HEALTH AND SPORT COMMITTEE

AGENDA

4th Meeting, 2014 (Session 4)

Tuesday 4 February 2014

The Committee will meet at 9.45 am in Committee Room 6.

1. **Decision on taking business in private:** The Committee will decide whether to take item 3 in private.

2. **Scrutiny of Inspection, Regulation and Complaints Bodies:** The Committee will take evidence from—

   - Dr Denise Coia, Chairman, and Robbie Pearson, Director of Scrutiny and Assurance, Healthcare Improvement Scotland;
   
   - Dr David Snowball, Head of Scotland and Northern England, Field Operations Directorate, and Alistair McNab, Head of Field Operations Directorate Operations, Scotland, Health and Safety Executive;

   and then from—

   - Annette Bruton, Chief Executive, and Paul Edie, Chair, Care Inspectorate;
   
   - Jim Martin, Ombudsman, and Paul McFadden, Head of Complaints Standards, Scottish Public Services Ombudsman.

3. **Assisted Suicide (Scotland) Bill:** The Committee will consider a list of candidates for the post of adviser to assist in its stage 1 scrutiny of the Assisted Suicide (Scotland) Bill.

Eugene Windsor
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5410
Email: eugene.windsor@scottish.parliament.uk
The papers for this meeting are as follows—

**Agenda Item 2**

PRIVATE PAPER  
HS/S4/14/4/1 (P)

Written Submissions  
HS/S4/14/4/2

**Agenda Item 3**

PRIVATE PAPER  
HS/S4/14/4/3 (P)
Scrutiny of Inspection, Regulation and Complaints Bodies

Healthcare Improvement Scotland

1. Introduction
We are the national healthcare improvement organisation for Scotland, established to advance improvement in healthcare. We have a vital role in supporting healthcare providers to deliver safer, more effective and more person-centred care.

We are committed to collaborating with healthcare providers to make improvements for patients by providing:
- sound evidence
- open, informed scrutiny and assurance, and
- effective quality improvement implementation support

We believe that by integrating our evidence, scrutiny and assurance, and quality improvement implementation support functions we can effectively drive the delivery of world-class care for the people of Scotland.

Leading both quality improvement and quality assurance from one organisation offers a unique opportunity to establish and embed complex, and often cultural, change. The Berwick report highlights the vital role that ‘intelligent inspection’ plays. However, this cannot stand alone and must be combined within a system of improvement. One thing is very clear to us: simply criticising the standards of care is not enough to make sure that change happens.

First and foremost, it is NHS boards across the country that are responsible for, and make, improvements to the care we all receive. However, we provide advice, support, tools and encouragement when it is required.

Our Strategy 2014-2020, ‘Driving Improvement in Healthcare’, is currently out for consultation. Our strategy will evolve over the next six years so that we can respond to the changing policy context and needs of the people of Scotland.

2. Key developments and priority areas
There are a number of recent developments and priority areas going forward which we wish to highlight to the Health and Sport Committee:

Scrutiny and assurance
• Healthcare Improvement Scotland’s draft Scrutiny and Inspection Plan 2014-15 sets out a range of proposals for the future shape of scrutiny. An earlier consultation (carried out in late 2013) referred to the opportunity to undertake more comprehensive assessments of the quality of care in NHSScotland and there was broad support from respondents for such an approach.

• The Whittle Review of the Healthcare Improvement Scotland methodology and process for the inspection of the care of older people in acute hospitals, along with the Independent Review of Healthcare Improvement Scotland’s inspection of the care of older people at Ninewells Hospital, are informing how we continue to develop our scrutiny approach, with better communication and stronger quality assurance of our work, and a move towards enhanced, multidisciplinary service review teams with enhanced clinical input and public partner roles.

• At the request of the Cabinet Secretary, Healthcare Improvement Scotland undertook an extensive, independent review of the factors influencing the quality and safety of care in NHS Lanarkshire’s acute hospitals (published in December 2013). The review team included a range of experienced healthcare professionals from across NHSScotland and members of the public. The NHS Lanarkshire Rapid Review covered a broader range of dimensions than previous topic specific reviews or inspections. This approach has demonstrated the opportunities for a more comprehensive approach to the scrutiny of healthcare, ensuring that the views of patients and staff are heard throughout the process.

• In 2014-2015, we are working with a range of bodies, including NHS National Services Scotland, the Care Inspectorate, NHS Education for Scotland, the Scottish Public Service Ombudsman, and Audit Scotland to establish a Healthcare Intelligence Review Group. The Group provides a forum to share data and information to build as comprehensive a picture as possible about the quality of care in NHS boards and to use this intelligence to determine how we and our other partner organisations can work to support scrutiny and improvement. The bringing together of hard and soft intelligence to form a picture of the quality of care in NHS Boards rests within the organisation’s overall business intelligence strategy.

• We believe that enhancing our scope to act independently in response to concerns and intelligence strengthens the independence of our scrutiny activity. In addition, the nature of the system in Scotland provides us with direct access to Ministers, supported by the Public Services Reform Act (2010) which gives Healthcare Improvement Scotland the power to
escalate issues to Ministers. We believe that, in this way, our independence and integrity can be retained, while involving skilled professionals from the service in our scrutiny activity.

- We also believe that there are greater opportunities to listen to patients and the public by sharing and using information from feedback, comments, concerns and complaints to help inform our priorities. Through the Scottish Health Council we are looking at the way NHS boards are complying with the Patients Rights (Scotland) Act 2011 in managing and acting on feedback comments, concerns and complaints.

- We have undertaken a programme of reviews across NHS Boards on the management of adverse events, which has informed the development of a national approach for managing adverse events, and which helps Boards to share and learn from each other to put improvements into practice. During 2014-15 we will be embedding the framework for management of adverse events into our wider safety improvement initiatives.

- Healthcare Improvement Scotland sees scrutiny activities as just one part of the improvement process. It is essential that more comprehensive assessments of the quality of care are integrated with improvement activity. The context, close relationships, size and scale of NHSScotland offers an opportunity for scrutiny and improvement to be closely aligned and, as a result, realise substantial gains in the quality of patient care.

- We continue to work closely with the Care Inspectorate and in the course of 2013 tested a new methodology for joint inspection of adult services. A similar model to the comprehensive quality and safety assessments would apply to this joint work, to ensure a comprehensive approach which would encompass the scrutiny of the quality of care as well as the strategic commissioning of services that support more people to live independent lives at home or closer to home.

- There is a substantial opportunity with the commissioning role of the new health and social care partnerships to commission services that refocus the pathway of care with more emphasis on community rather than acute inpatient care. We have the opportunity to lead on the development of clinical standards that reflect such pathways of care – especially for the care of older people and/or those with complex chronic conditions – and quality assure, through scrutiny, the delivery of better outcomes for patients, such as reducing presentation at accident and emergency departments. We will ensure that the new arrangements support the
direction of travel with the proposed establishment of Health and Social Care Partnerships.

- During 2014-15 we will be undertaking six joint inspections, with the Care Inspectorate, of services for children. These will have a multi-agency and strategic approach and in so doing will not evaluate the effectiveness of individual services, but consider the effectiveness of integrated working to improve outcomes for the most vulnerable children.

Evidence

- We develop the evidence base to improve patient outcomes and support effective and cost effective clinical practice in NHSScotland through primary (research collaborations and commissioned work) and secondary research (Scottish Intercollegiate Guidelines Network (SIGN), Scottish Health Technologies Group (SHTG), and Scottish Medicines Consortium outputs). We are working to improve the responsiveness of our evidence processes to reflect the need for advice in the face of rapidly developing medicines, technologies and treatments and the increase in the incidence of multi-morbidity in an ageing population.

- As a result of the Health and Sport Committee Inquiry into Access to Medicines, the Scottish Medicines Consortium (SMC) will implement a number of far-reaching recommendations. In particular, as a priority, the SMC has developed a new methodology for the assessment of medicines used at the end of life and for very rare conditions. In addition, in support of greater transparency, SMC meetings will be held in public from May 2014. As a first step, Patient Interest Groups will be invited to attend SMC from February 2014. The SMC presented a business case to support its response to the recommendations to the Scottish Government in December 2013.

Improvement support

- We design, drive and deliver national improvement programmes which support NHS boards and their key partners to deliver sustainable improvement in key priority areas. As set out in our Strategy 2014-2020 we will continue to build our capacity and capability to drive quality improvement across NHSScotland, and to be the ‘go-to’ organisation for improvement expertise within the healthcare sector.

- We aim to bring our knowledge, skills and expertise in improvement science closer to the service through greater local, regional and national collaboration. Through our leadership of the NHSScotland Quality Improvement Hub, which is a national collaboration among Special Health Boards, Territorial Health Boards and the Scottish Government Health
Directorate, we will help to develop quality improvement capacity and capability throughout NHSScotland.

- In 2014-15 we will work closely relevant partners to ensure a comprehensive and co-ordinated approach is in place for quality improvement support to integrated health and social care services.

- Through the Scottish Health Council, we continue to provide assistance to NHS Boards in the development and delivery of person centred services. We support Boards to use the Participation Standard to improve the way they work with patients and the public and monitor how they carry out their statutory duty to involve patients and the public in the planning and delivery of NHS services.

- We lead the Person Centred Care Health and Care Collaborative which is focussed on care experience. The collaborative provides a framework for change, and builds momentum for reliable testing and implementation of the five "must do with me" principles. The collaborative will help to support people close the gap between what we know we should do (the evidence) and what we actually do in practice.

- The world leading Scottish Patient Safety Programme has recently gone through significant change and expansion to include Mental Health, Maternity, Neonatal, Paediatric and Primary Care. The original Acute Adult care programme has also expanded to include sepsis and harms relating to blood clots (VTE) along with the development of a national harm indicator which incorporates pressure ulcer care, falls, infections related to urinary tract catheters and cardiac arrest. During 2014 we will undertake a fundamental review to strengthen the governance mechanisms and infrastructure underpinning sustainable delivery of our national safety portfolio.

- We have worked closely with NHS Education for Scotland and NHS Boards to spread and embed the Releasing Time to Care programme throughout Scotland. Releasing Time to Care frees nurses up to spend more time on direct patient care in an improved nursing environment, through practical models applied to improve and streamline hospital ward processes and allow time to focus on priority areas of care. The National programme came to an end in late 2013 and Boards have been supported to draw up their own local sustainability plans.

- Our 'Improving Care for Older People in Acute Care' workstream is a two-year programme to improve the care for older people in acute care. This work complements the scrutiny programme currently taking place to
identify strengths and areas for improvement across hospitals in NHS Scotland. This programme currently focuses on supporting NHS boards to improve their response to individuals with frailty and/or delirium, two key areas consistently identified as needing improvement within the inspection process.

Appendix 1: Our history

Healthcare Improvement Scotland was created by the Public Services Reform (Scotland) Act 2010 and formed in April 2011. We bring together the functions of NHS Quality Improvement Scotland and the regulation of independent healthcare that the Care Commission had previously been responsible for.

We have a strong record of delivering evidence, scrutiny and assurance, and quality improvement activities in healthcare.

- We continue to deliver evidence-based advice and guidance through the Scottish Intercollegiate Guidelines Network (SIGN), the Scottish Health Technologies Group and Scottish Medicines Consortium.

- Since 2009, we have delivered a programme of Healthcare Environment Inspections, a programme of inspections of the care of older people in acute hospitals since 2012, and we have regulated and inspected all independent healthcare services in Scotland since 2011. We have also collaborated with Her Majesty’s Chief Inspector of prisons providing the healthcare advice to prison inspections since 2011.

- Our scrutiny activities include an ongoing programme to quality assure clinical governance processes and the quality of healthcare services provided across NHS boards in an impartial and objective way, for example the rolling programme of NHS board adverse event reviews.

- We lead independent reviews, such as the investigation into an individual patient treatment request and the review of the national paediatric cardiac service.

- Patient Focus and Public Involvement in the NHS in Scotland has been monitored by the Scottish Health Council since 2005 leading to demonstrable improvements in the quality of participation at local level.

- We have delivered, in collaboration with NHS boards, the world-leading Scottish Patient Safety Programme since 2008 and are spreading the improvement programme across four key work streams of Acute Adult, Maternity, Mental Health and Primary Care.
• We continue to deliver quality improvement support, education, training and technical expertise through the Quality Improvement Hub.

• We have delivered collaborative programmes of improvement support in priority areas such as nutritional care, pressure ulcer care, infection control and mental health.

• We have an established clinical engagement strategy to ensure clinicians are involved across our whole portfolio of work.
1. Introduction

The Committee and the Care Inspectorate share important objectives in seeking to protect vulnerable people who use care services, and improve quality. The Care Inspectorate is therefore pleased to give evidence to the Health and Sport Committee about its role and activities.

The Care Inspectorate was established in 2011 to bring together the Care Commission, the Social Work Inspection Agency and the child protection functions of HMIE. The Care Inspectorate employs some 600 staff in 16 offices and has a budget this year of £33.7 million.

Our work is into two key areas: inspecting individual care services, and carrying out joint strategic inspections of services for young people and for older people in local areas. We also provide scrutiny of criminal justice social work services and undertake other specialist functions. We hope this paper is helpful for the Committee in illustrating the wide range of our scrutiny and improvement work.

2. Regulated care services

Care services cannot, by law, operate in Scotland unless they are registered with the Care Inspectorate. At the end of the most recent inspection year, there were 13,523 care services registered in the following categories:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childminders</td>
<td>5,640</td>
</tr>
<tr>
<td>Daycare of children</td>
<td>3,755</td>
</tr>
<tr>
<td>Nurseries, playgroups, etc</td>
<td></td>
</tr>
<tr>
<td>Care homes</td>
<td>1,493</td>
</tr>
<tr>
<td>For older people, adults &amp; children</td>
<td></td>
</tr>
<tr>
<td>Support services</td>
<td>1,325</td>
</tr>
<tr>
<td>Care at home &amp; day care of adults</td>
<td></td>
</tr>
<tr>
<td>Housing support</td>
<td>1,020</td>
</tr>
<tr>
<td>School accommodation</td>
<td>67</td>
</tr>
<tr>
<td>Fostering services</td>
<td>62</td>
</tr>
<tr>
<td>Nurse agencies</td>
<td>39</td>
</tr>
<tr>
<td>Adoption services</td>
<td>39</td>
</tr>
<tr>
<td>Adult placements</td>
<td>37</td>
</tr>
<tr>
<td>Childcare agencies</td>
<td>32</td>
</tr>
<tr>
<td>Offender accommodation services</td>
<td>9</td>
</tr>
<tr>
<td>Secure accommodation services</td>
<td>5</td>
</tr>
</tbody>
</table>

Each of these services is inspected regularly. They operate in the public, private and voluntary sectors.
2.1. Registration
Before a care service can operate, it must register with the Care Inspectorate. This is a robust process, designed to protect potential users. We check:

- whether the provider and manager are fit to provide or manage a care service;
- whether the premises are fit for purpose and safe; and
- that the service will make all the proper provisions for the health, welfare, independence, choice, privacy and dignity of everyone using it.

We may also check aspects of the financial viability of the service. Last year, there were 902 new registrations and 965 cancellations.

2.2. Inspection
Every care service is inspected. Last year, we completed 8,835 inspections – a 15% increase on the year before. The frequency, agreed by Scottish Ministers, is based on the type of service and the risk we attach to it. Care homes for older people must be inspected at least annually, but those which cause us concern may be inspected much more regularly.

Our inspectors have a background in care and support, and undertake a professional qualification in inspection. This year, we established specialist inspection teams so that our staff are, in so far as possible, inspecting types of service in which they practiced. A health and wellbeing improvement team comprises consultants and professional advisers in rehabilitation, pharmacy, nutrition, palliative care, infection control, tissue viability, dementia and more. They support inspections where there is an identified need.

Most inspections are unannounced. Last year, just 4% of inspections were announced. A further 36% were short-notice inspections, where inspectors telephone shortly before an inspection to establish a service like a childminder or care at home is operating that day.

We inspect against the National Care Standards. After each inspection, we grade the service and publish a report. Services are graded in four areas:

- quality of care;
- quality of staffing;
- quality of environment; and
- quality of management and leadership.

In addition, we sometimes carry out wide-scale inspection in particular thematic areas. From April 2014, we are planning an Inspection Focus Area in children’s services to look at the quality of infection control.

Each area is graded using this scale:

- Unsatisfactory 1
- Weak 2
- Adequate 3
The majority of services in Scotland perform well. In the last two years, the number of services where all the grades were judged to be good, very good or excellent rose from 84.3% to 86%. Further detail on grading data is published in our Annual Report and Accounts.

All inspection reports are published online. The purpose of inspection is to drive improvement, so inspections will make recommendations and formal requirements in inspection reports. We generally require an action plan from providers showing how requirements will be met, and these are checked at the next inspection.

Last year, our inspection satisfaction questionnaires showed that 83% of people using a care service and 92% of care staff felt the inspection process directly improved the quality of care in their service.

2.3. Enforcement

Our job is not just to inspect, but is to support failing care services in their improvement. If a service fails to improve, we may ultimately close it. If we think there is serious risk to life, wellbeing or health, we can ask a Sheriff for an emergency cancellation. This is rarely necessary, but is an important power.

The Public Services Reform (Scotland) Act 2010 permits us to add or vary specific conditions of registration. If the situation warrants it, an Emergency Condition Notice takes effect immediately and remains in place until we remove it or a Sheriff sets it aside. Where regulations or conditions have been breached, we can serve a Section 62 Improvement Notice which makes specific requirements that the service must comply with or face closure. If we close a care service, the provider has the right of appeal to the Sheriff.

Last year, we issued 59 enforcement notices as follows:

<table>
<thead>
<tr>
<th>Notice Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Notice</td>
<td>37</td>
</tr>
<tr>
<td>Proposal to cancel</td>
<td>10</td>
</tr>
<tr>
<td>Decision to cancel</td>
<td>2</td>
</tr>
<tr>
<td>Proposal to impose conditions</td>
<td>6</td>
</tr>
<tr>
<td>Decision to impose conditions</td>
<td>2</td>
</tr>
<tr>
<td>Emergency Condition Notice</td>
<td>2</td>
</tr>
<tr>
<td>Emergency cancellation</td>
<td>0</td>
</tr>
</tbody>
</table>

2.4. Complaints

Complaints do not just resolve problems for people using care services; they help us plan inspections. We use intelligence from complaints and other sources to identify patterns of risk which may indicate the need to bring forward or increase the intensity of an inspection. We actively promote our complaints function and how we can help service users, families and carers.
We accept anonymous complaints using our 0845 6009527 hotline, and try to conclude complaint investigations within 20 days. Summaries of those upheld are published on our website and can result in requirements, recommendations or re-grading.

Last year, 5.4% of services had at least one complaint upheld against them, and 1.5% had more than one upheld. We received 3,172 complaints which led to 1,800 complaint investigations, and we upheld 66% of these.

Care homes and support services (mainly care at home) account for almost two-thirds of all complaints and the number upheld involving these is above average. The most common reasons for complaints were:

- general health and wellbeing
- communication between staff and people using services, their relatives or carers
- staffing levels
- other staffing issues
- medication.

Most complaints were made by friends, relatives or visitors to a service user, followed by employees, followed by service users. Last year, we commissioned research from the Queen Margaret University and the University of Stirling into how people found our complaints process. While making a series of valuable recommendations, the researchers noted that the Care Inspectorate’s role in supporting an effective complaints process is valued and the attitude and the approach of its complaint investigators receives plaudits from many complainants... The Care Inspectorate plays a fundamentally important role for people who feel ‘at the point of no return’, having complained to the service provider several times without a satisfactory response. It is generally seen as an independent and authoritative third party in establishing what should be done. Third party involvement can be effective in ‘turning up the volume’ on complaints. The role of the Care Inspectorate is of fundamental importance to people in giving them a sense of empowerment to proceed with their complaint.”

3. Strategic joint inspections

An approach which only looks at individual services doesn't go far enough, so we are implementing new ways of checking that services work together to

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1 Outcome of Complaints Research for the Care Inspectorate, July 2013. Available from www.careinspectorate.com
improve the outcomes for young people and older people in every part of Scotland. These joint inspections bring together experts from different scrutiny bodies to ensure people are supported well.

Following Scotland-wide inspections of child protection services and social work departments ending in 2013, the joint inspections allow strategic inspectors to support further good practice and improvement in council social work departments. In addition to joint inspections, each council is paired with a link inspector to ensure good scrutiny and contact with the Care Inspectorate outwith formal inspection periods.

3.1. Joint inspections of services for children and young people
Scottish Ministers asked the Care Inspectorate in 2011 to develop a new model of joint inspections for services for children and young people. After developing a methodology, four pilot reports were produced looking at Orkney, Edinburgh, North Ayrshire and Argyll & Bute. The first two substantive reports, covering East Dunbartonshire and Midlothian, were published in January 2014. Six reports will be published each year.

As part of these inspections, we look carefully at how vulnerable children and young people are looked after and supported, and ensure that there is good awareness of child protection matters. Young inspectors with experience of the care system join specialists from care, social work, education, health and the police regulator as full members of the inspection team. We have worked with Who Cares? Scotland to recruit, train and support young inspectors.

3.2. Joint inspections of services for older people
The Care Inspectorate and Healthcare Improvement Scotland are developing and testing a methodology for joint inspections of services for older people. A number of small-scale pilots have been completed, and Aberdeenshire is currently undergoing inspection. We are particularly keen to ensure that the gaps between the care system and the NHS are being properly bridged, which means careful examination of the care pathways people follow as they need to use different types of service. The aim is not simply to ‘mind the gap’, but ensure the gap is being eliminated.

4. The duty of user focus
Our duty of user focus is not simply a requirement of the law, but is an essential way of making sure the work we do benefits people. People who use care services are intimately involved in the work of the Care Inspectorate. As well as participating in senior recruitment in the Care Inspectorate, our Involving People Group brings service users and carers together to discuss issues relating to care and support services. They also look at ways that the Care Inspectorate can improve its own activities by giving us important feedback on policies, plans and approaches to inspection and improvement.

We have around 70 inspection volunteers (formerly called lay assessors), who have personal or family experience of care. They accompany inspectors, talk to people using the service, and make observations based on their own
experiences. The inspector uses their findings when assessing quality and awarding grades. Inspection volunteers were involved in 406 inspections last year and we are launching a recruitment campaign in February 2014.

5. The duty of co-operation

We work closely with other bodies in care and social work, and other scrutiny bodies. We carry out joint inspections with Education Scotland and are planning concurrent inspections of secure care with the Mental Welfare Commission. Where necessary, we make referrals about staff malpractice to the Mental Welfare Commission, the Scottish Social Services Council or the Nursing and Midwifery Council, and we regularly share information with them. To date, we have agreed 15 memoranda of understanding and play a full role in Audit Scotland’s strategic scrutiny group. Our Chair sits on the boards of Healthcare Improvement Scotland and the Scottish Social Services Council, ensuring there is effective strategic working across these related bodies.

Where appropriate, we work with colleagues furth of Scotland and have effective relationships with fellow regulators in Wales, England and Northern Ireland. At the request of the States of Jersey and the Isle of Man government, we provided scrutiny of their support for vulnerable and looked after children. In recent months, we have hosted a number of delegations of regulators from the People’s Republic of China who wished to learn from our system of care inspection and regulation.

6. Scrutiny of serious incidents

The Care Inspectorate has specific responsibilities around a number of serious incidents in social work.

6.1. The deaths of looked after children

Where a looked after child dies in the care of a local authority, we must be informed within one working day. The local authority must then submit a report which we review to examine the arrangements for the child’s welfare and whether any lessons need to be learned. We publish an annual report on the deaths of looked after children.

6.2. Criminal Justice Social Work Serious Incident Reviews

In addition to the inspection of regulated services, the Care Inspectorate is responsible for the scrutiny of social work services, including criminal justice social work services. Where an offender on licence is being supervised by a local authority’s social work department and is involved in a serious incident, our specialist inspectors review the local authority’s handling of the case to determine if there are any lessons to be learnt which might prevent a similar incident in the future. We publish an annual report on these.

6.3. Intra-country adoption

Where a person or persons propose to adopt children from outside the UK, our specialist inspectors review paperwork on behalf of Scottish Ministers.
6.4. Deaths of care service users
Previously, we required any unusual or unexpected deaths in a care service to be reported to us, but now expect all deaths in care services to be notified to us. Inspectors review these notifications and use them to inform our views about the risk of a service and the frequency of necessary inspection.

6.5. Significant case reviews
Where a significant case review is held, the Care Inspectorate can and does provide support and input in our areas of involvement. We have also, occasionally, called for significant case reviews to be conducted where we identify failings from which lessons need to be learned.

6.6. Child and adult protection
During the course of an inspection, inspectors may find evidence or suggestion of abuse or poor practice which potentially places children or adults at risk. When an allegation of abuse is made, irrespective of the nature of the allegation or source, it is acted upon regardless of evidence. This involves immediate notification to the relevant local authority social work department and/or the police. Responsibility for the investigation of allegations of child abuse or adult abuse rests with the local authority and the police, and we work closely with both.

7. Key issues in care and social work
We are supporting a number of upcoming policy initiatives.

7.1. Review of the National Care Standards
We have seconded a member of staff to support the Scottish Government’s review of the National Care Standards. We strongly support a human rights based approach to care standards, underpinned by specific requirements relating to different service types. This would allow our inspectors not just to make assessments against set standards, but use greater professional judgement to ensure care is compassionate, person-centred and protects the rights of individuals.

7.2. The Public Bodies (Joint Working) (Scotland) Bill
We strongly support moves to ensure closer working between social care and health care and our Chief Executive sits on the bill advisory group. Our joint inspections with Healthcare Improvement Scotland will assure the quality of joint working between care providers and the NHS locally. We welcome proposed responsibilities around the scrutiny of strategic commissioning and believe we can best execute these by examining the outcomes such commissioning leads to. We are happy to speak to the Committee in the future as the Bill makes parliamentary progress.

7.3. The Children and Young People (Scotland) Bill
We have provided evidence to other Committees on this Bill. One of our key areas of interest is to support young people in, and leaving, care, and supported the call to raise the age of statutory support for care leavers. Our
current pilot of a new way of inspecting childminders, using the approach of Getting It Right For Every Child, will support the principles of the Bill.

7.4. Tackling child sexual exploitation
Although most child protection services in Scotland perform well, children may still be at significant risk of sexual exploitation. Senior Care Inspectorate staff sit on the ministerial working on child sexual exploitation and we have worked with CELCIS and other regulators to help inform ways in which our inspections of such services can be strengthened further.

7.5. Self Directed Support
We recognise and strongly support the importance of greater choice and flexibility to deliver more person-centred care, which in turn requires a continued shift towards the transfer of power and control to individuals who require care and support services.

One possible consequence is that a significant number of support services currently provided by registered care services may in future be provided by individuals who do not fall within the regulatory regime currently operated by the Care Inspectorate, and are not required to be registered with the Scottish Social Services Council. It is important to balance this with promoting professionalisation of the social care workforce, as exemplified by the continuing requirements for staff to achieve registration.

7.6. Care Inspectorate developments
We are currently reviewing our methodology for inspecting all types of care service. This will support any changes to the National Care Standards and ensure that our scrutiny remains proportionate and targeted on risk. A wide process of consultation with the sector and people who use care services is now beginning.

We have also begun a process to be much more proactive about our inspection findings, which is a recommendation stemming from a previous Health and Sport Committee inquiry into the regulation of older peoples’ care. While all inspection reports are published online, from January 2014, we are implementing a process of proactively alerting the public in cases where we see either very good sustained practice, or where care services are falling below the standards we expect and do not improve. We hope this will provide better public assurance about care services.

Annette Bruton, Chief Executive
Paul Edie, Chair
February 2014
Scrubtity of Inspection, Regulation and Complaints Bodies

The Scottish Public Services Ombudsman

The Committee already hold copies of my annual health complaints report. In this letter, I provide an update to that report highlighting some key numbers and themes arising from our experience of the first three quarters of 2013/14.

SPSO complaints: 2013/14 Update

1. Increase in complaints

The coverage of our health complaints report and also of the figures from health boards themselves has concentrated on the significant rise in numbers of complaints reported in 2012/13. At the SPSO, this rise has slowed but continues and, while the figures I quote in this letter remain provisional until year end, in the first three quarters of 2013/14 we have seen a 17% increase in complaints received on top of last year’s increase of 23%.

As I said in my health complaints report, research has shown that there has traditionally been a reluctance to complain about healthcare. A rise, certainly in the short term, may simply reflect a greater willingness to complain and more confidence in the process. It is not possible to say that an increase in numbers, on its own, means a decrease in the quality of care. This is why it is important to take a considered approach to the analysis of complaint numbers. For example, in my health complaints report, I highlighted the importance of the numbers we uphold as an important indicator. I remain concerned when I see cases where the health board found nothing wrong and yet we find significant failings. The uphold rate for the first three quarters remains high at 55% (an increase of 3% on the 2012/13 rate).

We will look at the full-year figures in more detail in my next health complaints report. At present, I can report that we have been working with some of the larger health boards to seek to understand what may lie beneath the figures and are hoping, resources permitting, to provide some tailored support where we think it may be of most benefit. The impact of this work will not be seen in 2013/14 but we hope to see some benefit to patients and others complaining to health boards in the years that follow.

2. Key themes emerging from case work

In my regular monthly e-newsletters, I focus on significant points that have come out of our case work. Between May and December 2013, I have highlighted the following.

2.1 The problems prisoners are having accessing the health complaint process

Following the transfer of responsibility of health care in prisons to the NHS I have identified some barriers to prisoners raising complaints. In a report in May\(^2\) I found that a prisoner had been unreasonably denied access to the

\(^2\)http://www.spso.org.uk/sites/spso/files/communications_material/commentary/2013/2013.05.22_SPSO_Commentary.pdf
process. I was pleased to be able to report that the Scottish Government was being proactive but also had to say that:

‘It is now 18 months since the transfer of responsibility and it is high time that these issues were fully addressed.’

I reported again on the same issues appearing in a different health board in October. I appreciate there will be a time lag while problems are ironed out but I will be very disappointed if I am continuing to report on access issues into 2014.

### 2.2 The care of vulnerable adults

This was highlighted as a result of a number of concerning cases I reported in July and August. I have shared these concerns previously with the Committee. I continue to see problems with carers, advocates and the family of those who lack capacity not being listened to. There are also on-going problems with assessment of capacity and the care provided to the vulnerable in hospitals. I had to report on cases where legal safeguards put in place by this Parliament were not being followed. This year I took the unusual step of highlighting one particular case to the Mental Welfare Commission. I also found that in one case there had been a failing to respect the rights set out in the Charter of Rights for People with Dementia and their carers in Scotland.

This is an area where training and time needs to be made available to ensure staff have the knowledge and resources they need to ensure that vulnerable adults are given the dignity and care they deserve. In response to one of the most significant complaints we received I said:

‘These complaints raise serious concerns about the quality of decision making, consideration of capacity issues and recording of these issues with respect to a most vulnerable member of society, namely an adult with life-long learning difficulties and dementia. There are a number of legal safeguards which should have been in place for Miss A precisely because of her degree of vulnerability, and it is of considerable concern that there were significant delays in enacting these.’

### 2.3 Communication failings

My reports regularly reflect on communication failings. These lead not only to direct failings in care but cause additional distress at very difficult times. There are examples throughout the cases I report but I would point to an

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3 SPSO May Commentary p 1
9 SPSO July 2013 Commentary p 4
investigation I reported in August\textsuperscript{10} where failings in communication around a stillbirth exacerbated a very difficult time for the parents. I was particularly critical of the failure to keep both parents informed and to ensure they were involved in important decisions:

\begin{quote}
This was always going to be an extremely traumatic experience for Mr and Mrs C, and when compounded by the failures in care described above, it must have been exceptionally difficult for them. The medical notes suggest that many discussions about the baby’s chances of survival took place with only Mrs C present, and that no hospital neonatologist spoke to Mr C before the birth. This was made worse by the fact that some important issues (such as resuscitation, or the options available around the operation, and its possible outcome) were not explained or were not clearly explained. This meant that, at times, the element of choice was removed from Mr and Mrs C. \textsuperscript{11}
\end{quote}

\section*{2.4 Recommendations}

The act of listening and providing an explanation of what happened is often greatly valued by our customers. Whenever possible we will provide a specific response to the particular injustice suffered by making recommendations for practical actions for the individual and to recognize the distress caused by recommending a personal apology. However, the most common reason someone brings a complaint about a health matter to this office is to prevent the problem happening to someone else. While I am unable to investigate beyond the individual complaint, I do still seek to make recommendations that go beyond those individual circumstances when appropriate. In looking at the broad themes of 2013/14 so far, I would like to highlight some of these wider recommendations.

Importantly, I would like to reassure the Committee that we do not simply let the board decide if these have been achieved. I ask for documentary evidence and, where the change is clinical, this is often assessed by one of my clinical advisers to ensure it fulfills the recommendation made.

Recommendations made so far in 2013/14 include that the individual board:

\begin{itemize}
\item carry out an audit of the standard of their trauma management;
\item review the arrangements for providing cover for absent staff to ensure that urgent test results are reviewed timeously;
\item provides evidence that the falls risk assessment policy and procedures on the ward have been appropriately reviewed and any learning points form part of an action plan for improvement;
\item review their policies and procedures for patients with diabetes admitted to non-specialist wards to ensure that adequate systems in the management of their care are in place;
\end{itemize}

\textsuperscript{10} \url{http://www.spso.org.uk/sites/spso/files/communications_material/commentary/2013/2013.08.21_SPSO_Ombudsmans_Commentary.pdf}

\textsuperscript{11} SPSO August 2013 Commentary p 3.
• undertake an assessment to ensure that the Obstetric Team has the correct training and equipment to perform assessments of extremely pre-term infants with abnormal umbilical blood flows, and prepare an action plan to address any shortcomings; and
• consider introducing a protocol to fast track patients with a potentially poor ovarian reserve.

3. Supporting the NHS
People will only bring concerns and complaints if they feel they will be listened to and receive a genuine, human response. To achieve this staff need to feel supported to manage difficult situations, understand how to respond to complaints and also to feel that their own suggestions for improvement are listened to. The responsibility for achieving this lies with the NHS but, where we can, we provide support.

This year we have worked closely with NHS Education Scotland. I have personally presented three master-classes on complaint governance to board members across Scotland. We have also continued our support for training. An e-learning module for staff investigating complaints is in preparation and will be launched shortly. We have delivered training direct to about 200 GP and dentist practice managers. The training we deliver with NES is one that is designed for the practice managers to be able to then deliver to staff in their own practices so we anticipate this training will have much greater reach. E-learning modules for GPs and dentists are also being prepared.

I also appreciate the need for this office to demonstrate we also listen to the NHS and to our own customers. We will be more effective as an organisation in supporting change and listening to others if we demonstrate that ourselves. This year we set up a series of sounding boards to help us hear the voices of those who complain and those who are complained about. The NHS sounding board was the first to meet and is made up of senior NHS professionals from across Scotland. This allows for frank, two-way discussions about the role and effectiveness of this office. A sounding board is also in place to represent the role and effectiveness of this office. A sounding board is also in place to represent the voice of the complainant.

4. Policy engagement
Our focus this year in health has again been on the integration of Health and Social Care. We raised the important issue of the need for clarity around complaints in separate Scottish Government consultations on guidance in relation to Self-Directed Support and on the delegation of certain local authority functions under the Mental Health and Adults with Incapacity legislation. We also responded to this Committee’s call for evidence about the Public Bodies (Joint Working) (Scotland) Bill. Our consultation responses are at: http://www.spso.org.uk/consultations-and-inquiries.

Alongside this, we have also been working more closely with HIS. Our Director Niki Maclean sat on the working group looking at new guidance for Adverse Incident Reviews. I continue to meet the Scottish Government Health Directorate regularly and recently met with the new Chief Executive of the NHS.
5. Looking forward
The integration of Health and Social Care is moving forward. As I have said previously to the Committee I recognise the potential benefits of this approach.\(^\text{12}\) I was also pleased by the Minister’s positive comments about complaints before this Committee last year when he highlighted the need for a clear complaints procedure against the body corporate or the lead agency\(^\text{13}\). However, I remain concerned that it is still unclear to us how complaints about the new bodies and integrated services will be handled.

The Scottish Health Council recently published their comments on the first annual complaints reports produced by boards. They are now taking forward an assessment of the Scottish Government “Can I help you?” Guidance and its effectiveness. This assessment has been fully supported by the Scottish Government and I am pleased they have taken an early opportunity to look at the way the implementation of the Patients Rights (Scotland) Act is working in practice. This does indicate that complaints are being taken seriously at a senior level. We will be feeding in our own experiences and comments to this process.

In closing, I hope this overview of the first three quarters of 2013/14 provide the Committee with a helpful insight to our work and the issues brought to us. I would be very happy to discuss any matters arising from the annual report, this update or of particular interest to the Committee.

Yours sincerely

Jim Martin
Ombudsman


\(^\text{13}\) Official Report 1 October 2013 col 4424-4426