

18 December 2017

David Cullum  
Clerk  
Health and Sport Committee  
T3.60  
The Scottish Parliament  
Edinburgh  
EH99 1SP

**Corporate Office**

Corporate Project Officer – Sim Sharp

Letter sent via email: [HealthandSport@parliament.scot](mailto:HealthandSport@parliament.scot)

Dear David

### **Clinical Governance Inquiry**

Thank you for your letter of 7 December requesting information further to the evidence provided on 28 November. I have addressed the points made in your letter as they relate to Healthcare Improvement Scotland (HIS) and would note that some of the evidence referred to was that of Scottish Government, who I understand you have also written to.

During the evidence session I referred to the framework we are trying to create at HIS, to support the sharing of good practice and the best evidence. For clarity, this does not relate solely to our work on guidelines and standards but is the development of a national approach to improving the quality of health and social care in Scotland.

We want to ensure that all parts of HIS are working together for best outcomes; this will involve sharing good practice, identifying learning opportunities, providing focused improvement support and strengthening the voice of patients, families and carers, and following this up through appropriate and balanced external quality assurance.

### **Guidelines and standards**

Your letter asks for thoughts on how to ensure the continued relevance of guidelines given the increasing complexity of care. Our Evidence Directorate strives at all times to make its evidence based advice fit for purpose and timely for NHSScotland. Closer liaison across the Directorate, for example between SIGN and the standards development team, will ensure that patients and carers, individual healthcare staff and organisations are aware of evidence-based, best practice and what these means for them.

The [Evidence Directorate Strategic Plan](#) (March 2017) highlights the range of factors that need to be considered in respect of effective implementation of evidence-based advice – including the central role of patients or service users in decision-making about their treatment, and the need for advice to be timely and responsive in the increasingly dynamic care environment.

There are known to be many challenges in supporting effective uptake and implementation of advice in the health service and the integration of health and social care adds a further level of complexity.

The strategic plan outlines how the work, working arrangements and outputs of the Evidence Directorate will be developed to support patients, service users, clinicians, other health professionals and social care practitioners, as well as other teams in Healthcare Improvement Scotland to ensure we are maximising our resources to support the delivery of high quality care.

The SIGN guideline development process involves patients, carers, public partners and front line clinicians. The group determine the questions to be addressed and the recommendations that are made. These factors support the relevance and usefulness of recommendations, and all SIGN guidelines take cognisance of major comorbid issues and make practical recommendations for the care of patients.

To further facilitate shared decision making, lay versions of guidelines are produced. These are available in various formats and hundreds of thousands of these have been downloaded from the SIGN website. It should also be noted that anyone can suggest a topic to SIGN, via a simple process on the website.

### **National framework for adverse events**

You ask about implementation of the framework and the extent to which this has improved consistency of approach across boards, with particular reference to categorisation of adverse events.

The national framework for managing adverse events supports NHS boards to standardise processes. It includes a national definition of an adverse event, guidance on categorisation, reporting, accountability, responsibilities and learning, and principles for an open, just and positive safety culture. The framework was published in 2013 and NHS boards were required to align their policies for the management of adverse events with the national framework. All NHS boards have revised their policies in line with the framework.

Since the framework was published in 2013, HIS has held meetings with all patient-facing NHS boards in 2014 and 2015 to discuss how they are implementing the national framework. A summary of these discussions (*Learning and Improvement Summary*) was published in May 2016. It detailed many areas of good practice and examples of improvement but also 5 key challenges:

- Capacity and capability to carry out AERs
- Providing support to those involved (patients, carers, families, staff)
- Ensuring recommendations translated into practical actions for improvement
- Identifying and sharing key learning points widely
- Working across primary care, secondary care and social care to move towards a more consistent approach

We are in the process of revising the national framework again to support and improve current approaches to adverse events management, incorporating:

- organisational duty of candour requirements;
- adverse events governance and assurance reporting;
- internal and external quality assurance; and
- improvements defined in response to recommendation 8 of NHS Ayrshire & Arran's Maternity Unit review.

## **Monitoring and reporting of adverse events**

In relation to the identification of “changes in patterns of incidents or concerns” occurring in an individual board, on a local basis, the national framework states that NHS boards should undertake trend analysis of adverse events data, linking this to data from complaints, concerns and claims, and develop appropriate action plans. Such analysis can act as an early indicator that a system is not functioning effectively and allow valuable insight into where improvements may be required.

In 2018, it will be a legal requirement for NHS boards to publicly report on adverse events where the duty of candour has been applied and on the learning and improvement actions resulting from the review of these adverse events.

The [national framework](#) also contains details of specific events that need to be reported to external organisations. HIS continues to receive quarterly reports on suicides of individuals in contact with mental health services and progress with reviews of these, and our particular focus is on how learning is shared and improvements are made as a result of the reviews. In addition, the independent healthcare providers that we regulate are required to notify HIS of specific events that occur in their premises: [regulation of independent healthcare notification guidance](#).

HIS is also able to escalate issues or matters of evidence concern arising from our scrutiny of NHS services. Where a serious issue is identified which poses a threat to patient safety and public health, and there is a failure to take action to resolve issues, this can be escalated to the NHS board accountable officer, Chief Executive / Chair, and to Scottish Government.

When Robert Francis' report into the failings at the Mid Staffordshire Foundation Trust was published in February 2013, better sharing of intelligence within and between national agencies was among the recommendations. Significant progress has been made since then. During 2014/15, HIS took a leading role in bringing together a number of national organisations to explore the setting up of an inter-agency intelligence sharing forum in Scotland. This led to the establishment of the Sharing Intelligence for Health and Care Group, which has been functioning since 1 April 2015.

The Group is a partnership between HIS, NHS Education for Scotland, the Care Inspectorate, Audit Scotland, the Information Services Division, the Mental Welfare Commission for Scotland and the Scottish Public Services Ombudsman. The Group provides an opportunity for the triangulation of available intelligence, including emerging concerns about the quality of systems of care. This means that where a significant risk is identified, this enables prompt, proportionate, co-ordinated, and effective collaborative working between the relevant scrutiny and improvement bodies. One of the group's key development priorities for 2017/18 is to

further improve its awareness and understanding of noteworthy variation on key metrics from national datasets. The 2017 annual report of the group can be found [here](#).

The Quality of Care (QoC) approach we are developing puts in place a single framework for both organisational self-evaluation and external quality assurance and validation. In relation to adverse events, we would expect boards to evidence learning from adverse events through governance systems and be looking at this internally; through QoC we would provide risk-based external assurance. We will publish the new QoC Framework on 19 December 2017.

We will review completed self-evaluations, along with nationally available data and other intelligence such as publically available papers and reports and nationally held datasets to form the basis of supportive conversations with service providers, and to intervene as required. Interventions resulting from quality assurance activity may include:

- focused improvement support
- further quality assurance activity in a particular area
- development of national standards, indicators or guidance, or
- signposting to support from outwith Healthcare Improvement Scotland.

The emphasis is on regular open and honest organisational self-evaluation. This, combined with other data and intelligence available to us, will form the basis of supportive improvement-focused conversations with organisations to diagnose where there are issues or difficulties in initiating, sustaining and spreading improvement.

Your letter also asks about the role of the performance management infrastructure in monitoring adverse events, as well as government guidance and adverse events reporting; performance management is the responsibility of Scottish Government who would be better placed to advice on these particular aspects of adverse events.

### **Learning from adverse events**

I do not believe that creating a national reporting system is the best approach to improving systems for responding to and learning from adverse events. Our priority instead is to work to create a culture of openness, transparency and learning.

In its report on the improvement of health and social care governance arrangements in Northern Ireland (*The Right Time, The Right Place*, December 2014), the review team which included Sir Liam Donaldson 'strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses'. The report states that 'the most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it'. It goes on to note that 'there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients'.

Our adverse events programme has established mechanisms for providing support to NHS boards in capturing and acting on the learning, including:

- facilitating adverse events community of practice peer support networks

- providing guidance and tools to support local adverse event management system improvements ([Adverse Events Toolkit](#) and [Suicide Review Learning and Development](#))
- promoting a consistent approach to being open and communicating well with people following an adverse event
- promoting the sharing of learning points following adverse event reviews through learning summaries, our [Community of Practice site](#), and the publication of a [Learning and Improvement report](#) featuring good practice and improvement examples
- disseminating Patient Safety Alerts, and
- facilitating topic specific adverse event national thematic analysis.

Many of the key elements of good practice which the programme supports will be placed on a statutory footing when the new organisational Duty of Candour on health, care and social work services comes into effect on 1 April 2018.

One of the key principles of the national framework is that organisational culture is based upon the values of trust, openness, equality and diversity which encourages and supports staff to recognise, report and learn from adverse events. As part of the national approach we have also published a [reference document for Scotland](#) that builds on the principles within the National Patient Safety Agency's (NPSA) Being Open Framework (2009) to support care providers develop their approach to communicating and engaging with people who have suffered harm following an adverse event.

We are working to strengthen approaches to engaging with patients, families and carers and valuing their involvement in learning reviews:

- (i) building on interim key findings from family and carer interviews and taking forward proposals with mental health services to further learn from and improve the patient, family, carer experience;
- (ii) developing being open resources, work with NHS Lothian, Openness and Learning Unit and NHS Education for Scotland on core skills development and national training support for implementing duty of candour / being open principles and reviews of learning.

There is no simple, immediate solution to the challenges around adverse events, rather a combination of factors. HIS is uniquely and ideally placed to provide the necessary improvement support, learning, mechanisms for sharing good practice and external assurance.

It may be helpful for the Committee to hear about work we are undertaking on the development of a national approach to quality management across health and social care in Scotland. We are looking at quality management systems in other fields and countries to find out what needs to be in place. In this, we are working with others who have a role in quality management including the Scottish Government, the Improvement Service, COSLA, NHS Education for Scotland and the Care Inspectorate, and will be making recommendations for next steps in spring 2018.

We noted the discussion on 28 November regarding the volume of information provided to territorial board non-executives and the scrutiny of this. The Committee may be interested to hear that HIS has a programme of Quality Improvement for NHS board members. In 2016-17 we delivered two national quality improvement masterclasses which brought Board members together from across Scotland to share experiences and build understanding and awareness

of quality improvement. There has been strong engagement with approximately 120 NHS Board members in attendance at second masterclass and representation from every NHS Board in Scotland.

We are also undertaking work to support IJB public representatives, through the Our Voice Engagement in Integration Network. The network provides an opportunity for face-to-face networking in addition to the development of an online forum to promote continued peer support.

Finally, you asked two questions of all the witnesses at the evidence session on 28 November, and our comments are provided below.

### **How to ensure all staff get the opportunity to keep their practice up to speed and undertake necessary CPD?**

Staff access to CPD and keeping practice up to date is a joint responsibility of NHS boards as their employers and the staff themselves as regulated professionals.

Boards should also have systems in place to support and provide mandatory updates on key clinical skills and knowledge, supported by materials from NHS Education and guidelines and evidence from, for example, SIGN and the Royal Colleges.

It is important that educational as well as clinical governance is in place. 'Promoting excellence', the General Medical Council's standards for medical education and training, states that educational and clinical governance systems should be integrated, 'allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.'

Our Quality of Care Framework, mentioned above, includes a quality indicator on staff recruitment, training and development, and will provide a reference point for organisations to reflect and self-evaluate their delivery in this area.

### **How do we ensure dignity and respect are built into the healthcare system?**

The new health and social care standards will help to ensure that people across Scotland experience the same high standard of care and support, delivered in a way which reflects their own personal needs and circumstances, in all health and social care settings.

The standards are applicable to the NHS, as well as services registered with the Care Inspectorate and Healthcare Improvement Scotland (HIS). Like the Quality Framework, the main objective of the standards is to drive improvement in the care that people receive.

Services should use the standards as a guideline for how to achieve high quality care. From April 2018, the standards will be taken into account by the Care Inspectorate, HIS and other scrutiny bodies in relation to inspections, quality assurance activity and regulation of services.

The standards are written from the point of view of the person receiving support and set out what anyone, irrespective of age or ability, should expect when using health, social care or social work services in Scotland. They seek to:

- provide better outcomes for everyone
- to ensure that individuals are treated with respect and dignity, and
- that the basic human rights we are all entitled to be upheld.

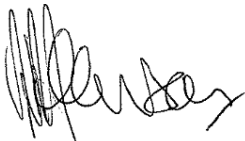
The standards are underpinned by five principles:

- dignity and respect
- compassion
- be included
- responsive care, and
- support and wellbeing.

Additionally, our inspections of the care of older people in acute hospitals give specific consideration to a number of key issues including treating older people with compassion, dignity and respect. Our standards for the care of older people (2015) form an integral part of the inspections and include specific standards on 'involving older people: what and who matters to me' and 'maintaining patient dignity and privacy'. The inspection programme works alongside our older people in acute care improvement programme and inspection findings can help to target areas for improvement support and inspectors have used the learning from improvement activities to inform priority areas for review.

I hope that this information is helpful to the Committee. We have also shared our response with Scottish Government. Please do not hesitate to get in touch if you require any additional details.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Robbie Pearson', written in a cursive style.

Robbie Pearson  
Chief Executive