Healthcare, Quality and Improvement Directorate
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By email

Lewis Macdonald MSP
Convener
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The Scottish Parliament
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Dear Mr Macdonald

Thank you for your further letter of 24 January in response to my letter of 18 December 2017, following on from the evidence I gave to the Health and Sport Committee on 28 November 2017, seeking clarification and further information under the headings below.

Adverse and Serious Adverse Events

You asked me to clarify how the current approach allows for the timely identification of similar incidents and avoids the build-up of systemic issues.

The Scottish Government remains unconvinced that holding numbers of adverse events centrally would serve a meaningful purpose. This information is collected at NHS Board level in order to drive local improvement and to identify locally emerging patterns of incidents and areas of concern. The information should then be managed in line with the National Framework for Reporting and Learning from Adverse Events produced by Healthcare Improvement Scotland (HIS).

In March 2017 I sent a joint letter with the Chief Medical Officer and Chief Nursing Officer to NHS Boards, in which we set out the Scottish Government's expectations with regard to their assurance processes in following the National Framework for Reporting and Learning from Adverse Events. Given the concerns expressed in respect of the findings of the review of the management of adverse events within Ayrshire Maternity Unit, recommendations were made to HIS to take the necessary actions required to support the further development of the Framework.

Role of Healthcare Improvement Scotland

As you know, the functions of HIS include: supporting, ensuring and monitoring the quality of health care provided or secured by the health service including the provision of quality assurance and accreditation. As was set out in the letter of 18 December to the Committee from Robbie Pearson, HIS' Chief Executive, when changes in patterns of incidents or concerns occur in an individual NHS Board, on a local basis, the National Adverse Events Framework is clear that NHS Boards should undertake trend analysis of adverse events

data. They should also link this to other sources of information, such as that flowing from the complaints process, and develop appropriate action plans. Such analysis can act as an early indicator that a system is not functioning effectively, providing valuable insight into where improvements may be required.

On occasion the work of HIS may identify a potentially serious concern with the service delivery, quality and safety of care and/or organisational effectiveness of a healthcare organisation. When such an issue is identified, and there is a perceived failure to take action to resolve issues, HIS can escalate this to the NHS Board's accountable officer, Chief Executive / Chair, and to the Scottish Government. The process consists of four steps:

i. **Identification** - Serious concerns may be triggered by a single event, or a combination of factors which may occur over a period of time. It is not possible to list all potentially serious concerns but triggers and prompts will include identification of an adverse event, unsatisfactory scrutiny report, failure to meet standards, concerns over routine review of data etc.

ii. **Validation and Prioritisation** - an initial assessment will be undertaken to clarify whether there is a genuine concern and to quantify the level of risk. Further information gathering and analysis will be undertaken to identify the extent of the concern. The analytical process, sources of information and the validation process used must be documented so that new information can be incorporated appropriately and checked as it comes to light. In addition to documenting any conclusions and recommended actions, it is important to ensure that gaps in information and key uncertainties are recorded. This helps to identify issues that may need further analysis and any uncertainties that must be monitored as part of the escalation process.

iii. **Issue Resolution** - where possible, the issue or concern will be addressed locally between HIS and the healthcare organisation. An issue that (a) cannot be resolved through direct liaison between HIS and the healthcare organisation; or (b) that is of sufficiently serious concern will be escalated directly to Scottish Government. The decision to escalate an issue or concern to the Scottish Government will be made at HIS Director level.

iv. **Escalation** - HIS will notify the healthcare organisation in question that the issue is being escalated to the Scottish Government, outlining the next steps and provisional timelines. Once an issue has been escalated, HIS and the Scottish Government will write to the healthcare organisation setting out the next steps in the process and the further actions that are required by all parties.

As an example of escalation, in August 2013 the then Cabinet Secretary for Health and Wellbeing commissioned HIS to undertake a Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire. The Rapid Review into NHS Lanarkshire was prompted by a higher than predicted level of mortality in the first quarter of 2013 (January to March 2013). This is measured by an indicator called the Hospital Standardised Mortality Ratio or HSMR. The HSMR is based on a complex model that looks at the ratio of observed deaths within 30 days of admission to an acute hospital to the number of predicted deaths. The terms of reference for the review were to:

- provide an independent expert diagnosis of the factors which may underlie the Hospital Standardised Mortality Ratio figures, including a Rapid Review assessment of any

systemic factors which may be impacting on the safety and quality of care and treatment being provided to patients in NHS Lanarkshire's acute hospital
- consider whether the existing action by NHS Lanarkshire to address any key issues, identified in the diagnostic phase is adequate and whether any additional steps should be taken.
- advise if any additional support should be made available to NHS Lanarkshire to help strengthen and accelerate their improvement programme, and
- advise on any areas that may require further action.

The Quality of Care approach referred to in Mr Pearson's letter of 18 December to the Committee has now been published and is available at:

http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx

This will be used for organisational self-evaluation and by HIS to provide external quality assurance and validation. Adverse events are included as a theme within the indicators on data for improvement and evidence-based learning.

Openness and Learning

The Scottish Government fully recognises that when adverse events occur during the provision of treatment or care, openness and transparency is fundamental in promoting a culture of learning and continuous improvement in health and social care settings. When harm occurs the focus must be on personal contact with those affected; support and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement.

As the Committee is aware, and as was mentioned in my previous letter, the Scottish Government plans to introduce the Duty of Candour Procedure (Scotland) Regulations 2018 on 1 April. The Regulations will place a legal duty on organisations that provide health services, care services or social work services to prepare and publish annual reports on all the incidents that have instigated the Duty of Candour Procedure. The reports must include:

- information about the number and nature of incidents to which the duty of candour procedure has applied in relation to a health service, a care service or a social work service provided by the organisation;
- an assessment of the extent to which the organisation carried out the duty of candour;
- information about the organisation's policies and procedures in relation to the Duty of candour, including information about procedures for identifying and reporting incidents, and support available to staff and to persons affected by incidents; and
- information about any changes to the organisation's policies and procedures as a result of incidents to which the duty of candour has applied.

Person-centred Care

Our strategic focus on person-centred care is measured in a number of ways, ranging from small, locally defined collections designed, owned and used by local service providers through to the Scottish Care Experience survey programme. This programme currently consists of four surveys:

- The Inpatient Experience Survey, which covers all aspects of inpatient stays from admission to care at home after discharge;

- The Health & Care Experience Survey, which covers GP services, out of hours care, social care and caring responsibilities;
- The Maternity Care Survey, which covers postnatal, antenatal and hospital-based maternity care; and
- The Cancer Patient Experience Survey, which covers a range of cancer care including diagnosis, support during treatment and inpatient/outpatient care.

Each of these surveys includes a number of questions related to person-centred care, including, for example, whether people felt they were treated with compassion and understanding, whether they were able to spend enough time with the people (including family and friends) who matter to them, whether staff took account of the things that mattered to them, and whether they were as involved as they would like to be in decisions about their treatment and care.

The national results from all of these surveys are available online on the Scottish Care Experience Survey Programme web site. The Committee may be particularly interested to review the report of the Scottish Inpatient Experience Survey 2016, which includes a chapter on the results of the questions related to aspects of Person-Centred Care, and to note that the 2018 survey is currently in the field.

The NHS Complaints Handling Procedure (CHP) is intended to support NHS Boards and their service providers to take a consistently person-centred approach in managing complaints in the NHS. This is aligned to the complaints procedures adopted across the wider public sector in Scotland. In particular, the aim is to implement a standard process, which ensures that NHS staff and people using NHS services have confidence in complaints handling, and encourages NHS organisations to learn from complaints in order to continuously improve services.

The new model CHP was implemented across Scotland from 1 April 2017 and introduced nine newly developed key performance indicators, by which NHS Boards and service providers should measure and report performance. The indicators, which are a mix of quantitative and qualitative measures, are set out below.

- Learning from complaints
- Complaint process experience
- Staff awareness and training
- Total number of complaints received
- Complaints closed at stage and stage 2 as a percentage of all complaints closed
- Complaints upheld, partially upheld and not upheld at each stage as a percentage of complaints closed in full at each stage.
- Average times
- Number and percentage of complaints at each stage which were closed in full within the set timescales of 5 and 20 working days
- Number of cases where an extension is authorised.

The indicators will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

NHS Boards are required to review and report internally on complaints handling information quarterly, including any recommendations made by the Scottish Public Services Ombudsman (SPSO) in relation to the investigation of NHS Complaints. This is with a view to identifying areas of concern, agreeing remedial action and improving performance. Boards must publish their complaints handling performance information annually, and send

this information to Scottish Ministers, the SPSO, Healthcare Improvement Scotland, the Patient Advice and Support Service (PASS) and where appropriate the Scottish Prison Service.

Complaints statistics gathered through the quarterly reporting of complaints must be submitted by relevant NHS bodies to the Information Services Division at National Services Scotland, within three months of the year end, in an appropriate format to allow collation and publication of national complaints statistics. The first public reports under the new process are due by the end of June 2018.

From 2017/18 onwards ISD will produce an annual short statistical release and will also provide links to all NHS Board complaints reports. The final public release of NHS Complaints (2016/17) by ISD under the previous complaints process was published in October 2017.

CPD for all Staff

Launched in June 2013, Everyone Matters: 2020 Workforce Vision is our workforce strategy for NHS Scotland and our commitment to changing the workforce processes and practices that need to change or be done better. A key priority we have been progressing is to ensure a Capable Workforce and ensuring that all staff have the skills needed to deliver safe, effective and person-centred care. There are systems and processes in place locally to support all staff development and also importantly, people management. Development review/appraisal is one of the tools available. Engagement work we had undertaken showed that not all development review/appraisal discussions are meaningful and this has been a specific area of focus and action for NHS Boards since Everyone Matters was launched.

Conclusion

Finally I would make the point that in my capacity as National Clinical Director and as a health professional safety is central to everything we do in NHS Scotland and is vital to building a culture which allows all frontline staff time and safe spaces to learn in order to improve services in a culture of openness and without fear of censure. The Scottish Government's commitment to this is strongly demonstrated in the development of our approach to openness and learning.

The Committee may be aware of the commentary surrounding the High Court of England and Wales judgment on the case of Dr Hadiza Bawa-Garba. The Joint Statement issued by my colleagues Dr Catherine Calderwood, Chief Medical Officer; Prof. Fiona McQueen, Chief Nursing Officer and me, restates the need for all staff to be able to reflect safely and openly when things go wrong.

I hope this is helpful to the work of the Health and Sport Committee.

Yours sincerely

JASON LEITCH