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Clinical Governance in the NHS in Scotland

We welcome the opportunity to respond to this call for evidence as part of the committee's 'NHS Governance – Creating a culture of improvement' inquiry. We would like to respond to the questions from the perspective of pharmacists who, as registered and regulated health professionals, are accountable for continuously monitoring and improving the quality of their care and services, maintaining the highest of standards. We are happy to discuss any aspect of our response in more detail with the Committee.

Context

A simple definition of clinical governance is the recognition and maintenance of good practice, learning from mistakes and improving the quality of services provided to patients. As a professional leadership body, the Royal Pharmaceutical Society in Scotland (RPS) provides extensive support to pharmacists on many aspects of clinical governance. Clinical governance and patient safety are core to pharmacy practice and robust systems are in place. Clinical governance is a multidisciplinary responsibility but pharmacists have a key role in medicines governance and, therefore, to ensure safe systems are in place pharmacists must be strategically involved wherever there are medicines involved.

We recognise that within the NHS, quality improvement and clinical governance are priority areas and standards of care are in general, excellent. There are however system and process issues across the NHS which impact on clinical governance, and we will expand on these issues in our response.

Question 1: Are services safe, effective and evidence based?

Medicines are the most commonly used intervention in the NHS. They cause harm as well as benefit, and good clinical governance on all aspects of medicines use is essential**.** Studies have found that between 1.4% and 15.4% of hospital admissions are drug related and preventable, with this figure rising to 27% in our frail elderly population[1]; the commonest causes reported are prescribing and monitoring problems (53%) and non-adherence (33%)[2].

The RPS in Scotland Manifesto 2016, "*Right Medicine, Better Health, and Fitter Future*"[3] describes the unintentional harm being caused, and outlines where more strategic decision making around the role of pharmacists could improve overall safety and quality of care. This would see a more holistic approach to treatment being taken to address the growing numbers of people living with multiple diseases, resulting in more complex interactions from their medicines. This requires more pharmaceutical care to ensure treatment remains safe and effective. The evidence base for prescribing is generally based on clinical trials for single disease in a defined patient group. Increasingly this is not a realistic representation of an ageing population's needs.

Care Homes, Care at Home and Home Care

Care home residents have particularly high levels of co-morbidity and polypharmacy; seven out of ten residents experience some form of medication error each day (mostly a result of factors outside the control of the home). While many errors are of little or no clinical consequence, the high prevalence of errors will mean that a number of people will suffer an adverse event as a result of taking medicines and emergency admission to hospital will result.[4]

Care at Home offers specific challenges to both health and social care services particularly around the safe and effective administration of medicines, the appropriate use of monitored dosage systems and awareness of the governance issues with their use such as those arising from relating to changes to medication.

Home Care services are relatively new, delivering medicines straight to a patient's home rather than patients travelling to hospital or supply via community pharmacy. These medicines can be specialised and possibly high-risk, and will increasingly become personalised for individuals and may require additional knowledge and understanding in terms of preparation, administration or disposal. Developments in this area must be closely monitored to ensure that patients, carers and healthcare staff have access to the support, advice and expertise they need, and that there are clear lines of responsibility within the governance framework for the service.

We are currently exploring the issues still outstanding from our "*Improving Pharmaceutical Care in Care Homes*" in 2012[5] report around Care Homes and Care at home, and plan to publish our recommendations for change early 2018.

Question 2: Are patient and service users' perspectives taken into account in the planning and delivery of services?

There are examples of successes where services have been planned and delivered from a patient perspective e.g. testing for Hepatitis C in community pharmacies, which has been estimated to reach four times as many people as previously.[6] The supply of new treatments directly from community pharmacies being piloted across selected Health Boards in Scotland, was devised in order to provide enhanced pharmaceutical care, improved adherence, improved clinical outcome, and support normalisation of care in a community setting that could be expanded to other services.

In a similar way, the new gluten free service from community pharmacies improves access and allows patients to self-manage their gluten free prescriptions. The governance framework for this service ensures that the patient receives ongoing high quality pharmaceutical care. In addition to being person centred this service frees up GP time, with an efficient use of skill mix, using community pharmacy support staff.

The Primary Care Collaborative document "*The Future of Primary Care in Scotland*. *A view from the professions*"[7] defines the professions' principles of primary care and states:
"The full range of services available across the primary care network is informed by evidence, responsive to assessed population need and shaped by individuals and families within a locality".
We are currently awaiting a response to the principles document from Scottish Government as to how they will take forward the representative views of the 60,000 front line clinicians.

Sharing of Information

Access to the correct information is a basic requirement for safe and effective clinical practice and outcomes and therefore governance arrangements must be robust enough to protect the patient but enabling enough for clinicians to have the required information to keep patients safe when providing care. Read and write access for the wider primary care team to relevant information in patient health records would enable more informed and safer decision making.

The RPS, in collaboration with the other health professions in Scotland, responded to the Digital Strategy consultation[8] *"A Digital Strategy for Scotland 2017 and beyond"*. This collaborative document details clearly where there are gaps in the sharing of information which impact on the quality of care for patients. It states:
"All healthcare professionals routinely record important information about their patients' care which could often be useful or crucial to other health and social care professionals involved in their care but often the information held within these separate systems cannot be shared"

The RPS believes that the inability to share accurate, up to date information between health professionals is a significant gap in the Clinical Governance framework. This is increasingly challenging as more non-medical prescribers are introduced to the healthcare system, increasing the number of prescribers involved in an individual's care at any one time.

Access to the Emergency Care Summary (ECS) was promised for community pharmacists in 2014 however this has still not been actioned. The lack of access to the ECS, and the inherent difficulties encountered in sharing health information across any appropriate health and social care professionals, is now an urgent patient safety concern and one which has been raised by the RPS[9], the Primary Care Collaborative[10] and within the Caldicott Review.[11]

The Caldicott review highlights concerns around the reluctance for sharing of information. Principle 7 states:
"*Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies."*

Negative interpretation of the issues around confidentiality can work against a patient's best interest, resulting in lack of information preventing the health professional involved in care from making fully informed decisions for the patient. Our work with patient groups has indicated that the public assumes all health professionals have access to their relevant data and according to research from You Gov[12], an overwhelming majority of the British public, 85%, said they want *any* healthcare professional treating them to have secure electronic access to key data from the GP record. A recent survey of over 7,000 patients using a pharmacy vaccination service[13] showed that 80% of patients are happy for the pharmacist to be allowed access to their GP record.

In 2013 the "*Review of NHS Pharmaceutical Care of Patients in the Community in Scotland*[14] *stated that:*
"*Access to and sharing of relevant clinical, including medication information between professionals is fundamental to safe and effective care. This is particularly important where patients move from one care setting to another.*"

Question 3: Do services treat people with dignity and respect?

As regulated professionals, pharmacists must adhere to the General Pharmaceutical Council's Standards of Professional Behaviour[15]. In particular, Standard 1 "*Pharmacy professionals must provide person-centred care"* and Standard 6 "*Pharmacy professionals must behave in a professional manner"* both refer to treating patients with dignity and respect.

The RPS also produces professional standards for members and our annually updated Medicines, Ethics and Practice guide[16] clearly states the requirement for dignity, respect and putting the patient at the centre of all decisions in healthcare.
An example of quality improvement in this area is the training that has been developed for community pharmacy staff to address attitudes and stigma around Opiate Replacement Therapy.

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

Pharmacy staff are confident in the safety and quality of the NHS services they provide due to the robust governance framework within which the profession operates.

The public is less well informed about the role of pharmacists and are less aware of the clinical governance framework which is embedded across the profession. The Our Voice Citizen's panel survey[17] highlights a limited public perception of the role of the pharmacist, and a lack of awareness of the profession's role in supporting clinical governance and patient safety.

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

The Quality Strategy[18] has embedded the concept of safe, effective and person centred care in the decision making processes within the NHS but there is always room for improvement and a balance must be struck to ensure efficiency savings do not impact on quality.

The Scottish Patient Safety Programme is an example of using continuous quality improvement methodology. It has been successful in improving patient safety in secondary care and the recent two year programme in community pharmacy focused on high risk medicines and medicines reconciliation, (all of which could be more effective with shared access to health records.) This project however has now come to an end and we await formal evaluation.

We are all aware of the financial constraints within the NHS which impact on decision making and sustainability is frequently quoted as a challenge. It is important that pilots showing improvement in patient safety and health outcomes are taken forward nationally and that a longer term strategic view is used for decision making.

A balanced workforce is essential to ensure both patient safety and quality of service provision. We are concerned that to date, despite calls by the combined professional organisations[6] and in our 2016 Manifesto[2], there has been no comprehensive workforce planning for pharmacy despite creation of new roles in primary care which will impact on future secondary care community services. RPS in Scotland responded to the Scottish Government consultation on workforce planning[19] earlier this year and has produced a vision for the pharmacy workforce across GB.[20]

Question 6: Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

Traditionally, pharmacists have been the safety net for prescribing errors, but they have an important role further upstream to ensure safe systems are in place. Under the current healthcare structure, systems in pharmacy are focused on supply and in the medical profession on prescribing.

A range of healthcare professionals might give advice to patients to ensure they understand why and how to take medicine, but we know that almost 50% of people do not take their

medicines correctly. With 59% of people over seventy taking more than five medicines and this figure set to rise with the future demographic changes there is an urgent need to act now to prevent further pressure on every sector of the NHS. We believe there should be a clearer pharmaceutical care pathway, using the expertise of pharmacists in all sectors.

There is also no clear policy on ensuring good clinical handover between health professionals when patients transfer between the different health and social care settings. There is a substantial body of evidence that shows when patients move between health settings the risk of miscommunication and unintended changes to medicines remains a significant problem.[21] Estimates suggest that between 30 and 70% of patients will have either an error or an unintentional change to their medicines when their care is transferred.[22]

We advocate the clinical role of pharmacists within the multidisciplinary team to influence prescribing in secondary care, community pharmacy and in GP practices[23], to support clinical governance and reduce prescribing errors which a survey by the General Medical Council found occurs in 1 in every 20 prescriptions.[24]

It is therefore imperative that there is pharmacist input at both strategic and operational levels within any new integrated health and social care structure.

At the request of Scottish Government and The Department of Health, RPS in Scotland led work across all health board areas in 2016/17 with quality and safety roadshows designed to highlight the requirement for shared learning ahead of the proposed changes to legislation on dispensing errors. In tandem with Safety Climate Surveys[25] for pharmacy staff, this work has promoted a culture of quality improvement and improved reporting, aiming to ensure processes and systems are in place to detect unacceptable quality of care and describe how to act when things go wrong.

About Us

The Royal Pharmaceutical Society (RPS) is the professional body for individual members of the pharmacy profession across all sectors in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders across a number of different forums.

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