The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 15 January 2013

Session 4

Tuesday 15 January 2013

CONTENTS

HEALTH AND SPORT COMMITTEE
1st Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Dorothy Armstrong (Scottish Public Services Ombudsman)
Dr Denise Coia (Healthcare Improvement Scotland)
Jim Martin (Scottish Public Services Ombudsman)
Robbie Pearson (Healthcare Improvement Scotland)
Dr Brian Robson (Healthcare Improvement Scotland)
Ian Smith (Healthcare Improvement Scotland)
Susan Went (Healthcare Improvement Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 15 January 2013

[The Convener *opened the meeting at 09:45*]

Healthcare Improvement Scotland and Scottish Public Services Ombudsman

The Convener (Duncan McNeil): Good morning. I welcome members and the public to the first meeting of the Health and Sport Committee in 2013. As usual, I remind everyone present to switch off mobile phones, BlackBerrys and so on, as they can often interfere with the sound system.

The first item on our agenda is a general evidence-taking session with Healthcare Improvement Scotland and the Scottish Public Services Ombudsman. I welcome our first panel of witnesses, all of whom are representing Healthcare Improvement Scotland: Dr Denise Coia, chairman; Susan Went, director of evidence and improvement; Robbie Pearson, director of scrutiny and assurance; Ian Smith, regional inspector; and Dr Brian Robson, executive clinical director.

We previously agreed that Dr Coia would make an initial statement, after which we will move to questions. Dr Coia, please take the floor.

Dr Denise Coia (Healthcare Improvement Scotland): Thank you very much, convener. You have already introduced my team, but I must pass on apologies from our chief executive, Dr Frances Elliot, who is, unfortunately, on annual leave today.

It might be helpful to tell the committee a little bit about who we are and our roles and responsibilities. The committee has received a briefing from us, so members will know that we were set up in April 2011 under the Public Services Reform (Scotland) Act 2010 and that we have two purposes: first, to support healthcare providers in Scotland to deliver high-quality, evidence-based, safe, effective and person-centred services; and, secondly, to scrutinise those services to assure the public about the quality and safety of that care. We do that through the three functions—evidence, improvement and scrutiny—that we have structurally realigned our organisation to deliver.

Members will know of our evidence work through the Scottish Medicines Consortium, the Scottish intercollegiate guidelines network and the Scottish health technologies group. We also drive improvement programmes, have put in place national patient safety programmes and provide improvement technologies at the coalface to help clinicians drive improvement in their own services. Finally, we have a number of programmes related to our scrutiny function, and I understand that the committee's key interest is in the scrutiny programme for older people and acute care.

We look at these three functions as a continuous cycle of improvement. Indeed, the key point that we want to get over to the committee is that, although Healthcare Improvement Scotland is a scrutiny organisation, the improvement component is crucial. One does not happen without the other, and what is important is not only the reaction of health boards to our findings but what they do about them. Our organisation is unique in that no other—apart from one, I think, in the Netherlands—provides both a scrutiny and an improvement function. Wrapped around those three functions is the Scottish health council, which, as part of our organisation, ensures that the public and patients are at the centre of what we do.

Another major strength of the organisation can be found in the powers that we have in the legislation under which we were formed, which include a duty on user focus, a duty to co-operate with other public sector organisations and a duty to publish our reports. I simply highlight the point that we are still learning about the full extent of our powers under the 2010 act.

We are a new organisation, are still developing and have had to hit the ground running. We have developed a new structure to try to improve our capacity and capability in order to meet our growing portfolio of work, particularly with regard to patient safety and scrutiny, and we are also growing our intelligence base.

Let me end with two challenges that we face for the future. The first is to demonstrate the impact of our work to both Parliament and the public because, as an organisation, unless we are making significant changes for patients and the public in healthcare, we are not really of much value. The second is to look at the patient journey over time. At the moment, a number of our programmes are focused on acute care, but most patients spend most of their healthcare journey in the community, so a focus over the next couple of years will be to quality assure healthcare both in community services and in primary care.

That is all that I will say for the moment.

The Convener: Thank you for those opening remarks. Let me begin with some general questions on the role and priorities of Healthcare Improvement Scotland that I note are laid out in the submission. We have asked previously about

the capacity of organisations to fulfil their roles, commitments and priorities. The submission refers to tasks such as "Improvement Support", "Scrutiny", "Prisoner healthcare", "Healthcare Environment Inspectorate" and "Improving learning", so Healthcare Improvement Scotland has a lot to do. As a committee, we know that the funding for special health boards has not been maintained. What is the funding position and the capacity of your organisation to carry out all those roles?

Dr Coia: I will briefly answer that question and then hand over to two of my colleagues.

To be perfectly honest, as a chair I think that it would be lovely to be able always to ask for more money and it would be nice to say that we require additional resource. As a new organisation, we have had to try to ensure that we have the right people in our organisation in the right place so, to start with, internally we have tried to focus our capacity and capability. Because we have new functions within the organisation, we have spent this year doing that. Yes, we took a larger percentage hit than the territorial boards did and times are very difficult in Scotland at the moment, so a key point is that we would struggle to take on additional work without additional resource. However, our main priority at present is to stabilise our core funding. If I hand over to my colleague on my left, he will be able to tell you more about the arrangements for our core funding and programme funding. Our key issue is much more about sorting that out than looking at additional resource.

Robbie Pearson (Healthcare Improvement Scotland): I echo the point that the issue is about our skills and competencies to perform the role that is vested in us by the Public Services Reform (Scotland) Act 2010. We receive core funding of around £16 million from the Scottish Government. That core allocation is enhanced with additional funding that we receive from the Government for a range of initiatives, such as those within our safety programme. However, the important point is that Healthcare Improvement Scotland has the skills, competencies and capability to fulfil the tasks that are placed on us. As a young organisation that is maturing, we are giving active consideration to that.

The directorate of scrutiny and assurance, for example—to dwell for a moment on my own directorate—has a team of around 45 people, including around 12 inspectors. We are developing our skills, competencies and capability and we are thinking about what skills and capability we need to inspect and regulate the independent sector. Within the directorate, we bring to bear a mix of skills and experience, but we are also increasingly thinking about how we can draw on the skills and experience out there in the national health service in Scotland to help us to do our work of scrutiny and assurance.

Dr Coia: Perhaps Susan Went can comment on the improvement side.

Susan Went (Healthcare Improvement Scotland): The improvement function forms one half of the evidence and improvement directorate, which has just over 100 staff, so my directorate has both those remits within its core function. The evidence portfolio includes not only the SIGN guidelines, as our chairman has outlined, but the improvement programmes, which include the safety programmes and other improvement programmes such as the more recently initiated person-centred care programme.

Much of our dilemma in the improvement portfolio is the one that the chairman has identified. Much of the resource that is associated with delivering that programme comes in small pieces over one, two or three years of funding rather than through core funding, which would allow us to flexibly use the resource across the entire portfolio of work.

Dr Coia: However, our clinical engagement strategy gives us additional resource in terms of people. Brian Robson might want to comment on that.

Dr Brian Robson (Healthcare Improvement Scotland): We have a small core clinical team in the organisation with a chief pharmacist, a chief nurse, midwife and allied health professional and a consultant in public health medicine and me. Our engagement strategy means that we bring in national clinical leads from the service experts in their field to work with us. At any one time, 20 or 30 of those will be working with us each session to help us to support our improvement programmes. Beyond that, we have access to thousands of clinical staff across the NHS in Scotland and the United Kingdom as well as internationally, to help us with our work. We do not have a large employed clinical staff, but clinical staff and clinical assurance run across all the programmes.

The Convener: Will you have more or less money in three years' time to carry that out? What efficiencies will you have to put in place during the next three years to build up your capacity? I presume that there are 12 inspectors, so have they got the right clinical background or do you have to depend on the service that you are responsible for inspecting and regulating to provide you with that resource? How will you maintain that level of independence? I am all for partnership but, if you are dependent on the service for your wider resource, will that bring into question the independence of your operation?

Dr Coia: I will hand over to Robbie Pearson in a moment. Because the new organisation acquired

a range of other groups and bodies, during the past year the board has put together for next year a local delivery plan that contains a clear prioritisation process. It is important for us to be able to say that we can do X number of things and that we can do them well, and we need to be robust about that.

The convener is right to talk about partnerships, because that is where independence comes in. We have to be able to say what we can do well and what we will major on during the next year. That is what is important to the public and patients in Scotland and to our ability to deliver good healthcare in Scotland.

We have been extremely robust in reviewing other pieces of work that might be less important or might have been inherited from the past. Our directors had a development day a month or two ago to focus on the organisation itself—not the partners or the Scottish Government—and on what it is important for us to deliver.

Susan Went: I will start with the two points that the convener raised. I am certain that, as far as the evidence and improvement portfolios are concerned, it is vital that we engage through our contacts with the service either through clinicians or directly with teams who are working on the ground, in the boards, and with the staff who provide the care. That link is vital to ensuring that the programmes that we design, draft, and deliver are relevant to the service, that they make sense, are understandable, are deliverable, and that they are targeted at the issues that matter to staff, patients and families. That is a vital part of our work and it adds huge value.

It is a reality that the NHS is constrained. Like all the other NHS organisations, we work to a defined budget that is limited and reducing. Therefore, we are looking at, and will continue to look at, any efficiencies that we can gain internally by having teams work more closely together and by considering how we can share staff, skills, competencies and resources between teams. I am certain that that will be part of the way that we work for a considerable period going forward. However, if new work comes into any portfolio in the organisation, we will be under severe pressure to deliver that additional new work within our existing resources.

10:00

Robbie Pearson: The question was about how we will exert our independence as a body—

The Convener: The question was how, with less money over the next three years, you will manage those efficiencies while meeting the organisation's priorities, which the chairman, Dr Coia, outlined. What efficiency savings need to be achieved over the next three years? How will those impact on the organisation?

Robbie Pearson: The raw numbers are that the budget will decline from £16.7 million to £15.9 million in 2013-14 and is projected to be £15.2 million in 2014-15—that is for our core running costs.

For scrutiny and assurance, current resources provide a team of 12 inspectors, with a mix of skills, from clinical and non-clinical backgrounds. Over the next six months, I would like to enhance that by bringing in a range of skills and experience from the service. For example, in thinking about specialist dementia nurses and dementia champions, or the patient voice that is so fundamental to the public assurance that our inspection reports provide, we need to consider how we can thread that professionalism and expertise into our inspections. We will do so in a way that does not take away from the independence of our organisation's voice but ensures that we have a breadth of skills and competencies to support our inspections. That is what we are starting to think about. We can bring in other expertise as appropriate to enhance our inspections and to bring to bear a level of perspective and experience in our inspection reports, whether on older people's services or other aspects such as our work reviewing the management of adverse events by NHS boards.

The Convener: You have 12 inspectors, but you consider that that is not enough and you need to increase capacity. How many inspectors do you need?

Robbie Pearson: I think that we could probably have more inspectors to support our work, but we are currently reviewing that as part of a scrutiny and assurance directorate review. The directorate is being developed and the intention is that, over the next six months, it will be further developed and enhanced with some of the messages that I have just conveyed.

Current planning is for perhaps another two or three inspectors to support our work. However, what is fundamental is not the raw numbers but the skills, experience, capability and competence that we bring to our inspection work. Again, that emphasises the importance of the additional expertise that we may bring in from the service. As Dr Robson mentioned earlier in the context of our clinical engagement strategy, we need to consider how we can use the breadth of experience, skills and expertise that are out there to support us in our work as a relatively small organisation.

Dr Coia: I should also mention that we have joint inspections. You asked about our core numbers for inspections in the NHS, but we also engage with the care inspectorate—Social Care

and Social Work Improvement Scotland—on inspections of adult services and children's services. Part of our contribution to integrated inspections over the next couple of years will be not just raw numbers of inspectors but improvement methodologies and specific methodologies that have an evidence basis. We contribute a range of things apart from people with specialist experience. I think that it is important to balance that.

The Convener: I am sure that we will come on to some of that detail, but it is important to put the situation in context: you have a reducing budget; if possible, it would be desirable to increase the number of inspectors; efficiencies will need to take place at the same time as you are carrying out your duties; and, if you were given any additional responsibilities, you would be hard pressed to deliver those. Is that fair?

Dr Coia: I would absolutely agree with that summary.

Mark McDonald (North East Scotland) (SNP): Thank you for attending.

What percentage of the inspections that you undertake are proactive and what percentage are reactive?

Robbie Pearson: We have a mix of inspections. There is the healthcare environment inspectorate and its work on healthcare-associated infection. There are inspections as part of the regulation and scrutiny of the independent sector, as well as inspections that relate to the care of older people.

I will give you some raw numbers. Around 30 inspections for HAI are carried out each year; those are chiefly unannounced inspections. As regards the independent sector, I think that about 16 inspections are carried out each year; Ian Smith might keep me right on that. Around 13 inspections in relation to the care of older people have been carried out so far. In total, we carry out 50 or so inspections a year.

There is an increasing emphasis on moving towards unannounced inspections. If you were to speak to the service, the clear message would be that it values unannounced inspections more than announced inspections that are prepared for. Increasingly, a greater weight will be attached to unannounced inspections within the service.

Mark McDonald: You will have a plan for who is to be inspected and when in the year, but there will always be occasions when events will overtake that. For example, complaints will be received that will require inspections to take place. What is the prevalence of such incidents? You say that you plan for roughly 50 inspections a year. That is what you plan for at the beginning of the year, but how many unplanned inspections, roughly, do you encounter a need for during that period?

Robbie Pearson: I will make a broad statement before handing over to Ian Smith to talk about our responsiveness to that. It varies according to the area that we are inspecting or regulating. Each quarter, we produce a quarterly inspection plan. From time to time, as you infer, we have to adjust that plan according to events. Ian Smith can talk about the detail.

Ian Smith (Healthcare Improvement Scotland): At the moment, we have carried out 13 inspections in relation to the care of older people, two of which were follow-up inspections that came from issues that we found in the hospitals that we visited. One of those 13 inspections was unannounced. In general, our follow-up inspections are based on previous inspections of a hospital that have raised concerns that we feel are significant enough to make us go back and inspect it again.

Mark McDonald: I am still not 100 per cent sure that I am getting the information that I am looking for, so I will word my question in a different way. You have annual or quarterly inspection plans. If a member of the public or a whistleblowing member of staff contacts you and says that there are issues at a particular care home or independent provider, how quickly can you react to that complaint and factor in an inspection?

Ian Smith: For the NHS inspections, we do not investigate complaints—that is not our role. The boards have to investigate complaints. We would take intelligence from the complaints and use it to inform future inspections.

We react to complaints about independent healthcare providers. When necessary, that can be an inspection the next day or it can be follow-up activity. Depending on the significance of the complaint, it will usually be followed up initially by a phone call to the organisation. If appropriate, that will be followed up the next day with the organisation.

Mark McDonald: What criteria do you use to determine your inspection timetable? Do you have a spreadsheet that shows when operations were last inspected? Are different criteria used? Are some places likely to be inspected more regularly because of what has been found on previous inspections? What criteria are used?

Robbie Pearson: I will make a general point, if I may, then Ian Smith will pick up the detail. As Dr Coia indicated, we are increasingly maturing our intelligence base to inform our inspections. That will require us to work more closely with other regulatory bodies in Scotland and the UK and think about professional regulators such as the

General Medical Council. We are maturing that idea by thinking about hard data and whether we get information from the Information Services Division or other data from programmes such as, for example, the Scottish patient safety programme. We are also increasingly thinking about how we use more granular information at the local level in wards and hospitals to inform our intelligence and ultimately how we shape our scrutiny programme.

Ian Smith might want to answer the specific question about the intelligence that is used to inform an inspection.

Ian Smith: For the inspections of acute care services for older people, we had no baseline from which to work because the inspections were new. When the risk assessment was put in place, six areas were put together. They were generic measures of quality and safety, measures of quality that are relevant to older people in acute care, patient experience data, staff engagement data, complaints and adverse events, and priority topic areas for nutrition and pressure-area care. Those data were put into a risk matrix and we now have 18 hospitals on that and can calculate risk from those data. As time goes on, we will use our own data about previous inspections to inform subsequent inspections.

For the HEI healthcare-associated infection inspections, we used data that were based on our experience of the previous three years of where hospitals are and our risk rating of them. We have also started to use the prevalence data that came from Health Protection Scotland's prevalence report, which also informs inspections for healthcare-associated infection. For independent healthcare, the initial commitment was to visit every facility within Scotland. We take a lot of intelligence from that about complaints, notifications that are given to us, and any issues that arise from inspections, and we use that intelligence to plan future inspections in those areas.

Mark McDonald: You mentioned the relationship with other regulatory bodies. We recently took evidence from the Health and Safety Executive. What is your current relationship with it and how closely do you work with it on the regime of inspections that both organisations carry out?

Robbie Pearson: We have a memorandum of understanding and a close working relationship with other bodies, such as the Health and Safety Executive. We share intelligence about issues of concern. Ian Smith might want to pick up on that point.

Ian Smith: When we started inspections of care for older people and healthcare-associated infection inspections, we developed a memorandum of understanding with several organisations, including the Health and Safety Executive. Since then, we have escalated two instances to the Health and Safety Executive. It informs us if it has any issues in hospitals, but it might not fall within our remit to investigate that. What we will do is bring anything that we find to its attention.

Mark McDonald: How much sharing of information goes on in the forward planning to ensure that organisations do not all turn up at the same place to carry out different or conflicting inspections?

Robbie Pearson: We have started to do that by sharing intelligence. We probably do not do enough sharing of inspection programmes with other bodies. Internally, we are increasingly thinking about the burden of scrutiny that Healthcare Improvement Scotland is under and how we manage it across the piece. Inspection is only one part of a broader scrutiny and regulatory landscape in Healthcare Improvement Scotland and beyond.

One area in which we can deliver greater integration of our scrutiny is with the care inspectorate. We are starting to think about and pilot work for the sharing of intelligence and scrutiny in a more integrated way with the care inspectorate that takes away the focus on the acute hospital setting and, while giving that setting its appropriate place, thinks about the individual patient's journey of care from home into hospital and the support for their discharge back into the community.

10:15

Mark McDonald: I presume that there is nothing to prevent organisations from sharing that kind of information to ensure that the inspection landscape is as streamlined as possible and that no duplication is taking place.

Robbie Pearson: Absolutely. It is fundamental to the Crerar principles that, as scrutiny bodies, we should be doing that and minimising the burden on those that are scrutinised.

Dr Coia: The chief executive and I both sit on a group that is chaired by John Baillie in the Accounts Commission for Scotland, which has all the scrutiny bodies in the public sector on it. That group exchanges information and also has a practical working group associated with it to ensure that we are exchanging methodologies and trying to streamline as much as possible. The group will probably grow in influence over the next couple of years, as we would also like to share some of the training of our inspectors for core modules of inspection.

The Convener: Just for the record, we had long discussions with the care inspectorate concerning announced inspections, unannounced inspections, the frequency of inspections and how many inspection themes there would be per visit. The care inspectorate has changed its practice. Do you match its practice and the frequency of visits? Will each of the settings be inspected annually? Will there be unannounced inspections on an annual basis? We have had 30 inspections, of which one has been unannounced. Has anything happened in the long-term care settings yet?

Robbie Pearson: No. I will develop your point about the work with the care inspectorate. We are meeting this week, as a new programme board, to develop and shape our approach to multi-agency integrated inspections for adults in the community. In doing that, there is a real opportunity to share our different methodologies and combine the methodology of the care inspectorate with our work, our intelligence and the approach that we take to scrutiny in HIS. The intention is to test the methodology for integrated inspections for adults in up to three local authority areas in the next four or five months. That will provide an opportunity to share skills, experience and learning, and, in a more practical way, to share methodology and how we increasingly paint a picture of the journey of care from home into hospital and out again with the provision of effective support and rehabilitation to maximise individuals' independence.

The Convener: I am sure that we will get some questions on that pathway.

The cabinet secretary announced at this committee that acute settings and elderly care were going to be inspected. What was it agreed would be inspected and with what frequency? When is that inspection process to be concluded?

Robbie Pearson: The older people's inspection programme commenced in February 2012, with the Western infirmary in Glasgow. It was agreed that every NHS board would receive an announced inspection in the first instance, followed by unannounced inspections thereafter. We have concluded 13 inspections, which have been chiefly in NHS Greater Glasgow and Clyde, NHS Lothian and larger board areas. We will carry on with that programme with, in the first instance, announced and then unannounced inspections. At the moment, we are taking stock of how the methodology is working. The review group has had a number of meetings and is led by Pam Whittle. We are taking the opportunity now to review the methodology and its robustness—

The Convener: What does that mean? Does that mean an inspection per month per health board?

Robbie Pearson: Roughly, although it has been a little more than that, given that we have completed 13 inspections since the start of February. The last inspections that were undertaken are in the last report that was published, which was for NHS Western Isles. We will go back to the programme of announced inspections in the next month.

The Convener: When will you conclude all the inspections that need to take place under the agreement with the Scottish Government?

Robbie Pearson: We will probably conclude those by the first half of 2013-14.

The Convener: That is a long time.

Robbie Pearson: We have taken the time to get it right. It is a complex programme of inspections. It is different, in a sense, from the HEI inspections because it is looking at the systems of care for older people within the acute hospital setting. I think that we are getting it right and learning from it. We are undertaking a review of the methodology to ensure that there are opportunities to build in more learning and to strengthen the improvement work that follows the inspections.

The Convener: I compare that to the care inspectorate, which has a responsibility to inspect residential settings. It is expected to do that on an annual basis—each of those care homes is inspected annually.

Dr Coia: I will make a general point about that, as I sit on the board of the care inspectorate. The care inspectorate's inspections are regulatory inspections that are necessary for care homes to receive licences. There are quite strict rules laid down about the frequency of inspections, which have an impact on whether a care home can function. HIS is not a regulator in legal terms; we scrutinise and quality assure. The difference is that the inspections of older people's acute care are not regulatory inspections. We have no mandate to go round hospitals in a cycle, if you like, as the care inspectorate goes around care homes.

The issue for us—the crucial one around older people, in particular—is the culture of care. It is not so much about the frequency of inspections as about what we find when we make those inspections. When we have identified issues around the culture of care in acute care, we work with our improvement colleagues and with clinical engagement to make changes to that.

We could keep inspecting and finding things wrong—or extremely good—but there is a problem if we do not change the wrong culture. The big issue that came out of the NHS Lothian work and Anne Jarvie's review in 2006 was that although

problems were identified, sustainable solutions to them were not put in, and that led to a further inspection from us four years later because there was no change. What is crucial for us is not the frequency but that, when we find issues, we demonstrate that, over time, those issues are changing in NHS Scotland.

That is particularly crucial around care of the elderly in our hospitals and at home—the care inspectorate is discovering the same issues. Our joint inspections, which we are carrying out in the light of the integration of health and social care and in which we start to look at quality assuring pathways of care, are really about what care is like for the older person as they travel that pathway and what their experience of it is. The important thing is not the frequency of inspections, but whether we have changed anything.

The Convener: We will definitely come on to pathways and care standards.

Nanette Milne (North East Scotland) (Con): I am slightly confused. I was not a member of the health committee at the time of the previous inquiry, so I am learning about the subject as I go along. According to your website, the reports that you have published so far cover five NHS boards. Are all those reports to do with elderly acute care, or were those general inspections? Why did you focus on those five boards initially?

Robbie Pearson: For the older people's inspections, we made a judgment about population size, but the areas were also identified in the rating and there were a number of factors, which Mr Smith referred to earlier as the indicators. Those may have been infection or readmission rates. We considered a range of indicators in building that picture. Increasingly, that intelligence will develop and evolve, becoming a bit more sophisticated. I am thinking about the more granular information and intelligence that we have at the local level, whether that is from complaints or other intelligence from system and professional regulatory bodies. That is evolving and we need to invest in it and think about how we use it in a more sophisticated way.

Nanette Milne: How much influence does the experience of patients, their families and carers have on your decisions about which boards to inspect?

Robbie Pearson: The patient voice is of crucial importance for our inspections. For instance, our older people's inspections include two public partners, who are crucial in ensuring that we not only look at the system of care, but think about the experience of NHS patients and their families. We collect information from questionnaires and from interviews with families and we thread those factors into our inspection reports. We have also traditionally done that with the HEI inspections and we give some thought as to how to do that within the independent sector as well. We are keen to develop the involvement of the patient voice and ensure that it is threaded through our inspection reports, because it is fundamental to our role as an organisation that we ensure that we give that public assurance and allow the patient voice to be heard.

Nanette Milne: I understand that you can make recommendations to NHS boards but not enforce them. Following on from a report, what do you do to ensure that your recommendations are carried out? Do you make further recommendations? What clout do you have to ensure that your recommendations are implemented?

Robbie Pearson: Alongside our inspection reports, we generally publish an action plan from the NHS board that responds to our inspection report. If we have significant concerns, we can escalate them on the day. If we have further concerns, we can carry out a further unannounced inspection. We also have a system whereby we go back to the NHS board 16 weeks after the inspection improvement plan has been published to seek a follow-up or update on the actions. If we are not satisfied, we will come back to the board for a further unannounced inspection, so there is a process of inspection and scrutiny that follows on the back of the improvement plans. The crucial thing is that the NHS board owns and values the inspection improvement plans and that the NHS board demonstrates, within the board's governance system, that it is making progress.

Nanette Milne: If you come across a recalcitrant health board that just is not responding, what is your ultimate sanction? Is that with the cabinet secretary? Who would deal with that?

Robbie Pearson: We are not a regulatory body with enforcement powers, but we have significant powers under the Public Services Reform (Scotland) Act 2010 that allow us to carry out our duties. We do that in a way that I believe is proportionate and is increasingly risk based. An issue of fundamental importance for us is that we are able to carry out our work under the act in a way that emphasises that it is about scrutiny, but it is also about improvement and how we facilitate that improvement within NHS boards.

Dr Coia: We also have an escalation policy whereby, if an NHS board is simply not going down that route, our chief executive can speak to the chief executive of that board. We can also refer beyond that to the Scottish Government's performance management unit and to the director-general in our sponsor division in the Scottish Government. From there, the issue can be escalated up to a minister, so there are ultimate

sanctions. Scotland is a very small country and you can go up that ladder fairly quickly if you need to. I think that the important point—perhaps Susan Went will talk about this—is trying to ensure that there is improvement and action by boards, rather than constantly escalating things.

10:30

Susan Went: The vast majority of boards take action on the back of scrutiny and inspection reports. As Mr Pearson has identified, we expect an improvement plan that is owned by the board or organisation that has been inspected to be in place after the information and details of the inspection have been passed back to the board.

In addition, we have responsibility for improving services, so the lessons that have been learned from the collective reports from the first six months of inspection of care of older people in hospital have been used to build an improvement programme, to support not just the boards that have been inspected, but the entire Scottish system, to improve the services that are provided for older people in hospital.

The key and consistent themes that have been identified in the inspection reports are therefore at the centre of an improvement programme that is already in place. The programme started in April 2012 and will run for two years, until March 2014. The key themes that are embedded in the programme and that have come out of the collective learning from the reports are to do with the co-ordination of care and ensuring that the pathway of care is consistent, coherent and seamless from the family and patient points of view, and with the assessment mechanisms around cognitive impairment and specialised pathways. Assessments might be needed in the context of delirium, dementia and frailty for the very frail elderly. Those are the core elements that are in the improvement programme, which is already designed and running.

Dr Coia: Our clinical director can give a few examples of improvement programmes that are working in Scotland.

Dr Robson: Although not every board has been inspected to date, every board has been actively involved with us in learning from inspections elsewhere. As Ms Went said, we have focused on the areas that are of greatest risk to patients. We know that nutrition, cognitive impairment and pressure ulcers are problems for patients out there, because clinicians, the data and patients and relatives tell us that.

Those are the areas of focus for the whole country and not just for the boards that have been inspected. The impact of the inspections goes way beyond the number of inspections that have taken place. The improvement programme that was launched earlier this year has been widely welcomed by boards across the country and all boards are keen to be actively involved in it.

The Convener: If that has all been worked out and it is clear that everyone with dementia or cognitive impairment who goes into hospital should have an assessment, why is that not happening?

Susan Went: In many cases it is happening. In many organisations, the techniques and skills, and the needs of the patients in the system, are complex, and sometimes the staff need help if they are to identify not just what to do but how to make changes successfully. That is the purpose of the improvement programmes. It is about not just looking at the evidence and identifying what should happen, but learning how to make the change in practice, which takes time. Often, particularly in the context of complex pathways of care, a lot of staff are involved—many teams, several wards and often more than one organisation. Making changes in that context simply takes time.

The Convener: I understand the challenge, but I am thinking about the provision of appropriate utensils so that a patient can have a drink and be fed, and about the provision of care that preserves a patient's dignity. We have seen reports about such issues. When you go in and identify a problem, as you have done at nearly every inspection, you send the information to the health board. What is a good outcome? What does the health board tell you that leads you to be satisfied that it has taken action? Must it just recognise that something has happened, or must it get to a real understanding of why the culture in a particular ward or hospital failed the person? What is a good outcome of your inspection?

Dr Coia: I sense your frustration. We are also frustrated by unforgivable events, such as when utensils are not provided, someone speaks rudely to a patient or a patient is left in an undignified state. There is no excuse for that; it is a matter of compassion—you do not need training for such things.

We need to distinguish between events in hospital that are unforgivable and events in hospital that are unfortunate, because of the circumstances. For example, when pathways of care get blocked because there are not enough community services and we find that acute hospitals are managing patients who would probably be more appropriately managed in the community, we might say that the care is inappropriate at that point and we need to do something about it, but we would not say that the care is completely unforgivable in the way that not handing over utensils—

The Convener: But what action do you expect a health board to take when it is confronted with a breach of its standards of care? What is the norm? What action is acceptable to you? Should the people in charge be disciplined? What happens when unforgivable care is identified?

Dr Coia: My view, as chair of HIS, is that if we have pointed out an unforgivable event, we would expect the board to fix the problem immediately—I would not expect any discussion beyond that. When chief executives and boards are presented with unforgivable events, they are shocked by them. I would expect the problem to be fixed instantly.

We ask boards to produce an action plan, and my colleagues can tell you about what happens when an action plan is drawn up after care that is inappropriate, if you like, rather than unforgivable.

The Convener: Are you saying that all that the health board needs to do is provide the utensils? It does not need to examine the culture; it can just say, "We've put in place the utensils and everybody has them now."

Dr Coia: I would hope so—

The Convener: So that is what we do. We do not ask the board why there was a failure of the system. We do not ask why there was a failure of compassion and of care.

Dr Robson: We do ask boards that. In the action plan, we are not simply looking for the board to say, "We'll do it." We are looking to see that the board's governance arrangements ensure that things are done. The process of assessment is simple if just one element of care is considered, but when patients must be assessed for a range of elements of risk—risk to nutrition, risk of falls, risk of pressure ulcers—the situation is complicated. We expect boards to understand what makes the process complicated and to simplify it on their wards, so that it can be done more reliably.

Our reports on older people in acute care are fundamentally different from the reports that inspection processes produced in the past. They look at behaviours and they include verbatim reflections of what we heard and saw on the ward. They very much consider the culture of the ward, as you suggested, rather than just whether the board can tick a box and ensure that certain things are done reliably.

The Convener: Boards and ward managers are unlikely to say, "Well really it's our fault, because we should have got a bank nurse in. We were operating one nurse down and we should have had more people on." They are highly unlikely to admit that failure, are they not?

Robbie Pearson: When serious failings are identified, our inspectors escalate them on the day directly to senior management in the NHS board. If further concerns are identified that do not require immediate escalation, we pick them up through the improvement plan for the board. We take such issues extremely seriously in our inspections and we follow up on an unannounced basis when we have concerns. Our unannounced inspections might be focused and targeted or they might cover a larger area of the hospital. We have a process of following up and ensuring that the NHS board takes ownership of the problem.

I go back to my earlier point about the improvement plans. They should not be tick lists; rather, they need to address fundamental issues to do with the culture of care and leadership to which Dr Coia referred earlier. Leadership is fundamental to the successful delivery of high-quality care that respects patients' dignity and privacy.

The Convener: Are the improvement plans public? Are they available to the committee?

Robbie Pearson: Yes, they are available. We publish them on our website, and they remain on it for a number of weeks.

Gil Paterson (Clydebank and Milngavie) (SNP): I would like to go back to funding, if you do not mind. My question is about funding for providers. Just yesterday, your colleagues in the Healthcare Environment Inspectorate gave St Margaret's hospice in Clydebank the maximum score of six out of six in the categories. That score is extremely high; indeed, I believe that it is the highest ever achieved. The hospice receives the lowest health board funding for a hospice in Scotland. It is the place that I probably know best, so my question is parochial. Do you look at funding or resources when you make an inspection and report?

Robbie Pearson: We do not directly take into account the funding of NHS facilities or the independent sector. We consider the quality of care that is offered, which may reflect a number of factors, including staffing and funding.

Gil Paterson: That leads on to a question about the viability of an institution—whether or not it is a hospice—which may affect the delivery of its service. Do you have any tools in the box to scrutinise that? I know that you cannot force the issue in any way, but bearing in mind the committee's work on Southern Cross Healthcare—if you currently have that on your radar—do you consider viability?

Robbie Pearson: We do not have a direct toolkit for doing that. As I said, we take into account the quality of care that is offered. We are very clear about where our responsibilities begin and end in relation to institutions' provision of care, accountability and governance, including financial

governance. Whether an institution is inside or outside the NHS, we are careful about not straying into matters that are within the purview of the NHS board or the trustees of a particular charity.

Gil Paterson: If, in your expert opinion, some of what is going wrong may be due to funding and may be causing a lack of resource at the coalface, would you put that in your report? Would that see the light of day? Would it get into the public domain in some way if you thought that that was genuinely a problem, as with Southern Cross? Would we get to know about such issues through your work?

Robbie Pearson: I do not believe that that is our role. Other bodies, such as Audit Scotland perhaps, have a more appropriate scrutiny role in that regard. However, we increasingly comment on leadership and how it supports the delivery of high-quality care.

Bob Doris (Glasgow) (SNP): Good morning. I will ask about inspecting the care pathway shortly. First, I will follow up the convener's line of questioning about the distinction between unforgivable practices and inappropriate practices in an acute setting, which was quite interesting. I should also declare an interest: my wife works as a nurse in an acute setting. There was some discussion about that distinction. By and large, is most care of a good standard and of high quality, or is there a significant number of inappropriate or unforgivable practices? It is important that the committee captures what you see when you inspect hospitals and acute settings. By and large, what do you see?

10:45

Dr Coia: Dr Robson and I can both answer that. You have made a really interesting point. Scotland is a world leader in some aspects of healthcare. In the acute sector in particular, day surgery—to take one example—has mushroomed in Scotland in a way that is a credit to the Scottish health service.

Our clinical director could tell you a lot about the good practice that is going on in Scotland. It would be useful to touch on that before we talk about the rest of the practice.

In our experience, the baseline in Scotland is reasonably high. The issue of the pathways of care for older people is separate. We have a lot to say about some of the issues around the care of older people. I will ask Brian Robson to speak about that.

Bob Doris: Can I ask you to do so briefly, Dr Robson? My intention in asking my question was not to give you an easy ride; it was to give you an opportunity to put something on the record. I have some follow-up questions to ask.

Dr Robson: I echo Dr Coia's comment. By and large, the care is safe and of high quality. We detail that in our reports, which also deal with the improvements that are required.

Bob Doris: The questioning is about to get tougher, I am afraid—I hope that it will not be too bad.

The culture is one of health improvement. It is not about identifying where there are issues; it is about improving the overall quality of the service. That, for me, is what care pathway inspections should do, but I would like you to put some flesh on the bones of my understanding.

If an older person is admitted to hospital in an acute setting, for example, and Healthcare Improvement Scotland is conducting an inspection at that time, what could I expect you to do? Would you look through that person's notes to see whether they lived at home or in a long-term residential unit? Would you look at the social care assessment that was done for that individual? Would you comment on why that person found themselves in acute care and make recommendations about what could be done to prevent that from happening? For me, that is what inspecting the care pathway is about, and I want to ensure that, when we move down that road, it is not just a tick-box exercise but is something that drives improvement for the individual. Could you bring to life the process of inspecting the care pathway for me and say what it actually means?

Dr Coia: Mr Pearson spoke about that to the NHS health board chairs group yesterday, so I will leave him to tell you that story.

Robbie Pearson: In our inspections of older people's care, we review the case notes for information about nutrition, cognitive assessment and so on. We try to capture broadly the journey of care and determine where there might have been an element of service failure that precipitated an admission to hospital, how the service supports discharge from hospital into the community and what support there is for rehabilitation and maximising independence. Painting that journey of care is increasingly important as we think about a more holistic approach to the provision of care.

In developing our inspection methodology for the care of older people, we would like to do a more formal case note review by taking a sample of 20 or 30 patients and examining their journey of care over, say, a six-month period to learn about the factors that supported them at home—informal carers, social workers, aids and adaptations and so on—and the way in which the support that they received in hospital allowed them to be rehabilitated and sent back home. That group would include people who had fallen at home and

been admitted to hospital with a fractured hip, for example.

Drawing a picture of that pathway requires us to think about how we draw on a range of case notes and pieces of intelligence. That is something that we are going to test out as we develop and evolve the inspection methodology. It will also give us a tremendous opportunity to connect that inspection work and review of the case notes with our integrated inspections with the care inspectorate in the community. We will be able to show the patient's care journey and talk about their experiences of it.

Mr Smith might want to comment more directly on how we use case notes to inform inspections.

Ian Smith: At the moment, we follow the patient journey from admission to hospital to where the patient is at the time of our inspection. We focus primarily on our topics for the day—that is, the topics that have been identified as important through the self-assessment—and on areas that we wish to look at further. We look at assessments and at care planning, and we follow those through to look at care at the bedside.

With our current methodology we do not look at care in the community or how that is planned through discharge planning when the patient is due to go home. From an inspector's point of view, I think that that is an area into which we should be going and that we will get there through integrated adult inspections. The two things will complement each other, and that will be a positive way to address the patient's needs, which are central to what the organisation does.

Bob Doris: Do you have to wait for the integration of health and social care bill to do that? You are doing some work just now, and I assume that you are talking about having a joint inspection team with the care inspectorate that, when you start the inspection in the acute setting, will look at all the facts including those from pre-admission. If that is what we are moving towards, when will the pilots start?

Dr Coia: There are three pilots.

Robbie Pearson: We will start work on the pilots next month with several interested local authorities. We have the opportunity to work with them to test the methodology.

As Ian Smith said, we like to see this as a journey through care, so the question is how inspections of older people's care in acute hospitals sit within the overall scrutiny of older people's care. We will give some thought to that.

Picking up on an earlier point, I think that we need to be careful and thoughtful about the burden of scrutiny on the NHS and on the local authority, and we have to think about how this should come together as an integrated package and programme of scrutiny.

Bob Doris: With which local authority are you doing the first pilot? You said that there are three pilots and that they will start soon.

Robbie Pearson: We are in discussion with Perth and Kinross Council, and on Friday we will have the first meeting of the multi-agency board to consider how the methodology will work in practice. We will also engage with two other local authorities in the next couple of months.

Bob Doris: I ask the witnesses to indulge me further, because I have a genuine interest in this area. Let us say that you go into an acute setting in Perth and Kinross and that you decide to look at 10 older people in a bit more detail. If an older person has been admitted for a slip, trip or fall, will you assess whether they have suitable adaptations in their house or have had a continence check? How much detail will you go into, and will that work drive recommendations about how local authorities should change their practices, ahead of full health and social care integration?

Robbie Pearson: We will look at individual case notes, co-ordination between primary care and social work teams and the extent to which there is an integrated journey of care that supports people through their admission into hospital and discharge. We will track the patient's journey of care. Ian Smith may wish to comment on the detail of what that might mean.

Ian Smith: The appropriate assessment is carried out whenever a patient who has had a failed discharge comes in. The question is whether that failed discharge is recognised as part of that assessment. At the discharge planning stage, we would ask whether anything had been learnt from the patient's journey that would make their stay in the community better; we would also consider where the patient said that they wanted to be. Such information should link in so that we have a loop of scrutiny that tells us whether the process has worked.

Bob Doris: I know that my colleagues want to come in, but I have a couple of further, brief questions.

The Healthcare Improvement Scotland briefing paper refers to the themes under which you inspect care for older people in acute hospitals, one of which is dementia and cognitive impairment. However, mental health and wellbeing are not mentioned. Social isolation, happiness and wellbeing are fundamental: it is fundamental to have older people happy, healthy and at home. Is any assessment done of older people's general mental health?

Dr Coia: I will answer that because I am a psychiatrist by background. We talk about "dementia and cognitive impairment" because many older people who are depressed do not require a full mental health assessment, but they become cognitively impaired as a result of their depression, so that is a good proxy indicator. That is why, when we were thinking about the inspection of older people's care, I was keen that we looked at not only dementia but cognitive impairment, because that is a good proxy measure of what is going wrong with an older person's mental health. We do not do a full mental health assessment as such, but picking up on cognitive impairment begins to get us into the area that you talked about.

Bob Doris: Thank you. That is very interesting. I referred earlier to the care pathway and speaking to different agencies. What about older people's carers? Are we engaging with carers in the overall inspection process? When the committee has previously looked at work in this area, we have found that carers are not necessarily listened to as much as they could be to inform inspections.

Robbie Pearson: There are two parts to that. One is that we take time in our inspection of older people's care to interview carers. A number of verbatim accounts are threaded through the inspection reports, so the carers' views are captured. It is also increasingly important that we think about the carer dimension in the integrated inspections and the extent to which informal carers support individuals at home. For example, if an informal carer became unwell, we would want to know what support mechanism there was for the cared-for person to remain in their own home. The carer aspect will therefore be part of the design of our integrated inspections with the care inspectorate.

Bob Doris: You are managing a lot of what I hope will be positive change over the next few months. I am sure that we will follow it with interest. Thank you.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have a quick supplementary question before my main question. Will you publish on your website the new methodology for examining care pathways?

Robbie Pearson: We are happy to do so. For the purposes of openness and transparency, we will ensure that we do that jointly with the care inspectorate.

Dr Simpson: That will be welcome.

The Patient Rights (Scotland) Act 2011 has tried to introduce a new system involving the four Cs—compliments, comments, concerns and complaints—so that people do not feel that they have to go through a formal complaints process but can make an observation.

I have an elderly relative who has cognitive impairment and has just been admitted to care. I have no concerns whatsoever about her medical management, but because she is cognitively impaired, feeding her, ensuring that she is taken to the toilet and so on are important. One of my relatives saw a patient who was an elderly lady lying in an accident and emergency section or booth, with a catheter in and her nightgown half way up her body. I regard that as unacceptable behaviour, as I am sure you would. However, the fact is that that happened and nobody there observed it.

In the new system, we must find a way of engaging all observers or families in relation to not just their own cared-for person but others. Do you ask questions about that in your inspections? Are families asked whether they observed anything in a ward regarding not just their own relative but others that they would not like to happen to them or to their relative?

Robbie Pearson: Mr Smith may want to comment on that.

Ian Smith: Part of the process is that we speak to as many patients as we can on the wards. We also speak to relatives, next of kin and carers through the Princess Royal Trust for Carers, which is involved in the inspection and speaks to patients or relatives at the door. Therefore, we try hard to get the viewpoint of patients and carers and to feed that into the report and ensure that it informs the inspection on the day. We also feed their views back to the authorised persons within the board. If there is an immediate concern, we escalate it at the time; if the issue is part of the inspection report, we will raise it with the accountable officer at the end of the inspection.

11:00

Dr Simpson: You said that you do not deal with complaints—that is quite correct—but the boards are now supposed to aggregate all the concerns, comments and complaints in a report. Do you get access to those reports? Are you sent those reports by each board each month? I do not know where we are with the implementation of the 2011 act, but have you got to the point of saying to the boards, "We want your monthly or quarterly reports on patient comments, so that we can see what you are doing with them, how you are aggregating them and how you are looking at the culture"? I entirely agree with Dr Coia that our problem is not acute care, which I think is of a very high standard, but the culture relating to the underlying care, particularly of people with cognitive impairment, which is a massive

challenge for the service. Are you getting those reports from the boards yet? Will you get them?

Dr Coia: We are not getting them yet, but work is being done. Susan Went may be able to talk about that.

Susan Went: A supplementary point that perhaps deals with Dr Simpson's comments and those made earlier is how we use personal and other examples cited by individuals in the care system. In our improvement programmes, including in the older persons acute care programme, the person-centred care programme and our safety programmes, we make very strong use of examples of exactly the sort that you have just quoted. Those patient stories or carer stories inform the work that the teams do. They are not hypothetical cases but real examples. Some may be taken verbatim and some may be taken from inspection reports or complaints. We use all those sources to find examples of things to lever in the learning about why something happened, what should have happened that did not happen and how the processes of care can be changed so that the result or outcome is more reliably good and less indifferent.

Dr Simpson: I have one more question about the inspection system. Boarding out is a problem in hospitals that are under pressure. To some extent, one can determine what is happening in a hospital by the levels of boarding out and the frequency of shifts, by which I mean not just how often patients are moved from the surgical ward to another ward but how often they are shifted on again. The response to a recent freedom of information request revealed that the worst example was 18 shifts within a hospital—I hope that the patient involved was fully cognitively aware, because it would have been appalling if the patient was slightly impaired. Are you now convinced that, as the previous cabinet secretary promised, every hospital has a boarding-out monitoring system in place and that that is linked to the cognitive assessment so that those with a cognitive impairment are not subjected to unnecessary shifts within the hospital?

Robbie Pearson: As you will have seen, we have identified that as a recurrent issue within our inspection reports, particularly for those with a cognitive impairment or dementia. Perhaps Mr Smith can pick up on those examples.

Ian Smith: So far, inspections have shown that most of the hospitals have a monitoring system for the boarding-out of patients, but in general they do not have a monitoring system for those patients with dementia, although that is part of the dementia standard. The hospitals themselves realise that they need to have such a monitoring system and, in all the improvement plans that we have had back, the hospitals and boards have said that they are working towards that.

Dr Simpson: Thank you very much.

I will move on to a slightly different topic. In England, there is a system of incident reporting and alerts. Do we have that system of sending out alerts in Scotland? Are we working closely with our colleagues in England, who appear to have pretty good rapid alerts and monitoring systems? I know that we have a very good patient safety programme, but the *British Medical Journal* no longer reports on Scottish issues very much; it does not seem to give us much credit in these areas. How is our system for handling incidents and adverse events working?

Dr Robson: I was about to clarify whether you were asking about incidents and adverse events. Robbie Pearson will be able to give you a little more information on that.

Robbie Pearson: You may be aware that we are undertaking two pieces of work nationally to review the position on the management of adverse events in NHS boards. First, we are reviewing all NHS boards' systems and processes for documenting and learning from—and, ultimately, making improvements as a result of—adverse events. That is partly about technology. The Datix system is used widely throughout Scotland for recording incidents and adverse events. We are learning from that review programme.

Secondly, we are thinking about what a national approach to reporting, measuring and learning from adverse events should look like. That is partly about leadership, systems, documentation and the involvement of staff and patients, but it is also about the culture that supports that, which should be one of openness, willingness to learn and transparency. That work will proceed over the next six months or so with a view to our adopting a new national approach. I think that our size and scale and the opportunity for learning that we have in Scotland give us a great platform in that regard.

Dr Simpson: Dr Robson might want to comment on the incidents side of things.

Dr Robson: No. I think that all that is wrapped up in our work to improve the reporting framework for significant adverse events and the actions that are taken as a result.

Dr Simpson: Are you being consulted on no-fault compensation and how that might improve reporting in this area?

Robbie Pearson: We are aware of that consultation. A number of strands of national work will come together to sit alongside and complement the work on adverse events. The work on the Scottish safety indicators is a good example. In addition, there is the confidential alert

line for staff, which the First Minister announced recently. There are a number of strands of work that will support a more open and just culture, whereby people feel that they have an environment in which they can raise concerns and have them listened to and, ultimately, acted on.

Dr Simpson: The Government has acceded to the request that I made for two years to introduce a national whistleblowers line. Have you had discussions with whoever is to run that about how you can connect with it so that you can pick up critical information that comes in from staff?

Robbie Pearson: Yes, we have. Just last week, I and a number of my colleagues from Healthcare Improvement Scotland met Scottish Government officials to discuss the new telephone line and what role HIS might play. Those discussions will continue.

Drew Smith (Glasgow) (Lab): There has been quite a lot of discussion of this already, so I do not intend to dwell on it. When HIS was in Glasgow last year and examined Glasgow royal infirmary, its report said that there was a consistent failure to respect the dignity of older people. Two examples of that are the failure to assess for cognitive impairment and dementia, and specific instances of, for example, people being showered in cubicles without screens, which I think Dr Coia would describe as being "unforgivable" or "unacceptable".

You have set out the difficulties that HIS, as an inspectorate regime, faces and you want NHS boards to fix such issues immediately. My constituents would, by and large, think that such things are basics. If we cannot assess a person's ability to understand what is going on around them in a cared-for setting, something fundamental is going wrong. Inability to respect people's dignity in terms of cleaning them, toileting or anything else like that is a fundamental problem, but it appears from your reports that there are instances of such problems. How do you seek to deal with that systematically? We can say that such cases are, by and large, the minority. How can we, in two, three or five years, reach a position in which we can monitor the situation?

How do you categorise problems, including what Denise Coia described as "unforgivable" instances? In some cases, there will be a better method of treatment in the area, and we want to roll out better practice. That is all well and good and should be supported, but where a situation is unacceptable, how do you categorise it and monitor it through time, while acknowledging that although such things happen in only a minority of instances, we want the number to reduce?

Dr Coia: I think that we will respond from both the scrutiny and improvement sides, because there are two answers to the question. The quick answer relates to scrutiny and how we feed back comments about completely "unforgivable" instances. I think that Ian Smith was talking about instant escalation at the time of such instances being found.

Robbie Pearson: Yes. There can be an immediate escalation on the day of the inspection. If there are concerns about aspects of care that might reflect leadership at ward level, we will escalate those to senior management on the day.

We do not underestimate the challenges in dealing with the culture; we are trying to address cultural issues as well as issues about quality of care. It is important that we have a process for tracking improvements over six weeks in order to determine the extent to which change takes place. If we are not satisfied with the response from the NHS board, we carry out a further unannounced inspection.

However, it is also important to reflect on the extent to which inspection leads to improvement. If we go back to where we were with the healthcare environment inspectorate when it was established in 2009, a wide range of concerns were identified in its inspection reports that were, to be frank, pretty basic issues of infection control. There were more than 300 requirements and recommendations on NHS boards in the first year of inspections by the healthcare environment inspectorate. In the latest figures, that has dropped to fewer than 200 requirements and recommendations. I do not say that to take away from the importance of those requirements and recommendations, but we are seeing greater leadership, greater involvement of staff in infection control, better understanding of policies and procedures and—ultimately—improved compliance.

That is an example of improvements in practice. The improvement infrastructure within Healthcare Improvement Scotland is also fundamental to the area; it is not about inspection and scrutiny in isolation.

Susan Went: I will give a couple of examples that might help. Immediate and longer-term issues that are identified during the inspection process are raised with the senior team; they are raised with the leaders on the wards, but also with the board team and the expectation is that it will address and deal with those concerns. Issues are raised with the board team partly to raise awareness of matters whose scope might not have been understood at board level. That is an important part of the process.

The medium to longer-term picture is the one that we focus on in the improvement portfolio, or the improvement programmes. We take common

and consistent concerns—such as the one that Drew Smith raised about dignity and compassion and the importance of the behaviour that is involved in care, rather than just the techniques and interventions of care—and we build them into improvement programmes that are designed to deliver increased reliability, and to make the right thing easy to do. That involves changes to processes in order to enable staff to deliver more reliably the right type of care with the right behaviour and the right outcomes.

I will give an example from the recently designed and launched person-centred care programme. Interventions are identified as part of the bundle of changes that we wish teams to make, and "must do with me" is the terminology that is used. It is about identifying what is crucial and vital for the individual patient—what must be done with them and for them—rather than for the collective or group that happens to have a particular diagnosis.

11:15

Accompanying that is a set of interventions on assessment of need and intentional addressing of that need. It is about asking people, hourly or two hourly, whether they need help to go to the toilet, rather than waiting for the buzzer to go when they need help to be taken to the toilet. It is about asking whether there is anything they need, or whether they have the water that we know they need to take because their fluid intake needs to increase.

Another part of that is looking at the environment of care—not just in the ward, but for the individual patient. Is the buzzer on the same side of the bed as the chair in which the patient is sitting? Is the food and water within reach? Does that person need help? The "must do with me" elements might show that the person needs help to eat their meals. Therefore, every time a meal is served, somebody must be there to help them to take in the nutrition and hydration that they need. I hope that that example helps.

Drew Smith: When someone comes to my surgery and tells me about their own or a relative's care in hospital, they tend to say two things: they explain to me what has happened, and they ask for my help to get an explanation of why it happened and, possibly, to ensure that there is an apology, if that is appropriate.

They also tell me—this is the crucial bit—that they do not want what happened to them to happen to someone else. That is the hardest thing to respond to for any of us who are involved in this system: I cannot give that guarantee because I know full well that there will continue to be instances in which people are not treated with dignity. The best assurance that I can give my constituents is if I have from bodies such as HIS raw data that says, "We know that we're not getting all of this right, but we're categorising these instances and measuring over a long period in order to establish that they are being reduced." If I cannot give them that assurance, I cannot even begin to respond to their statement that they do not want what happened to them to happen to someone else. That is the key issue.

I absolutely accept that the cases to which I referred will be a minority of instances in individual reports. Individual wards will not be inspected hugely often—that is the nature of the beast—so unless we have a system of recording that information and analysing it over time, we will not get anywhere. Is that fair?

Robbie Pearson: That is a crucial point. We need to be able to measure against a baseline the changes and improvements that are brought to bear in NHS Scotland. In October, we published, at the six-month point, the initial summary of the inspections to date. We will continue to record areas of improvement and strength in NHS Scotland. We will be able to capture that with the data that we collect as we further develop and evolve inspection methodology. We will then have a sense of the journey of improvement in NHS Scotland.

Dr Robson: To underline that, we have developed our measurement capacity and capability so that we have people with the skills to measure the sorts of things that you have highlighted. Although we get national data from the Information Services Division and other national bodies, how do we make the best use of data that are coming through in the inspections and the improvement programmes? We have invested in that. We agree with Drew Smith that unless we measure those things, we will not know whether improvement is happening, he cannot reassure his constituents and we cannot reassure our patients.

Drew Smith: I want to understand the practicalities. Before inspecting a facility, ward or whatever, what information do your inspectors collate? I assume that for a follow-up report, they look at previous reports. Over time, there will be a bank of previous reports about an institution or service, which the inspector would want to look at.

Dr Simpson talked about getting from the boards information on what they get complaints, comments and praise about. Are such things among what the inspector looks at, or does he or she simply write a checklist of what he or she wants to see and look at things objectively on the basis of that checklist? Do you go in knowing that concerns have been raised within the service about X and look at that specifically?

Ian Smith: As part of the inspection process, prior to the inspection we review the self-assessment that has been submitted by the board. That includes corporate data and data that are directly related to patient care—audits or surveys of the patient experience, or whatever. We use that information along with data from other organisations. For example, we get copies of complaints that have been upheld by the Scottish Public Services Ombudsman and we review those. We also review our relationship with, for example, carers organisations. That informs our decisions. In particular, it informs us about what aspect the inspection process will focus on—for example, nutrition or pressure area care.

Drew Smith: That is very helpful. We will pick that up with the SPSO later.

I want to touch on the general efficiency of HIS. Early on in our questions, the convener touched on the challenges that you face in the current financial climate. Can you give specific examples of efficiencies that you have had to make? There might have been expectations on the organisation when you came together, or on your predecessor organisations, that you have decided are no longer core expectations and from which you will withdraw—it is to be hoped that that would be because someone else is better placed to do those things if the need has been identified for them to be done. I am interested not just in how individual organisations within the national health service broadly respond to their own budgetary challenges, but in how we can change across the board. Can you also give us an example of something that the health boards or special health boards used to do and which HIS has taken on?

Dr Coia: I will kick off. HIS has made a range of efficiency savings, not least by moving our headquarters from the centre of Edinburgh to the Gyle to enable us to share services across a health campus, which has resulted in a major efficiency saving. We have become extremely robust as we have brought in organisations. There were some quite small projects that were not strategic priorities of Government, HIS, the NHS or the public, so we have honed such work down to key areas of activity—older people's services being one—at which we target our resources. Robbie Pearson, who is our deputy chair and chief executive at the moment, can tell you a bit about our efficiency programme.

Robbie Pearson: We have, over the past couple of years, made a range of efficiencies that have delivered a leaner and smaller organisation. As Dr Coia said, we inherited from our predecessor organisations some projects that we have taken the opportunity to reconsider as part of the prioritisation process. I will give one practical example. The work on the clinical governance risk management standards was subject to an extensive peer-review process with the NHS boards, and we have taken the opportunity to pause it. The standards remain, but following the outcome of the Francis inquiry there will be an opportunity to review how we can change and adapt in accordance with that and with findings from across the United Kingdom.

There are things that we have chosen to pause and reflect on, and areas that we have decided are not priorities for our organisation. That gives Healthcare Improvement Scotland the headroom that affords us the capability and capacity to meet the range of requirements that the 2010 act places on us.

Susan Went: I will give a couple of small examples. As part of our Scottish patient safety initiative, we provide a raft of training programmes to build capacity and capability in the service. The aim is to develop skills and competencies at board level and clinician level. We are, with colleagues in Education Scotland, working to transfer programmes; Education Scotland will deliver the programmes instead of us.

Members will be aware that we work with the Scottish Government. Prisoner healthcare, which used to be a Scottish Government service, was devolved to boards, so we have employed the core clinical staff, who play into our inspection processes for prisoner healthcare.

Dr Robson: We also have six national safety programmes; Scotland is the only country in the world with such wide ambition on safety. Rather than run all the programmes individually with individual programme-management resources, we have condensed or truncated what we do so that the approach operates across the portfolio. We work closely with the Scottish Government to gain its support in securing efficiency in the organisation with no detriment to our ambitious safety programmes.

The Convener: I understand that a review of the methodology of inspections is going on. Who is involved in the review group and when does it expect to report? I presume that the idea is to review the process to date and to examine how inspections might be improved.

When the committee reported on its inquiry into regulation of care of older people, we recommended that there be a review of the national care standards for older people, which were then 10 years old. How is that review progressing and what is your role in it? When can we expect to see the fruits of your work and that of the Scottish Government, which accepted our recommendation?

Dr Coia: The chair and chief executive of the care inspectorate meet the chair and chief

executive of Healthcare Improvement Scotland every six to eight weeks, and the national care standards have been a topic of our conversations. The Scottish Government is carrying out a review and we will begin to play into the review. Both organisations are keen that, whatever the outcome, the national care standards include health and care, so that when we start to look at programmes of quality assurance across the community, the national care standards are meaningful for us across the integrated landscape. We need to ensure that the standards are robust in picking up issues that have been raised today, in relation not only to in-patients but to patients in the community. We are playing into that work strongly, in partnership with the care inspectorate.

The work is crucial for both organisations, across the public sector, because as we move towards having integrated services and considering how community planning partnerships and community health and care partnerships will start to work together, we will need to use the revised care standards as one way of quality assuring what is happening in partnerships. We are starting out on that journey, and as the integration agenda moves forward we are trying to run in parallel, as it were, to ensure that the care standards are in place by the time we reach the end point.

The Convener: Has the review process begun formally?

Dr Coia: It has not yet begun.

The Convener: Will the Government start the process?

Dr Coia: Yes.

The Convener: The review has not started yet, though.

Dr Coia: It has not, that we are aware of.

The Convener: It might be more appropriate for us to ask the cabinet secretary when the review will begin and why it has not begun.

Robbie Pearson: You asked about the review of the older people's inspections methodology. That review is chaired and led by Pam Whittle, who is chair of the Scottish Health Council and a non-executive member of the board of Healthcare Improvement Scotland. The review group has had three meetings since December and the intention is to make the draft revised methodology available next month.

The Convener: I presume that you will send the committee a copy for our observations and comments.

Thank you all very much for attending.

11:30

Meeting suspended.

11:36

On resuming—

The Convener: We continue with item 1. Our second panel of witnesses is from the Scottish Public Services Ombudsman. I welcome to the committee the ombudsman, Jim Martin, and Niki Maclean, who is director at the SPSO, and Dr Dorothy Armstrong, who is nursing adviser at the SPSO.

I invite Mr Martin to make some opening remarks before we move to questions.

Jim Martin (Scottish Public Services Ombudsman): Thank you, convener.

In our written submission to the committee, we focused on your request for views on the regulation of the care of older people in acute settings. However, I am more than happy to answer any questions about any other aspects of the health work that my office does.

I found the preceding session to be extremely interesting. I will not go over points that were made, because I am sure that some of them will recur, but I will mention a couple of issues that might be worthy of discussion this morning.

Our written submission sets out some of our recent experiences. Members will see that I said in it that we are seeing the repetition of incidents of failure to care adequately for people with pre-existing conditions in acute settings. Some cases that we see are extremely distressing. We do not go out looking for cases. We are very much a demand-led organisation; the cases that come to us are generated by the public and come through a process in which health boards have seen them before they arrive at my door.

Last year, I upheld around 56 per cent of all the health cases that were brought to my office and which were fit for us to look at. That means that health boards had already seen and not upheld more than half of those cases. Not all of those cases involved care for the elderly, but that particular area gives me great concern, because, as was said in the previous discussion, many of the issues go to the basics of not only care but human dignity. For me, that is quite distressing.

When I first took up my post, I had a meeting with the chief executives of the health boards. I took Dr Armstrong with me to ensure that I did not say anything wrong—now I bring her with me only to tell me that I have said things right. I said to the chief executives that, three or four years previously, my predecessor had listed 10 key issues that faced the health service, as they had

come up in complaints, and that at that time—three years ago—the issues were the same. Three years on, they are the same again. At some point, the committee and perhaps others might have to look at whether our regulatory model is producing improvement and operating efficiently.

There is a question about quantity and quality. Last year, I chaired a regulatory conference in Glasgow of regulators from across the UK. More than 200 people were at the conference and the organisations that were represented numbered in the dozens. As I look at the cases that come into my office, one of my concerns is whether I can see the impact of regulation on the nature of the complaints that come to me. Is there a danger that we look at the health service purely in care provision terms? Do we not recognise the impact on the time of the people who work in the health service of a regulatory system that is in my view cumbersome and of management that often seems to be overly complex?

When we investigate cases, we tend to go to the records of care. We base our judgments on fact, not an impression. One critical element is whether the people who work in the health service have sufficient time to address the issues that are in front of them. No one goes into work in the health service saying, "I intend to operate with a lack of compassion today." However, the circumstances in many of our wards mean that time is of the essence.

In the earlier evidence session, Dr Simpson made a valid point about the impact of boarding out patients. People—sometimes those with cognitive problems or an amalgam of issues other than those with which they went into hospital—are increasingly being boarded out to different wards. The basic level of care that such older people require needs to be established, whatever setting in a hospital they are in. That applies whether an older person has gone into a respiratory ward for a respiratory illness or into accident and emergency and ended up in a gynaecological ward—I heard about such a case on the way here. Nurses and doctors in such wards need to be aware of older people's needs.

Our regulatory landscape needs to take account of the reality of what is happening on the ground. I was pleased to hear Robbie Pearson discuss how Healthcare Improvement Scotland is beginning to look at the patient journey. "Policy-centred regulation" is perhaps a decent description of what we have, but a person-centred regulatory model might well serve us better, and I am pleased that that is being examined.

People most commonly tell me that they brought a complaint to me not for compensation but to ensure that what happened does not happen to someone else—Drew Smith talked about that. That aim can be achieved best through learning lessons from individual patients' experiences. The use of process and policy-centred regulation rather than person-centred regulation is an issue in relation to older people.

I see a need—not from the complaints that come to me but from the noise from health boards and others that surrounds complaints—for people to listen more to the people on the ground who deliver care. We often have top-down wisdom, although what is happening on the ground is being impeded by management processes, and the last people who are listened to are those who must deliver the service. I say all that in general terms—I have given impressions that I have gathered from the work that I have done and from nearly four years of studying the health service and how it responds to the difficult things that are brought to me.

I was pleased to hear our colleagues from Healthcare Improvement Scotland say that, when doing inspections, they would take into account the work of my office. We are sitting on a database of real cases that have come through from real people. We are happy to make that available for people to look at as part of the process of working out whether to do inspections and when and how to do them. We are quite happy to help in that regard. The discussion that the committee has instigated is timely, because I believe that the issue is growing, in terms not only of the number of complaints that we see but of the public estimation and how the public value the national health service.

11:45

The Convener: Thank you. The first question will come from Drew Smith.

Drew Smith: I had intended to ask the panellists a question about interaction with Healthcare Improvement Scotland and how that fitted in with their processes, but as the ombudsman has made quite a challenging statement to the committee, I would rather stick with some of the issues that he has raised.

How far along the road to a genuinely person-centred regulatory system are we? What are the next steps that we need to take to get further along that road?

Jim Martin: Having raised the issue, I will now dodge the question. I raised it because I hope that the committee will look at it, as I think that the committee is in a particularly good position to take a view.

In the earlier session, mention was made of the Crerar principles for scrutiny and the work that Lorne Crerar and his committee did in, I think,

2007-08. One thing that came out of that was that, for two or three years, we could not go to a meeting without people talking about cluttered landscapes. It would be an interesting activity for this committee to assess how the landscape lies today because, as well as the regulatory bodies, we have a number of bodies that seek to influence what happens in the health service and elsewhere. In addition, we have remit drift, whereby the remit of organisations that were set up for a particular purpose broadens out. Someone—this committee or perhaps the Scottish Government—needs to take account of how all that work, every bit of which is good, is impacting on the ability to deliver on the ground.

Drew Smith: You mentioned in your opening statement that the ombudsman has a database that you think tells a big part of the story of what is happening on the ground. Who uses that database at present? What is your impression of how well it is used? You are right that HIS said that it would want to use that as a basis for thinking about inspections and to inform some of its inspections. As the ombudsman has been around for a considerable period of time, that database represents a considerable bank of knowledge. To what extent do you feel that we utilise it?

Jim Martin: The ombudsman has been around for 10 years—this is our 10th anniversary year. In 2010—or perhaps 2011—we were given the power to make our decisions public other than in reports that we lay before Parliament. Every month, across the public service, we lay a number of reports. That number is now relatively small, because we work on the basis of putting important issues to Parliament. Alongside those reports, we publish anonymised summaries of our decisions over that period. Tomorrow, we will publish three or four reports that will be laid before Parliament and 94 or 95 summaries of decisions that we have taken in the past six to eight weeks. All those are available and are being used.

I have taken the time to go round most of the health boards in Scotland, and I am encouraged by the number of nursing directors, medical directors and others who have said voluntarily to me that that is an important resource for learning that they are using in their area. That is heartening. That database is there in an anonymised form to be used. I am also pleased that the director general of the health service and others use it at their level in their discussions with boards. Last year, we decided that, when we issue reports, we will send them not only to Parliament and to the chief executives of health boards but to the chairs of health boards as well. That is because we believe that there are lessons to be learned from complaints. The Mid Staffordshire NHS Foundation Trust is a good example of a situation in which complaints were missed.

To be clear, the ombudsman's office is not a regulatory office. We are here to consider complaints that the public has not had resolved, to make decisions on them and to tell Parliament and others what our decisions are. However, I would like more people to use the information that we have.

Drew Smith: I guess that, by their nature, complaints will relate to only a minority of situations—we certainly hope that that is the case; there would be a much wider problem if it were not. Does that make it difficult to put in place systems that respond to what complaints are telling us? It is always easy to say, "We appreciate that something went wrong in that individual instance, but we are fairly confident that that would not normally happen, across the board."

Jim Martin: One of the problems of sitting where I sit is that you can get very depressed very quickly. I see all the situations across the public sector where things have gone wrong and people are unhappy. You have to keep a perspective on things. A lot of stuff is going on out there that is done well. However, the situations from which we are going to learn are those in which things have not gone well and where improvements can be made.

It is tempting to make generalisations from individual cases, but we tend not to do that. Since coming into my post, I have issued only two press releases. One was criticising Greater Glasgow and Clyde NHS Board and one was praising Greater Glasgow and Clyde NHS Board. Guess which one of them got coverage.

We are careful not to go off half-cocked when we see something bad. We make sure that the recommendations that we make are followed through, as far as we can—we have limited resources to do that. In a situation such as the one that we are in today, in which we have an opportunity to contribute to a piece of work that you are doing and can go back and consider our experiences over a period of time, I can confidently say that there are issues that are impacting on not only the care of older people but other areas, and that this committee should examine them.

Dr Simpson: Drew Smith asked about some of the things that I wanted to talk about.

This morning, we heard that HIS is not a regulatory body, and you are saying that the office of the ombudsman is not a regulatory body. I am slightly at a loss as to where the regulation in Scotland is. In England, it is clear: Monitor is at the top of the pyramid, and it has the power to go in and say what should happen and fine boards or trusts if it feels that something is not right. I am not suggesting that that is the route that we should go

down, but you seem to be saying that we need to alter the regulatory landscape in a significant way. Are you saying that we need to have a much tougher approach and that the current system, which involves advisory reports on inspections, accompanied by an improvement plan from the boards and perhaps a follow-up, is not adequate?

Jim Martin: When Lorne Crerar conducted his review, he helpfully talked about scrutiny bodies rather than regulatory bodies. Five or six years after Crerar, it would be valuable to consider the impact of what the scrutiny bodies are doing on the delivery of healthcare on the ground. I do not think that whether I am a regulator in the Healthcare Improvement Scotland sense or a scrutineer matters much to the people who are delivering the service on the ground when the SPSO—or indeed HIS or any other body—descends on them. It is the impact that needs to be looked at.

I think that at every committee meeting that I have attended in the Parliament I have been asked whether I have enough powers and whether I should have the power to direct people to do things. I am changing my view on that. I had always been of the view that the powers of the ombudsman are sufficient, in that recommendations are carried out 90-odd per cent of the time, but I am increasingly aware that people—not in the health sector but in the local authority sector—are trying to test that. I am wondering what is in my armoury that will ensure that things happen. If I am in that position, I am sure that other advisory bodies are in the same position.

However, as I said, we must be careful that the health service does not become overmanaged, with too many people directing things to be done. In discussions with my advisers the other day I heard about an interchange in which a consultant was asked not to refer to his place of work as "my ward". He was told, "It's not your ward." Such pettiness is almost laughable, but it relates to the convener's point about culture. What does it say about the culture in which healthcare is being delivered in our hospitals? What are the most important things? What things are taking up most time? Are they the same?

Dr Simpson: Your answer leads nicely into my other question. I spoke in a parliamentary debate recently—in fact I got my figures slightly wrong. I referred to NHS National Services Scotland—it should have been NHS Scotland—and I said that NSS had reported that 60 per cent of staff have reported bullying. That was incorrect; someone drew my attention to that during the past few weeks, so I need to make a correction. Nevertheless, in staff surveys about 16 per cent of staff are reporting bullying. Even more worrying, more than 50 per cent of staff say that they do not think that attention is paid to their concerns. Only 45 to 48 per cent say that they feel that their concerns are paid attention to.

Now that I have corrected all that stuff, this is my question: if that is the culture that we are in, how should we endeavour to make further changes? When you get into the complaints side of things, do staff tell you, "Well, yes, at front-line level we would like to have done things differently but, because of time constraints, management or direction, we were not allowed to do so"? In other words, are you aware that staff feel that their concerns are not being addressed? Is that coming across to you? The situation will get worse with austerity.

Jim Martin: I am not in a position to answer your question, because I am precluded from looking at issues to do with personnel and human resources, which includes bullying and how staff perceive the management styles in institutions.

I have one observation to make, which might or might not be helpful. We talk about the national health service quite a lot, but there is not really a national health service. There are a number of health boards, within which there are a number of hospitals and different areas, each of which has probably got a different culture. What may impact most on those who bring complaints to me is the culture in an individual ward. The people who come to me are less interested in Greater Glasgow and Clyde NHS Board's overall policy position on particular issues than they are in the actual practice that a particular patient experienced in a ward at a particular time.

We try to look at the constraints that people were under at the time of the complaint. Occasionally, I will not uphold a complaint and people may be annoyed at me, but we often take our decisions in the context of what was happening in that place at that time. In other words, we would apply a test of reasonableness rather than an ideal, and reasonableness will occasionally take into account other factors. For example, a member of staff may not have done something at a particular time because the ward was two nurses down and a clear decision had been taken to prioritise something else. That is an important point.

12:00

I do not uphold every complaint that comes my way. From time to time, particularly if the complaint relates to a difficult bereavement—and all bereavements are difficult—I will meet the family whose complaint I have decided not to uphold so that I can try to explain why. Those are never easy meetings because people may have a

very strong view on what has happened in the individual case, but it is important that people understand that the ombudsman's office takes a balanced decision based on reasonableness, although that can sometimes be quite difficult.

Dr Simpson: When complaints are upheld, do you get a report back saying that the individuals involved have been given additional training? I am not really interested in disciplining the people involved, but are they given the necessary additional training to ensure that they improve?

Jim Martin: When we issue a recommendation, it will have a timescale attached to it. For example, in each of the cases that we upheld that are appended to our written submission, we have made a clear recommendation to the board that the psychiatrist or whoever should have the matter brought to their attention at their next appraisal and that that should be done within X number of months. We will follow up that recommendation to ensure that that has happened. More broadly, in at least one ward and perhaps even one hospital, we highlighted an issue with pressure sores. We asked the board to review its policy on pressure sores, to assure us that it had done so and to give us evidence that changes had been brought about.

We will follow up such recommendations, but my organisation is relatively small and I do not have the resources to have an inspectorate that can follow up every matter. That is where it is good to know that the health service and Healthcare Improvement Scotland can pick up our complaints and recommendations and run with them.

Dr Simpson: Does Healthcare Improvement Scotland come back to you and say, "We have picked up the issue of pressure sores in this hospital"?

Jim Martin: Not as yet, but I was encouraged by what I heard this morning.

Dr Simpson: Good. That is helpful.

Bob Doris: I want to pick out one very interesting sentence from your submission, which I thought is perfectly balanced and demonstrates why we need the SPSO:

> "There is excellent and outstanding care in the NHS but we do also need to recognise that it does not always reach those standards."

It is when we do not reach those standards that we learn, whereas it is dead easy to say that things are going well so we do not need to change. As was mentioned in our conversation with Healthcare Improvement Scotland, even if things are okay, okay is not the standard that we are striving for, because we are always trying to get better care.

I am interested to find out how Healthcare Improvement Scotland and the care inspectorate might use the data and real-life experience that you generate in the risk assessments that they apply in their inspection regimes. The committee might seek to follow up on that issue—obviously, we will need to discuss it among ourselves—but that seems like a concrete way forward for us.

I always ask questions about the patient journey, which your submission says is important. I am also keen to get more information on how you see that being taken forward and on what the SPSO's role could be. I have put on record what I think that following the patient journey could involve, but I am more interested to know how you, as the ombudsman, would like to see it being developed. From what you heard this morning, are you content with how Healthcare Improvement Scotland is starting to explore that pathway?

Jim Martin: I heard a lot this morning from Healthcare Improvement Scotland that I found quite encouraging. I think that you raised the point about the integration of health and social care, and local authority housing, and about the need to look at the person as a whole. Understanding the context in which someone arrives in a hospital setting is very important. I understand the point that was made about following the patient from admission onwards, but it is important to understand the person's circumstances at the point of admission.

I know that it is wrong always to use anecdotes, but I visited an accident and emergency unit where a very experienced consultant said to me that the most significant change that he had noticed was when elderly people were brought in from care homes. In the past, someone may have stayed with the elderly person, which was helpful to the hospital staff as they tried to understand that person, their needs and their background. However, increasingly the consultant was finding that those people were so pressed for time back at the ranch that they had to just drop the elderly person off and go, returning to get them later. That suggests to me that, at the point at which people are admitted, services are maybe not joined up enough.

The important point was made this morning that someone who goes into hospital for one thing may bring other things with them. Understanding that is a core part of the care of that individual. If we think of them in terms of silos such as health, social care and housing, we are missing a trick. I recently had a discussion with one of my advisers in which he explained to me that he and his colleagues find it frustrating that the pressure of work on social workers is such that, in some areas, there can sometimes be a delay in their having conversations with social workers in order to get to

the point at which they feel that it is safe to discharge someone from hospital. Increasingly, the public are becoming aware of the joined-upness of care, whereas I am not certain that we always approach the way that we look at, value and evaluate the care that is being given in a joined-up way. I thought that the discussion this morning took us to a very good place.

Bob Doris: You mentioned Crerar and used that well-known expression, "cluttered landscape". Do you think that the care inspectorate and Healthcare Improvement Scotland having a multidisciplinary team to look at inspections in Perth and Kinross is a way not of decluttering the landscape, but of rationalising the inspection process? You seem to be saying that inspection and scrutiny is important, but that we must ensure that it is done efficiently and appropriately and that it does not outweigh the benefits of front-line care.

Jim Martin: It is important that it is holistic and proportionate. What I heard this morning was encouraging. I do not know any more than what I heard this morning, and I suspect that some members of the committee are in the same position. However, if the overall vision for the national health service in Scotland is to be patient and person centred, that must be a step in the right direction provided that it is not just another addition—that we are not just piling something else on top. At some point, we need to have a qualitative look at scrutiny and the interventions that we are making to ensure that they are supplementing what happens in our healthcare and not diverting resource and perhaps diminishing the care that we can offer.

Bob Doris: You mentioned all the individual complaints that you deal with. You clearly analyse and report on those complaints, but do you make formal representations to the care inspectorate or Healthcare Improvement Scotland? Do you advise them that you have analysed the data, that you see a cluster of issues around X, Y or Z and that they might want to look further at that area? Do you think that it is appropriate for the SPSO to make such recommendations or to give the care inspectorate or Healthcare Improvement Scotland the data to allow them to do that analysis? Where does the balance lie between your role as the ombudsman and their role as the bodies that scrutinise the delivery of care on the ground?

Jim Martin: The two must be separated, because it is very important that there is a public access route for unresolved health complaints to come through health boards to an ombudsman as the final place for a decision. After all, a lot of these matters require closure. It would therefore be wrong to confuse the two roles.

Since 2002 and the inception of my office, the Parliament has twice, I think, examined the powers that my office should have and, both times, has been very careful to make it clear that I should not have the kind of own-initiative powers that other UK ombudsmen have, under which they see a certain issue arising in a number of complaints and investigate, initiate an inquiry or whatever. The Parliament also made it clear that the ombudsman was not a regulator. As a result, I have to walk a tightrope between the legislation that I work under and what I see happening and what I think needs to happen out there; indeed, that is why this particular opportunity has been taken in the way that it has been.

Bob Doris: That is very interesting.

The Convener: In your submission, you refer to the committee's work on the regulation of care of older people; we have also discussed the national care standards review, which has been accepted by the Government. Are you supportive of that review? Could it play into the person-centred regulation that you have been calling for and does it present an opportunity to develop some of your ideas?

Jim Martin: Every opportunity to examine this issue has to be taken. One of my great fears is that we spend an awful lot of time talking about the issue instead of starting to think about what the hell we are going to do about it—if you will pardon my French. The issue has been under discussion ever since I came into office; indeed, my predecessor was raising the same matters. Looking around, I believe that the problem will only get worse, not better. There will be more and more older people and greater expectations among the public about the levels of care and healthcare that they will receive—and, frankly, that I expect to receive as I approach that very age. I therefore encourage the committee to pursue its current route and to keep pressing for improvements in these areas.

Mark McDonald: We are about to embark on the process of integrating health and social care. Given your role in scrutinising the health service and local government, I imagine that we could glean an awful lot of information from you on the various health and social care areas that need to be examined in the process. Should we be tapping that resource as the integration process moves forward?

Jim Martin: One of the reasons that I wanted to publish the decision letters that we have sent, as well as the parliamentary reports, was to get into the public domain the issues that people are raising with me and which we are upholding. From that point of view, my answer to your question is yes.

One of my concerns in my role is that a person can take three or four routes if something goes

wrong. The SPSO is setting up standardised complaints-handling procedures across the whole of the public service in Scotland that are based on the national health service model. As a result, from April, all of Scotland's local authorities will have the same model as that in the national health service. That should make it a little easier to see how things are progressing.

12:15

However, there is an unintended consequence with regard to my powers as ombudsman. If someone has a problem—say, one that affects an older person—that runs across health and social care and they take the issue through the health service complaints route, I can look at the clinical decision making of nurses, doctors and others. I can look at everything. If it comes through the local authority sector, however, the position is different. The legislation precludes me from looking at decisions that are made by local authorities unless there has been maladministration or clear service failure; even then, if the decision that has been taken is a discretionary decision, I may not look at it unless there has been maladministration or service failure. In the context that we are discussing—I can look at some areas of social work, although I cannot look at much—I would be fettered.

If we look outside the health area, the best example is planning. More and more decisions are taken by planning officers rather than by elected members in committee. If those officers have the discretion to make a decision, by and large, I cannot look at it. With the integration of health and social care, if someone has a complaint, how they instigate it and where they begin will determine how I may investigate it. If they go down one route, I might be unable to look at it, but if they go down the other route I might be able to look more fully. That is an unintended consequence of the legislation.

Mark McDonald: My next question might be a little on the parochial side, but what is your role in relation to arm's-length organisations? The reason why I ask is that, in the area that I represent, Aberdeen City Council has decided to develop a local authority trading company that would, in effect, see social care delivered by an arm's-length organisation. What is your role with regard to such organisations? Do you have any concerns about that, given the way in which it would impact on the ombudsman's role?

Jim Martin: My view is that service delivery by a public service that is procured by a public body should fall within my ambit. I can guarantee that, when I leave here and go back to my office, my legal advisers will say to me, "On the one hand, Jim—" and "On the other hand—", because these things are not clear. When we have new methods of delivering public services but our public institutions were set up and constituted to handle the old-style delivery of public services, we inevitably find that that will happen.

The answer to your question is that I do not know. However, in principle my view is that the public pound that is spent and the public service that is delivered under an arm's-length arrangement should be under as much scrutiny—perhaps even more scrutiny—as they would be in the case of a body that is currently under my jurisdiction.

Mark McDonald: Perhaps I should pursue the matter with you outside the meeting.

Jim Martin: Please do.

Mark McDonald: In your letter and your submission, you state that there are areas in which you have not seen improvement and that you have seen the same themes continuing to arise. However, in your letter you state that

"there are areas of genuine improvement."

By and large, is the direction of travel positive albeit that progress is slow, or are there areas in which we are in the same position that we were in a number of years ago?

Jim Martin: Where we identify a failing, I am confident, by and large, that health boards will address it in the particular area in which we raised it. I mentioned two press releases about NHS Greater Glasgow and Clyde. One was about an horrific case of pressure sores. The board dealt with that very well, but we still see pressure sores issues arising in health boards, including in NHS Greater Glasgow and Clyde. One of my great drum-banging exercises is about whether we are learning the lessons. Are we ensuring that, when the next person comes into a ward in a different hospital, the staff there have learned the lessons from the mistakes in the first one?

Part of my job is to determine complaints, but an equally important part is to try to ensure that the learning from the experiences of people who have brought complaints to me is not only recognised but applied.

Mark McDonald: Obviously, you deal with individual cases that are brought to you. Are there points at which you see those cases start to develop into a pattern? We spoke about the fact that the issue may just be down to the behaviour of an individual on a ward. However, if you see similar cases in other wards in the same hospital, or in other hospitals in the same health board area, are you in a position—outside of the report that you have to do on an individual case—to raise concerns with health boards about the potential

emergence of a pattern that they may need to look at and address?

Jim Martin: Yes. Dorothy Armstrong—she is my nursing adviser, and also co-ordinates our advisers—and our colleagues will flag to me if they see things. A year or two ago, we saw incidents happening in a particular ward in the Borders NHS Board area. We had not finished our investigations into the complaints that were brought to us, but we were sufficiently concerned to draw to the attention of the health board the fact that we were looking at those incidents and that it should perhaps look at them, too. When we see cases, we can flag them up. However, the committee should bear in mind that the cases that we are talking about have already been through the health board, so the health board has had an opportunity to pick them up.

Dr Dorothy Armstrong (Scottish Public Services Ombudsman): To add to what Jim Martin said, we see the same themes coming into the office and we feed that into the boards formally and very much informally. A lot of our work involves going out and talking to boards. The example was given of pressure ulcers. That issue has been targeted by the Government and we have seen a lot of improvement in the figures over the past couple of years.

The issue that continues to come up, in which there has not been the same improvement, is communication. That is highlighted in almost every complaint. By "communication", I mean the way in which people are spoken to, body language and written communication. The relationship that a patient or carer has with a manager, doctor, nurse or physiotherapist is an important part of their experience but is difficult for us to measure. It is not that we do not believe what complainants are saying; it is just that it is much more difficult to evidence. Almost without exception, the complaints that we uphold include issues about communication and the behaviour and attitudes of the people who are impacting on the patient's journey and experiences.

Aileen McLeod (South Scotland) (SNP): I want to pick up some of the points that were made by my colleague Mark McDonald regarding what you said in your submission about areas of genuine improvement, for example the increase in transparency in the system. We have seen that by the very fact that Healthcare Improvement Scotland has been created since 2011.

Last March, the previous health secretary ordered the NHS boards to undertake an internal audit of their management of waiting times, following the PricewaterhouseCoopers report on the management of waiting times in Lothian. The audit reports were published back in December, when the current health secretary delivered a ministerial statement. It was the largest investigation into management practices. The latest Scottish in-patient patient experience survey, from 2012, showed that patient opinion is at a high level due to the improvements in the system.

Under the Patient Rights (Scotland) Act 2011, patients have the right to give positive or negative feedback and comments and to raise concerns or complaints about the healthcare that they have received. The act requires a health board to encourage, monitor and learn from the feedback and complaints that it receives. What impact has that had on your role, the complaints that you receive and the quality of patient experience?

Jim Martin: I asked that question before I left my office, but we have little sense that people are quoting their rights under the 2011 act when they come to us. As yet, it is too early to determine whether the move to the patient advice and support service has been effective; it will need to run for a period of time before we can determine that.

However, we had a 12 per cent increase overall in complaints last year, with roughly the same figure for the health area. So far this year, the figure is up by about 7 or 8 per cent. Either the number of complaints is increasing because we are still not getting things right, or more people are complaining because they are more aware of their rights. Perhaps it is neither of those and something else is going on out there, given that we are still getting an increase in complaints about local authorities and so on. Once we have seen the quarterly reports and the annual report, we will have a better view.

There is an area that I have a concern about and which I have raised with the committee previously. An unintended consequence of the new system of feedback of concerns, complaints and compliments is that, now that the national health service has taken over prison healthcare, there is anecdotal evidence to suggest that the feedback system is being seen as an extra stage in the complaints process—the feedback system becomes the first stage of the process before moving to a complaint. I am sufficiently concerned about that that I have raised it with the chief executive of the Scottish Prison Service.

We are monitoring the situation closely, because in the last year of the SPS health regime, 511 cases were reported to ministers for a decision outwith the prison service, whereas the most recent number that I saw in that regard for last year, which was for roughly a full year, was 46. There is therefore a disparity; either we are getting something very right or something is not quite working.

We may have to look at how the system is operating generally. I would hope that patients would be more aware of their rights because of the discussion around the 2011 act and that they would be keen to use PASS and their pathways to bodies such as mine if they were unhappy with what was proposed. However, I think that it is too early to provide evidence of that.

Nanette Milne: I am interested in the paragraph in your written submission that refers to the defensiveness of some health boards and how that can be a barrier to getting to the nitty-gritty of problems. It states that

"there can be a complex mix of personalities, systems and resource decisions behind any issue."

Looking ahead to the integration of health and social care, when your organisation will deal with not just the health culture but the local authority social work culture, will the problem to which I referred be compounded? Do you foresee increasing problems as the integration goes ahead?

Jim Martin: I am not sure that it is possible to read across from one area to the other in that regard. One of the issues in health boards—this is a contentious point, on which people disagree with me—is that there is still a culture in some senior areas of health boards of fear of litigation and that admitting that something had gone wrong would leave the board open to being taken to court.

The most frustrating part of my job is to have an adviser come to me and say, "Jim, it is obvious. This went wrong and it is pretty obvious that it went wrong." I recall one case in which an adviser said, "There's the X-ray", which showed of course that something had gone wrong. However, the complaint had been through all the board's procedures. When we go back to a board in such a case, it states that it accepts that something went wrong. It is good that the board accepts that eventually, but the patient has gone through unnecessary stress in the meantime.

The only reason that I can see for such a situation is not incompetence—I do not believe that it is that—but worry about litigation. I think that we need to look at no-fault compensation and an appropriate means for giving an apology—whether that follows the British Columbia model or whatever—so that people feel that they can say sorry.

The General Medical Council has excellent guidance on how to say sorry. One or two of our health boards are exemplary when things go wrong. I have seen a couple of apologies from Highland NHS Board that were exemplary, although I have also seen one from that board that was not. When we get that right, that means a lot to the people who receive the apologies.

12:30

The Convener: All the issues that we have discussed, such as pathways and the integration of health and social care, are of interest to the committee. You have certainly had something important to say about the process in your oral and written evidence. We heard that the care inspectorate and HIS were meeting informally to discuss some of those issues. Have you or your organisation had an opportunity to take part in those informal discussions, as we lead into the review of the national care standards and the debate that is going on?

Jim Martin: We are aware of the discussions and we know how to input into them if we want to do so. In the past few days, we have been invited to take part in the adverse incident review that Healthcare Improvement Scotland is conducting. I welcome that, because taking complexity out of that area and putting simplicity into it would help a lot. We know how to get involved in such discussions if we need to do so.

The Convener: Who co-ordinates the various regulators and advisory bodies, of which there seem to be a lot? We all agree that there are important issues and we have agreed on recommendations and reviews. That is all taking place, but the arrangements still seem a bit ad hoc.

Jim Martin: Our body sits outside all that you have described. We are an arm's-length body. We are willing to be consulted and to have input when that would help, but the bulk of the issues that the committee has discussed are for the Scottish Government and the national health service to deal with.

The Convener: I accept that we might need to raise such issues with the relevant minister.

Thank you for your attendance, your thought-provoking evidence and your encouragement to the committee to carry on the work.

Reporter

12:33

The Convener: Item 2 is consideration of whether to appoint a reporter. Members will have read the paper that invites the committee to consider appointing Richard Simpson as a reporter to visit Oldham, where a number of successful initiatives have been undertaken, with dramatic results, to reduce the number of teenage pregnancies. I ask Richard Simpson to comment before I invite other members to speak.

Dr Simpson: The committee's papers are useful. As they say, Oldham is not the only area in which improvements have been made, but it took early action. I happen to be going down to the Liverpool area on the first weekend in February, so I thought that I would take the opportunity to go to Oldham. Doing that in a personal capacity would be one thing but, if the committee felt that it was appropriate for me to go as a reporter, that might be worth while. That would allow formal notes to be sent to the committee about what was done in Oldham, how that was done, whether it was of benefit and whether the situation has been sustained—it is all very well to achieve something, but the question is whether that can be sustained and carried forward.

The Convener: Do other members have comments?

Bob Doris: If Dr Simpson is prepared to be a reporter, I think that the committee welcomes that.

I say as an aside that, when we talk about reducing teenage pregnancy, I am a lot more comfortable with the expression "unplanned teenage pregnancy". The committee has previously used that phrase; the issue is sensitive.

Dr Simpson: The visit will be at no cost to the committee, because I am travelling to the area anyway. That saves the Parliament a little money.

The Convener: Are we content with the proposal?

Members *indicated agreement.*

The Convener: I thank members for their attendance, participation and patience.

Meeting closed at 12:35.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78307-143-2

Revised e-format available
ISBN 978-1-78307-157-9

Printed in Scotland by APS Group Scotland