

Royal College of Physicians of Edinburgh

**Response to the Scottish Parliament Health and Sport Committee
Clinical Governance call for views**

The Royal College of Physicians of Edinburgh (“the College”) is pleased to respond to the Committee’s call for views on clinical governance. The College is an independent clinical standard-setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

In order to inform our response, the College sought the views of our Fellows working in clinical practice and members of our Lay Advisory Committee.

Are services safe, effective, and evidence-based?

The College received generally positive responses to this question, but there was an acknowledgment that this does not apply universally across services. It was noted that Scotland is a world leader in terms of its Scottish Patient Safety Programme (SPSP), but there are still significant steps left to be taken in terms of sharing and implementing best practice across the NHS and taking a whole system approach.

Of key importance is a need to ensure there are sufficient numbers of appropriately trained staff. Investment in our current and future workforce is essential to create a culture where colleagues have the time to care, time to train and the time to research. This depends on a variety of factors: workforce planning informed by robust data including population size and morbidity; excellent career guidance with equality of opportunity and access to relevant further or higher education or apprentice type models; adequate support of undergraduates including the availability of bursaries, loans etc; diligent attention to rota and shift planning to minimise burnout and fatigue and thus attrition; local and national recruitment strategies with unified input from universities, NHS Boards, Royal Colleges, Deaneries etc; access to Continuing Professional Development (CPD) opportunities with adequate staffing numbers to allow release of colleagues; maintenance of safe staffing levels with strategic input into how this is defined and provided; and recognition and valuing of staff to ensure retention. Without adequate staff numbers it becomes impossible to provide safe care, let alone high quality care.

To ensure effective and evidence-based services, a range of steps are required. The NHS must improve at critically appraising existing services: there is the risk that once a service is established it continues indefinitely even as newer, more efficient, effective and evidenced techniques or procedures are developed. Different departments and boards adopt different approaches when evaluating services: this local flexibility is vital, but a more defined and transparent system is desirable, with less variation in practice. In addition, several experiences since the formation of the Integrated Joint Boards suggest that service planning initiatives are often undertaken by non-clinicians in a top-down approach with little or no clinician input. Often the evidence for change is lacking, or change is planned on a large scale, where a quality improvement approach starting with small tests of change and scaling up or spreading only if successful should be employed. Better platforms for sharing of experiences in different departments or boards would be beneficial, as would opportunities for multidisciplinary networking - requiring release of staff time.

As the Chief Medical Officer emphasises in *Realistic Medicine*, there remains too much variation in care, and a risk of waste. Those best placed to identify areas for improvement are the staff on the ground who are rarely given formal time to undertake improvement work. Consideration should be given to quality improvement in terms of training, time, resource and support from quality improvement experts should be available universally and to all staff regardless of grade or discipline. Assistance with data collection, display and feedback should be available in order to reliably inform change and next steps. This need not utilise significant resource in terms of time or manpower, and could yield substantial improvements in patient care: consistency and reliability are key.

Although clinical staff work from an evidence base, it is not always straightforward to know if a particular treatment would suit an individual although the majority are seen to benefit. Patients need to be able to question their treatment and to know the side effects, and clinical staff need to feel empowered to say if a treatment is appropriate even with pressure from patients to receive it. Evidence changes over time but treatments can continue even when more current research points to a less effective outcome. The cleanliness of hospitals must also be a paramount feature to avoid infection.

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

Not consistently, and where views are sought they are not always taken into account. Consistency in approach across departments and boards would help- with adequate resource and expertise to support and advise healthcare staff on how to seek opinions and how to feedback and incorporate. Open and honest conversations with patients about illness, impact and prospective treatment are essential. Feedback is vital to maintain public engagement and confidence when opinions and perspectives have been offered, especially when these have not been incorporated into service planning or delivery.

Do services treat people with dignity and respect?

Not always: this can be due to high pressure environments and /or insufficient staffing, and care needs to be taken by management to ensure that staffing levels are appropriate. Time needs to be allowed for staff to fully ascertain 'what matters' to a patient and not to assume that everyone's needs are the same. There needs to be an understanding of the different circumstances surrounding patients which might not be the direct result of the particular illness/accident. There are always opportunities to improve the way in which staff care for individual patients in relation to staff attitudes, routines and sufficient information. Poorly resourced or designed facilities can contribute to failings, and efforts must be made to ensure sufficient numbers of trained staff are available and that facilities including buildings, ward design, equipment etc allow for dignified care.

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

On the whole, public confidence in the NHS remains high despite negative portrayals in some public fora. The recent prolonged period of financial and political instability with its ramifications on the NHS has dented staff confidence, as evidenced by the significant recruitment and retention issues in the medical profession. Brexit; sustained real term pay cuts; increasing clinical workload and higher public expectation have led to an erosion of staff resilience and increased attrition rates.

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

Not always: colleagues at the service frontline have expressed concerns that there is a perception that targets; financial efficiency and constraints drive the NHS, rather than the pursuit of excellent, high quality patient care.

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

Colleagues have suggested that time should be allocated at the end of every shift for a debriefing as to what went well and what needs attention, in addition to knowing about each individual patient. Over-stretched staff are more likely to make mistakes. The system to resolve issues should be more immediate than relying on a periodic inspection, and it is the business of all staff to highlight issues which affect patients and safety.

Some colleagues have concerns that despite recent initiatives in this area, they still feel it is difficult to speak up when they are concerned about standards of care despite GMC guidance and support on whistle-blowing. A genuine organisational promotion of an open culture of blame-free scrutiny is vital to make progress. For example, collecting data that is meaningful to patient care and experience and is then used in a constructive, rather than punitive way, to improve care.

Royal Colleges could be utilised more effectively by encouraging and enabling support of organisations with professional and personal development, including education, training and peer support. In general, there exists the opportunity for more collaborative cross-organisational working to improve care and staff and patient experience. It was suggested by Fellows that the NHS currently relies too much on rather arbitrary measures of care via inspections that are also often conducted in a less constructive manner rather than encouraging openness and collaborative problem and solution finding. Examples include mandatory training of staff- with HSE inspections looming staff are suddenly sent multiple missives demanding they complete mandatory training, much of which may have no relevance whatsoever to do their day-to-day work, and shifting their focus away from their own improvement work. Other examples include directives to use specific national tools- eg falls tools, again with no acknowledgement of the quality improvement process allowing adaption to local need and resource.

Finally, the College believes that investment in staff and recognition of their work is vital to the provision of safe, effective, efficient care. Investing in NHS staff in terms of training, recruitment and retention is more likely to lead to the provision of excellent and safe care. In addition, investment in quality improvement, in terms of time, training and expertise is essential, rather than relying on untrained or unsupported staff to fit improvement in around multiple conflicting interests.