OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 28 November 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 November 2017

CONTENTS

HEALTH AND SPORT COMMITTEE
28th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rosemary Agnew (Scottish Public Services Ombudsman)
Aileen Campbell (Minister for Public Health and Sport)
Professor Nick Fluck (NHS Grampian)
Dr Tracey Gillies (NHS Lothian)
Professor Jason Leitch (Scottish Government)
Dr Christopher Mackintosh (South Lanarkshire Health and Social Care Partnership)
Sheena Morrison (Glasgow City Health and Social Care Partnership)
Robbie Pearson (Healthcare Improvement Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 28 November 2017

[The Convener opened the meeting at 10:00]

Interests

The Convener (Neil Findlay): Good morning and welcome to the 28th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobiles for social media but please do not photograph or record proceedings.

The first item on our agenda is a declaration of interests. In accordance with section 3 of the members' code of conduct, I invite Sandra White to declare any interests relevant to the remit of the committee.

Sandra White (Glasgow Kelvin) (SNP): I have nothing to declare.

The Convener: Welcome to the committee.

NHS Governance

10:00

The Convener: The second item on the agenda is a round-table evidence session on clinical governance in the national health service. We have received apologies from Dr Brian Robson, medical director of Healthcare Improvement Scotland, who was due to give evidence this morning.

I ask everyone to introduce themselves. I am a member of the Scottish Parliament for Lothian and I chair the committee.

Ash Denham (Edinburgh Eastern) (SNP): I am an MSP and the deputy convener of the committee.

Professor Nick Fluck (NHS Grampian): I am the medical director for NHS Grampian.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for Lothian and the Conservative spokesman for health and sport.

Dr Tracey Gillies (NHS Lothian): I am the medical director for NHS Lothian.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the MSP for Edinburgh Western and the Lib Dem health spokesperson.

Dr Christopher Mackintosh (South Lanarkshire Health and Social Care Partnership): I am the medical director for South Lanarkshire health and social care partnership.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I am the MSP for the Mid Fife and Glenrothes constituency.

Professor Jason Leitch (Scottish Government): Morning. I am the national clinical director.

Emma Harper (South Scotland) (SNP): I am an MSP for South Scotland.

Robbie Pearson (Healthcare Improvement Scotland): I am the chief executive of Healthcare Improvement Scotland.

Alison Johnstone (Lothian) (Green): I am an MSP for Lothian.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

Rosemary Agnew (Scottish Public Services Ombudsman): I am the Scottish Public Services Ombudsman.

Brian Whittle (South Scotland) (Con): I am an MSP for South Scotland and the Conservative spokesman for health education, lifestyle and sport.

Sandra White: I am the MSP for Glasgow Kelvin.

Sheena Morrison (Glasgow City Health and Social Care Partnership): I am head of public protection and quality assurance for the Glasgow city health and social care partnership.

Colin Smyth (South Scotland) (Lab): I am an MSP for South Scotland and Labour spokesperson on public health and social care.

The Convener: There are a lot of people around the table this morning, so it would be helpful if contributions were brief. We will try to cover as much as possible in the time that is allocated. If people want to contribute, indicate to me and, hopefully, you will catch my eye.

Emma Harper: At last week's meeting, which was my first as a committee member, we heard that, in general, patient groups think that the existing standards and guidelines are good. How should we implement the guidelines and feed them down to the shop floor? How do we ensure that the staff delivering the care follow the recommended guidelines?

The Convener: Who would like to begin?

Robbie Pearson: If I may, I will provide a bit of context. Healthcare Improvement Scotland has a pivotal role in supporting the production of the guidelines and standards. The Scottish intercollegiate guidelines network currently has around 50 guidelines and around 15 standards. Healthcare Improvement Scotland is trying to create a framework and the tools for good practice to ensure that the best evidence is shared.

One of HIS's key roles is the dissemination of guidelines and standards. It is also important to think about how best we implement them, although there is no single answer to that. For example, while digital technology is required for dissemination of the guidelines and standards, it is also important that we provide the environment for staff working in the health service to use those guidelines daily.

One of the key challenges in a world of more complex care, in which more patients present with comorbidities, is how we ensure that the guidelines are tailored to individual needs. An important part of this discussion is how we ensure that the guidelines are relevant and can be implemented in day-to-day practice.

Rosemary Agnew: The ombudsman has a specific focus, which is on handling complaints. Often, that involves instances in which guidelines have not been adhered to. It strikes me that the issue is not just implementation; two other things are crucial. One is about ensuring that if the guidelines that are in place are not adhered to, there is effective learning from them; and the other, which I feel strongly about, is about ensuring that if something goes wrong, staff are given the support to understand why. Organisations need to embed a learning culture and clinicians and non-clinicians need to have the soft skills as well as the clinical skills.

For example, frequently we see issues with record keeping or communication, but people do not go into work to do those badly; it is just that the facilities and support do not always exist. Governance mechanisms must embrace that and embed those to understand why standards are not met, if that has been the case. What was the root cause? It is not necessarily human error; it might be that the systems that surround the guidelines enabled something to happen that should not have happened.

Putting standards in place and disseminating them are important but, once they are in place, we must continually monitor their implementation and, if they do not deliver the outcomes that we expect, learn from that.

Professor Leitch: How we implement best-practice guidelines is a crucial question in health and social care around the world. Scotland has 55 guidelines just from SIGN; each of the royal colleges has guidelines; and the National Institute for Health and Care Excellence has 297 guidelines. It is almost impossible for people to keep up with the guidelines in their own specialties, never mind the generic guidelines. Therefore, relying on sending guidelines to clinicians is clearly not the final answer—it is part of the answer but it cannot be the final answer.

We have to make it easy for guidelines—whatever they are; they could be on hand washing or on putting a cannula in the back of the hand in a certain way, using five steps—to be followed inside the system. Scotland has an enviable reputation for applying improvement science techniques in delivering guidelines. We are not perfect, but people come from all over the world to see how we have implemented elements of the guidelines.

When I trained, 100 per cent of people got a needle put in the back of their hand when they arrived in hospital; now, about 60 per cent get one, because we know that 40 per cent of healthcare-acquired infections come from those needles, so we do not put them in for people who do not need them. We implemented that by applying methods inside the system, not by sending everybody a letter to tell them what to do. We require the evidence that Robbie Pearson's organisation finds, writes up and publishes, but boards, wards and general practices implement the guidelines inside the system. The Scottish patient safety programme is our neatest example of how we

implement such guidelines, but you would expect me to say that.

Dr Gillies: I will give an organisational view of how we take on guidelines when they are published by SIGN. We have a process for examining all newly published guidelines, which come with recommendations that are graded on the quality of the evidence. We involve local clinicians in assessing whether our system is delivering care to those standards and, where it is not, we put in place an action plan.

An important point has been raised about how clinicians contextualise that for patients and discuss with them what options there might be, because although the evidence might say one thing, their particular circumstances, preferences and beliefs might mean that they wish care to be provided in a different way. We need to remember that end part of the process, which is important. Rosemary Agnew picked up on the point that if sometimes we do not provide care according to the standards, we need to get better at explaining in the notes why that is, so that afterwards someone else can see what the reason was.

Emma Harper: Guidelines are to be followed to implement best practice in patient care. Last week, Dr Bennie talked about some of them being only for a single, specific condition, but patients come in with multiple diseases. Should the guidelines take cognisance of that? Should we rewrite them to consider comorbidities, which might be complicated?

Dr Mackintosh: That is a very good question. I come from a general practice background and the majority of patients that we see in general practice have more than one long-term condition. At times, the guidelines for one condition fight against the guidelines for another, to a certain extent. One could give examples.

Some of that comes from the fact that the evidence behind the guidelines is good quality. SIGN and HIS are good at rating evidence, but good-quality evidence tends to come from single disease processes, for all kinds of research reasons.

The separation between a protocol and a guideline is also important. A protocol is something that has to happen; a guideline should cover 90 to 95 per cent of what should happen. We are using clinicians' learning and experience to make best use of the guideline but not to be an automaton.

Professor Fluck: The landscape is very complex and there is a risk of us, increasingly, multiplying guidelines to try to address individual circumstances. That is counterintuitive and we should be heading back in the direction of simplification.

We have talked about organisations' responsibility in implementing guidelines and, much as Tracey Gillies said, our organisation takes that approach. However, we must also consider the professionals in the system. They rarely have the accountability to sit down with patients and plan the right treatment for the individual, although that combination of high-level guidelines and individual clinician discussion is what generates good care. We need to caution against generating hugely detailed and ever-expanding guidelines and work in tandem with our professional bodies.

Sandra White: You have spoken about how complex the landscape is and about the different ideas that are proposed. How do you monitor whether the guidelines are being used properly so that fewer complaints go to the ombudsman? Who is responsible for that? Is it multiple agencies or is one agency responsible?

Professor Leitch: There is no single, neat answer. Nick Fluck is right that, at the individual level, it is up to the clinical team and the patient to decide on treatment, using all the knowledge that they can possibly gather. You might have a gentleman who is diabetic and has depression, who has a complex family history and kids to look after. There is no guideline for that. Elements of the guidelines will tell us how to look after his diabetes and depression, but there will not be a guideline for how he looks after his children. Making that intellectual decision, usually with a general practitioner initially, is quite complex.

When it is something obvious, such as when someone is having an operation, everybody knows, for example, that the surgical checklist should be completed prior to the operation—we should know who the patient is, which part of the body we are operating on, that the x-ray is up the right way and that they have had the correct drugs. That sort of guideline, which comes from all kinds of authorities, is implemented by the boards. In NHS Lothian, Tracey Gillies, as medical director, has responsibility for that and the surgical teams have responsibility for implementing it. If it was not done for somebody and an error was made, that would be a challenge for the board, which would look into why the error had happened.

Nationally, Robbie Pearson's organisation will go in and check the number of people who have a surgical checklist and the number of people who are following the diabetes drugs protocol. HIS and its scrutiny arm inspect more at the national level the implementation of guidelines that it is more appropriate to implement nationally.

Therefore, there are three levels: individual clinicians, boards, and HIS.

Rosemary Agnew: On the comment about simplification, by the time complaints reach my organisation, the guidelines become standards against which we assess, and we do so on the ground of reasonableness, but there is a strong argument for making it clearer that the conversation that goes with the guideline is as important as the guideline itself. Patients often feel that they have not been given the treatment that they should have had because although the guidelines might cover 90 to 95 per cent—not 100 per cent—their expectations are high. Simplification is a good idea, but we need to emphasise the importance of the conversation at the individual, board and patient levels.

10:15

Sandra White: We need to look at simplifying the guidelines so that professionals adhere to them, but, on the basis of what all the witnesses have been saying, that would seem to be a long way off because everyone is different. There are guidelines for X, Y and Z, but one cannot put X, Y and Z together. Would it be impossible to get to that stage?

Professor Leitch: You should standardise what you can standardise and individualise everything else. As a health and social care system, we have decided that some practices are no longer acceptable. For example, it is no longer acceptable not to wash your hands before you perform an operation; it used to be—decades ago you did not do it. Similarly, in modern times, we have decided that it is unacceptable to put lines into the necks of patients in intensive care without full barrier protection—that is a guideline, or standard. Now, it is almost impossible to find a case of a patient with an infection caused by a line in their neck, because full barrier protection has been adopted throughout Scotland, but that was not true 10 years ago. Therefore, we have standardised some practices and that will continue to be done. New evidence might emerge next year that dictates something that should be done about people with kidney injury or dementia.

However, behind that, there are individuals, families and carers, and houses and all the other public health elements that make up somebody's health and wellbeing. That complexity is almost impossible to standardise and it should not be, which is why general practitioners, health care professionals, and physios have conversations every day about what would be best for the patient and what they can do for the patient. In some cases, that might be off guideline. It might be that an elderly lady in her house who, strictly speaking, should do something according to the guideline says, "You know what? I do not want to do that because I am 85 and I have lived in this house all my life." That is a conversation for individual healthcare teams to have with patients or carers. That is about individualisation around the standardisation that we have adopted across most practices.

Dr Mackintosh: Professor Leitch has outlined the general practice line superbly.

I want to draw attention to the west of Scotland cancer network reports, because they illustrate very well how a guideline gets translated into real work, which can then be looked at and checked on an annual basis. The network, which is a professional-led group, takes measurements for specific cancers that have led to improvements year on year in measurements and outcomes. That is about adopting standards, and while the work relates to a single disease, it is impressive. It would be worth while to pick up one of the network's reports to see how standards get converted through evidence and professional regulation into good outcomes.

Robbie Pearson: Professor Leitch referred to context. Each year in Scotland, there are 17 million GP consultations and each has a context and has to be individualised for the patient in front of the particular GP.

It is also important to separate out guidelines and standards. HIS has carried out inspections and produced 64 reports on the care of older people over the past five years, which tell the story of not only the improvements that there have been in care standards but where further improvement is needed. Similarly, the healthcare environment inspectorate has produced around 270 reports. The number of requirements and recommendations has fallen consistently, year on year, and there has been a reduction in infection. MRSA rates, for instance, have fallen by 90 per cent. Therefore, it is important to put in context what we should and must do in respect of standards, while also contextualising them for individual patients.

Ivan McKee: I want to follow up on Jason Leitch's point. There are things that staff must do, such as washing their hands, and things that they might consider as just guidelines, such background information on a particular issue and how to approach it. Is it clear in the way that those things are documented what the difference between them is, or are all such documents called guidelines and is all that stuff thrown together?

Professor Leitch: It is a good question. We are dealing with a human system and there are 160,000 staff with NHS payslips. If you add in social care, there are well over 200,000 people who are interacting today—while we are in here—with families and carers around the country. To naively send everybody a list of must-dos—as

some countries suggest that you do—does not work. Instead, inside a framework of improvement for the health and social care system and in the Scottish patient safety programme, we state what things need to be done. We call them the 10 essentials and they include the central line infection bundle and the surgical checklist for every time that there is an operation.

We make decisions about those practices after a period in which they have become embedded and we know that people are doing them, that they are working and that there is evidence for that. There are other approaches that are slightly more innovative, such as the acute kidney injury bundle in which people who are in hospital with kidney injuries are in not renal units but surgical units. We are implementing that gradually throughout the whole country and, eventually, if that works and outcomes improve, we will make that one of our essentials. There is a scale of evidence and implementation according to where we are on the journey.

It would be lovely if healthcare was neat and you could just take off the wall the evidence for how to treat dementia, for example, or how to look after a guy with diabetes and whatever, but it is not quite as neat as that. That becomes most apparent if you spend a day in a general practice, where the undifferentiated unwell arrive in those rooms with all kinds of diseases and there is no guideline for that on the wall.

Professor Fluck: To build on that point, at the extremes, it is pretty clear to most people what are absolute must-dos and what are guidelines. The territory in the middle is a bit more confusing.

Rosemary Agnew's point is interesting. There is sometimes an anxiety for some professional groups and clinicians about the generation of guidelines, because something can move into the territory of, "You must do this because the guideline says so." We have quite a lot of material that sits in the hinterland. It can be genuinely just a guideline to help to guide clinical management and conversations, but the individual interpretation of that might be, "I have to do this. If I don't do it, I will be found to have done something wrong."

We have to recognise that, in that middle ground, there is anxiety for professionals but, at the extremes, as Jason Leitch described, it is clear. There is a top 10 of things that we absolutely must do, which is a good example of simplification of the system, and it works well. At the bottom end, there are specialities that produce great volumes of information about their area and it is quite clear that that is guideline material.

Ivan McKee: What you said makes a lot of sense. If there is that grey area in the middle, is there a requirement for more clarity on the things that have to be done?

The Convener: Why are some things monitored very closely but other things are, apparently, left alone?

Professor Fluck: Those are two separate questions. The clarity question is interesting. If you go to one of the regulators, such as the General Medical Council, you will see that it is very careful about the use of words such as "must" and "should". In legislation, there is the same care about the use of "mandatory" and "statutory". Careful use of language and a lot of education might help at the extremes. In the middle ground, where there are so many different bodies generating information and guidelines, it is tricky to get a degree of consistency so that people know, for example, that if we say "should", it means that something must never not happen, if you see what I mean.

Emma Harper: Some of the standards, procedures and guidelines can be translated into LearnPro modules or e-learning modules. Some can take five minutes to do, but some can take an hour or even longer. I am aware that some of the education is even delivered in one minute outside the dining room on a high-travelled pathway for staff. Essential information that covers the one-minute scrub of the central line, or whatever is needed, can be passed on in that way. Are we able to make the guidelines on what is required—the must do, the nice to know and the need to know—more accessible for the front-line staff?

Dr Mackintosh: I was a GP until recently. The SIGN guidance comes as a big book, a small book and a leaflet. A real effort is made to ensure that, as far as possible, the main points and structures are presented in a way that is accessible to staff. I give credit to SIGN for being able to do what you describe. That said, some of the very small bits still become quite large. For example, the management of type 2 diabetes requires a lot of thinking and a lot of business goes on behind it.

From a general practice point of view, we have talked about the morass of guidelines that are available. If you look at the diseases that come through, you see that there is a big bunch of circulatory diseases, respiratory diseases and cancers, but there is also a big bunch of rare diseases. Although one might have a command of most of the first collection of diseases, it can be difficult to even recognise that a rare disease exists and requires that the patient be referred to a secondary or tertiary centre.

Last week, I picked up a patient's opinion about rare diseases. The person had asked why, if there is a guideline about a rare disease, their GP does not know about it. That is a good question, but the

fact is that a rare disease is only one of a huge range of rare diseases.

Professor Leitch: The basic answer is yes. If the information can be summarised into something neat and tidy, NHS Education for Scotland is the organisation that will translate that into an educational product. We do that in relation to cleanliness and dementia champions, for example. If the information can be standardised, we have an organisation that will do that, and the boards, the institutions, the practices and the hospitals will use that information.

We run pharmacy awareness days or hand washing days, or whatever the implementation might be. At some level, that is supervised and monitored by the individual boards. If the information can be summarised—and not everything can be—it can be done in that educational environment.

The other point is that the individual clinical team has responsibility for doing its best for every individual who they meet. There may be cases of a rare disease that the team has never seen before, but they would be absolutely certain that someone will have said something about it somewhere. The team will tell the patient that they have a very rare disease and they will go and find out about it. It is okay for the team to say that they do not fully understand the process and that they will come back after they look into the matter.

Professor Fluck: I will build on that important point about rare diseases. Rare diseases are actually quite common. They are classified as having a frequency rate below one in 5,000. We have a great big manual that is full of them. About 8 per cent of the population has a rare disease. Although individual rare diseases are uncommon, and signposting is critical, they represent quite a bit of the cases that come in front of general practitioners or other clinicians.

Dr Gillies: I am the chair of the rare diseases implementation strategy oversight group, which is a bit of a mouthful to say. The role of the group is to think about whether we are implementing the United Kingdom-wide strategy on caring for people with rare diseases.

A huge number of people have rare diseases, and it is a very fast-changing field. The best way in which patients and their families can receive the best information and signposting to the right care would not be for individual professionals to try to carry that information in their heads; rather, it would be for them to have a level of awareness and access to good resources, so that they know where to go to get the most up-to-date information and how to get professional-to-professional support about the best diagnostic path or the best support mechanism to then be able to discuss that with the patient and their family.

The Convener: Have we got the right systems in place to do that?

Dr Gillies: We have access to good systems, and we have a lot of collaboration and participation going on in the right professional networks.

10:30

Alex Cole-Hamilton: I would like to move the discussion on to service redesign and quality, and the tensions that can be created for patient groups, particularly for communities in geographically remote locations. My first question is for Jason Leitch. I know that there is a formula for the certain number of surgical procedures that surgeons need to undertake in order to retain their ticket, as it were, and that, if a surgeon is not getting the daily exposure of performing enough surgical interventions, service redesign can relocate them to somewhere where the demand is greater and they can meet that number. Who calibrates that? How is that done? How do you come up with that number and who determines that when somebody falls below it they are going to lose their edge?

Professor Leitch: For clarity, I no longer meet the number of surgical procedures required, so that is why I no longer operate.

The royal colleges of surgery, of which there are four—Glasgow, Edinburgh, London and Dublin—are the hosts for that surgical standard. A standard also applies in medicine, across other specialties and in general practice, but it is neatest in surgery, as you have illustrated. It is unusual for there to be an actual number, although it is true that there is one in some areas, such as knee revisions. A second artificial knee replacement is quite a difficult and complex procedure. I cannot remember the number—Tracey Gillies might remember—but I think that a surgeon might have to do 15 knee revisions a year, because the procedure is hugely complex. A person is only going to need a knee revision once in their life, probably—maybe twice, but it would be unusual to have three knees in a lifetime. I do not mean three knees; I mean three consecutive knee revisions on the one knee. A health system—whether Danish, Scottish or Swedish—will make a decision that knee revisions will be done in a knee revision expert centre. Our knee revision expert centres are in the Golden Jubilee national hospital and in Lothian, so people have to travel for a knee revision.

When you ask the public what they think about what happens with knee revisions, or cleft lip and palate surgery, they probably consider it to be

reasonable. About 100 babies a year are born with a cleft lip and palate, and it is pretty clear that we are not going to deal with that in five centres, but will deal with it in a very small set of units. However, diabetes is hugely common and affects hundreds of thousands of people, so we are going to have to do that everywhere. There is no choice: GPs will have to see diabetics. We are not suddenly going to say, "You can't go to your general practitioner if you're diabetic. You have to go to the Golden Jubilee."

The two extremes are okay. Every healthcare system in the world is struggling with where the line is in that continuum, particularly those with rural challenges, such as Scotland's. In Inverness, at some level we will have to continue to provide most surgical specialties at Raigmore, but there are decisions to be made around trauma, cardiothoracic surgery and neurosurgery, where the numbers are not tiny but they are not big enough to be managed at huge centres. There would not be enough cases at Raigmore to provide surgeons with the number of major trauma surgeries that they would require to maintain their skills.

There are both numbers and competencies about how that might be done. The fundamental answer to the question is that the royal colleges decide and can inspect our surgical levels. We then give advice to the ministers about how we should distribute that care around the nation, taking in the views of the public, the clinical teams and the local elected officials at every level in those environments, but at some level somebody has to make a decision about what will be provided in NHS Grampian or NHS Highland, and that will not always be everything.

Alex Cole-Hamilton: You touched on two particular issues. Cleft palate surgery is obviously close to the heart of everyone who represents constituencies in the Lothians, where we have lost our unit because of the service redesign.

You also mentioned rurality, which I think we would all accept is one of the negative consequences of the system. How is it reviewed? Does the system take account of the views of patients in the affected areas or the fact that an absolutely white-hot physician who is practising might get a few shy of the 50 procedures, or whatever the number is, that they need to perform? How much flexibility is there in that approach?

Professor Leitch: Nobody is making a decision based on somebody being just shy of 50 procedures. It is much more complex than that, I promise you. The support teams, the staffing around them and the other services that we can provide around, for example, neonatal intensive care are also considered.

There is also the question of where that expertise might live. We moved extensive departments of cardiothoracic surgery into a single unit in the Golden Jubilee, because combining that expertise made the on-call service much more efficient and the research base better—it is just better for everybody.

The advice is given based on the quality of the service provided. However, even at an official level, when I give advice about what we have to do with our service, it is based not only on the quality of the clinical care but also on the patients, families and carers who are in that environment. We do our best at local board level and nationally to listen to that conversation, and then advice is given to the ministers of the day about what we believe should happen inside that service.

Most of those decisions are made without any controversy at all. The public are engaged, everybody agrees and we move on to that service redesign. The decisions that reach the level where this committee gets them or makes a case for them are often at the edge. In those cases we have to make a countrywide decision about how we are going to deal with them.

The decisions on whether a service is provided are not always made on the basis of whether an area is rural or not. NHS Dumfries and Galloway has doctors who are employed by NHS Greater Glasgow and Clyde. They might be getting the core of their work in the Queen Elizabeth university hospital and travelling to Dumfries and Galloway or Stranraer to do outreach clinics or other work. NHS Lothian has surgeons who go to Grampian and Fife who are maintaining their clinical expertise. The senior group of clinicians is kept in Lothian or in Glasgow, where the bulk of the work is, and then they go on the road.

I used to do the clinic in Oban when I was a head and neck surgeon. I would do my main work in the west of Scotland, but because some young guy always had to go to Oban once a month, I would go. I loved it. I went on a Thursday and a Friday once a month and did a surgery in a clinic in Oban. They could not have a head and neck surgeon or an oral surgeon in Oban because there was not enough work for one. I would go from my clinical base in the west to Oban to do that work.

Alex Cole-Hamilton: As a final question—by all means let me open this up to the wider room, although Jason Leitch might want to come in first—will the changing landscape of the NHS necessitate a review of how we do things?

I will give an example. I was visited by a constituent—Mr Patrick Statham, who is a neurosurgeon at the Western general hospital and is happy for me to name him—who is very concerned about the fact that he and his

colleagues consistently have to cancel elective neurosurgical operations because of bed blocking in the wider hospital. There have no inpatient beds to receive those patients, which, as we know, is an escalating problem—

The Convener: Alex, you are going way off what we are supposed to be talking about. You might want to speak to Jason at the end of the meeting.

Alex Cole-Hamilton: All right. I will do.

The Convener: We want to get on to accountability, so I will bring in Ash Denham.

Ash Denham: We have had a number of evidence sessions, which our witnesses will no doubt be aware of, during which concerns were raised with the committee about the accountability of NHS boards. I will run through some of those concerns. One was about variations in treatment and care among boards. Another was that complaints are dealt with by the boards themselves. Another was about serious adverse events also being dealt with by the boards, with witnesses saying that they had not been reported to either HIS or the Scottish Government. I am interested in the views of the panel on whether NHS boards are sufficiently held to account for what they deliver.

Rosemary Agnew: It would be remiss of me not to say something about complaints. It is worth recognising that in the past few years there has been a significant change in the approach to complaint handling. Part of my role is serving on the complaints standards authority.

From 1 April 2017, NHS boards and rest of the sector came under a new model complaint-handling process, which brought in significant changes. There are now two stages. The board tries to resolve a complaint and looks at it in more detail, but if the person who complained remains unhappy, they come to the ombudsman. What is significant about that is that it changed the approach of some NHS boards from having up to seven stages to having something much more simplified. Our challenge is to make the system that we now have work as well as it can, which is why the role of my office is so important. We pick up inconsistency in complaint handling. It is part of our strategy and our aim that there must be learning from complaints and that they must be valued. We monitor how that happens.

We have not reached a perfect place. In Scotland, we are collectively on a journey. To change things now would undo a lot of good work that has been done. I would like to see more education for complainers so that we can achieve better consistency in how boards carry out their complaint handling. We do that in a variety of ways—for example, my staff attend a network meeting of complaint handlers. For me, there is still a gap in the process, which is at the corporate governance level. It is very difficult to separate clinical and corporate governance. Based on my observations of seven months or so, I do not always see the right level of connection between the clinical and corporate functions. We see that in responses to us in which there has clearly been a corporate explanation for a response to a complaint but I am not convinced that there has been the right level of clinical input. If that is true for us, I suspect that it will also be true when boards and organisations respond to complaints.

I would like to see—and my organisation will continue to work on—a shift in the culture so that it is more about learning and valuing as part of the wider framework and not just for its own sake. It must also be embedded into governance systems so that, rather than simply monitoring numbers and how many complaints we upheld and how many we did not, boards play a much more active role—particularly in governance terms—in the more qualitative aspects, such as looking at views about the quality and standard of care and how both parties felt about the case. That is so that we have a better understanding of why we are or are not getting the outcomes that we want and need. As we discussed before, that can link to standards. However, ultimately, it is about taking a different approach to how we use information through organisations such as HIS. We are on that journey, and we have a good system in place, but we still need to embed it more at governance and cultural levels.

Dr Gillies: I will build on that point. It is helpful to think of a complaint as a patient experience adverse event, because that is really what it is.

It is very important that, as a system, we own and understand adverse events. As Rosemary Agnew said earlier, looking at such events is not now about pointing the finger or blaming an individual but about understanding what has happened and what we need to put in place to make sure that it does not happen again. That needs to be done by people who work within the system. If it is done entirely from outside, there is a risk that there is no ownership to drive change in the system and to embed the change into everyday practice.

I understand the point about the interweaving of corporate and clinical accountability. It is about how open a system is as a whole system and about trying to learn when things are not going according to plan. We meet every fortnight as a group of executives—both the clinical and the non-clinical members of the team—to talk about significant adverse events and what we have learned from them, and about serious complaints or difficult cases that we have in our system. That

has led to a much greater focus around the board table on what is happening in our system and what we need to change.

10:45

The Convener: It is quite telling that you used the phrase "patient experience adverse event". I bet that most people just want to call it a complaint. To me, that is an indication that there is a gulf between the patient who makes a complaint and the board and others, who want to call it something else and to pretend that it is something else.

Dr Gillies: I am sorry—maybe I should have been clearer. I am not trying to pretend anything; I am trying to say that, when a complaint is made, things have not gone according to plan for the individual concerned and their family. We are not trying to call complaints anything other than complaints—that is what we call them. I might not have been clear in my explanation.

Sheena Morrison: I want to reinforce some of the points that Rosemary Agnew made. It is important that there is an expectation of openness within an organisational culture, as well as a valuing of learning and a continuous improvement loop that reinforces the need for learning. The complexity of the health and social care world, which involves the interplay of many different elements, has been emphasised in the discussion. Those various elements come to fruition, to an extent, when someone makes a complaint or there is a significant adverse event.

From an integration joint board/health and social care partnership point of view, I want to reinforce the point that we must recognise that we are talking about individuals who do not just have complex medical circumstances involving a range of medical requirements and comorbidities but who are in social circumstances that play a major part in their health and wellbeing issues. The resolution of a number of those issues involves the interplay of different health and social care services, as does the resolution of a complaint or a significant adverse event.

In the IJB that I report to, we have reinforced the importance of having a culture of openness and valuing learning, because that is the only way to reaffirm the need for accountability. Whatever processes and governance arrangements an organisation has, the inherent value of its culture lies in its ability to recognise when something has gone wrong, to admit and accept that, and to move on.

The Convener: Brian Whittle has a question on accountability.

Brian Whittle: Good morning, panel. I am interested in adverse events and what constitutes an adverse event. Is the same definition of "adverse event" applied consistently across all health boards? Whose responsibility is it to review the level of adverse events? What happens if there is a major change in the number of adverse events in a health board?

Robbie Pearson: Healthcare Improvement Scotland has created a national framework that covers what an adverse event looks like, what the processes are and how adverse events are categorised. The categories include events that have caused permanent harm, those that had the potential to cause harm and near misses. In that framework, we have sought to put in place the building blocks to allow local NHS boards to move to a system of openness and learning, as opposed to one that, frankly, can look as though it is based on defensiveness and evasion. The framework is an important part of the process of putting in place the necessary building blocks.

To go back to the point about accountability, there is a clear line of accountability from NHS board chief executives to the director general of the health service and chief executive of the NHS, the cabinet secretary and, ultimately, the Parliament. In some ways, the accountability system in Scotland is simpler than the one south of the border, but we in HIS have a role to play in improvement support and in providing the necessary tools to build that open culture; we also have a role to play with regard to subsequent external assurance and scrutiny.

One of the key points for HIS relates to our powers and our independence, which are pretty clear. What is important for us is that we have a system of follow-up, whereby we can ensure that progress is being made.

Dr Mackintosh: At board level, through its healthcare quality assurance and improvement committee, the NHS board monitors the number of significant adverse events. There is a timeline for responding to and investigating issues, and where we are in the process of each investigation is also monitored. The board is interested in the outcome of each investigation and the action that has been taken to follow through on that, so there is a clear line of accountability.

Professor Fluck: The line of accountability is pretty much laid out and is very straightforward. The question raises the issue of the degree to which boards should handle things internally as opposed to involving people from outside. A lot can be done in that regard, but we sometimes fall into the language trap to which the convener alluded. We talk about the various processes that we go through, but different regulatory organisations will describe them in different ways.

The third critical issue, on which we are trying to move forward, is how we bring in the people who are involved in making the complaint or raising the issue. That is where we can really make a difference by ensuring that accountability brings tangible benefits for people.

The convener is quite right: if someone makes a complaint, there is nothing better than having a direct dialogue with them and asking, "What is the issue for you?" rather than telling them that we are trying to categorise the issue. Our complaint system still uses language that refers to whether or not a complaint is upheld. Our business is not to decide whether someone is complaining—they have written a letter, and they are complaining—but to understand the issue. Some of the stuff on the duty of candour will probably help, as will increasing the involvement of patients at a very early phase in the investigation or resolution process. There should be a balance between internal and external investigation.

Dr Gillies: We started incorporating into our adverse events process a requirement to ask the family or the individual what questions they would like to be answered as part of the investigation. It makes for a far more powerful investigation.

The Convener: Does Brian Whittle have a follow-up question on accountability?

Brian Whittle: Yes. I am hearing that accountability stops at board level, but my specific question was about who is counting the number of adverse events that happen in individual boards and what happens if that number changes. We know that there is currently a huge disparity across health boards. I did not get an answer on that.

Robbie Pearson: To pick up that point, there is an issue with the consistency and quality of reporting and with the quality of investigations, but I would caution against creating an accounting system alone. The important point is the learning. When a national reporting system was set up in England, a very large database was created, but that in itself does not lead to learning. To pick up the SPSO's point about a genuine system of openness and learning, the duty of candour will be part of that, but a cultural shift is also required.

Brian Whittle: I am still not getting my question answered. If there is a huge change in adverse event reviews and reporting in a health board, who is counting those events and what happens afterwards? Who is watching that? I am currently hearing that a board alone is responsible for its own adverse events. I completely understand that, but we are trying to create an environment of openness and learning. If that is being left to the board itself—we know that HIS is not responsible for counting or monitoring the number of adverse events in boards—and there is a huge change, that must surely instigate some kind of reaction.

Robbie Pearson: The numbers are only part of the system. If we see changes in patterns of incidents or concerns, that is an issue for the individual board in the context of its clinical governance, but HIS has a broader role in the external assurance of the systems and the quality of care. That is all part of our role.

I caution the committee against the creation of a system in which we count something based on an indicator. We want to create a culture of openness and transparency which—to be frank—relates to some of the issues that we discovered in our recent reviews. In NHS Ayrshire and Arran, there was a failure to follow fetal monitoring protocols and a lack of involvement with families, and the quality of the adverse event review itself was poor. We are trying to build a system that takes us away from defensiveness and towards openness. That is all part of the approach that HIS is seeking to embed, and it requires a cultural shift.

The Convener: However, we are trying to find out who knows the numbers. That is a critical point. Perhaps Jason Leitch can help us on it.

Professor Leitch: I will not give you a neat answer—I presume that you can predict that. The Government gets knowledge of some reportable events. We know how many infections and stillbirths there are. We also know how many people have an instrument left in after surgery, although that is very unusual.

There are very unusual and rare events for which we know a number, and we react if that number changes dramatically. Infection is the neatest example; because it is so unusual, even a small number of infections leads to activity. We would contact the board and ask it what it was doing about the ward with Clostridium difficile or E coli, for example, and would react. That reaction would principally be to check whether the board's monitoring was adequate. If it needed external help for that, we would provide it. If we felt that its system of older people's care was failing in some other way, we would contact Healthcare Improvement Scotland and ask it to scrutinise that service.

The addition of adverse events into a table would not help us, because the definitions are so broad and varied. Individual clinicians make the judgments. We have to rely on the boards to have processes in place such as clinical quality committees and regular morbidity and mortality meetings so that clinicians talk about the adverse events, the failures and the good cases that happened.

Let us keep the matter in context: complaints and adverse events are unusual. There are

millions of transactions every week and it is still unusual to have a complaint or adverse event. We have systems in place for learning from both those elements.

A few years ago, we decided that we did not know enough about feedback. We knew the complaints and the adverse events, but we did not know what the vast majority of people experienced. Therefore, we decided to use Care Opinion. It now has 9,500 positive, negative and mixed stories that the system then uses. The MSPs in this room get reports from Care Opinion, if they have signed up for them. If they have not, they should, because it gives you an understanding of what is happening in the system.

The boards and, even below that, the local systems—a general practice or a surgical environment—

The Convener: Jason, can we focus on the consistency and inconsistency of reporting on adverse events? That is what we are trying to get to the bottom of.

Professor Leitch: If you seek a national reporting system for adverse events, it is the wrong answer. Most countries that had one have abandoned it and most countries that still have one just have a big database of counting.

Brian Whittle: That is not what I am asking. What I am getting at is that, if there is a huge change in the number of adverse events reported in a health board, that could indicate that the bar is being set at a different level for whatever reason. Who monitors that?

Professor Leitch: The Scottish Government monitors that. Through performance management frameworks, we monitor a board's papers and its governance committee papers. We would know if that happened.

Brian Whittle: In that case, what protocols are put in place to address that? It is not my experience. When I asked that specific question in an HIS review, I was told that nobody monitored the numbers of adverse events in any health board.

Professor Leitch: You asked a broader question than that. You did not ask just who monitors the individual numbers.

We—the Government—have a performance management infrastructure that meets boards regularly, monitors the board papers, sees the minutes and sees the data along with Healthcare Improvement Scotland, which is involved in improvement science, improvement organisations in those boards and the scrutiny. Between us, if such a thing as you described were to happen, we would know.

The Convener: To be helpful, and bearing in mind the time, the committee will write to you to clarify the situation and get some more information from you on it.

Jenny Gilruth: Good morning. I have a specific question about your submission, Dr Mackintosh. You say that

"evidence about safety and effectiveness … comes through the DATIX Incident Management System".

Last week, we heard from the Royal College of Emergency Medicine, which said that the system "hindered rather than helped", and that it was a barrier to changing the culture of resistance to learning from mistakes in the NHS. Do you agree with that?

11:00

Dr Mackintosh: There are questions about how the system is used in different boards and an issue of culture. It is probably accurate to say that, at times, the system has been a barrier. In part, that is about how easy it is to use and issues to do with information technology solutions and access. However, some of it is to do with the response. That picks up on the question whether we use complaints as a measure, a way of monitoring and a way of saying, "You have not performed well—bad person," or whether we use them as a learning experience, which gets a better response and which is what we increasingly tend to do in Lanarkshire.

A huge number of things that go into Datix never really see the light of day and are not of great benefit, but they tend to show us patterns and allow us to make changes before we reach the level of significant complaints and adverse event reviews. There is a huge area where we have not had a significant event and may not even have got to a near miss, but where things could have been done better. That area can be improved, and it tends to get picked up in Datix. However, the system is not perfect.

Professor Fluck: There is a point about expectations. Datix is a relational database. It is better to have something where we record what happens than not to have that. The question is how we improve its utility for individuals and how we make it bespoke for different purposes. That requires on-going work in each of the boards. We have done lots of work to customise the system for different settings and to make it easier for people to enter information. People can just go into a front page on the intranet and, on the next screen, they can enter something that has happened in their area and assign it to one of their line managers to have it looked at.

We can do a huge amount to improve the system. However, over the years, I have heard a

lot said against all sorts of IT systems and I have not met anyone who loved an IT system when it first arrived. We should just accept that recording stuff is a really good thing to do, and that we have to do a pile of work on the culture, processes and behaviours around how we use that information to learn from it.

Professor Leitch: I watched last week's meeting, and I was surprised by Dr Chung's evidence on that. I intend to contact him and see how we can help. Datix is just a company that happens to be the one that we mostly use in this country. I asked other boards about Datix and most of the feedback that I got was not the same as Dr Chung's; it was the much more nuanced approach that Nick Fluck describes. I heard about front-line teams adapting the system for their own use and having front pages where information can be entered quickly. There are morbidity and mortality meetings where the data and knowledge are used very well. The approach in NHS Grampian, which Nick Fluck described, is a particularly good example. NHS Lothian also gave me particularly good examples this week about how it has adapted the system for use.

There is a national Datix users group where users come together to share best practice so that we get better at it as a country. I will make sure that NHS Ayrshire and Arran is involved in that. In particular, we will see if we can make the system better for the emergency department that Dr Chung described.

The Convener: In conversations with staff, the issue comes up very regularly—

Professor Leitch: It does with me, too—

The Convener: —and not in a positive way, I have to say. That is my experience of people coming to surgeries or people I know.

Robbie Pearson: I echo some of the points that have been made. Datix is a system that allows information to be imported. The really important thing is that we take the learning from it and ensure that it is embedded in day-to-day practice. There must be a feedback loop, so that, when there is an incident, we get the feedback and then the learning. That is the key thing that we are trying to do in introducing an adverse event framework. That is important not just for staff but to give meaning to patients who wish to share in that learning. That is a crucial part of what we are seeking to do. We are trying to bring together adverse events, complaints management, which we have touched on, and the duty of candour, because we need to see those things in the round.

Alison Johnstone: Last week, the witnesses spoke about the lack of a feedback loop. I think that Dr Bennie reported that there is a culture of "learned helplessness" in the NHS, because staff see no point in passing on bad news, as they do not think that anything will happen.

In its written submission, the SPSO highlights the importance of learning from these events, although it has concerns that that does not always happen. We keep hearing about the need to change the culture. However, at last week's meeting the witnesses suggested that it is difficult to change a culture when resources and capacity are really stretched.

In his evidence last week, David Chung said that he felt really uncomfortable that, as a doctor, his continuing professional development was protected whereas the nurses who are responsible for delivering so much healthcare in Scotland do not have the same automatic entitlement to that time and have to come in on their days off. Why are the bodies here not insisting that all professionals who work in healthcare have access to CPD? We expect people working in that environment to take on board and deliver all the guidelines and standards, but that is really difficult. The Royal College of Nursing employment survey found that 37 per cent of members in Scotland reported not receiving any CPD in the past 12 months. If staff are to keep up to date with how to carry out various practices, how can that be sufficient?

Rosemary Agnew: The word that I am thinking of is "accountability". We take quite a process governance approach to that. We are accountable collectively to many people in many different ways. Staff say that they put lots of things into Datix, and I hear lots of talk about learning and improvement, but it is important to the users of our services that something changes as a result of that. If we constantly ask for information and feedback and constantly say that we are learning from complaints but nothing actually happens, credibility and trust will be undermined.

I go back to Nick Fluck's point. It is also about getting feedback on the front line in a different way, and having the conversation about how care is delivered. The danger is that we will become too focused on the numbers, the reports and the governance, and lose sight of the fact that accountability is also about experience and how people feel about the healthcare that they are receiving. That is where we have to make better use of all the information that we gather.

We are one of a number of organisations that provide information to the HIS intelligence group. An obstacle for my organisation is our ability to share the information that we have. We have very rich information but I am under no illusions—it covers a very small sphere, because it is specifically about those complaints that reach the ombudsman. Often, the challenge for us is that we cannot share some of the information that we think

would help to develop services. I strongly urge that consideration be given to how we can share information so that it is shared not just within boards but across boards, and across Scotland, too.

Sheena Morrison: I have a quick point on Datix, again in the context of integrated governance arrangements. In Glasgow health and social care partnership, Datix provides a huge amount of information and rich data. The accessibility of that information and the ability of social care staff, for example, to input to the system is more limited. That aspect needs to be considered as we begin to progress and, I hope, improve a range of governance and accountability processes.

I have another quick point on the feedback loop and the importance of having in place structures that allow people to reflect on a range of activity, but particularly adverse events, significant clinical incidents and case reviews. It is really important to build in that dissemination process to ensure that staff feel more involved in the developments that come from the learning from such events.

The Convener: No one has answered Alison Johnstone's question about CPD and people's opportunities to learn. We will make sure that that question is answered before we finish, but I want to stick with the topic of accountability.

Ash Denham: I want to follow up the idea of high-level oversight that perhaps takes place above the boards. I will be happy to be contradicted if this is not the case, but the evidence that we took last week seemed to suggest that there was no process for sharing good practice between boards—for example, when one board has really good processes leading to excellent outcomes in an area in which another board is perhaps struggling. I have read HIS's submission, and there seems be more of a collaborative approach taken with boards to work on improvements. Is there an ability to compel boards to share best practice? If not, should there be?

Robbie Pearson: There are limitations to compliance when it comes to building the commitment and the will to share good practice. Healthcare Improvement Scotland has just published an impact report that sets out a range of excellent examples of improvements in the quality of health services. We know, for example, that there has been a 72 per cent reduction in ventilator-associated pneumonia and an 8.5 per cent reduction in hospital standardised mortality. In that report, which is a public report and which I will happily share with the committee, there are lots of examples, many of which come from colleagues who are around the table today. I caution against taking an approach in which a letter comes out that calls for something to be implemented. Ours is a much more nuanced approach.

I will say something more broadly about Healthcare Improvement Scotland sharing intelligence and good practice. The ombudsman has touched on the issue of sharing intelligence. We responded to the Mid Staffordshire public inquiry by assembling the key organisations that had the intelligence in Scotland. At Mid Staffordshire there was a failure to share and a failure by regulators to act on intelligence. We now meet Audit Scotland. We have the intelligence from the ombudsman, and we have the overview from NHS Education for Scotland on the quality of the training environment for junior doctors, for example. We have that intelligence in the room, and we can then decide whether we need to act in concert or individually. That is not just an important safeguard when there are concerns—for example, when boards may be having service provision difficulties—but an increasingly important part of sharing good practice. Therefore, earlier this year, we published the annual report of the sharing intelligence group, which outlines good practice while being overt about the challenges.

A number of mechanisms are in place. The Scottish patient safety programme is a great example of where we are sharing good practice and ensuring that it is reliably implemented and spread across Scotland.

One of the challenges internationally is how we spread good practice consistently and reliably. There is no simple answer to that, but we are making good progress in Scotland.

The Convener: It has been suggested that there is a legislative barrier to sharing information. Can Rosemary Agnew shed light on that?

Rosemary Agnew: If information is anonymised, cannot be attributed to anyone personally and is general intelligence-type information, we are pretty much like other organisations. There are named organisations that, in certain circumstances, we can share specific information with. However, the Scottish Public Services Ombudsman Act 2002 places restrictions on my organisation that are a barrier. I could share more at an individual level about patient care from what we have seen from complaints than I am currently able to do because of those restrictions.

The Convener: Will you write to us with the detail?

Rosemary Agnew: Yes, absolutely.

The Convener: We would be very interested in that.

Some people consider that territorial boards are a bit tokenistic on accountability. I have looked at NHS Lothian's board papers for the past couple of months. In October, the board was presented with 307 pages of information, in June it was presented with 568 pages and in April it was presented with 514 pages. Presumably, that information was for board members to scrutinise and sign off or interrogate. Is it realistic to believe that, if a board is presented with 568 pages, that information will get the scrutiny that it possibly deserves?

11:15

Dr Gillies: I will answer that first, since it was our papers that you looked at. I agree that it is an awful lot of information to look at, but it is important to see those board papers in the context of the wider way in which the board works. A governance committee that is chaired by a non-executive provides assurance for the wider board—as set out in the submission—so there is a system that feeds down from that. There are also board development seminars at which we might explore a topic in more detail, which would allow the board paper to be more of a highlight report. The healthcare governance committee, which I guess is the committee that is most pertinent to this morning's discussion, receives a lot of papers, but my experience of sitting round that table is that members of the committee read all those papers.

The Convener: I seriously find that difficult to believe. Having sat on a local authority, where we were presented with massive amounts of paper, I know from experience that people do not read everything, and I do not believe that NHS Lothian, or any other NHS board, is any different.

Dr Gillies: I know that my non-executive colleagues sometimes ask quite detailed questions, or ask for things that are not in a section for discussion to be moved into a section for wider discussion. I can only go by my experience.

The Convener: It would probably take the average reader a week or so to read a 568-page novel, but maybe I am just a slow reader. We are looking for proper scrutiny and accountability. Is that kind of volume of stuff being presented to a board that meets monthly or bi-monthly?

Dr Gillies: The board meets bi-monthly.

The Convener: I do not think that that is credible.

Dr Gillies: I understand that it is a lot of information. That is why we try to have presentations on particular topics for discussion, which makes the information easier for people to access.

The Convener: I say that that is not credible because if there is a difficult issue that you want to get through the board without much controversy, or if there are statistics that might throw up concern, it would be easy to hide that information in 568 pages of documentation so that people would miss it. I am just sceptical.

Professor Leitch: Let me balance that with a reassurance that we are not trying to hide anything or cover up numbers in board documents. I have not looked at the same papers that you have looked at, but I imagine that those board papers are divided into items for discussion, which will be a smaller set and items that will need a vote. Let us remember that the board is the peak of that governance pyramid and that underneath it is the committee structure. There are committees for audit, clinical governance and so on, and those committees will, I imagine, send to the big board meeting papers that they have previously scrutinised. The chair of the clinical governance committee will be at the boardroom table and will be able to say very quickly that the governance committee looked at the issue and that this is what is being done.

You make a good generic point, which is to ask what the board should do. I go round board meetings and often present at them or discuss issues with members. During the past 10 years, boards in the health system have matured significantly, and—this is increasingly the case in the IJB world—the quality report, or however you want to describe it, accounts for the bulk of that conversation. There is a big conversation about finance and efficiency inside that quality report, but there is also now a conversation about the quality of the delivery system. Those are robust conversations. I have not been at a board at which there has not been a robust conversation about the quality of the delivery system.

The Convener: In relation to IJBs, could Sheena Morrison comment on lines of accountability and how they operate?

Sheena Morrison: It is similar to the way that Professor Leitch has identified. A finance and audit committee and a performance scrutiny committee sit under the integration joint board. I am sure that others will have done something similar to the development sessions that we have had, with focused reports and presentations on certain areas, particularly around finance and on how that relates to patient and service user care and the potential impact of any changes.

Those development sessions were important, particularly in the earlier days of the IJB. Non-executive members as well as elected members in the city have had the chance to get information about slightly more informal types of presentation and are being encouraged and supported to ask

questions so that they have a better sense of the field of operation. There is particular emphasis on the impact of decision making on patient and service user care and service delivery.

Professor Fluck: I am not going to argue with the point that a 500-page document is not a reliable single way to transmit information or to achieve accountability. Everyone is describing multiple layers of approach, and we have heard about tiered governance systems, which start from ward level and go all the way up to the board, and the involvement of non-executives in other types of activity.

We have done a lot of work around the presentation and interrogation of data, and we have done development work with the board on how we look at data and ask the right questions. We also work on understanding our systems and processes for the board. Most importantly, we get the board members to meet the teams who are involved. When we put together that review of information and understanding of system and process and the board members meet the people who are involved in delivering that, they get a much better idea of whether they can be assured that what they are seeing or the assurances that they are getting are valid.

Emma Harper: I have a quick point about near misses and significant adverse event reporting across the IJBs. We are focusing on boards, but health and social care integration is a major issue for us now. I assume that IJBs follow the same processes for SAEs and near misses.

Sheena Morrison: The processes are complementary and compatible but not exactly the same. The process is exactly the same within the health element of health and social care partnerships. There are critical incident reviews and significant incident reviews and processes within the council and social care element of the partnerships.

We have worked really hard, particularly in my role, to bring those together to make sure that we are following one overarching policy when a patient or service user is in receipt of a range of services. We have looked at people with multiple and complex needs such as individuals who are having treatment for addiction and mental ill health and are in the criminal justice system or are using services because they are homeless, and we look across the way at the issues that have impacted on whatever the event was.

We have learned a lot from mental health services, particularly in relation to the emphasis on openness, involvement of the family whenever possible and being really clear if there is no family involvement in the investigation and the feedback loop. We also make sure that staff have the opportunity to learn from those events through dissemination in the appropriate forum.

One of the issues for the IJB and the health and social care partnership, certainly in Glasgow, is the need to make sure that, as far as possible, we do not duplicate effort or allow anything to slip between two stools. It is about pulling together all the complexity of health, social care, the relationship between the IJB and the health board—and, in NHS Greater Glasgow and Clyde, six local authorities—and services that have cross-cutting influence.

The Convener: We are in our final five minutes, so questions will need to be rapid fire. A number of members still want to come in.

Miles Briggs: I want to return to the issue of culture and follow up a comment that you made. Much of the evidence that we have taken has been about two issues. First, we have heard from people who work in the health service, who feel that the culture in the NHS is just target driven and that they are being forced to work towards those targets. Secondly, we have heard from families who feel that they are not being included or are being actively excluded. We have met many people who have felt that, especially in child and adolescent mental health services and mental health services in general. How do the witnesses feel about that evidence?

The Convener: The issue of the culture within the NHS has been a recurring theme in our evidence sessions, with people saying that there is a negative blame culture within the health service and that staff are afraid to report issues or feel that nothing happens when they do. They feel intimidated by that. We have heard that from middle managers and those who are working on the front line.

Dr Mackintosh: Don Berwick of the Institute for Healthcare Improvement talks about the three eras of medicine. The first era is the “we know best” or paternalist era. The second era, which we are probably in now, is about measurement and standards. Anything that can be counted is counted, and it is what we count that counts. We then move on to a more professional and more moral era, which is the change that many people describe.

It is correct to say that family involvement has not been as good as it should have been. We have picked up on that, and change is on-going. I am involved in a significant adverse events review at the moment. It starts off with a question to the family: what questions would you like answered? As Tracey Gillies pointed out, that creates a powerful check, although we have found other issues that we need to address. It is not everything, but it is important. A report is then

made specifically back to the family, with the offer of a meeting. The culture is changing.

Professor Leitch: I recognise some of what Mr Briggs describes. In western healthcare, we are on a bit of an evolutionary path to being more inclusive of patients, families and carers, and, in Scotland, we have tried to include them. The Nuffield Trust report suggests that people from other countries should come to Scotland to see some of that work, although the system is not perfect and there is still lots to do.

The chief medical officer's report "Realising Realistic Medicine" talks a lot about sharing decision making with families, which goes back to the beginning of our conversation about the individualisation of care. The what matters to you? work is world leading, and there are conversations with education services, care homes, hospices and primary and secondary care about how to involve patients and families. Last week's report by Sir Harry Burns on targets and indicators will help us to move the conversation on a little about how that target-driven culture might be changed for front-line teams, in particular. Some of the scrutiny and accountability that we have discussed, though, seeks numbers, targets and indicators, so we have to get that balance right. We have had a good conversation about where the balance lies, but we must release the front-line teams who see the patients and families to do as much of that work as they can while still holding the system accountable for it.

The Convener: How is that being done? We are hearing about staff being under huge pressure at the moment because there are not enough of them. They need resources and, because of that pressure, they are finding it difficult. For example, nurses are finding it difficult to do their CPD. When they make suggestions to improve issues like that, they are being stifled from the top. How can that culture be changed?

Professor Leitch: There are times when that is true, but there are other times when it is not. I visited a number of NHS Grampian teams a couple of weeks ago, and they did not just take me to the nice people. I was taken to a number of teams that had been empowered and that had chosen to improve practices. They had learning inside the environment. In the evening, I met the junior doctors for pizza and I asked them what it is like in that environment. It is not perfect, of course, and there are opportunities for improvements, but, in the main, they are happy with the environment in which they work. They understand the resource and staffing constraints, but they talked about the reduction in infections and the fact that they had never seen a central line infection or a case of clostridium difficile. They also talked about the culture within NHS Grampian.

I did the same in NHS Highland the following week and the experience was very similar, with lots of work being done on clinical efficiency. We must ensure that, as far as possible, that applies universally across the 160,000 staff. Today, we have touched on how we might strike a balance between the work of HIS and the boards' work in that respect. Please do not leave here with the impression that I think that the system is perfect or that it has been fixed—I do not. I spend my days trying to make it better.

11:30

The Convener: You are with the nice people today. Colin Smyth is next.

Colin Smyth: My question was on integration, which has been covered.

The Convener: Okay. I will bring in Sandra White.

Sandra White: I want to ask about patient involvement. I am not saying that your hands are tied, but you have no legislative power over health boards in that respect. A lot of people feel that, when services are changed, patient involvement is simply a tick-box exercise. An example of that relates to the minor injuries unit that is based in Partick, in my constituency. Partick was the only area that was not invited to the consultation, but the people themselves pushed for consultation in the area from which the service was going to be removed.

Do you agree with those who say that consultation is a tick-box exercise? If it is not, can we do anything to improve the process and convince people that such consultation exercises on changes to services are genuine?

Robbie Pearson: That is a very important point. I have previously given evidence to the committee on the importance of ensuring that there is high-quality engagement from the very start of the process as opposed to presenting people with changes as a done deal further down the track.

We need to think about every part of service engagement and redesign, not just the controversial bits at the major cut-off points. That is really important in the context of the Scottish Health Council's future work on quality assurance. We need genuine and meaningful engagement in service redesign.

The point that Miles Briggs made earlier about CAMHS is crucial. It is not only children and adolescents but their families who need to be supported. As a colleague said to me the other day, those people are not just informed carers but intensive carers for those individuals. We are attending a CAMHS event today, which will be an opportunity for patients, families and carers to be

involved in the design of those services in the future. We are on a journey, but I recognise the points that have been made.

Professor Leitch: I was meant to be speaking at that event today, but Robbie Pearson trumped me.

The Convener: We are pushed for time, as we have the minister coming in to discuss a piece of work. I will ask a couple of quick final questions on issues that we have not covered. Perhaps the witnesses can answer them very briefly. Why are some service standards monitored while others are not?

Robbie Pearson: Service standards for older people are monitored through a regular inspection programme, and HEI standards are monitored. It is a matter of prioritisation. Some of the standards are out of date, which is an issue, so there is an on-going refresh programme.

The Convener: Who chooses the priorities? You obviously want patients to be treated to the highest standards.

Robbie Pearson: The prioritisation process involves patients and clinicians in its design. We also need to ensure that the standards are relevant and up to date. For instance, we have been working on the national screening programme to review breast screening standards, because technology has moved on and the environment for breast screening services has changed considerably over the past five or six years. There is a process of prioritisation.

The Convener: I am not quite sure about that. Who decides that another area is not a priority?

Robbie Pearson: Prioritisation is not about what the standards are; it is about how we deploy our resources. We made a commitment that, as part of the £3 million that we spend on scrutiny, we should invest time in inspecting and undertaking quality assurance work with regard to the dignity and respect that older people are afforded in our hospitals. We have a comprehensive inspection programme for older people, and, in the context of the issues at the Vale of Leven hospital, there is a comprehensive and rigorous HEI inspection programme.

The Convener: I have two final points to put on the record. First, Alison Johnstone raised the issue of CPD. How do we ensure that staff who are under pressure get the opportunity to keep their practice up to speed? We have heard evidence to suggest that that is not happening. Secondly, how do we ensure that dignity and respect are built into the system? If witnesses could follow up on those areas after the meeting by sending information to the clerking team, that would be really helpful, as we are very pushed for time today.

I thank you all very much for coming.

11:35

Meeting suspended.

11:37

On resuming—

Subordinate Legislation

Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Amendment (No 2) Regulations 2017 [Draft]

The Convener: Item 3 is consideration of an affirmative instrument—the draft Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Amendment (No 2) Regulations 2017. As is usual with affirmative instruments, we will have an evidence-taking session on the instrument with the minister and her officials.

I welcome to the meeting Aileen Campbell, who is the Minister for Public Health and Sport, and, from the Scottish Government, Peter Stapleton, carers policy; Brian Nisbet, health and social care integration; and Ruth Lunny, who is a lawyer.

I invite the minister to make a brief opening statement.

The Minister for Public Health and Sport (Aileen Campbell): I thank the committee for giving me the opportunity to speak about the regulations—[*Interruption*.] I could hear you in stereo, convener.

The Convener: I thought it was a heckler.

Aileen Campbell: Members will all be aware that, when the Parliament passed the Carers (Scotland) Act 2016 in February last year, the integration of health and social care was already under way across Scotland. As the committee will recall, the purpose of the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) Regulations 2014 (SSI 2014/345) is to provide for the mandatory delegation of adult social care functions to integration authorities so that those functions must form part of their strategic commissioning plan for delivering health and social care services locally. We have put forward the draft regulations to further amend the principal regulations so that they take account of the provisions in the 2016 act in the same way.

If approved, the regulations will remove section 3 of the Social Care (Self-directed Support) (Scotland) Act 2013 from the schedule to the Public Bodies (Joint Working) (Scotland) Act 2014, because that provision will be repealed by the Carers (Scotland) Act 2016 when it comes fully into force on 1 April next year.

In addition, the regulations will prescribe the functions that are conferred on a local authority under sections 6, 24, 25, 31, 34 and 35 of the 2016 act as ones that must be delegated to integration authorities. Those sections cover a range of local authority functions in relation to carers. For example, section 6 will require integration authorities to offer and prepare an adult carer support plan for identified adult carers. Section 31 will require that they prepare a local carer strategy that will outline how carers will be identified and supported in their local communities.

It is important to note that, in line with existing integration legislation, the requirement to delegate those functions applies only in so far as they are exercisable in relation to adult social care. Delegation of those functions in the context of children's social care remains a matter for local decision.

I will not detail all the functions under the 2016 act that must be delegated, as they are laid out in the supporting policy note for the regulations, but I want to emphasise that the prescription of those functions will ensure that there is legislative synergy between the carers and the public bodies legal frameworks and will allow functions that stem from the 2016 act to be carried out in an integrated health and social care context.

Supporting those changes will allow integration authorities to continue with their strategic planning and commissioning priorities and will ensure that objectives to improve outcomes for carers that we as a Parliament put in place when we supported the passage of the 2016 act can be taken forward as an integral part of the integration of health and social care.

I again thank the committee for allowing me to give evidence, and I would be happy to take questions on the regulations.

The Convener: Do members have any questions?

There being none, we move to item 4, which is the formal debate on motion S5M-09005. I remind the committee that members should not put questions to the minister during the debate and that officials may not speak in the debate. I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017 be approved.—[*Aileen Campbell*]

The Convener: As no member wants to speak in the debate and the minister has indicated that she does not want to sum up, the question is, that motion S5M-09005 be agreed to.

Motion agreed to.

The Convener: I suspend the meeting to allow the minister to leave.

11:42

Meeting suspended.

11:46

On resuming—

Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017 (SSI 2017/381)

The Convener: Item 5 is consideration of a negative instrument. No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on the instrument. Do members have any comments?

There being none, that is agreed. Thank you very much.

As agreed at a previous meeting, we now move into private session.

11:46

Meeting continued in private until 12:28.

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