have an opportunity to scrutinise the systems they are working in and so that they can feel able to bring up issues as they arise without fear of blame or personal recrimination, which our members tell us is an issue for them.

Sara Conroy (Allied Health Professions Federation Scotland): I echo what has been said. There can be no doubt that new guidelines are a challenge when they come out. They can be up to date but are the resources available to put them into practice? Much of the short-term funding from the Scottish Government supports successful pilot projects, but budgets are still siloed, so rolling them out can be a huge challenge for allied health professionals. We do not always have the biggest budgets to start with and, although we can show that we can make an impact, all too often the money is in a nursing budget or a medical budget and nobody wants to let go.

Dr David Chung (Royal College of Emergency Medicine Scotland): Like everything in an organisation as big as NHS Scotland, there will be variation. There are some good aspects and some aspects that are not quite as good.

With regard to culture, there has been a lot of reasonably positive work to try to address the issue of how to promote guidelines, good practice, and so on, through initiatives like the Scottish patient safety programme and Healthcare Improvement Scotland. People understand methods to promote quality much better than they did even a decade ago. People, including SPSP

fellows, in various departments of different hospitals have taken a lead on quality improvement. The culture is in place and awareness has improved a great deal. People understand that there are good ways to introduce good practice. You do not just tell somebody to do it, although that still happens through email and so on. Good work has been done but, like everything else that has been alluded to, the trade-off between resource allocation and quality is a perennial issue in every healthcare system throughout the world.

Because of some of the limitations on funding during the past five years, it feels as though there has not been the same time or money to develop guidelines as there used to be. However, a lot of good work has been done, and, as a nation, Scotland has shown that it is willing to adopt a leadership role in this area compared to other countries. We have adopted and embraced that better than other countries, but getting it through to become part of the normal day-to-day routine is the challenge, and that depends on some of the issues that have been raised.

As a doctor with protected CPD and so on, I find it incredibly incongruous to have to watch my nurses come in on their days off to do courses because they cannot do them as part of their normal work. That is completely unfair.

Emma Harper: I refer to the Scottish intercollegiate guidelines network. The network has an app, which is great because it can be accessed immediately from an iPad. However, we are not just talking about national guidelines, as there are procedures, policies, new ways of managing insulin, and sliding scales that are not sliding scales any more. The challenge is about how to get information directly to the front-line staff. Education delivery can take one minute and that has been piloted in some areas. How do you get the guidelines directly to the staff? I know that some staff are having to come in on their days off, although some departments have protected time for that.

Dr Chung: People talk about death by pro forma, but lots of policies are much more prevalent and the documentation that people use nowadays usually incorporates guidelines. To give an example, the medical clerking sheets for patients include several bits about what staff should be measuring and how they should be measuring it. I work in Ayrshire, but I know that Glasgow has good internet-based clinical guidelines, policies and procedures for junior doctors to refer to.

The challenge, especially in emergency medicine with its high turnover of staff every few months, is to reduce the variation that new doctors bring by putting as many policies in place as possible and making the systems work so that the new doctors slot into the systems, rather than bringing unwanted variation and poor practice. In secondary care, we are much more used to doing what the guidelines say, and are happy to do that, rather than thinking, "I am an independent practitioner; I know better than the guideline". That culture has shifted a wee bit. I am not so sure about primary care, as I have no experience of that. It is much more accepted now than it was even 10 or 15 years ago.

Peter Bennie: It is important to remember that guidelines, particularly those for individual conditions, have limited or no relevance when dealing with a patient who has multiple conditions. That is one of the core messages of the chief medical officer's realistic medicine approach. It is important to strike the right balance. Doctors deal with that on a day-to-day basis: they have the guidelines, but they also need to have an awareness about particular situations when the evidence does not fully support what they should do.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I have a brief supplementary question. Dr Chung, in your written evidence, you said:

> "The DATIX reporting system ... 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".

Dr Bennie, in your submission, you said:

> "The culture within the NHS in Scotland does not encourage staff at any level to challenge perceived wisdom".

To return to Gordon McDavid's point, is there cultural resistance to learning from mistakes in the NHS?

The Convener: I want to add to that before the witnesses answer. Does the Datix system have the confidence of the staff who use it?

Dr Chung: In my experience—I am qualifying my answer—no, it does not really have the confidence of staff, because it is quite cumbersome. I will give you some examples.

Feedback is crucial for quality improvement of any kind; you need to know whether you are doing something right or wrong. Part of the problem, which has been alluded to by my colleagues from the MPS, is that the only robust feedback mechanisms in the NHS provide negative feedback—staff only get told the bad things—and the means to give positive reinforcement are not so good.

I have been moaning about Datix almost for my whole working life. They said that they would make it a bit better but, compared with any other form of information technology that you might use, it is still very cumbersome. When we have tried

other things, we have come up against a bit of a diktat that we must use Datix. Every now and again, someone will try something like a near-miss form that is quick and easy to fill in and to put in a box. It seems like common sense to use such a form if someone has seen something that did not quite go wrong, but from which we could learn. However, people are told, "No, we will not permit you to do that—you need to use Datix. It was bought by the NHS so you have to use it", so they just say, "I'm not going to do it then". When we had the old IR1 forms 20 years ago, we might have had a big pile of them, but they were easy to fill in, so we would get them done.

We have tried to bring in things such as positive reporting. I have seen very successful examples of that in emergency departments in England, where, if they see something good or see a good learning point, they quickly write it down. However, we are told that we have to use Datix, which takes a lot of doing. It creates a trail and creates more problems, because people come back to you. It is not a very slick system and it is a barrier to getting proper feedback and learning.

The Convener: Is that unanimous across the witnesses?

10:15

Dr McDavid: I echo what David Chung said. When I worked as a doctor in various hospitals in the west of Scotland, the situation was exactly the same: there was feedback when things went wrong. However, we do not take that to its natural conclusion: you do not get feedback on your feedback. The cycle is not completed, so we probably do not get any useful learning out of an event.

There needs to be a change in culture—I sound like a broken record; I am sorry about that. Let us get people to be open and to highlight the issues that they come across. That should apply to what is good and bad and to staff and patients. We need a process that allows that to happen and further learning to come out of it. MPS members regularly tell us that they feel worried about things going wrong and what will happen to them when that happens.

I will pick up on the education point that we raised earlier. Everybody learns in a different way. As well as setting aside time and giving people the space to learn about the plethora of guidance that exists, it is important to ensure that information is available in different formats and that people can learn about it in different ways. We have online learning as well as workshops on mastering risk that we roll out to MPS members throughout Scotland and around the world. It is important that they have different ways of learning so that they can capitalise on the information that is available.

Lorna Greene: I am not sure that I will say anything vastly new. Whether it is Datix, having a system where people can log their concerns is a vital part of any improvement culture. A feedback loop is very important to our members. We hear about that a lot from nurses. In terms not only of raising concerns but of measuring against standards or indicators, they are often the ones who collect the data and put it into the system but they do not benefit from hearing about what it was used for or how it is part of an improvement culture. To encourage people to continue with those good practices or good behaviours, it is really important that they hear back.

There is also a need for time to report and authority to act. That links the matter back to leadership within nursing teams, from senior charge nurses and across the multidisciplinary team. People need time to raise concerns and the authority to act on the information that has been gleaned from the feedback that has been given.

Peter Bennie: It is important that we examine near misses carefully, as well as looking at where something has gone wrong. We can often learn more from a near miss and, if we do it well, we can resolve the issue before a catastrophic error occurs. In general, we are not good at doing that in the health service.

We have also talked a little about people being unwilling to pass bad news up the line. Part of that unwillingness is a fear that there will be consequences. However, it is more about the fact that, in much of the health service, there is a culture of learned helplessness—a sense that passing on bad news will have no effect and, therefore, there is no point in doing it. That tends to be quite pervasive across the system, so that even an individual who has never had the experience of passing on bad news will pick up from colleagues the idea that there is no point in doing it. Often, that is a problem at both ends because it is absolutely not the case that all senior managers in the health service do not want to hear bad news. They do but they often do not hear it because the ones who could give it to them feel that there is no point.

Emma Harper: I am interested in Datix because I have direct experience with data entry and the redesign of the system to track and manage pressure ulcers. They take a long time to heal and patients might come in with them or develop them and end up going through care home processes or back home. There was a way of reviewing the processes around that. Are we able to track Datix statistics, facts, figures or feedback individually in NHS boards?

Dr Chung: The front-line staff perceive Datix as exactly what you described. It is a great way to collect data to analyse, show or demonstrate something but it does not seem to work well in providing feedback loops for learning. There is sometimes a cynical attitude that it is in use just so that we can say that we have so many Datixes and so many slips, trips and falls or whatever but it is never really analysed to the degree that brings about change, so people ask why they should bother if the feedback falls down. However, the data is all there and relatively easy to access for people who are familiar with the system.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. I thank you very much for coming to see us.

I want to move the discussion on to the target culture and whether we are getting that right. When I met David Chung and the Royal College of Emergency Medicine last year, my eyes were opened to the fact that the situation with regard to the four-hour waiting time in accident and emergency and its use as an indicator of the wider health of a hospital is not as black and white as it might appear. If there are no in-patient beds for A and E patients to be admitted to, that will cause people to stay longer in A and E waiting for somewhere to go.

I would like each member of the panel to give me their reaction to last week's report by Harry Burns on the target culture. I would also like to get some examples of how targets are getting in the way of the wider story and examples of the fact that performance on targets is not as good an indicator as we might think that it is. Perhaps David Chung would like to pick up on that.

Dr Chung: The four-hour target is a good one to choose, because it is more of an indicator than a target, which means that, if we focus on achieving the target for its own sake, that will not work. Instead, we should observe performance against the target and ask, "How well are we doing?" The engine warning light that comes on in the car or the canary in the mine are good analogies to use for the four-hour target. There are other things that we could choose to measure in an emergency department that might tell us how well the job is being done.

There is always a slight tension between the A and E target and other targets, such as the waiting time targets on elective care. For targets to work, the clinicians need to own the standard, as it were, and accept that it is a good thing. For the four-hour target in emergency medicine, that is pretty much a given. Across the world, the evidence has shown that, if we measure how long patients stay in an A and E department, that provides some safety, but clinicians in elective care might think that it is daft to have to treat someone by a particular time, because they might get better in a couple of months. Targets can drive practice that is unnecessary.

The value of targets depends on clinical engagement and doctors' ownership of them. Targets must be valid. Doctors and other staff must think that the practice that they encourage is a good thing to be doing. Any target that is arbitrary and imposed from above will not be that successful, and it might have some unintended consequences. The four-hour target will have unintended consequences somewhere else, even if it works for emergency medicine; equally, elective care targets can have unintended consequences. It is often the case that acute patients cannot get a particular test done, while people who are well can get an elective test done, because that target has to be met. Clinical urgency can be overridden by the need to meet another target. There will probably always be such tensions; we will not be able to factor that out unless we have completely separate systems.

What is important is where the target comes from and what the evidence base behind it is. Is it proven to improve the care of patients? Do the people who are working towards it agree that it is a good thing? If it is and they do, the target is probably a good thing. If any one of those factors is missing, the target might start to cause tension or to result in wasted resource.

Peter Bennie: I have a few points to make. I will look at the four-hour A and E target first, because it is a good example. For us to be able to achieve that target—which I agree has a core validity—there are many broader aspects of the system that it is crucial are working well.

Alex Cole-Hamilton said that it was not possible to meet the A and E target without having the necessary hospital beds, but the issue goes wider than that. The hospital beds will not be available if the community supports to move on those people who are fit and ready to come out of the hospital are not in place and if there is not a fully functioning, highly effective primary care system that can prevent referrals to A and E in the first place. Focusing on the emergency department alone will never resolve all of that.

I have an additional point to make, in passing, about the A and E target. Performance against it is reported so often that it becomes a bugbear for clinicians on the ground that it is almost the sole way of measuring whether the NHS in Scotland is functioning. As the committee is well aware, it frequently becomes a hot topic in Parliament, usually without Parliament having the broader picture.

Harry Burns's review of targets—which came out just last week and which we are still

digesting—is a very interesting take on the target culture. There is a lot that he has to say, outside his recommendations, that we would certainly be very much in favour of, along the lines of the broader message about what we are trying to do to improve the health of the population and how we do that, and the key message that that requires contributions from well outside the NHS, including all the other departments of Government.

In particular, he says how crucial it is to ensure that children in Scotland are getting a proper start. He highlights the importance of measuring, recording and doing something about adverse childhood experiences, because of the huge impact that they have in the future. In my clinical job I am a psychiatrist, and with almost every adult patient that I see I find myself thinking, "If only we could have done more when this was happening when the person was four." We are picking up the pieces 20 or 30 years later. That is a key message in the review.

Turning to the targets, Harry Burns has quite a bit to say about what he calls co-production. That, in other words, is what David Chung was saying: if we are going to have a valid target then we should have proper input into it from the staff who know what they are doing and from the patients who are going to be affected by the target, rather than having it seeming to be set in an arbitrary way.

We need to build into any target the need for clinical judgment to overpower some of the stuff on the margins of the target. Again, that is the kind of thing that David Chung was talking about, such as people who end up getting treatment or an investigation not because they need it there and then—in fact, they may need it less than someone else—but because the target says that that has to be achieved.

We also need to be aware of the potential for gaming any target system. If there is a specific target to be achieved, people may try to achieve it in ways that will simply meet the target, rather than in ways that improve patient care. Taking all of that together, we ask people to think as much as possible about the whole system, rather than individual targets.

The Convener: The cabinet secretary released a statement last week in relation to what appears to be gaming of the system in the accident and emergency department at St. John's hospital in Livingston. Will anyone comment on that or give us some idea of what has been going on?

Peter Bennie: I would do the opposite, to be honest, which is to say that we are aware of the situation, but we will have to wait and see what comes of it. The cabinet secretary seemed to be suggesting that something has been happening there that was addressing the target rather than delivering patient care. Derek Bell is looking into it on behalf of the Government, via the colleges, and we will need to see what comes of that.

The Convener: In every submission that we have received, people refer to the staffing pressures. They say how people are under pressure like never before and they refer to systematic shortages of staff in the system and nights when they cannot get an extra pair of hands. Is that the key thing that is going on in our NHS at the moment? Certainly, constituents, friends and family who work in front-line care are continually raising the issue of the shortage of staff. Is that the key issue at the moment?

Peter Bennie: Yes.

Dr Chung: Yes.

Sara Conroy: Yes.

The Convener: Will you elaborate on that? How does it impact on the care that we give and whether we can deliver the standards of care that we want to? How does it impact on morale? Does it prevent people from sitting down to learn and improve things, because they are not getting their CPD? Those are the things that we want to know.

Dr Chung: You are absolutely correct. You have summed it up quite nicely: staffing is the problem. There are well-documented issues with medical staffing and vacancies, but I would say that the problem is probably more pronounced in nursing and other professions. The situation in medicine could certainly be better, but in terms of what globally affects patient care, talking about the four-hour waiting time or whatever, the question is whether there are enough staff to provide decent home care, to staff the wards downstream and in the EDs.

Specifically on emergency medicine, the college organises a clinical directors forum twice a year. Not every CD was at the most recent one, but most of them were in the room. When we asked what the biggest issue was for them, all of them without exception said that it was nursing staffing. They felt that that was the biggest issue with being able to provide the best care in an emergency department. However, the wards downstream feel it just as much, as does everywhere else. If you do not have enough staff, you cannot release people to have the time and space to drive quality improvement.

10:30

Sara Conroy: It is about joined-up thinking. AHPs would like there to be parity of esteem.

We can make a big difference to, for example, achieving the four-hour target in A and E. I went to a patient flow event last week and listened at

length to what the medics could do, how we could free up theatres and what the nurses could do. When patients are sitting in hospital beds waiting to go home but cannot because they are immobile, do not have a care package arranged or just generally cannot get out and are not independent, AHPs come to the fore, but we are not really round the table discussing the matter. There is a four-hour target in A and E on which we could have an impact, but more often than not we are not round the table.

On the target culture, we have a target for podiatrists and physiotherapists that out-patient musculoskeletal cases will be seen within four weeks. Where did that figure come from? Who decided that it would be four weeks? What happens if we do not achieve it? At the moment, a good area of Scotland will be sitting at eight to 10 weeks' wait, but we also have areas that are nearer to 40 or 50 weeks. There is a target, staff are under pressure, we are prioritising and prioritising and treatments are becoming shorter, but we still have to make 5 per cent cash-related efficiency savings—CRES—and lose, for example, another 10 members of staff, as happened in one health board recently, and we are already sitting at waits of more than 30 weeks. We cannot achieve the target with the staff that we have, so we have no chance of meeting it if we are losing another 10 posts.

What do the targets mean? Who is buying into them? Are we talking about quality or a tick-box exercise? AHPs feel that we have some solutions, but we are not often round the table.

Lorna Greene: It is important that the development of targets includes real, meaningful engagement with the professionals who will work with them. That would help to develop targets that are more meaningful to the people on the ground and those who receive the care.

I will pick up on the point about the extent to which targets can capture quality. At the heart of it, we want service users to have good-quality, safe care that helps them to reach the outcome that they need and want. How often do targets obscure quality or get in the way of meaningful engagement?

On staffing, we know that having the right number of registered nurses is linked to better outcomes for patients. The centenary survey that we conducted in 2016 showed that staffing levels were the biggest concern among RCN members, which is not a surprise when the vacancy rate is at its highest ever, with one post in 20 vacant in Scotland. The safe staffing report that we produced in September showed that just over half—51 per cent—of the respondents to our survey said that their last shift was not staffed to the level planned and 53 per cent said that care was compromised as a result. That speaks volumes about the link between staffing and quality of care. It also tells us what our members are extremely concerned about. They want to be able to go into work, deliver high-quality care and take care of people in the way that they were trained to do. They are being impeded in doing that because of the high vacancy rates and the shortage of staff around them.

Peter Bennie: Staffing levels are a major problem. To give a snapshot, about one consultant post in 10 is vacant and one general practice in four has at least one vacancy. Let us turn that around and consider some of the things that we can try to do about it.

The committee will be aware that the BMA is just concluding negotiations with the Government on a new contract for general practitioners. It is about far more than terms and conditions, although those are included; it is about a completely different way of working in primary care. It is about maximising the opportunities and the experience of allied health professionals in particular, as well as nurses, so that the people who are best placed to provide care to patients do it and GPs move to working primarily as expert generalists in a team with other staff who do the other work with them.

There are simply not anything like enough GPs and it is increasingly difficult to recruit people into general practice because of the crisis. The approach in that new contract is a way of addressing that and improving the quality of care for patients by involving the whole team, which will also make the experience of being a GP better.

Alex Cole-Hamilton: On improvement in the target culture, I was surprised to learn that the only health board that seems to be doing reasonably okay on cancer waiting times is NHS Lanarkshire. The reason for that is that, when staff there log delays, they log the reasons for them and steps that they will take to mitigate them in the future. However, NHS Lanarkshire seems to be doing that in isolation; no other health board seems to be following that pattern.

That really struck me. What is the point of measuring something if we do not learn from that data? Are there other examples of good practice where that is the case? How do we extrapolate that across the 14 health boards? They are sometimes fiercely siloed and do not like to be told that another health board is doing things better and that they should really follow.

Dr McDavid: I am not sure that I can offer any specific examples of health boards. I absolutely take the point that the right staff numbers are needed—that is almost a given—and I echo what my colleagues said about buy-in from staff. That is

part of the puzzle of how we improve governance within NHS Scotland. We do not have buy-in from the staff, so they do not understand why the targets exist and there is no positive incentive, not even one such as knowing that achieving a target and doing a good job will feed into good patient care. For whatever reason, such messages seem to be getting lost. I like to think that, if the good example that you gave could be shared more widely and there was better communication among staff and patients, that would have a positive impact on the governance of the NHS as a whole. It is part of a wider issue, so it is just one piece of the puzzle.

Dr Chung: It is a frustration that, although we find good practice throughout NHS Scotland, it is isolated. The challenge for the healthcare system is how we spread it out across the entire nation. SPSP and Healthcare Improvement Scotland, for example, attempt to do that, but the trouble is that people are always able to put up a barrier and say—to give a hypothetical example—that something works in Lanarkshire but will never work in Ayrshire for whatever reasons. The trick is overcoming those barriers and the reasons why something might or might not happen.

The need to remove or minimise unnecessary variation is recognised globally in healthcare improvement. It is recognised by the big guns in the Institute for Healthcare Improvement in the US, for example. That is basically what we are trying to do, but squaring that circle has proved challenging throughout the world. Even in the States, people are struggling with the same problem. If you have somewhere that is good and everything else appears to be the same, how can you roll out that improvement?

It is tricky. You would think that it would be common sense. You would think that, if a doctor or a clinician of any kind who wanted to be good at their job saw that people had done something really well somewhere else and that it was a success, they would just copy them. However, those other people often have something extra, such as access to funding that the doctor or clinician does not have.

The will exists. If people knew that there was an easy way to do their job and improve patient care, they would want to do it. We need to create networks to enable people to learn about that. That is also a problem. You could argue that it is the job of the royal colleges or other organisations to point out good practice. That is what we are trying to do with RCEM Scotland, because the nation is small enough to enable us to create a network so that, if somebody does something that is good, everybody else just knows about it and can decide whether they want to follow that example and own it, as opposed to being told to do it.

That is a challenge and has been a challenge worldwide. Unfortunately, nobody appears to have the magic bullet as yet. You could say that we should all be like McDonald's and standardise things. That works up to a point. I was initially attracted to that and thought, "Yeah, why can't we?" but patients are complex and medicine is complex. It is not aviation; it is much more complicated. Therefore, the analogies that people use are not as transferable as we hoped that they were at the start.

Peter Bennie: In theory, the tentative moves towards regionalisation could make a difference, and they might change health boards that currently work to their own agenda on issues that are broader. It remains to be seen in practice.

Brian Whittle (South Scotland) (Con): Good morning, panel. This question may be a bit off piste. We talk about establishing an environment in which learning from our mistakes becomes the norm. However, society is becoming more litigious—is that starting to drive behaviour within organisations and to prevent even discussion about how we can learn from things that have gone wrong?

Dr McDavid: Litigation is what we do at the MPS, and our figures—they are more from the other nations within the United Kingdom—suggest a huge increase in the number of claims. Members tell us that litigation feeds into a fear factor when they are at work. They are scared of what will happen if they speak up or are honest when something goes wrong. Will they be sued? Will they face a complaint or a referral to the General Medical Council and potentially lose their livelihood? Those issues go through the minds of MPS members.

It is difficult for a person who works in that environment to say, "Okay, I'm happy to stand back and be very open when I see that there is an issue." The fear of blame and personal recrimination is a major problem. I do not think that there is an easy solution on how to address that—

Brian Whittle: That was going to be my next question.

Dr McDavid: I have my psychic hat on. The solution has to begin with a change in culture. It has to come from the leaders in organisations in the NHS in Scotland, who need to show that it is okay to be open and to communicate—in fact, people should be encouraged and positively incentivised to do that, as has happened in other industries. Leaders need to say, "Let's speak up when we see things that might not be as good as they should be. Let's put things right before they

go wrong and before we get into the situation of someone trying to sue someone else."

Dr Chung: An unfortunate example in England in the past year or so involved a GP trainee who wrote a reflective practice log for her learning portfolio about an incident that had not gone as well as it should have done. That log was used as evidence of negligence and she was prosecuted. An unintended consequence is that trainees who think of that example will never write anything honest if that evidence could be used against them and make them liable in the future. That is what people are worrying about now. Gordon McDavid or the other witnesses might be able to elaborate on that.

Dr McDavid: I echo that point. There is concern. I cannot comment on the specific case, as I do not know the details. If people are asked to reflect on their work in an open and honest way, but a little voice at the back of their mind is saying, "I'm writing down the case against me, and I will find myself being sued in court", those two situations are not compatible.

Lorna Greene: Something that Harry Burns said springs to mind: "If you do something well, tell everyone. If you do something really badly, tell everyone." I cannot remember when or where he said it. The idea was that learning from both examples is what an improvement culture would look like. We need to get to that culture and move away from a blame culture.

Organisations can start to look at ways in which to address human factors and system failures. An example of a human factor is a nurse who has not had a chance to have a break or stay hydrated or even to run to the loo; that will possibly impact on the care that she is able to provide. An organisation can make sure that there is time for its staff to step aside, have a drink of water and get a chance to run to the loo quickly, and those things can start to make a difference. An organisation can tell staff that they and their health and wellbeing are important. That contributes to a culture in the organisation that says to staff, "You matter." That can help by making people feel that they can trust the leadership when it comes to reporting errors or near misses if they occur.

A similar point applies to system failures. We keep hearing about how clunky IT systems are getting in the way, creating red tape and preventing people from getting the care that they need at the right time from the right people.

Those are steps that we could start to take as part of an improvement culture and as we gradually—or hopefully speedily—move away from the current approach, which leans more towards a blame culture.

10:45

The Convener: On that point, the BMA's submission says:

> "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."

Lorna Greene set out an ideal that we want to work towards, and everyone would agree with that, but I sense that we are a billion light years away from it. I speak to NHS staff every week—people in my circle of friends, relations and people who come to my surgeries—and it seems that we are so far away from that ideal. I see that disconnect.

Lorna Greene: There is a frustration for our members, because they can see where the areas for improvement are and areas that need to be addressed. I do not want to keep making the same point, but for us as the Royal College of Nursing, that is where leadership in nursing teams is so important. Senior charge nurses and team leaders in the community need to have authority to act so that, when one of their team members raises an issue or when the data that they get shows that there is an area for improvement, they can act on that and support their team. That would mean that their team members continuously feel listened to and there is a feedback loop in place.

The Convener: I want to push you on that. We took evidence from NHS middle managers who told us that they are being pushed from above to do certain things through the targets culture, but they also have to manage on the ward on a day-to-day basis and deal with their staff, who are attempting to deliver good care. They are stuck in the middle, unable to make any decisions because they are getting stood on from above. We have a real problem.

Lorna Greene: That is exactly the point that I was making—senior charge nurses do not have the authority to act.

Peter Bennie: Another aspect to bear in mind is that a lot of health professionals have exceptionally high personal standards of how they feel that they should practise. I was really struck by Lorna Greene's model of people looking after themselves, because many of our members pretty much abandon their self-care when they are in work. They will work for hours and hours beyond what they are supposed to and still go home thinking about what they could have done if they had only stayed another couple of hours. That is a product of trying to run a health service that is not sufficiently well resourced.

It is important to remember how poorly resourced we are by comparison with similar nations in Europe. We are at the bottom in terms

of numbers of doctors and health spend per head of population. That is the cloud that hangs over this discussion. Those of us who work in the service are desperately trying to do as much as we can within our limited personal resources, and many of us work way beyond what we should be doing, which eventually leads to burn-out and higher sickness levels. Far from a positive cycle, it becomes a negative cycle.

Dr Chung: In a previous incarnation, I was a clinical director and I remember hearing in various management meetings the phrase "discretionary effort" used by chief executives or people in that kind of strata, but it kind of filters down. When we get down to the bare bones of that, it means that we want people to work for nothing.

Peter Bennie: And they do.

Dr Chung: Yes, they do. Up to a point, that is about being a professional, but it is unfair. We often wonder why so many doctors go to other parts of the world and what those other parts have that we do not. Lots of the other negatives are there, but one thing is that they have much better staffing levels. Also, people who go say that, if they do things, they are always paid for that and somebody thanks them.

In Britain, we expect lots of people in the public sector to work for nothing—full stop—and then slag them off in the press. The only feedback those staff get is a complaint or a significant adverse event notification. There is nothing positive and they are under the cosh all the time. They need some recognition that they should be paid for the work they do or that if they do something extra there is a reward somewhere—they are not looking for money as long as they get some acknowledgement. That kind of positive feedback is lacking and that brings down morale.

The Convener: Peter Bennie mentioned investment levels and comparisons with other countries. Could you provide the committee with evidence on that at a later date? Could you also send the information on staffing levels?

Peter Bennie: We will send you those figures.

The Convener: That would be very helpful.

Ivan McKee: The discussion has been interesting and everyone is agreed on what the issues are with regard to the improvement process and about how we take opportunities for improvement and funnel them through the process to drive change in the system for both smaller and larger issues. I would like to explore the next step, which you have covered a little already, but perhaps you could go into more detail.

There are a number of things that we can do to make progress. We talked about culture but there may also be issues in the way that organisations are designed—Healthcare Improvement Scotland could have a role in that, as we have heard previously. Is there an issue with leadership in the health boards? Is there a need for clearer direction from the Scottish Government, or is there a need for legislation to change the way we do things? Are there issues with IT systems? Where would you start in order to make some progress?

Peter Bennie: It is never great to just repeat an answer, but sometimes we have to think broadly about the whole-system situation. That is what my colleagues and BMA GP negotiators have done. They are not just saying, "Well, we're stuck with this situation and we'll tell you what is wrong with it"; rather, they are saying that we should think broadly and use all the resources that we already have, while continuing to ask for further resources. That is a good example, although it remains to be seen whether it will find favour with the GPs of Scotland. However, the initial feedback from recent roadshows is positive. That is a way of saying, "Here is the situation, but let's do the best we can while making it clear that we still need to improve the funding position."

Dr Chung: I would echo that to some extent. Unfortunately, we sound like a broken record, but it comes down to resources. You asked for comparative figures and off the top my head I would say that only Slovenia and Albania have fewer doctors per head of population than the UK. The situation is the same for hospital beds—everyone apart from those two countries has more.

It is a difficult problem to solve because it is about not just the Government or healthcare, but society as a whole. According to the Commonwealth Fund, we have the most efficient healthcare system. Efficiency is very good and that is to be lauded, but patient-centred care and efficiency are often diametrically opposed, particularly if you spend a lot of time with one person. That is why people like alternative medicine, because the biggest impact is that someone spends two hours listening to them properly as opposed to 10 minutes or less in a GP surgery. It is such a big societal issue because people have to accept how much healthcare actually costs and understand what it will take to pay for that if they want it to be high quality, or they have to choose not to do that and to live with the kind of healthcare that they are prepared to pay for.

There is a mismatch between the perception of what high-quality healthcare costs in an OECD country and what we are paying in the UK. We are getting very good value for money and many people are working very hard on behalf of patients to make that happen, but we need to find more

money from somewhere to do what we have to do. Everybody has to think about that.

Sara Conroy: I agree with everything that Peter Bennie has said. It is about having a joined-up approach. Sometimes the narrative is about doctors and nurses, but the new GP contract recognises the contribution that many professionals can make. There are examples of AHPs working alongside GPs and taking on significant parts of their case load, leaving the GPs to carry out the real doctoring, which others cannot deliver. It is about the right person doing the job. That would be a start.

We talked about four-hour targets in accident and emergency, but it is about looking at the situation across the piece rather than at what is happening only in the emergency department. We need to change the narrative and look at budgets. I have said this already, but budgets are set and there might be this bit of budget and that bit of budget. The new approach might be innovative but there is not a budget to cover it. Perhaps if another post was lost, dare I say it, the right person could step up and deliver the safe and effective service that the patient needs.

Dr McDavid: Ivan McKee hit on one of the most important questions of this inquiry: how do we fix it? We are identifying some issues, so what can we do? I agree with my colleagues that it must be about increased resource and staffing. Alongside that, we have to make sure that we address the cultural issue and that there is openness and ways and means for staff and service users to hold open dialogue so that they can discuss their experience. What can they learn from their experience and how can we address some issues with systems?

I do not doubt that it is about communication, having more informed and better-educated staff, and good leadership by example. Those in the NHS in Scotland need to show a willingness and incentivise everyone who is involved in healthcare to point out when things are not going as well as they should be, and what we can do within the confines of our finite system to address those issues.

Education will be one of the key components for staff members. The MPS runs loads of different workshops on mastering risk, and good communication is at the heart of each of them. That means making sure that you are identifying and speaking to your patients so that they know what is going on and any issues are flagged up very early. That prevents situations from snowballing into the claims that Ivan McKee talked about.

Lorna Greene: The RCN in Scotland is calling for safe staffing legislation, which is focused on ensuring safe and effective quality care through the provision of appropriate staffing. That would be a major step.

We are talking about healthcare being delivered as part of an integrated health and social care system. Anything that is delivered as part of primary and community care will be overseen by integration authorities. We have not talked about them at all today and it is really important that we flag that. From work that we have done with our members, we are hearing that there is a need to move towards more robust clinical care systems within integrated health and social care. Some IAs have done that work but some really need to get started on it, because it is not being done to a level that will assure our members.

Service users should have the right to expect the same levels of clinical care governance and transparency from services that are commissioned or delivered by integration authorities as they would from services that are delivered directly by NHS boards. That is a major area that we need to start looking at so that we can understand how care across acute and primary services is delivered.

The Convener: Whose role is it to drive all this ambition for change? Whose responsibility is it? I know that you will all say that it is everyone's role; that is the answer that we expect. However, is it ultimately the job of Healthcare Improvement Scotland? Do we need an independent regulator or should the health boards raise their game? What about the integration authorities? Who will be held accountable?

Dr McDavid: It is everyone's responsibility.

The Convener: But if it is everyone's responsibility, does it not end up being no one's?

Dr McDavid: There is that risk, for sure. Regulation and legislation serve their purpose but, at the end of the day, healthcare is already a heavily regulated profession. Our members are already talking about multiple jeopardy: one clinical incident leading to a complaint or a fatal accident inquiry, a GMC referral or press intrusion. All sorts of other issues can arise from one clinical incident.

I am not sure that more regulation will necessarily be the key to getting what we are looking to achieve. Rather, we should find a means of embellishing the processes that are already in place to regulate and check the levels of safe practice in order to make them more fit for purpose. Different levels of staff in the NHS should be involved in that; I do not think that one body or person will be able to have full and appropriate oversight.

11:00

Peter Bennie: I would certainly counsel against further regulation. It is useful to look at the Care Quality Commission, which conducts external investigations of various health premises south of the border. The experience of BMA members south of the border is that that process is often a negative experience. Many of the bodies involved in high-profile scandals about extremely poor care passed their CQC assessments not long before it became clear that there had been systematic problems for years. An external regulator will often miss what is really going on. Ownership by managers and clinicians on the ground is what will change what is really going on.

The Convener: We have seen that happen in Scotland as well.

David Chung's paper states:

"Some of our Members and Fellows working in Scottish EDs"—

emergency departments—

"have reported that due to funding constraints, organised approaches to clinical governance have been significantly diminished or abandoned altogether."

Dr Chung: Seven or eight years ago, there was a better support staff network, whereby information was gathered so that it could be measured. At that time, if someone was looking to drive clinical governance in an emergency department, they might have identified five or six important things that they wanted the department to be good at, such as times and compliance with sepsis bundles—things that relate to the work that comes out of the SPSP and HIS—but they would have had people to help them do it. There would have been somebody saying, "Let's create an information system and we'll help regulate it," perhaps with run charts or statistical process control charts.

That is now gone; those people are not around. If we ask for such things, we are told that we are not resourced for that any more. The support staff who previously would have helped us implement and measure things to give us feedback to improve the system are not there any more. That element was there five years ago, but it is not there now. The things that we are measuring are slowly being eroded. We are measuring less and therefore it is very difficult to say how well we are doing. Our alternative as clinicians is to take more time to collect stuff laboriously. It should be easy to collect stuff—electronic systems would probably give us the answer.

Lorna Greene: It appears from the conversation that we have had this morning that there are two issues. One is culture and the other is resources. On the culture issue, the point is that everybody is responsible and everybody needs to feed in to changing the culture and turning it into a true and meaningful improvement culture. In the area of resources, there is perhaps a more direct line of responsibility. We have all said that the right quality of care cannot be delivered if the right people are not there to deliver it.

The Convener: So you do not want an independent regulator and you cannot identify a key organisation to drive that change; it is all going to come about by everyone holding hands. Is that right?

Dr Chung: No. If I was a clinical director in my ED, I would be responsible for providing good care. Every doctor is responsible for doing that. People have various interests and some people like some things more than others; if someone is an enthusiast they will do a better job.

There is a general consensus in emergency medicine about what good care looks like—which members of staff should be there and what standards we should aim for. The difficulty is in setting up the system and measuring it to make sure that we are providing that. Previously, we just relied on doctors being good eggs and doing their best, but that is not good enough now—we need to find some way to measure that. The resources, which are required to measure the things that we want to measure, are not as good as they were, although they are still there.

Every doctor should keep up to date; it is part of good medical practice and part of their appraisal. There is individual responsibility and systemic responsibility, depending on where one's responsibility lies.

The Convener: One of the submissions states that staff have not had appraisals.

Dr Chung: Again, appraisals can be a box-ticking exercise, but I think that most staff are intrinsically motivated. Of course, it is a large organisation, and there will always be an anecdote—a true story—for every situation, but the majority of people want to do well and know what they need to do in order to do well. However, something is stopping them and, unfortunately, a lot of the time it comes down to resources.

The Convener: So what are we saying?

Dr Chung: This is everyone's responsibility at an individual and an organisational level, and above that, we have the SPSP and SIGN—and in England, I would cite the example of the National Institute for Health and Care Excellence—to set particular standards. The question is: how do we make these things happen?

The Convener: Is hard cash the key element, then?

Dr Chung: I am afraid so, but we would say that, wouldn't we? I sound like a broken record, but it is a big deal.

The Convener: We will have a final word from Lorna Greene.

Lorna Greene: Yes, resources are very important, but I would point out again that staff need to have the authority to make changes and act in response to the feedback that they get or have been exposed to. If learning is coming back to, say, nursing teams, does their team leader have the authority to make changes to ensure that those improvements can be implemented?

The Convener: I am sorry, Alison—I forgot about you.

Alison Johnstone (Lothian) (Green): That is all right, convener.

I thank the panel for a really interesting evidence session—we will take away a lot from this morning. Last week, we heard from Action for ME, Down's Syndrome Scotland and Age Scotland a general concern about patients being treated without dignity or respect. Down's Syndrome Scotland, for example, highlighted the case of a parent who had taken their child to be vaccinated, only to be asked a lot of development questions to which they had to constantly give no as an answer. They left feeling really downhearted and distressed. There is not a lot of regulation around treating people with the dignity and respect that we would all expect, and I wonder whether you have a view on what needs to be done to ensure that all patients are treated in that way.

Peter Bennie: I am really glad that you have raised that issue. I had noted down three points that I wanted to put across this morning, and one of them was that this is about patients. Dignity and respect are suffering in the current circumstances. I would cite an example from my clinical specialty—psychiatry—in which it frequently happens that someone requiring emergency admission will have to wait hours and hours without any indication of where their bed is going to be. They get fed what little information we get—I work in Paisley, and we might be told, "There might be a bed in Perth or Edinburgh"—only to find out that there is no bed there. Others might not be admitted overnight and might have to wait on, say, a sofa on the ward for a bed to become available. We have to remember that that sort of thing happens at a time of real crisis for the individual and their family; after all, someone has to be very unwell to be admitted to a psychiatry unit. That represents a complete failure to treat people who are at their most vulnerable with respect and dignity, and the same is true of the example that you have just given.

It all flows from the lack of availability of appropriate care, which, as others on the panel will tell you, runs across the health service. No one receives poor treatment deliberately, and very few receive poor treatment because of thoughtlessness. The problem, mainly, is that the systems simply cannot cope.

Alison Johnstone: Is that view shared by the other witnesses?

Sara Conroy: I think so. AHPs carry out a care audit twice a year, and the scores across the professions are really quite good. With the tool, which was developed for GP trainees, people are asked questions such as, "Did you feel listened to?" and, "Were you able to ask the questions that you wanted to ask?" The skills are there, but it all comes back to the pressures on people.

Errors or instances of poor communication start to creep in if people feel under pressure or are not comfortable or confident with the patient in front of them. One can see supervision sessions or, indeed, the annual knowledge and skills framework reviews as tick-box exercises, or one can see them as a useful learning exercise that gives people time to reflect and talk through the learning that they can take. If, as in the example that Alison Johnstone highlighted, a junior had been asking question after question to which the answer was no, I would be saying to them, "How could you have changed that to make it better?" However, time needs to be set aside for that sort of on-the-job learning. As Peter Bennie has said, no one wants to have a bad consultation, but they happen, probably as a result of the pressures on staff and the lack of access to proper supervision and learning.

Alison Johnstone: Last week, the Scottish Association for Mental Health mentioned a survey that it had carried out in which 40 per cent of respondents felt that they had been treated disrespectfully—they might well have been engaging with your service, Dr Bennie. However, Lorna Greene has talked about nurses being dehydrated or not even having the chance to visit the loo. I understand that the area is complex, and I realise that there is frustration about the impact on patient care. You have said that this is all about resource, but obviously it is also about the culture and understanding that every patient has to be treated with respect.

Lorna Greene: All nurses should, in line with the NMC code, be delivering care in a way that dignifies and respects the people who receive it. However, as colleagues round the table have said, resources, pressures on time and staffing will all impact on the quality of care that is delivered. That is not desirable from anyone's point of view.

Another issue is the extent to which all experiences are captured and used in a feedback loop to those delivering care. Someone might genuinely not realise that their action has been interpreted by a patient as disrespectful, and the question then is whether there is a mechanism in place to allow the individual in question to raise their concern and to ensure that the matter goes back to the member of staff and is dealt with in a proactive and productive way so that something similar does not happen. Feedback loops are really important in ensuring that meaningful learning takes place.

We also have to look at the service users who are giving us feedback. How much are we listening to, say, children and young people, people with disabilities or people in prison who are receiving care? Whose voices are getting back to us? We need to keep an eye on that, as it will have an effect on how we use learning to improve the care that is received in the future.

Alison Johnstone: I suppose that there are two aspects to this: first, the increasing pressure that staff are under; and secondly, the difficulty of addressing some of these issues if we do not have sufficient time for CPD.

Lorna Greene: Indeed.

Alison Johnstone: Thank you, convener.

The Convener: Before we finish, I want to thank our witnesses for what has been a really interesting session, and I will now give each of you 30 seconds to tell us how we are going to deliver on some of the priorities that you have highlighted this morning if there is no more money and there are no more staff.

Dr Chung: You have just described the status quo. Stuff will keep on happening in a fragmented and ad hoc way; that might not be to everyone's satisfaction, but staff will not stop trying. Indeed, that is what we have relied on to get us through this situation. However, we need a better system than that.

Peter Bennie: The one issue that we have not talked about as much as we might have is how we foster better engagement between managers and clinicians on the ground. I have said a little bit about the concept of learned helplessness—in other words of people thinking, "What's the point of telling them, because they won't do anything?" Actually, if you do tell them, they often will try to do something. We have to foster a better and more positive culture between managers and clinicians on the ground.

Sara Conroy: The issue is having the right person at the right time delivering care, so we should not forget about AHPs when we get round the table.

Lorna Greene: The impact on staffing will continue to hit hard, and there will be an increase in vacancies through either sickness or people leaving the profession because they feel that they cannot deliver the care that they were trained to deliver.

Dr McDavid: I would suggest a three-pronged approach of, first, empowering leaders to lead by example; secondly, educating staff and patients alike about feedback; and thirdly, making feedback commonplace and ensuring that there is open feedback, whether good or bad, from staff and patients and that it is acted on.

The Convener: Thank you all for coming. As previously agreed, we will now move into private session.

11:14

Meeting continued in private until 11:35.

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