RCGP SCOTLAND

Healthcare Improvement Scotland

Clinical Governance Draft Standards

RCGP Scotland Response

3. Do you have any general comments on the standards? *

- Yes
- No

If yes, please give details.

RCGP Scotland welcomes the opportunity to respond to this consultation on clinical governance draft standards. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

We recognise that clinical governance is fundamental to delivering safe, effective, and continuously improving healthcare. We therefore support efforts to strengthen governance across the health system. Within general practice and the wider primary care sector in Scotland, activities such as clinical audit, quality improvement, risk management, education and training, and patient involvement are already well established and actively contributing to better care.

4. Would you like to give more detailed feedback on any of the individual standards?

- All of the standards
- None of the standards
- Standard 1: Staffing and staff management
- Standard 2: Clinical audit and quality improvement
- Standard 3: Clinical effectiveness
- Standard 4: Risk management and safety
- Standard 5: Education and training
- Standard 6: Service user and patient involvement
- Standard 7: Data and information

5. Do you feel that anything is missing from the standards? *

- Yes
- No

If yes, please give details.

We are disappointed to note that the draft standards appear to have been developed primarily with large secondary care organisations in mind. This could have been avoided through greater inclusion of primary care and GP representation on the development and steering groups.

It is important to emphasise that the majority of healthcare interactions in Scotland take place within the primary care setting. The standards should therefore be designed in a way that reflects this reality and ensures they are relevant and applicable across all parts of the healthcare system.

The Blueprint for Good Governance in NHS Scotland (Second Edition, November 2022) does reference independent contractors: noting in the introduction section 1.3 that contractors are not the primary audience of the document but that it would be of interest to this group; in section 3.17 describing the NHS working closely with independent contractors as part of the collaborative approach; and in section 4.38 around influencing culture, suggesting that the ethos of the staff governance should be reflected in arrangements with independent contractors.

5. Do you support Standard 1: Staffing and staff management as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don't know**

Please tell us why you think this.

The majority of GP practices in Scotland operate under 17J contracts, meaning GPs are engaged as independent contractors to provide NHS healthcare services. GPs typically work in partnerships and tailor their staffing and organisational structures to meet the specific needs of the communities they serve.

RCGP Scotland supports the independent contractor model for general practice, allowing the delivery of primary health care and family medicine to individuals and communities. In May 2025, RCGP published our GP Partnership Principles, which affirmed our backing for "a mixed economy of contractual models for delivering general practice, while recognising the benefits and importance of the independent contractor model."

We note that Standard 1 states: "Organisations have workforce plans to ensure current and future levels of staffing are safe and sustainable." However, general practice in Scotland is currently facing unprecedented pressures, including a shrinking workforce, an ageing population with increasingly complex care needs, and chronic underinvestment. While we welcome the Scottish Government's General Practitioner Recruitment and Retention Action Plan 2024–26, we do not believe a credible long-term workforce strategy is yet in place to ensure a sufficient GP workforce to meet population needs. It is therefore unclear how Standard 1 can realistically be applied to independent general practices, which operate within the funding frameworks set by the Scottish Government.

Standard 1 also suggests that "use of staffing tools and workload models to plan required capacity" may be an example of good practice. However, we regret that general practice continues to suffer from a lack of robust, high-quality data, making it difficult to accurately assess both demand and capacity. Without significant investment in GP IT systems and digital infrastructure, we do not believe this standard can be meaningfully implemented.

6. Do you have any changes you would like to propose to Standard 1: Staffing and staff management?

- **Yes**
- **No**

If yes, please give details.

We are concerned that Standard 1 appears to be written with large statutory organisations in mind, and does not adequately reflect the realities of smaller, independent GP practices. Given that the

vast majority of patient interactions in Scotland occur within primary care, it is problematic that this standard does not take that into account.

We recommend that Standard 1 be revised to better reflect the unique circumstances of general practice - specifically, smaller, more agile organisations operating under significant time and resource pressures. A more inclusive approach would ensure the standard is relevant and applicable across the full spectrum of healthcare providers.

7. Do you support Standard 2: Clinical audit and quality improvement as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don't know**

Please tell us why you think this.

RCGP Scotland welcomes the ambition behind Standard 2. Using data, audit, and quality improvement to drive safer, more effective care is essential and the emphasis on learning, collaboration and proactive improvement is welcome.

However, we would slightly temper our support for Standard 2 as currently drafted because it has been written with large, secondary care organisations in mind. It is not clear how Standard 2 applies to general practice where services are smaller, more independent and work under significant resource constraints. Primary care delivers most patient interactions on any given day in Scotland; it is therefore regrettable that Standard 2 has been constructed in such a way.

Quality improvement and audit is already happening in general practice and community settings but at a different scale and structure as would be expected in larger organisations. For example, general practice actively contributes to national audits and has a longstanding tradition of reflective learning and quality improvement. Recognising this context would make the standard more relevant and achievable to general practice and primary care.

We regret that the Standard does not mention GP Quality Clusters which were included in the 2018 GP Contract to improve the quality and integration of local healthcare services in Scotland to drive quality improvement. It is RCGP Scotland's view that GP Quality Clusters have been under resourced and unsupported.

8. Do you have any changes you would like to propose to Standard 2: Clinical audit and quality improvement?

- **Yes**
- **No**

If yes, please give details.

We suggest the following changes to improve clarity, inclusivity, and practicality:

- Make Standard 2 more relevant to general practice and community-based services, where formal audit structures and improvement teams may not be in place, but quality work is still ongoing. This could be achieved by using language or examples that recognises how quality improvement happens in small teams or at a practice level.
- Review some of the criteria for clarity and legibility: 2.5 is not clearly worded: "Organisations have systems and process in place to improve quality and safety across the whole system by: share intelligence and learning..."
- Acknowledge the need for support and protected learning time to embed meaningful quality improvement. This is particularly important in general practice where workload pressures can be a barrier to participating in quality improvement activities.
- Strengthen the emphasis on cross-sector learning - quality and safety are shared responsibilities, and improvement is most effective when organisations learn from each other across boundaries.
- Include examples relevant to primary care settings in the section on “what meeting this standard might look like.” For instance, this could include collaborative quality improvement projects across GP clusters, or practice-led audits with measurable changes to care.
- Consider highlighting the value of involving patients and communities in shaping improvement work - something already well established in many areas of general practice.

9. Do you support Standard 3: Clinical effectiveness as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don’t know**

Please tell us why you think this.

We welcome the intent behind Standard 3: Clinical Effectiveness. GPs are highly skilled in managing risk within the community, ensuring patients receive the right care, at the right time, in the right setting. Many of the responsibilities outlined in the “What does the standard mean for staff?” section are already being met within general practice.

We note that Criterion 3.4 states: “All staff groups have time, resources and support to participate in knowledge development and exchange and remain up to date with current best practice.” While this is a desirable goal, we must highlight that many practices are unable to access protected learning time due to the significant workforce and workload pressures currently affecting general practice. The availability of protected learning time remains inconsistent across Scotland.

RCGP Scotland would welcome further efforts to ensure that all GPs have equitable access to protected learning time, enabling teams to learn together and to be engaged meaningfully in professional development and reflective practice.

10. Do you have any changes you would like to propose to Standard 3: Clinical effectiveness?

- **Yes**
- **No**

If yes, please give details.

NA.

11. Do you support Standard 4: Risk management and safety as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don't know**

Please tell us why you think this.

RCGP Scotland welcomes the ambition behind Standard 4 and supports its focus on openness, responsiveness and learning when it comes to patient safety. The emphasis on a culture of candour, psychological safety for staff and effective reporting structures is both timely and appropriate.

We support the overall intent of the standard, but would suggest some revisions to improve its clarity, relevance and application - particularly in primary care settings such as general practice, where the infrastructure and context differ significantly from that of large NHS organisations.

At present, the standard appears largely written with hospitals and large statutory bodies in mind. Terms such as "ward level," expectations around board-level oversight, and references to "named officers" do not translate easily into small, independent general practices. General practice teams are deeply committed to patient safety, but their capacity, systems and governance frameworks often look very different. Recognising and reflecting that difference would go a long way in making the standard feel inclusive and realistic across all parts of the health and care system.

We would also encourage a move toward plainer, more accessible language. For safety standards to be embedded meaningfully across diverse settings, they must be easy for teams - clinical and non-clinical - to understand and act on.

The standard would also benefit from clearer recognition of the risks that occur at the interface between services - particularly between primary and secondary care. For example, risks relating to discharges, communication, medicines reconciliation and access to diagnostics are frequent sources of concern in general practice and community settings. Stronger emphasis on cross-boundary working, shared learning and joint improvement planning would help build a more joined-up approach to managing clinical risk.

Similarly, the role of digital clinical safety could be better reflected. As services become more reliant on shared records, e-prescribing, AI tools, and third-party IT systems, the potential for harm increases. Including expectations around safe implementation, risk assessment, and response to digital system failures would strengthen the standard considerably.

We were pleased to see the emphasis on supporting staff who raise concerns. However, the standard could be clearer that locums, trainees and contractors - who are a significant part of the general practice workforce - must also have access to safe and well-signposted reporting mechanisms. It's important these systems feel accessible and psychologically safe to everyone, regardless of contract type or role.

The commitment to learning from adverse events is welcome and we suggest the standard should also set an expectation that organisations - and where possible, GP clusters and networks - share

anonymised, thematic learning widely and accessibly. This doesn't have to be complex; even simple "you said, we did" summaries can help build a culture of transparency and improvement.

Finally, we would recommend that communication with patients and families following incidents is highlighted not just as timely, but also as compassionate, inclusive, and easily understood. Offering support and signposting where needed - particularly for those who may be vulnerable or distressed—should be part of the standard response to harm.

12. Do you have any changes you would like to propose to Standard 4: Risk management and safety?

- **Yes**
- **No**

If yes, please give details.

In summary, we slightly support Standard 4 as currently written, and believe it can be strengthened by:

- Making the language and expectations more inclusive of general practice and community teams
- Clarifying references that assume a hospital-based model (e.g. "ward level", "named officer")
- Emphasising interface and digital safety risks
- Ensuring reporting systems are accessible to all staff, including locums and sessional workers
- Encouraging plain language, compassionate communication with those affected by harm
- Highlighting the importance of shared learning and impact evaluation
- Supporting a just, proportionate approach to incident response and improvement

With these refinements, Standard 4 would be more reflective of the realities of modern care delivery across Scotland, and more likely to support meaningful, system-wide learning and safety improvement.

13. Do you support Standard 5: Education and training as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don't know**

Please tell us why you think this.

RCGP Scotland is broadly supportive of Standard 5 Education and training as currently written. GPs are expected to engage in CPD activities covering a broad range of topics relevant to general practice, including clinical skills, professional development, and management skills. We again emphasise that the delivery of protected learning time for GPs in Scotland is variable which may make this Standard hard to implement in general practice settings.

14. Do you have any changes you would like to propose to Standard 5: Education and training?

- Yes
- No

If yes, please give details.

NA.

15. Do you support Standard 6: Service user and patient involvement as currently written?

- Strongly support
- Slightly support
- Neither support or oppose
- Slightly oppose
- Strongly oppose
- Don't know

Please tell us why you think this.

GPs believe that the partnership model allows them to innovate, and to understand the needs of the communities they serve, and to be responsive to these. However, we neither support nor oppose Standard 6, as we do not believe it is currently feasible to routinely incorporate formal patient input into the design and delivery of clinical services within general practice, especially where demand outstrips the available resources. Once again, the standard appears to have been drafted with larger healthcare organisations in mind.

We do, however, welcome Standard 6's emphasis on inclusivity and accessibility. Public polling conducted by the Health Foundation and Ipsos has shown that improving access to GP appointments is now a top priority for the public - highlighting growing concern around this issue.

Despite this, we note that Standard 6 calls for organisations to undertake regular local population needs assessments. In the context of general practice, this would be extremely challenging due to limited access to high-quality data, outdated IT infrastructure, and ongoing workforce shortages. These barriers make such assessments far more difficult to implement in primary care than in larger secondary care settings.

We regret that Standard 6 does not adequately reflect the operational realities of general practice and primary care. Furthermore, we are concerned that the standard makes no reference to continuity of care - a core principle of general practice that is highly valued by patients. Continuity of care is associated with improved health outcomes, reduced re-attendance rates, fewer unnecessary hospital admissions, and greater patient satisfaction. Its omission from the standard is a significant oversight.

16. Do you have any changes you would like to propose to Standard 6: Service user and patient involvement?

- Yes
- No

If yes, please give details.

We would support a redrafting of Standard 6 to better reflect the realities of service user and patient involvement in primary care and general practice. In these settings, engagement often takes place through informal and community-based methods, rather than through formalised structures more typical of larger organisations.

It is not sufficient to consider patient involvement solely through the lens of accessibility without also recognising the importance of relational continuity of care. Continuity is a cornerstone of general practice, offering significant benefits to patients and the wider health system.

Expecting GP practices to carry out population needs assessments without access to adequate data or sufficient staffing is simply not feasible. Standard 6 should be revised to acknowledge these constraints and reflect the operational context of general practice more accurately.

Additionally, we believe the standard would benefit from incorporating the concept of unmet need, which directly impacts patient involvement and service design. Recognising and addressing unmet need is essential to ensuring services are truly inclusive and responsive.

17. Do you support Standard 7: Data and information as currently written?

- **Strongly support**
- **Slightly support**
- **Neither support or oppose**
- **Slightly oppose**
- **Strongly oppose**
- **Don't know**

Please tell us why you think this.

RCGP Scotland is broadly supportive of Standard 7 as currently drafted. The ability to access personal data across different services is essential for improving patient outcomes and delivering high-quality clinical care. We know that the interface between primary and secondary care is a recognised area of clinical risk, where poor information transfer can lead to medical errors. We therefore welcome efforts to reduce this risk by improving the safe sharing and accessibility of patient data.

We note that the Scottish Government's Care Reform (Scotland) Bill includes provisions to enhance data sharing across organisations. We support the Government's approach to improving information systems through appropriate legal gateways and the development of interoperable systems that adhere to common information standards - without the need to create a single, centralised digital platform.

We also welcome Standard 7's recognition of the role of artificial intelligence (AI). While AI use in general practice remains limited, we are aware of some practitioners adopting AI voice scribes to summarise consultation notes. NHS England has already issued guidance on the use of AI scribes, and we would welcome similar guidance from NHS Scotland to ensure safe and effective use, helping make Standard 7 more achievable in practice.

Finally, we suggest that Standard 7 may need to be revisited in future years as the Digital Front Door becomes available and national roll-out takes place and its functionality expands. We anticipate this new service will alter the ways that individuals interact with health and care services. This will likely have implications for data access, interoperability, and patient engagement.

18. Do you have any changes you would like to propose to Standard 7: Data and information?

- Yes
- No

If yes, please give details.

NA.

19. Do you feel that anything is missing from the standards? *

- Yes
- No

If yes, please give details.

We regret that these Clinical Governance Draft Standards appear to have been developed with a focus on larger secondary care organisations. This overlooks the fact that the majority of healthcare interactions in Scotland take place within primary care and general practice settings.

RCGP Scotland would support a substantial redrafting of the standards to better reflect the realities of healthcare delivery in primary care. Ensuring that the standards are relevant and applicable to general practice is essential for their successful implementation across the health system.