The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 4 February 2014

Session 4

Tuesday 4 February 2014

CONTENTS

HEALTH AND SPORT COMMITTEE
4th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central 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)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Annette Bruton (Social Care and Social Work Improvement Scotland)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Dr Denise Coia (Healthcare Improvement Scotland)
Paul Edie (Social Care and Social Work Improvement Scotland)
Jim Martin (Scottish Public Services Ombudsman)
Paul McFadden (Scottish Public Services Ombudsman)
Alistair McNab (Health and Safety Executive)
Robbie Pearson (Healthcare Improvement Scotland)
Dr David Snowball (Health and Safety Executive)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 4 February 2014

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

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the fourth meeting in 2014 of the Health and Sport Committee. As usual at this point, I ask everyone in the room to switch off their mobile phones, BlackBerrys and other wireless devices. Some committee members will be using their tablet devices instead of hard copies of committee papers, so you may see us working away on those. I have received apologies from Dr Richard Simpson and Malcolm Chisholm joins us once again as the Labour substitute.

The first item on the agenda is a decision whether to take in private item 3, which is consideration of the candidates for the post of adviser to assist us with our scrutiny of the Assisted Suicide (Scotland) Bill. Does the committee agree to take that item in private?

Members *indicated agreement.*

Inspection, Regulation and Complaints Bodies (Scrutiny)

09:46

The Convener: Agenda item 2 is our annual scrutiny of inspection, regulation and complaints bodies. We will have two panels of witnesses this morning. I welcome to the committee those who are representing Healthcare Improvement Scotland and the Health and Safety Executive. From Healthcare Improvement Scotland, we have Dr Denise Coia, the chairman, and Robbie Pearson, the director of scrutiny and assurance. From the Health and Safety Executive, we have Dr David Snowball, head of Scotland and Northern England, field operations directorate; and Alistair McNab, head of field operations directorate Scotland. It is good to see you all here this morning. We will have a brief presentation from HIS and will then move directly to questions.

Dr Denise Coia (Healthcare Improvement Scotland): I welcome the opportunity to attend the committee. Thank you for giving me the time for a short opening statement.

Since our formal appearance here last January to discuss scrutiny, our organisation has taken a number of important steps forward.

First, we have built a stronger approach to the scrutiny of healthcare by securing skills and expertise from across the service and we are undertaking far more specialist inspections.

Secondly, we have drawn a closer relationship between improvement and scrutiny initiatives, with the focus on ensuring that we take a more cohesive approach. We felt that there was no point in identifying issues if we did not provide the support to resolve them.

Thirdly, we have strengthened our links with other bodies to promote the most systematic sharing of intelligence. The healthcare intelligence review group is now set up and we have strong links with the Scottish Public Services Ombudsman, the General Medical Council in Scotland, the Royal College of Nursing Scotland and Social Care and Social Work Improvement Scotland—known as the Care Inspectorate. The group allows us to identify where there are key issues.

Fourthly, we have tested the opportunities for more comprehensive assessments of the quality and safety of healthcare. We have moved from snapshots of individual areas to whole system inspections. We have begun to consider the wider issues in national health service boards that may impinge on the quality of healthcare, including

workforce and leadership. In the coming year, we will seek to build on that approach.

We have also made good progress with the Care Inspectorate in designing more integrated scrutiny for adult health and social care and we are very focused on the outcomes, reflecting the wishes of the Christie commission, and the extent to which new health and social care partnerships are delivering not only better co-ordinated care but, most important, more appropriate care in the right setting. We are happy to expand on that in our evidence.

Our scrutiny and inspection plan for the coming year sets out a diverse programme of work that we believe reflects important priorities for patients, for staff who work in the NHS in Scotland and for the general public. I believe that there will be a greater emphasis on the culture of care in NHS boards and on how boards support front-line staff to deliver best-quality care.

I have primarily focused on our role in scrutiny, but that is just one part of a broader contribution to improving healthcare in Scotland. We are currently consulting on our future strategy, called "driving improvement in healthcare". It reaffirms our commitment to support NHS boards to achieve their goal of delivering higher-quality healthcare through data and evidence, improvement support, and our leadership in the Scottish patient safety programme. We are happy to share our thinking on our strategy and its contribution to the broader 2020 vision for health and social care in Scotland.

The Convener: Dr Snowball, do you wish to say anything at this point?

Dr David Snowball (Health and Safety Executive): Yes, please, convener. Good morning, and thank you for the invitation. I will say a little bit about HSE interventions in the healthcare sector. We do not routinely inspect proactively in this sector, but we use other tactics, including working alongside our co-regulators, many of whom are represented here.

We do investigate. We investigate deaths—or incidents that were so serious that death might have resulted—that would not otherwise be reportable to us, where there has been a systemic management failure to meet a clear standard and other of our published criteria are met. We also investigate complaints and serious incidents that meet our published selection criteria. We do some proactive inspection of poor performers, which we define based on intelligence from accident reports, complaints and information that we receive from other regulators. We proactively inspect category 3 laboratories that handle dangerous pathogens. We are also currently involved in a number of major joint investigations with the police and others into significant failings, including the deaths of members of the public, in several care homes.

We seek to secure improvements in a number of ways. The first of those is by developing, promoting and publishing standards. There is an extensive health and social care microsite on the HSE website. We work with other key stakeholders to produce guidance and we liaise with key stakeholders and, most important, our co-regulators to improve standards jointly.

In our experience, investigation gives us effective leverage to secure improvement. Prosecution is important to us where failures and their consequences have been serious.

Gil Paterson (Clydebank and Milngavie) (SNP): My question is for Healthcare Improvement Scotland. You were gracious enough to give us some material and I refer to the third bullet point in section 2 of your submission. You tell us:

> "At the request of the Cabinet Secretary, Healthcare Improvement Scotland undertook an extensive, independent review of the factors influencing the quality and safety of care in NHS Lanarkshire's acute hospitals".

I am aware that you published that review at the end of last year. Could you share with the committee some of the outcomes and lessons of that investigation?

Dr Coia: I will hand over to my colleague to answer that.

Robbie Pearson (Healthcare Improvement Scotland): There are a number of things from that investigation that can help to shape and inform the future direction of scrutiny. We undertook that review very quickly. There were three principal elements within it. The first was about the assembly of data and intelligence: the information that we already had—the hard data, including that from the Information Services Division of NHS Scotland—as well as other, softer intelligence that we use to help inform the hard data. For instance, the information from the Scottish Public Services Ombudsman on complaints was important. A range of data and intelligence was used to help inform the review.

The second part of the review involved taking the information from that intelligence and building some key lines of inquiry. We were asking NHS Lanarkshire key questions about leadership, the configuration of the workforce, service delivery, how it responded to complaints and how it involved patients and carers. Those questions were all fundamental when we were on the ground in Lanarkshire in the course of October 2013.

From that we constructed a robust, fair and balanced report, which identified areas for improvement—there were 21 recommendations—to ensure safer care and a higher quality of care.

That built on work that NHS Lanarkshire was already doing in that regard, as was very much the intention. It was an opportunity for NHS Lanarkshire to use the external scrutiny to further develop improvement. Work is now being undertaken with the extra support that the Scottish Government has put in place.

We therefore have a number of points of learning and evaluation from that exercise to build the more comprehensive scrutiny approach that we will set out over the coming year. The more rounded consideration of the quality and safety of care will give a more balanced, objective picture when we start to include in it issues such as leadership and the workforce.

Dr Coia: One of the important parts of the inspection was the case note review. One of the strengths of the new model of inspection is that it gets underneath the skin of the organisation. There are now specialist reviewers who look at what is happening in case notes, from which we can get a much better understanding of the day-to-day practices in the organisation. Using that methodology is an important learning point.

Gil Paterson: Thank you for that. In my time as a member of this committee we have been very conscious of the benefit of dealing with staff and patients and getting their opinions and advice on how matters affect them. I wonder what engagement you had in that respect and whether there were lessons in that that would benefit the delivery of care throughout Scotland, rather than in just one hospital.

Robbie Pearson: A fundamental component of the review was listening to staff, patients, carers and families. We had a considerable process of engagement. For example, we had evening events with patients and families and we spent considerable time with staff, visiting clinical areas and holding focus group sessions. People had the opportunity to share their experiences of delivering and receiving care in NHS Lanarkshire.

We were keen to ensure that the review did not result in a dry, statistical report but that it tied together not only the data and intelligence that we assembled, but the narratives of patients, families and staff to give a more rounded picture. I think that that will be fundamental for how we carry out further reviews. We have already done that to an extent through our Healthcare Environment Inspectorate work, and our inspections of the care of older people, because we have gathered views. However, we are starting to do it in a more systematic and rigorous way, building on the other intelligence that we have, such as that from the SPSO.

Gil Paterson: Was what you did a new experience for staff and patients in NHS Lanarkshire, or had you previously engaged in that way there? If it was new, what was the attitude of staff, patients and families to it? How beneficial was it for them, rather than for the outcome that you sought?

Robbie Pearson: It was a new process for NHS Lanarkshire. We adopted the model that was trialled in NHS England by Sir Bruce Keogh and put it in the Scottish context of what we were seeking to do in NHS Lanarkshire. The patients and families we engaged with very much welcomed the opportunity for their thoughts, experiences and concerns to be raised with us as an independent body.

The staff were open and receptive to the opportunity to share their experiences. There were a range of experiences of some excellent practice in NHS Lanarkshire across the hospitals, but there were also areas of concern that staff were happy to share with us to ensure that there were opportunities for those to be reflected in the report and, ultimately, in the recommendations on areas for improvement.

We would like to reflect on that experience and how we do things in future. There are certain aspects that we want to adjust and change along the way, but what is fundamental is that we are listening to staff and patients in our reviews.

Gil Paterson: Did you uncover anything that would perhaps have benefited from a proactive mechanism such as whistleblowing? Did anything materialise that rang alarm bells?

10:00

Robbie Pearson: There was nothing of major concern. In the report we identified areas for improvement in continuity of care and aspects of care in accident and emergency and emergency medicine. The report reflected things that staff were keen to share with us.

Since October last year there has been, under the Public Interest Disclosure Act 1998, a responsibility on Healthcare Improvement Scotland to ensure that concerns about the quality of care are investigated and can be brought to our attention. That is an important extension as it gives people the opportunity to raise their concerns without fear of victimisation.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I was pleased by what Dr Coia said in her introductory comments about there being a closer connection between scrutiny and improvement and about there being a more comprehensive assessment of quality and safety.

I will deal with two aspects of those issues. First, the patient safety programme has rightly been praised and I have been a great admirer of that

programme, but I am conscious that the Lanarkshire report said that awareness of the patient safety programme was low in most areas that the review team visited. That made me wonder whether that reflected the situation across Scotland. Is it a great initiative that has influenced a lot of the clinical leaders but has not been widely disseminated, or do you not have the information from other boards to know whether that is typical?

Dr Coia: I will give you some personal information about that, because last night I visited a friend of mine who has had two knees replaced in a hospital that is in a very old building. I was amazed by the patient safety information that was outside and inside the ward and all the practices that were being adhered to. My friend, who is herself a doctor, did not recognise the hospital as being the same place. I can say to you anecdotally that the patient safety programme is alive and well and is doing fantastic work in a range of hospitals.

The issue in Lanarkshire was that it requires people to do walkabouts and to look and see, because if someone walks into a ward in Scotland, they should be able to see evidence of the patient safety programme and the impact that it is having on the care in that ward. That was certainly an issue in parts of the Lanarkshire system, where the information was not obvious and if people were doing walkabouts they would not have seen it.

I think that your question is whether the patient safety programme is known about at only a high level. It certainly is not and the programme is doing extremely well. Not only the acute programme but the mental health programme is now operating in every hospital in Scotland. The issue is that, like everything else, the programme has to be sustained and adhered to. The important point is that it needs to be built into the boards' performance indicators that they are adhering to it.

Robbie Pearson: I echo the point that front-line staff are very much adopting the key principles and techniques of the Scottish patient safety programme. We see the programme operating day in, day out in our hospitals in Scotland; it is about ensuring the on-going sustainability of that.

Malcolm Chisholm: Dr Coia also referred to the second aspect that I will ask about, which is the workforce. The issue attracted some attention in the newspapers a couple of weeks ago. Perhaps what has been discussed is currently just a proposal, but I wondered how it would work in practice. Clearly, people have workforce concerns but, equally, some of those can be addressed only through funding if the issue is extra staff. How would you approach that issue? You are clearly getting on to quite difficult territory if you are saying, "Well, there aren't enough staff on this ward." Is that what you have in mind, or is it something else?

Robbie Pearson: It is partly about staff numbers but, as was picked up in the Lanarkshire review, it is also about the skill mix on the wards and how that balances out in terms of the nursing staff, for example. It is also about recognising where the pinch points are in certain specialties in Scotland. I am aware that the deputy chief medical officer gave evidence about that to the Public Audit Committee the other week in, for instance, emergency admission and also spoke about attracting more consultants to work in remote and rural parts of Scotland.

It is about recognising where the pressures are and where we can, through scrutiny, identify opportunities either for additional staffing, which may have a financial consequence, or for reviewing the configuration and balance of services, whether within a hospital or across hospitals.

Dr Coia: The important point to pick up is about the pathway of care. You can look at staffing in the acute in-patient setting, but the report on the review of residential care will also be important, and the new Public Bodies (Joint Working) (Scotland) Bill will require more specialist staff to manage community services better. It is not about total numbers, but about who those staff are, their specialist expertise and how the pathway will look in relation to staffing.

Our colleagues in the Care Inspectorate will probably talk about that later. It is important to work closely with them so that we look at staffing across the whole pathway, because everybody needs to play their part.

The Convener: Before we move on from the Lanarkshire issue, can we take a step back and ask why a rapid review was necessary? You mentioned earlier that the intelligence that was being used would draw you to a particular situation. Why was the rapid review necessary when you were looking at complaints and statistics? Why were we not in earlier?

Robbie Pearson: Over a period of time, and with some support from Healthcare Improvement Scotland, NHS Lanarkshire had been reviewing its approach to safety and mortality in its acute hospitals, particularly because the hospitals' standardised mortality ratio had been higher than expected. It was recognised that, with the higher-than-expected mortality, a further rapid review should take place, so it was done proactively in response to that intelligence, building on the work that was already in place. It was to assess whether the steps that had been taken were sufficient or whether extra measures were required. In that context, it was decided to take a

further external look at the work that was under way in Lanarkshire, and to make further recommendations.

The Convener: You were already on the case, then.

Robbie Pearson: Correct.

The Convener: You were aware of the situation, and there were discussions. How did it escalate? Was the escalation point at the time of publication of the mortality rates, or were there earlier discussions with the Scottish Government about the concerns?

Robbie Pearson: There were earlier discussions with the Scottish Government, but the trigger was the further quarter's report on mortality, which required us to carry out the rapid review and a more thorough and comprehensive review.

The Convener: I am trying to get a flavour of the escalation process and how it happened. You had identified an area of concern in which action needed to take place. As an organisation that reports to the Government, what did you do at that point? Did you raise the matter with Government officials or with ministers? What happened when your organisation became concerned, and when was that?

Robbie Pearson: It was in the course of July 2013, when the quarter's statistics for January to March 2013 were about to be published. We had a discussion with the Scottish Government about the range of measures that had already been taken by Healthcare Improvement Scotland in support of NHS Lanarkshire. For instance, NHS Lanarkshire had been doing work on identifying deteriorating patients and ensuring that as patients grew sicker, more appropriate care and intervention could be provided, so work was already under way from an improvement standpoint.

In response to requests from the Scottish Government, Healthcare Improvement Scotland agreed to carry out a more thorough, independent and extensive review. That was agreed with the Scottish Government over the course of August, and further work took place towards the end of August, with the report finally being published in December. It was a proactive response to that intelligence, and we did a number of things in that rapid review that were different from what Healthcare Improvement Scotland had done before.

One of the most important of those was to bring together a large team of experts from around NHS Scotland to help with the work. We had medical directors and people who have been involved in safety, who have expertise in this particular area. Building on what Dr Coia said in her opening remarks, I see such specialist expertise as crucial in carrying out more comprehensive reviews.

Dr Coia: Convener, you asked about the escalation policy. It is very important to make it clear that we have a number of escalation options. In the case of NHS Lanarkshire, there was a slow build-up, as Robbie Pearson was saying, and improvement initiatives were not working. We escalated that through the Scottish Government to the minister. If there are issues that we are very concerned about, we could, should we choose to, escalate them directly to the minister. That is something that is really important about the Scottish system, as opposed to the English system. Health in England is so devolved from the Department of Health and the minister that there has to be regulation, because it is not possible to get into the system and escalate as quickly, whereas here we have a straight line to the minister and the Parliament. There is a series of tiers.

The Convener: I am trying to get to early intervention and see the prevention aspect of this. You described the intelligence that you have and how you look at all the facts and complaints. I think that you spoke to us informally in July or August, around the publication of those facts. Why did you not have access to the statistics? Do you have to wait until they are published? Do you not have any early indication of them? When was the earliest indication that the stats showed the increased mortality? Why was there action only after they were published? Is that not reactive rather than preventive?

Robbie Pearson: It would be fair to say that we have been engaged with NHS Lanarkshire on improvement for a period. It was not in reaction to a particular set of statistics.

The Convener: When did that begin?

Robbie Pearson: The period began in 2012 and there has been considerable work since the middle of 2012 to engage with NHS Lanarkshire on its improvement work and the elements of the Scottish patient safety programme that it was implementing. When, in summer 2013, the next set of statistics was published, it was clear that the level of improvement was not being reflected in the mortality statistics. That is when we decided, in conjunction with the Scottish Government, that further work should be done in the rapid review.

The Convener: So we were aware of the problem in 2012.

Robbie Pearson: Yes.

The Convener: The mortality stats that were published confirmed that progress was not being made, which led to escalation. We were aware of the problem.

Robbie Pearson: That is correct.

Rhoda Grant (Highlands and Islands) (Lab): We now have the benefit of hindsight. You say that you had been involved since 2012. What prevented you from escalating the matter at that point? Do you have to wait for Government to escalate it or can you do it yourself? With the benefit of hindsight, what would you have done differently? It seems that you were involved, things got worse instead of better, then the cabinet secretary got involved. What could have been done differently? I am not trying to apportion blame; I am just asking what could have been done.

Dr Coia: When we looked at NHS Lanarkshire, it was the first time that we had used that methodology. As well as us using the methodology to look at boards externally, we think that boards could use it themselves to pick up early warning signs before a problem gets to the point that it got to with NHS Lanarkshire. When boards pick up those warning signs, which we would quality assure, we would like to get in much earlier to work with them on the issues.

The difficulty is that we are talking about one set of figures: HSMR, which are mortality statistics. There are all sorts of complicated reasons why those might be outliers or not.

NHS Lanarkshire worked with Healthcare Improvement Scotland to ensure that there were no coding issues and that the figures related not to the area's population but to service provision.

The learning is about boards adopting some of those methodologies internally. A number of boards have done that learning; they are looking internally at what is going on and are beginning improvement programmes far earlier. There is a huge amount of learning.

10:15

Robbie Pearson: There is considerable encouragement for NHS boards to take such an approach. As Dr Coia said, a number of NHS boards have taken the template—the key lines of inquiry—that we adopted in NHS Lanarkshire and asked how their boards, systems or hospitals are performing against it, whether on involvement of patients and carers, leadership or the workforce and its design. NHS boards have tremendous opportunities and do not have to wait for a Healthcare Improvement Scotland review.

Our approach to scrutiny—how we go about it and using intelligence wisely and proactively—is maturing. We were established under the Crerar principles, one of which was that we would move to a much more risk-based, intelligence-based and proportionate approach to scrutiny. The work that we are doing with the Care Inspectorate, Audit Scotland and the Scottish Public Services Ombudsman is starting to share intelligence more systematically. That soft intelligence involves not just one indicator but a range of indicators. We are giving a lot of careful thought to how we use that and what the triggers or thresholds are for scrutinising and intervening in a health board.

Rhoda Grant: What other indicators do you use? Mortality rates are one thing, but they come late in the process, when the damage has been done. Would something else trigger your involvement much earlier, so that improvements happened immediately?

We think that health boards are struggling with budgets; sometimes, the feedback from staff is that nobody at a higher level is particularly interested in what goes on in the wards, where people are running about. It was true that, in NHS Lanarkshire, there were staffing issues and people were struggling, although they were doing the best that they could in bad situations.

People tell us that when they try to tell somebody about the situation, they come unstuck quickly, because they feel that they are picked out as being a troublemaker. What steps have you put in place to ensure that you are alerted much earlier, so that you can go in and do something, rather than waiting until people have died?

Robbie Pearson: We are starting to use a range of indicators more proactively. We have done a lot of work on infection rates and we are thinking about how to use complaints data and information on the workforce and vacancy rates—the use of bank and agency nurses, for instance. We are gathering a range of indicators.

With other national agencies, Healthcare Improvement Scotland is seeking to build an intelligence repository, so that we can identify whether NHS boards are not performing as well as expected over time. That will help us to build a more comprehensive picture of the quality of care in NHS boards.

Before we do a healthcare environment inspection or an older people's care inspection, we use data and intelligence—we might use some of our inspection reports, for instance. However, we need to assemble a much broader suite of data and information to inform inspections and to inform the triggers and thresholds. The range of indicators goes beyond mortality rates.

Dr Coia: Extremely good data is coming in. The public provide information through complaints and more informal channels, and the public can phone us to raise issues. In addition, staff now have the whistleblowing helpline. Good data also comes in from the General Medical Council, whose yearly survey of trainees is producing excellent data on

specific hospitals and wards that have issues, which is being fed in.

Data from the RCN's members and from the medical colleges feeds into the system, too. The group is pulling together a lot of the soft data that is out there, and that lets us understand where issues are beginning to build. They come out in a number of places, and often they are coming from the same ward.

Rhoda Grant: What other tools or powers might be useful to you in enabling you to operate more proactively?

Robbie Pearson: I believe that we have sufficient powers under the Public Services Reform (Scotland) Act 2010. The question is how we can use those powers judiciously, especially with regard to the triggers for us to carry out further independent reviews.

Over the course of the past year, we have carried out a number of proactive reviews, based on intelligence that has been gathered chiefly through our inspections. The existing framework that is set out in the act is sufficient for us to act in a way that meets the expectation that we will carry out independent and proactive investigations, reviews and inspections.

Dr Coia: The issue is more about perception than it is about powers. This year, we have worked hard to make it clear that we value being held to account by the Health and Sport Committee and the Parliament. It is important that we have that public accountability. We have succeeded in moving ourselves to a position in which we feel that it is the public who hold us to account, rather than our being seen as an arm of Government. We have reinforced that independence in the past year. As chairman, I think that it is important that we continue to make the point that we are an independent organisation and that we are accountable to the Parliament.

We do not need extra powers, it is more to do with our culture and feeling that the public should hold us to account rather than our being part of the NHS as such.

The Convener: Could we explore that further? In his presentation, Dr Snowball made a point about the enforcement powers that he has. The Care Inspectorate tells us about how important its enforcement powers are. However, now we hear Healthcare Improvement Scotland saying that it does not need similar powers. I am sure that we will deal with this issue later but, given that the patient pathway goes more into the community and that various organisations will be working together, of necessity there will have to be some sort of consistency. Could you respond to any of that?

Dr Coia: There is no easy answer; there is no right or wrong. We have to explore the threads of the argument.

NHS England is responsible for delivering healthcare in England. It is very much divorced from Government—it is at arm's length. That is because the system has become more privatised, with trusts and so on, and is more of a business, if you like. The Care Quality Commission—our sister organisation in England—could not walk into a trust unannounced without permission. Those permissions need to be given through regulation.

In Scotland, the NHS has a centralised system, with the NHS chief executive being a civil servant in the Scottish Government. We do not require permissions to go into the NHS in Scotland or to have dealings with the NHS in Scotland. As has been said, we have escalation procedures that can go right to the top—to ministers. Therefore, there is a different system, which perhaps does not require as much regulation. The Care Inspectorate regulates bodies that are independent businesses; it does not have permission to go into care homes that are independent businesses without a regulatory role in statute. That is one issue. There is no right or wrong answer, but I ask the committee to consider that.

The second issue, for us, concerns the specialist aspect. In the NHS and the health system, these intensive inspections require 30 to 40 people; that was the level of people involved in the inspection in Lanarkshire. We need to release staff from every health board in Scotland to get that specialist expertise. It pays dividends, because we need doctors, nurses and allied health professionals who know what they are looking at, to be able to get under the skin of NHS Lanarkshire and realise what is really going on in terms of understanding the problems about decision making and the acute pathways. Quite rightly, they are keen to do peer review and to scrutinise. In the aftermath of NHS Lanarkshire, they also are keen—because it is a small country and everybody knows everybody else—to be seen to support their colleagues to improve and to resolve difficulties and problems. To do that we need to have a quasi-role, as it were, of being part of the NHS in the sense of being able to seek specialist help. If we are not doing that, we have to do what the Care Quality Commission does—namely, we need a budget that is massively larger than the one we have and to formally appoint the teams. The CQC's teams all have 30 to 40 specialist staff whom they employ and pay. The funding that we would require would be so substantial that it would not be practical.

On the other hand, the real danger for our organisation is that the public see us as part of the

NHS and of a system that they think perhaps has not done well by them. That is a danger and there are huge issues around ensuring that it is not the case. There is still huge discussion to be had about that.

Scrutiny is probably only one third of what our organisation does. We do deliver. The Scottish Medicines Consortium is part of our organisation and we have a completely new way of looking at new drugs and orphan drugs. That is a huge piece of work, which involves the public and has huge resource implications. We are responsible for the evidence, the Scottish Intercollegiate Guidelines Network guidelines and all the health technology assessments in Scotland. We require a huge workforce that we borrow from the NHS to found that evidence base, to drive forward improvement in Scotland. The new protocols written all over Scotland for managing different operations in the NHS in Scotland—for instance, managing asthma—are produced by Healthcare Improvement Scotland. The improvement programmes and patient safety programmes also are delivered by us, so it is important that our staff for that, and all our clinical leads, are part of NHS Scotland.

The relationship is complicated. We believe that probably we achieve the right balance. We should build grit into the system through Parliament, the media and the general public holding us to account; but there are resource implications if we try to say that the work could be done totally outside the NHS. We are agnostic about how that will move forward in the longer term. It is not impossible, but we need to think through every single implication.

Aileen McLeod (South Scotland) (SNP): In her opening remarks, Dr Coia made the point that Healthcare Improvement Scotland is making good progress with the Care Inspectorate in relation to integrated inspections. From its written evidence, I know that HIS has been trialling a joint inspection methodology to reflect the adult health and social care in three local authority areas. Will you give us an update on the pilot for the joint inspections and tell us what lessons have been learned from the pilot inspections on ensuring the consistency of quality and safety of care? In the new pathway of care, there is more emphasis on community care than acute care.

10:30

Robbie Pearson: The work that we have been doing with the Care Inspectorate over the past year has very much been about testing and piloting the methodology and taking a different approach to scrutiny between us. A particular focus in that pilot work has been on outcomes and thinking about the experience of care for individual service users—patients and their families.

Over the past year, we have done three pilots, in Perth and Kinross, West Lothian and Inverclyde. We have now moved forward with two live inspections, in Aberdeenshire and Moray.

From that work, we have considered the pathway of care and how we ensure scrutiny of the quality of care and ensure that patients or service users have the right care in the most appropriate place. We have been thinking about the step-up, step-down approach and how we support more people to live independent lives outside hospital. The second thing that we will do more of in the coming year is scrutinise the joint commissioning and the value for money that has been achieved through the joint arrangements between health and social care partnerships.

I guess that there are two parts to the approach to scrutiny: first, value for money, commissioning and achieving outcomes; and, secondly, the quality of care. It is important that we not only consider the interface between health and social care, which is fundamental to joining up the service, but remember that primary care teams delivering NHS care sit within the health and social care partnerships, so a fundamental part is ensuring that general practitioners are involved as well. That is where Healthcare Improvement Scotland brings particular expertise in respect of standards on NHS and clinical care.

We very much see the approach to scrutiny as an integrated one. Over the past year, we have demonstrated excellent working with Care Inspectorate colleagues. We are bending with the approach that individual health and social care partnerships are taking to delivering services.

It is important that we do not lose sight of the locality in that. Localities will play a fundamental part in primary care teams working with social care professionals and the independent sector, so scrutiny of them will also be a key component over the coming years.

Dr Coia: We have just had a joint board development day for the boards of the Care Inspectorate and Healthcare Improvement Scotland. We explored all the issues around the inspections and the Public Bodies (Joint Working) (Scotland) Bill, which is going through the Parliament at the moment. We also considered how all that will link into community planning. As Robbie Pearson said, it is about localities and how all that work feeds into community planning.

The important point about the joint inspections is that they are working. The methodologies are being refined and that is going well. The Care Inspectorate and Healthcare Improvement Scotland are both pushing the Government

strongly on getting the new national care standards out and functioning because, to kick off with inspections, we must get those standards out as quickly as possible.

Aileen McLeod: I appreciate the detailed response that you have given. I am sure that the committee would welcome being kept up to date with what is happening with the joint inspections.

Richard Lyle (Central Scotland) (SNP): My question is for Mr Pearson. As a Central Scotland MSP, I attended a meeting with the board of NHS Lanarkshire last week along with constituency members and other regional members. How many meetings has HIS held with NHS Lanarkshire about its 21 recommendations since it made them? Does the board feel that any of the recommendations need clarified?

Robbie Pearson: The report was published on 17 December. We have not met NHS Lanarkshire formally since then. As outlined in the cabinet secretary's statement to Parliament on 17 December, the Scottish Government has set in train additional support arrangements. Those arrangements have been put in place to ensure that the 21 recommendations get translated into a robust action plan.

We have been in touch with NHS Lanarkshire about what support for improvement we can provide. We are absolutely committed to helping it take forward the necessary improvement. There is a meeting coming up shortly to discuss the case note review to which Dr Coia referred earlier and how we can provide clarification and learning.

Richard Lyle: Thank you.

Bob Doris (Glasgow) (SNP): I want to address a couple of questions to Dr Snowball and Mr McNab if that is all right. I am looking at the information that our clerks have prepared for this morning's evidence session; one or two statistics have been drawn to my attention. I refer to the data on workplace fatalities and major injuries in the workplace in 2011-12 and 2012-13. I want to put the numbers on the record and ask whether they have any statistical relevance. The number of fatalities, which is rather small, rose from 19 in 2011-12 to 22 in 2012-13 and the number of major injuries fell from 2,215 in 2011-12 to 1,914 in 2012-13. Although we are dealing with rather tiny numbers of fatalities, every fatality is of course important. Is there a statistical relevance to either set of numbers? Are they part of wider trends?

Dr Snowball: The statistical relevance is, as you say, subject to the fact that the numbers are small. Last time we were here, we emphasised that there are two things to be careful about when you interpret the statistics—one is the absolute numbers and the other is where they are. In Scotland last year, 22 workers were killed at work. Eight were in agriculture and five were in construction, which are two of our priority sectors for proactive intervention—the third is waste and recycling.

Every year, we scrutinise and ask ourselves the question that I suspect is on your lips, which is, "Is Scotland different?" We did exactly the same this year. We went back to our statisticians and said, "Please can you analyse these statistics again? Please can you tell us whether Scotland is more dangerous to work in than the rest of the United Kingdom and, if it is, what determines that characterisation and what should we be doing differently?" In common with previous years, our statisticians came back and said that occupation, not geography, is the key driver of the statistics. In other words, the occupations that are represented in Scotland tend to be in the sectors where Great Britain-wide, as well as in Scotland, there are a greater number of fatalities and major injuries. We know that to be the case in agriculture and construction. That is the simple answer to your question.

Bob Doris: On the fatalities figures, are you saying that you are not aware of any increasing risk of fatalities at work in Scotland? Are you saying that there is no particular statistical significance to the increase from 19 fatalities in 2011-12 to 22 in 2012-13?

Dr Snowball: There is not.

Bob Doris: Okay.

The sectors where the fatalities occur inform where you do proactive inspections.

Dr Snowball: Yes. That informs where we carry out proactive interventions, which include inspections. On the agriculture fatalities that we encounter in Scotland, it is horribly depressing that a significant number of farmers fall through fragile asbestos cement roofs and die when they land on concrete floors. A significant number of farmers turn quad bikes over. There is nothing uniquely Scottish about those characteristics; they are exactly the same sorts of fatalities that my colleagues in England and Wales are seeing. It is a horribly depressing litany of death every year.

Bob Doris: Although it is unfortunate that that is the reality, it is helpful of you to illustrate the types of fatality that occur in that sector.

On the second statistic that I gave, we are dealing with some larger numbers. Is there a statistical significance in the fact that we move from 2,215 major injuries to 1,914? Was that just a quirk of the figures or is it part of a wider trend during the past five or 10 years? Could you put that into some kind of context for us?

Dr Snowball: The wider long-term trend over the past five years is that fatalities and major

injuries are going down. There is, however, significant underreporting of injuries at work. It is particularly prevalent among what used to be over-three-day injuries but are now over-seven-day injuries. The reporting of injuries, diseases and dangerous occurrences regulations—RIDDOR—were amended so that people do not have to report until someone has been off work for seven days.

Interestingly, the pattern of major injuries tends to shadow the pattern of fatalities, with the single exception of agriculture. In agriculture, we find out an awful lot about the fatal injuries but not a lot behind them, whereas in other sectors, the fatals and the major injuries tend to shadow each other. There is a logic to that. If you work in an industry in which you can be killed—and I do not say that in a light or frivolous way—there is a pretty good chance that you can be seriously injured as well. Often there is a fine difference between being killed and walking away, or between being killed and being seriously injured.

Bob Doris: Can you give us some more information about RIDDOR and reporting after seven days' absence rather than after three days' absence? We were talking about people being accused of cooking the books in relation to employment and other statistics. When was the seven-day rule put in place and what were the reasons for it? How do you view the adjustment to those categories?

Dr Snowball: The change was made on the back of a recommendation by Professor Löfstedt, who did a review of the UK health and safety arrangements. That came on the back of a review by Lord Young. There was a neatness to it, which might sound an odd thing to say.

The reality is that seven days is, by definition, a week. It is much easier for companies to stay on top of statistics if they can talk about a week's absence. It does not, however, trivialise the injury. There is a difference between an over-three-day injury and a major injury as defined in the regulations. For example, if you broke your leg at work and were back at work after a week, that would still be classified as a broken leg and not as an over-seven-day absence. Major injuries are still captured by RIDDOR.

In the past month or so, we have produced some research—I will forward details to the committee—that answered the specific and detailed question that you asked, which was whether there is a major difference in what we are seeing now that we have classified over-three-day injuries as over-seven-day injuries? I will send that detail to the committee and you can reflect on it. I can then answer any further questions.

Bob Doris: Convener, I have one or two further questions to progress the point.

That is all very helpful. I see this in my briefing papers, and also remember that the last time we had an evidence session with the HSE, there was talk about budget cuts and the number of inspectors. The UK-wide budget cut was a meaty 35 per cent.

Dr Snowball: That is right.

Bob Doris: At that time, there were 162 inspectors working in Scotland. How many inspectors are working in Scotland now? Can we also talk about it in terms of full-time equivalents so that I know that I am comparing like with like?

Dr Snowball: The latest data that I have is that we have 152 full-time inspectors in Scotland.

Bob Doris: So we have not managed to retain the higher number. What are the reasons behind that?

Dr Snowball: Partly it is because of retirement and natural wastage, and partly because some employees have decided that they do not want to work for the HSE any more.

Bob Doris: In normal circumstances, you would recruit to replace them. Why is that not happening?

Dr Snowball: We have recruited 24 new inspectors nationally in the UK. We identified hot spots before we did that, one of which was Aberdeen. We originally planned to recruit two new inspectors into Aberdeen, but in the end we were only able to get one person to go to Aberdeen and join the HSE there.

Bob Doris: Of those 24 new inspectors, how many found positions in Scotland?

Dr Snowball: One.

Bob Doris: You will understand why, given the specific risks in agriculture and construction, and the sectoral risk of fatalities in Scotland, that might be of concern to the committee. How many fewer inspections or interventions have there been because we have 10 fewer inspectors?

10:45

Dr Snowball: It is not quite as simple as that. Nationally, HSE has a ceiling of 22,000 proactive inspections that it carries out across the UK, in sectors that we define as either higher risk or poorer performers. In 2011-12 the total number of inspections that we carried out in Scotland was 2,236, and in 2012-13 the number was 2,787. We increased the number of our inspections because we realised that we were having precisely the problem that Bob Doris has just defined.

On a further point of clarification, our intervention approach in the agricultural sector is primarily made through safety and health awareness days, which I described in my previous appearance before the committee.

A significant number of the 2,787 inspection visits that we did in 2012-13—958—were in the construction sector.

Bob Doris: We do not scrutinise the HSE's work very often, but we scrutinise the work of Healthcare Improvement Scotland and the Care Inspectorate. The Care Inspectorate, which will be represented on the next panel, can go into a care home and inspect on one theme or across all themes, so the breadth and the depth of an inspection is commensurate with the quality and robustness.

I am wondering how, with 10 fewer inspectors, you can go up from 2,236 interventions to 2,787. Has there been a change in the number of hours that are devoted to each intervention? I hope that you do not mind my asking, but that does not seem to add up.

Dr Snowball: I will give you some specifics. To echo what Dr Coia and Robbie Pearson said, we—the regulators—are all in this room today talking about the same sort of things. We are talking about inspection that is risk based and reactions that are proportional, and about being transparent and targeted in what we do.

I will give you an example. There is a world of difference between HSE and local authority inspectors doing a Legionella inspection, and an inspector walking on to a construction site or a refurbishment job that consists of two or three people, but both those things are defined as an intervention.

To give the committee some flavour, I think that I said on my last appearance here that we were doing a series of inspection visits on Legionella. We visited 163 sites in Scotland to look at Legionella risk and we have taken action in 32 of those sites. We are serving improvement notices—often more than one—to approximately 20 per cent of the sites.

The honest truth is that those inspections must be sufficiently targeted and deep to make sense. I am sure that my colleagues who are sitting in the public gallery and beside me at the table would say that there is no point in going into an inspection and smearing ourselves over a wide range of topics. Unless we pick up some sensible, focused and deep risks and look at those until we hit the tin, we are not doing a particularly good job as the inspectors or for the user.

To answer Bob Doris's question, if we look at the broad picture of 2,700-plus inspections, some of those will involve refurbishment and construction sites where we carry out routine and multiple interventions. Others will consist of visits that could take up to half a day or a full day, such as the Legionella inspections. Behind those statistics is a much richer picture of the types of visits that we are doing.

Alistair McNab (Health and Safety Executive): The key is to sample the right things in order to reach a conclusion about the management capability. That is what inspectors are doing. Yes, they will look at a safety or health issue such as Legionella, but the key is to ask whether the company management are managing health and safety in the way that the law requires.

Bob Doris: I have one final question, but I would still like information on how many person hours were devoted to interventions over that year. There must be a diminution in the time that is spent on interventions if there are 10 fewer inspectors. I would also like information—you do not have to provide it just now—on what you are doing to recruit to top up the number of inspectors to 162, because one new inspector out of 24 does not seem to be commensurate with the need in Scotland for intervention and inspection.

I will give a parallel to the interventions and inspections that are carried out by the Health and Safety Executive. We will have the Care Inspectorate before us shortly. The Scottish Government and the Care Inspectorate were moving to a wholly risk-based assessment of the care of older people. Before our inquiry on the regulation of care of older people reported, there was cognisance that unannounced inspections and interventions were essential to keep all organisations on their toes—even ones that had previously been inspected and found to be robust, sound, adequate and well managed—because announced planned visits tend to get the results that one would expect to see.

Where would you target additional interventions and inspections when using risk-based assessments? I fully accept the need for those interventions and inspections. How do you ensure that large employers in risk sectors that appear to be tickety-boo with regard to their health and safety requirements are kept on their toes and do not get complacent? Do you carry out unannounced interventions?

Dr Snowball: There are two sides to the issue that you raise. I take your point with regard to unannounced inspections, but sometimes an inspection is hampered by the lack of available people or material to make that inspection worth while. If you embrace the concept of unannounced inspection, you must be realistic and accept that you may not see everything in its untarnished form, if you like.

I also echo the points made by my HIS colleagues. A fundamental question arises for us all from what HIS, the Care Inspectorate and the ombudsman do: what is it that makes boards, senior managers and leaders of organisations sit up and take notice when things go wrong? Buried—well, not necessarily buried—in every ombudsman, inspection and investigation report are nuggets on what has gone wrong. That has two consequences. First, as regulators, we must have a clear idea about what we expect to see. Unfortunately, the HSE intervenes in many industries at the end of the process. The care industry is a good example in that regard. At the point that the patient's journey is over, we must—and do—ask what were the precursors, triggers and signs that could have been seen and might have given advance warning.

Every time that, as regulators, any of us faces an unsatisfactory, catastrophic or tragic outcome, we are left with a series of patent defects showing what has gone wrong. The questions for us are how we get from a patent defect and a body or a serious injury to knowing what should inform our inspection agenda and what latent issues must be brought to the surface.

Those basic questions translate for the boardroom. In any boardroom intervention, I ask the board to show me the information sources on which it bases its safety or healthcare management, or whatever the specific area happens to be. An awful lot of board members do not ask themselves the right questions. They get reassuring information that is potentially unworrisome and they make decisions in good faith, but—I hope that Denise Coia will echo this point; I see that she is nodding, so that is a good sign—boards need to ask the tough questions. A phrase that we probably all use is "a sense of vulnerability." That is not taken to mean what would stop the board sleeping at night; rather, it is about what makes the board feel vulnerable. The responsibility at the top of the organisation, whether that is a NHS board, a major hazard site operator or a major construction company, must be well and truly nailed to the boardroom desk—what questions are they asking themselves and do the answers to those questions make any sense? If they do not do that, they are not managing properly.

Bob Doris: I will not ask another question—given the time that we have spent talking, I need to let other committee members pursue lines of questioning—but I will make a request that you send information to the committee. The intelligence or the information that you glean to inform a risk-based assessment, which focuses on your work with workers and trade union representatives—I am sure that will be on public record—would be welcomed by the committee and might inform future scrutiny of the topic. I thank Dr Snowball and Mr McNab very much.

Nanette Milne (North East Scotland) (Con): I will ask briefly about nurse staffing in hospitals. Do you have any opportunity to look at the situation around the clock? I have personal experience of being on a ward a couple of years ago. The quality of nursing care—night and day—could not be faulted, but although the ward was very well staffed during the day, there were only a charge nurse and an auxiliary in charge of the whole ward at night. Have you had the opportunity to look at that issue? I was quite concerned about it, and I think that the management was, too. The staff were kind of on a knife edge, and not much would have had to go wrong to throw the whole thing into chaos.

Robbie Pearson: Yes, we have looked at that. For instance, in NHS Lanarkshire, we looked at the pattern of registered and unregistered staffing across the day, into the evening and night and over weekends. That allowed us to see the distribution of staffing, including bank staff usage. In addition to that specific example, we have recently extended our inspection work into evenings and weekends, as appropriate. It is important that we are not just there from breakfast to tea time, because we need to see the pattern and quality of care at the weekends and in the out-of-hours period.

Dr Coia: Another issue, which relates to clinicians and doctors, is that the hospital at night initiative, which was UK-wide, has proved to be extremely unworkable. It reduced medical staff levels substantially, particularly junior medical staff levels. Certainly, that has not been such a big issue in Scotland as it has been in the rest of the UK, but we are keeping in contact with NHS Education for Scotland on that, because it is starting to consider how it can slightly unravel the hospital at night initiative.

Nanette Milne: That is helpful. I just wanted to clarify that point.

Colin Keir (Edinburgh Western) (SNP): I want to return to some stuff that Dr Snowball referred to earlier. Perhaps he can help me, as a new member of the committee who is a bit light on background information. Our clerks have produced a note that refers to the UK draft deregulation bill, which includes elements from the Löfstedt review. What is the HSE's position on the proposals in the draft deregulation bill and how will they potentially affect the HSE?

Dr Snowball: There are various aspects to that. One is about shrinking the statute book. When I was at the committee previously, I think that I mentioned that we are obliged to give proper recognition to the fact that we cannot simply throw

away bits of legislation if doing so would reduce standards—that is a no no. Another aspect is that we are required to look carefully at the way in which we publish approved codes of practice. We have changed our website significantly to make it easier for people to find out what they need to do. One great criticism of health and safety legislation is not that it exists; it is that it is difficult to understand. We have not necessarily always been good at making our advice simple and straightforward, but our website is now much better equipped to deal with that.

One thing in the deregulation bill that I think applies north and south of the border is the requirement to take into account the growth agenda. We are required to follow the better regulation code of practice and to ensure that we do not make life unduly difficult in the pursuit of growth. We are a regulator, and I argue that, as such, we have to be careful that we regulate properly. When people are held to account for management failures that lead to death, injury or ill-health, we must be careful that we do not compromise and make decisions that are not in the best interests of working people. We need to ensure that people go home at the end of the day with the body that they came to work with.

Alistair McNab: Securing justice remains a key part of our raison d'être, and that has not changed under deregulation. Basically, we look at the evidence and follow its trail, and that has not changed. In the time that I have been in the job, inspection and the view that we take on enforcement have not changed—in truth, if anything, enforcement is probably slightly tougher now than it used to be, and we now send more cases to the procurator fiscal. So that part is not of concern.

11:00

Colin Keir: Will any particular industries be more affected than others by the draft deregulation bill?

Dr Snowball: That is unlikely. One of the great things about the Health and Safety at Work etc Act 1974 is that there are about six key sections and everything else sits behind that. Nothing has yet come along to overturn the basic principle that, if someone employs people or carries out activities that could affect people other than their employees, they have a responsibility, as far as is reasonably practicable, not to harm them. That is, if you like, the lode star of health and safety at work requirements in the UK, and it remains intact. Over time, we have seen variations in what "reasonably practicable" means, and it is perfectly right that that is slugged out in the courts, but the basic principle that underpins the 1974 act—that if someone creates a risk, they must manage it—remains intact.

Colin Keir: Okay. Thank you.

The Convener: There have been some announcements at the UK level, and they have been echoed here in Scotland, that wilful neglect should be a criminal offence. Do you have any comments on that?

Dr Coia: That is a loaded question. In Healthcare Improvement Scotland, we are in the business of improvement. To be honest—this is probably more of a personal view—I think that most people in Scotland get up, go to work and try to do a good job. A series of circumstances and personal issues sometimes mean that they deviate from that driving principle, but that is why we are there to scrutinise and, by and large, in doing that, our job is to help people to improve. That is not to say that, when there are major issues, we should shy away from being tough in dealing with them, but that is really about reshaping the workforce rather than wilful neglect.

Dr Snowball: You will have appreciated that this is a fairly complicated regulatory landscape. Particularly post-Francis—there was a chapter in the Francis report about the HSE—the phrase "institutional culture" keeps cropping up in pronouncements. I hope that my colleagues who are here today from the other regulators agree with the proposition that we cannot legislate culture into organisations. We cannot say, "From tomorrow, you will have a positive health and safety culture." Culture is the product of a series of organisational activities and norms, and it is lubricated by good communication, openness, transparency and dignity—all those sorts of things. At the risk of annoying everybody else, we all wrestle with those things on a daily basis in considering what regulation is and is not good for and where we are all going in our respective organisations.

It has been quite a febrile time for us all, I think, post Francis, and the spotlight is definitely on the healthcare sector. I come with a different set of baggage from the others, but we have to work with one another and we are trying to make sense of things. The idea that there is an offence that can neatly be entitled "wilful neglect" is an interesting challenge to us all.

Alistair McNab: It may sound as if I am a classic regulator, but I have more subtlety than just focusing on enforcement. In Scotland, as you know, the Crown Office and Procurator Fiscal Service has an interesting role. When major incidents or deaths are investigated and wilful neglect might be an issue, the procurator fiscal will liaise with the police, the HSE and other regulators to look at the evidence. That system involves a

great degree of independence, including on the part of the regulators, and it ensures that the justice system works well and is fair.

The Convener: The matter is of interest to the committee. I suppose that we take some gratification from the effects of our inquiry and subsequent report in 2011. Some of the themes are coming back to us—we could ask why it has taken so long to address staffing levels, the skills mix in the workforce and commissioning, all of which were the subject of recommendations in 2011.

On criminality and the procurator fiscal, does anyone know how the procurator fiscal is dealing with the inquiry into the case at the Elsie Inglis care home? That might not be a question for the witnesses, but the case has gone through the whole process.

We have not had any opportunity to see what learning has come out of the legionnaire's disease outbreak, which has been referred to—the same people are here whom we heard from then—or whether a clear cause or response has been identified. Unfortunately, a couple of years later, we have another case, involving the Pentland Hill care home and the procurator fiscal. The same outcomes are repeated, time and again.

Alistair McNab: As you know, there are constraints on the information that regulators can give out when an investigation is going on. The information on the care homes that you mentioned and the legionnaire's disease outbreak is therefore constrained. There is no lack of desire by the HSE to be open, but we have to recognise the Scottish legal position.

We have been involved in those care home investigations with the Crown Office and Procurator Fiscal Service, the police and the Care Inspectorate, and we have put a series of reports to the procurator fiscal on the legionnaire's disease outbreak. I cannot give any more details about our findings, but in relation to legionnaire's, the HSE put out safety information that was based on what happened in Edinburgh plus a review of 10 years of legionnaire's outbreaks. Therefore, we have put into the public domain information for employers on how to manage Legionella as an issue, but obviously we cannot go into more details on the specifics of the Edinburgh outbreak.

The Convener: And the cabinet secretary never had any discussions with any of the organisations here about progressing a criminal law for wilful neglect, did he?

Dr Coia: No.

The Convener: Committee members have no additional questions, so I suspend the meeting before we move on to our next panel. I thank you all for being here with us.

11:07

Meeting suspended.

11:12

On resuming—

The Convener: We continue our session on inspection, regulation and complaints bodies. I welcome from the Care Inspectorate Annette Bruton, who is its chief executive, and Paul Edie. I welcome from the Scottish Public Services Ombudsman the ombudsman Jim Martin, and Paul McFadden, who is the head of complaints standards. Do any of you wish to make any introductory remarks?

Paul Edie (Social Care and Social Work Improvement Scotland): Good morning. I am chair of the Care Inspectorate, which is the improvement agency for social care. We work to protect and support some of the most vulnerable people in our society by regulating and inspecting a range of services, which are diverse; there are childminders and early years services, residential homes, special units and other adult day services. We provide scrutiny of criminal justice social work services, and we conduct strategic inspections of services for adults and children across community planning partnership areas.

Almost everyone will use a care service at some stage in their life, and most care services perform well. The Care Inspectorate's vision is that every person who receives care should receive high-quality, safe and compassionate care—care that reflects their rights, choices and needs throughout their care experience. Their care should be seamless, regardless of whether it originates in social care or healthcare.

Inspection must be combined with improvement; one should not happen without the other. We are committed to supporting services to make improvements where necessary, while acting as a catalyst for change and innovation in the sector. We have placed the voice of people who use services and their carers at the heart of all our scrutiny activities, with their full and meaningful involvement in inspections. We provide feedback on policies, plans and procedures.

We believe in a person-centred approach to care, which is crucial to achieving our aims and, in turn, to making improvements in the sector. We would also like a human-rights-based approach to run through social care and healthcare policy and legislation. Experience shows that where there is failure in care, a breach of rights is normally involved. A rights-based set of standards would

put the rights of people at the heart of care provision, irrespective of the care setting. We could inspect against such standards in order to provide assurance that full regard is being paid to people's human rights, and that good-quality service is being provided and experienced.

The health and social care system is going through a period of unprecedented change; we at the Care Inspectorate accept that, as a result, new expectations will be placed on us. We believe that as a scrutiny body, and based on the experience of our joint inspection model, we already have in place the foundations to allow us to meet those expectations. By building on the lessons that we have learned, and on our close working relationships with scrutiny partners, we aim to meet that challenge and to contribute to the creation of a world-class system of care.

11:15

The Convener: Thank you. Do you wish to make some opening remarks, Mr Martin?

Jim Martin (Scottish Public Services Ombudsman): No, convener. The committee has already received my first health report and written submission. With an eye on the clock, I would like to leave as much time as possible for questions.

The Convener: Thank you.

Bob Doris: I have a couple of questions on regulation of care for older people, which is—as our previous inquiry showed—of particular interest to the committee. Mr Martin and Mr McFadden may by all means respond, if they so wish.

As I pointed out to the Health and Safety Executive, the committee perceived some deficiencies in having a purely risk-based scrutiny and inspection system—for all services, but in particular for residential settings for older people who have care needs, which is the last issue on which our inquiry focused. Do you feel that with the increase in unannounced inspections the quality of inspections has improved? I know that you inspect a wide range of services, but in the light of the committee's interest in older people, can you give us some general comments on how the approach has gone?

Paul Edie: I will say a few words and then Annette Bruton will respond.

Our carrying out far more unannounced inspections—I think every care home receives an unannounced inspection—has led to a great improvement because we get a much truer snapshot of the performance of those homes. Furthermore, we have in the past year brought our staff together into specialist expert teams, and the return of care inspectors to their original professional disciplines has deepened and enhanced the quality of their inspections.

Annette Bruton (Social Care and Social Work Improvement Scotland): We have improved our inspection system, particularly of older people's services, in a number of ways. As Mr Edie pointed out, one of the significant changes since 2011, when the committee last looked at the matter with us, has been the increase in the frequency of inspections of older people's services. We believe that some aspects of care are inherently risky and although we base some of our risk analysis on information from a self-evaluation form that every service has to fill in every year, we also inspect every care home at least once a year. In fact, one of the significant weaknesses with Pentland Hill, which the committee discussed earlier, was actually uncovered in an unannounced inspection, which shows that such inspections make a huge difference.

With the establishment of our specialist teams, which Mr Edie also referred to, a greater test of standards is now being applied to providers of care-home and care-at-home services for older people. In Pentland Hill, for example, we were able to put a team of 12 people in at short notice because we had the staff with the required specialist background, including tissue viability and pharmacy specialists, to examine the concerns that had arisen in that case. Over the past three years, we have made a significant difference in our flexibility, our ability to look more deeply at matters and our staffing structure, in order to allow experts to be brought together at short notice.

The next stage in deepening our inspections will focus on care-at-home services; in fact, we will shortly publish a report on that, because we believe that there are certain inherent risks in that area and we want to deepen our inspection of it.

Bob Doris: That is interesting. Are we reaching a time when there will be a new baseline for judging the quality of residential care? Please correct me if I am wrong, but I imagine that the more unannounced inspections you conduct, the more likely you are to identify where standards are not being met—which is not to say that standards of care are getting worse, but that previously unidentified issues are being brought to light. I hope that that will drive improvement. Should we be bracing ourselves—I do not know whether that is the right term—or should we start to expect further documentation showing that residential care is not all that it should be?

Annette Bruton: Our belief is that, as the Government develops the new care standards, two things should happen: first, there should be a higher expectation of standards and, secondly, our learning from services in which standards have not

been good enough and, indeed, in those where there has been excellent practice, should be newly applied.

As Mr Edie said in his introduction, we believe that putting human rights at the heart of that will take us a long way. Not only will it drive up standards; it will help the general public—those who use care services, their carers and families—to be more aware of what they should expect. Our complaints system allows people to bring their concerns and complaints to the Care Inspectorate, which means that the public can be the eyes and ears of the inspection body. What we have learned about what makes for good care in older people's services should be coming into the new care standards, so that we have a new baseline for what is acceptable.

Bob Doris: I am sure that my colleagues will want to go into much more detail on all those themes. I will deliberately ask one last general question before my colleagues come in.

I see from the Care Inspectorate's report that, last year, your

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

When taken at face value, without diminishing the fact that that means that 17 per cent of people using a care service did not find it satisfactory and that 8 per cent of staff did not feel that it was satisfactory, those are pretty high ratings. Could you provide some context for those figures? Do they represent an increase or a decrease? Do Mr Martin or Mr McFadden have any observations about people who complain or bring problems to light? I would be delighted to hear about that from the ombudsman.

Annette Bruton: The figures are quite stable. However, without wishing to minimise any satisfaction that people have with our service, I point out that the figures are based largely on questionnaire samples. Along with a group of people who support the Care Inspectorate—care users and the people who support them—we are considering whether there are better ways to get people's views. We believe that we need to move beyond questionnaires and to develop a range of ways to determine people's satisfaction levels.

Although the figures seem to be quite high, we would not like to rest on our laurels or to tell the committee that we think that the figures mean that everything is absolutely fine. We believe that we are not yet getting to all the people who have views on care and on whether our inspections make a difference. Although we are pleased to see those figures, we would like there to be a more challenging way for us to find out what people really think.

Bob Doris: Mr Martin may or may not wish to contribute. I am perhaps leading the witnesses slightly here, but I am interested to know what action would be taken, or what Mr Martin thinks best practice would be. Although 83 per cent said "fantastic", how, in a positive and constructive way, do you build a relationship with the 17 per cent who are not saying "fantastic"? How can you suggest to them that there are paths for recourse and for resolving problems? The same goes for staff.

Jim Martin: I can give you my view, but it is a view from outside rather than from the inside, which the Care Inspectorate can provide. When I became the ombudsman, I was concerned that we were getting quantitative information about whether people are satisfied with services. When we switched to a qualitative analysis of that information—the Care Inspectorate has suggested that it will do that—we were in a position to understand better why there was dissatisfaction, so people were better able to learn from that, to change how they worked and eventually to change the numbers.

We favour a qualitative approach. If an approach is to be truly person centred, it must involve listening to people in an environment in which they feel that they can provide valuable information, rather than just ticking a box. That is the right way to go.

Bob Doris: Does Ms Bruton or Mr Edie from the Care Inspectorate want to respond?

Annette Bruton: I agree with Jim Martin. Our board has asked Care Inspectorate officers to produce a new suite of quality indicators, in addition to the key performance indicators, against which we can judge the organisation's work. That is being done for the very reason that has been given; it is to get a sense of the quality of our work and its impact on service users.

Other than through questionnaires, we have two ways of reaching out to people to find out what they think of the quality of care services and of the inspectorate's service. First, under our complaints procedures, we take more than 3,000 complaints a year, of which just under 2,000 lead to full complaints investigations. That is a good way of testing whether people are content with the services that they or their loved ones are receiving.

Secondly, lay assessors or volunteer inspectors are increasingly joining our inspections. They are members of the public who have a care user or care supporter background. They not only help with inspections, but hold inspectors to account. They ensure that what we do focuses on what

people say about inspections. We have an involving people group, which gives policy advice and drives the inspectorate's methodology.

We are trying in a number of ways to improve how we find out what people want from us and from their care services, but we still have quite a lot to do. Last year, we did a piece of research on our complaints procedure. That showed us that people were satisfied with the service that they were getting—in fact, they praised the inspectorate for the help that they got with their complaints—but they felt that it was taking too long for them to find out what the inspectorate could do for them, and they were not aware of everything that was available to them. We know that we have work to do to ensure that the public are more aware of what they can get from the inspectorate.

The Convener: I am happy to put on record my experience with the inspectorate. Its system is less complicated than that in the health service. I have represented people for 15 years and I think that the health service and the Care Inspectorate could learn from each other. The inspectorate's system is much easier to deal with.

Bob Doris referred to the committee's inquiry into care of older people and we have discussed the consequences of the Elsie Inglis care home situation—at that time, a U-turn was made to return to annual inspections. We have discussed the capacity to take on annual inspections, given that a number of inspectors were made redundant in anticipation of the fact that only risk-based assessments would be done. Have you sorted that out so that inspectors are experienced and the required number of inspectors is available to carry out the heavy workload?

Annette Bruton: Yes. One in six of our staff is new; we have been on a major recruitment process since 2011-12. We have increased the number of inspectors—we have just under 300—and we are now recruiting inspectors with specialist skills. Our inspectors have been used to doing generic inspections and do very good generic inspections. People can operate across a range of inspection areas when they carry out their inspection duties, but specialist knowledge is essential to get the added value that supports improvement and drives in the right direction the services that are not performing well.

11:30

So, we have not only increased the number of our inspectors, but have ensured that we are moving towards having just the right number of specialists in each subject and in different locations around the country. That has meant a big change programme for the Care Inspectorate, so over the past year we have recruited a significant number of new staff and reviewed our inspection methodologies.

However, our addressing the findings of the inquiry, increasing the number of our inspections and moving to looking at all four quality themes in our inspections as opposed to having the capacity to choose just one, have all been based on the notion that there are aspects of care in which people are so vulnerable that there is an inherent risk. We therefore have a higher level of inspection and frequency in those areas. Much of that has flowed from the committee's inquiry.

The Convener: The other situation that you flagged up—it was in written evidence or it was mentioned earlier—is the upcoming focus on children's services. Has that area not had the focus that it should have had because of all the activity, scandal and whatever in and around older people's services? What is behind your decision to focus on children's services in the coming period?

Paul Edie: The bulk of the services that we inspect are childminders, private nurseries and so on. There has been no change in emphasis. We have had joint strategic inspection of children's services at community planning partnership area level since, I think, 2004, so I do not see that there is any particularly significant difference there. I know that the—

The Convener: Have you just taken a notion to do it? I listened to you earlier when you said that you look at old folks homes and other areas on the basis of intelligence. Is there any intelligence that points you to increasing your workload and hard-pressed resource, given the number of things that you must do, to focus on children's services? Why has that happened if there is no intelligence to direct you to children's services?

Annette Bruton: As the committee will be aware, we look at children's services in a number of ways. There are the regulated services, which include childminders and the day care of children, some of which we inspect jointly with Education Scotland. We also do strategic inspections, which is where we have moved towards widening out to children's services. That follows a six-year programme of child protection inspections that we inherited from what was then Her Majesty's Inspectorate of Education. The committee will be aware of our report last year in which we pointed out that there had been some improvements in child protection but that there was some way to go.

Following those six years of inspections of child protection and an agreement with the Government, we broadened that process to look at wider children's services so that we looked at not just child protection but vulnerable children across

a wider range. That is driven by intelligence that we have about children who are either coming into or leaving care. We have some concerns about child sexual exploitation. As the committee will know, a working group, of which we are a part, is looking at that issue in Scotland.

We are also concerned about 15 to 25-year-olds. We particularly want to focus on that generation of youngsters in which attainment might be lower, worklessness is higher and drug and alcohol addiction is prevalent. We want to conduct a two-year study. I am pleased to say that partner organisations such as Healthcare Improvement Scotland are joining us in doing that. We want to try to target those very vulnerable children in order to better understand the integrated needs of those youngsters and whether all the social policies that affect them are working together. That is a bit of work going forward.

Our children's services inspections are in the main looking at vulnerable children in the context of universal services.

The Convener: I am sure that we will come back to the issue of integration.

Colin Keir: I will move the focus a bit to the criminal justice and social work side. One of the things that we talked about in the Justice Committee when I was a member and which was seen as a bit of a success was the NHS taking over dealing with the prisons. I know that the ombudsman has highlighted that prisoners have problems accessing the complaints process. Can you tell the committee a wee bit more about that? Has anything been addressed?

Jim Martin: It is two years since the transfer of responsibility for the health of prisoners from the Scottish Prison Service to the National Health Service and we are beginning to get to the stage at which we are sorting it out. In the initial stages there was a very poor approach to due diligence on this issue: there was a presumption that the National Health Service could simply cope with what went on in prisons without looking at the quality of what was happening. For example, in the last year that the Scottish Prison Service had responsibility for health, 511 cases were referred to the Scottish ministers to appeal against decisions taken about the health of prisoners. In the first year that the National Health Service had responsibility, the equivalent action was to send a complaint to me; I saw 46. That told me that either we had done very well or there was an issue. Over the last year we have found that the different health boards have been interpreting the central advice on how to deal with prison complaints differently, even though the advice all comes from the same letters of instruction.

The health service has now got its act together and is beginning to work out that the "Can I help you?" guidance, which is the health service complaints procedure, needs to be applied uniformly and that people need to understand how it works. For example, one health board wrote to us to say that before a prisoner could raise a complaint about health care it was mandatory to fill in feedback forms and go through a feedback process. That instruction had not come from the centre, but was being applied by one health board. The health service is now on top of that and we are beginning to see some excellent practice. For example, some of my people recently saw really good work from NHS Tayside in Perth prison. We are beginning to address the problem, but we are two years on. There are lessons for the future: if we are going to have more structural shifts of responsibility and make more changes, we must do the appropriate due diligence in the first place.

Colin Keir: One of the reasons the transfer was seen as the right move was the throughcare of prisoners, from the point at which they came into prison. For instance, after their release it might be known that there was no GP contact or whatever.

Paragraph 6.2 of the Care Inspectorate's submission refers to cases of people who are committing serious crimes after release from prison. How do you see the review facilities evolving at all levels as somebody moves through these processes? Obviously, local authorities deal with this. How do you check to see that the right thing is being done from the perspective of someone moving from prison all the way through to the initial release? There have been problems in the past with people being released at 5 pm on a Friday with no support services. How do you check the individual difficulties across the country, in the knowledge that we hope to find a system that is robust enough to look after those being released?

Annette Bruton: Obviously, we also work with our colleagues in HM Inspectorate of Prisons. We have been meeting with them recently to talk about that journey. We have a clearly-defined role in the Care Inspectorate. Our job is to look at criminal justice social work, which is run by the local authority. We have discussed with HM inspectorate of constabulary for Scotland and HM inspectorate of prisons for Scotland how we can do more joint work around exactly the question you ask, because we have three parts to the jigsaw.

At the moment, to get a better understanding of how effective criminal justice social work is, we are doing a study that will look at every criminal justice social work department in the country, in all 32 local authorities. The most recent study of that type was done by the Social Work Inspection

Agency, and its report found a lot of significant weaknesses in criminal justice social work at local authority level. Because of that, our study is a combination of looking at the evidence and supporting self-evaluation to help to drive up standards in each of the 32 local authorities. The study will last 18 months, at the end of which we will publish a report that will give a view on the degree to which criminal justice social work services are improving. We hope that it will also lead to improvement as we go along, as our intelligence tells us that some of the same significant weaknesses that the SWIA report found still exist.

We are trying to identify good practice, support improvement and work with the other organisations that are interested in criminal justice social work. That includes, for the first time, having Care Inspectorate presence in the young person's unit at Polmont. We are working collectively to do those things, but we know that there is a need for significant improvement around criminal justice social work in Scotland.

Colin Keir: That is fine. I am aware of the time, so I have no more questions.

Rhoda Grant: I want to address the issue of personal assistants. In your submission, you point out that that issue is not covered by the regulatory regime. There is a move to give people more control of their care through self-directed support: their own budgets and the like. I have spoken to people who feel that they have to take on the role of employing someone directly, because the statutory services do not provide the flexible support that they require, especially in the case of adults with learning difficulties who are looked after by an elderly parent. What can we do to put that right? There seems to be a vulnerable group of people who are dependent on others and who may lack the training or knowledge to get protection—such as having a criminal record check done. I am interested in your views on how we might tackle that.

Annette Bruton: The Care Inspectorate supported the Social Care (Self-directed Support) (Scotland) Bill throughout its process. We support the principle, because we believe that people should be given as much control and ability to manage their own affairs as possible. We are very supportive of self-directed support, but we are conscious that it poses us particular challenges in the regulation of care.

It is right that we do not have the power to walk into someone's home to inspect their care for them, but we are working with the Scottish Social Services Council to look at issues to do with professionalism, support and flexibility in services so that people can either choose self-directed support or work with their local authority to get support that has been commissioned for them. We are also looking at ways in which we can support those who are managing their own support.

We have a significant number of people who manage their own support on our involved people group, which advises us on the issue. We are trying to find ways in which we can make available to members of the public who are directing their own support or who are receiving support from a commissioned service an easy way to contact the Care Inspectorate to get the care and advice that they need. We are looking at ways in which, if people need our support in getting a view on whether their service is up to standard, we can flexibly provide that. We are also acutely aware that we need to give control of that to the people who directly support themselves. We are looking at best practice models of care that are provided by agencies, directly by local authorities, by third sector organisations and by private companies to see where the best possible practice is in ensuring that the services put people's needs at the heart of what they do.

In answer to Mr Doris's earlier question, I mentioned that the whole area of care at home is one that we need to take a much deeper look at. We need to find mechanisms by which we can do that without being intrusive in people's homes but, nonetheless, get the intelligence that we need to show where services are performing well. We are currently working on a new methodology for that, which we will produce in the course of the next year. We are trying to base that on the advice of people who use services.

We hear a lot about people's concern about care homes, which is quite right, but our organisation is equally concerned to ensure that the quality of care at home is good enough. Currently, we do not think that it is always good enough.

11:45

Rhoda Grant: An issue that people have raised with me is the lack of support with recruiting and screening, to ensure that personal assistants have the right qualifications. I suppose that people do not have the resources to do that. For example, they cannot contact the police to ensure that someone is suitable for the job that they would be asked to do, and they cannot check up on qualifications and references—it is about the knowledge that people need if they are to recruit properly and safely.

People seem to be caught between a rock and a hard place. Either they take the service that is provided and have very little control over it or they take control of the service but have little support to enable them to do so safely and properly. The

Care Inspectorate is considering how to support people when things go wrong; is there any way that you can assist people so that we prevent things from going wrong in the first place and people feel that someone is in their corner supporting them through the process? I am thinking about people having to run the gauntlet of issues such as tax and contracts, but I am also thinking about safety.

Annette Bruton: You ask a very good question. There are a couple of things in that regard. First, when people decide to direct their own support, that does not mean that the local authority no longer has responsibility. We expect that the kind of support that you are talking about could and should come from the local authority.

It seems to me that it is within the gift of the Care Inspectorate to develop support materials and packs and perhaps some kind of online advice resource or DVD that people could use. We are learning a lot about how self-directed support works and where it is working well, and we are capturing some of that best practice. We certainly do that from a professional point of view, but your question has made me think that we could do more with our resources to develop support materials. Whether the Care Inspectorate would have the capacity to provide a one-to-one service is a far more testing question; we are not resourced to do that. However, we can consider where self-directed support is working extremely well and try to share some of that learning with members of the public.

Paul Edie: There are voluntary sector organisations that support people who opt to take direct payments and hire personal assistants—Lothian Centre for Inclusive Living springs to mind. That sort of approach, which is well established across Lothian, could be built on. Other voluntary organisations and a national umbrella group cover the area.

Rhoda Grant: I am aware that there are some good groups out there that are helping people, but not everyone knows where to access such support and everyone has slightly different needs. I suppose that it is about trying to equip people with the knowledge that they need.

There are also issues to do with the minimum qualifications and training that personal assistants should have. A person might get their own budget, but it will not include a training budget to develop the skills of the person who is working for them, to ensure that they can meet their needs.

Paul Edie: When a person applies for self-directed support, councils have a role in assessing whether they are capable of taking on that responsibility. I do not know whether more can be done to signpost people to independent living or other support organisations at that stage.

The Convener: What information do you have about complaints that clients pass to local authorities? The complaints that members hear are about the 10 or 15-minute care visit to give someone a meal and about continuity of care—a client might get eight, nine or 10 different carers coming to their door over 10 days, which can be upsetting.

Do you have access to the actual complaints from those clients, whether they are dealt with properly by the local authority or ignored? It seems to me that that is a good source of information on what is happening on the ground. Do you know the level of those complaints?

Annette Bruton: The Care Inspectorate does not get sight of those complaints. We are sometimes copied in to a complaint, but we do not have a locus in investigating complaints that go to local authorities. People sometimes complain directly to us and a local authority at the same time. Mr Martin might want to comment on what happens when a complaint has been through that process and comes to him, but we do not have a systematic way of seeing all those complaints. For example, there is no requirement on local authorities to tell us about all the complaints on care services that they have had.

Jim Martin: When we see individual complaints, we see many of the things that the convener describes. However, I am not aware that anyone in Scotland collates local authority complaints generally, never mind in relation to care. By contrast, the Scottish health council is beginning to collate the returns from health boards on health complaints this year and to consider what information they provide. I do not believe that there is a similar process in local authorities, even though we have recently established uniform complaint handling procedures for local authorities over the piece, and there are networks of people who operate complaints systems.

There is an opportunity for local authorities generally in Scotland to get more value from the complaints that they receive and to share the learning from them across local authorities. However, I do not think that that is really a matter for this committee. Given that each local authority is a separate democratically elected body, and that local authorities guard that status carefully, bodies such as the Improvement Service and perhaps the Society of Local Authority Chief Executives and Senior Managers and the Convention of Scottish Local Authorities could perhaps take on that work as something that would add value to the service that local authorities offer to the public.

The Convener: Does the standard complaints procedure that you have recommended to public bodies, including local authorities, suggest that it would be good practice to record phone calls and the action taken or, if an issue has not been resolved, the fact that a person has been advised that they can go to an advocacy service? We know that if people go through the whole process for local government complaints, they are usually advised that they can take the complaint to the ombudsman. However, further down the line, if the person is not satisfied with the assessment or the delivery of the service, are they advised that they can take up the matter with their local representative or the Care Inspectorate? Is there best practice out there that clearly shows that?

Jim Martin: Paul McFadden is the architect of the system, so I ask him to respond.

Paul McFadden (Scottish Public Services Ombudsman): There is more than best practice. We now have a fully implemented and standardised process for all local authority services, with the exception of those relating to social work, on which there is separate statutory provision and on which there has been further discussion with the Scottish Government and partners.

On the question about the procedure and the requirement to record, report and learn, when we started out to design the new system, we had been asked by the Sinclair report to get a better focus on performance in complaints handling, including on issues such as cost, and, importantly, the learning from complaints. When we looked at the system that was in place and the information that was available, it was clear that inconsistency and poor recording meant that that was not possible and was not happening. Therefore, the new system that we have put in place for local authorities and other parts of the public sector includes a requirement to record all complaints, including those that the convener referred to, which are the front-line complaints that are taken by telephone or that involve a relatively straightforward issue.

Going further than that, each local authority is required to report internally and externally on a quarterly basis on the complaints that it has received. Externally, that is less about the data and information—although those are important—and more to do with the outcomes, the actions that have been taken and how the local authority has improved as a result of the complaints that it has received.

In terms of learning, we have established networks of complaints handlers in the sector, as Jim Martin said. The aim is to take the annual information that local authorities are now required to publish on key performance, and what they have learned from complaints, and to start learning lessons from that. There is a robust system for local authority complaints, although social work complaints are separate from that because of current legislation.

The Convener: I would like to ask two brief questions. Some of the areas that have been discussed, such as assessment and care packages, would involve social work, so they would not be included. Is that right?

Paul McFadden: Yes.

The Convener: Getting home from hospital, if you found out that care workers were supposed to be there on the Saturday morning but were not there, would that be social work?

Jim Martin: Annette Bruton tells me that it comes to us, but a person could take it to the Care Inspectorate. They could also take it to the NHS, and I am sure that we will go on to talk about integration. If someone is discharged from hospital on an assumption that certain things are in place, and they arrive to find that they are not in place, it could be the case that the provision at the home end—whether in a care home or in the person's home—has fallen down, or that the system in the hospital for making a decision to discharge someone was deficient.

In my view, if we are truly person centred, the person who finds themselves in that position should not have to worry about who is going to look at the issue, but should know how it is going to be done and when. That is where the joined-upness and integration come in, but at the moment we have disparate ways of dealing with those things. Is that fair?

The Convener: Annette Bruton does not necessarily need to comment.

The only other question is about the new complaints procedure that you have described. Were local authorities involved in developing that?

Paul McFadden: Yes, we worked in partnership with SOLACE, COSLA and a group of representatives from the sector to help develop it.

The Convener: So, local authorities have all that information now. How many have said, "Thanks very much. We'll implement it immediately"?

Paul McFadden: All local authorities have implemented the complaints handling procedure in relation to their services outwith social work. This is the first year of operation, and the public quarterly reporting is identifying some issues about consistency and robustness of data, and we are working with the network on those. By the end of the first full financial year, local authorities will be under an obligation to publish information on

complaints against a set of key performance indicators, and we expect that to happen quite quickly.

The Convener: So will we not see any real public evidence of that until after April?

Paul McFadden: After April, once it is collated and published by each individual authority.

The Convener: That was helpful. Thank you very much.

Richard Lyle: I will stay on the subject of complaints. I refer to Mr Martin's report, and I am sure that Mr McFadden will also want to come in on this point.

The Scottish Public Services Ombudsman's report states that

"in the first three quarters of 2013/14 we have seen a 17% increase in complaints received on top of last year's increase of 23%."

However, what jumps out at me is a point on which I would like an explanation. The report states:

"For example, in my health complaints report, I highlighted the importance of the numbers we uphold as an important indicator. I remain concerned when I see cases where the health board found nothing wrong and yet we find significant failings."

Why can you find failings and yet the health board tells people, "No, your complaint is unjustified. We don't find in your favour"?

Jim Martin: Before anyone can bring a health complaint to me, they have to have gone through the local system. Sometimes people can be in that system for a long time before they get to me, and there has often been a great deal of examination of a complaint. It is one of the most frustrating parts of my job. Medical advisers say things such as, "Jim, this is a slam dunk. This is obvious." In those cases, I think that citizens have been let down badly.

When we go back to boards, we find that there can be various reasons for that. Sometimes things can be missed, and sometimes decisions can be reinforced up the chain, because people do not want to undo a decision that has been made. Sometimes it is as simple as people getting legal advice that it is better not to admit to failing.

12:00

Last year, I took the initiative and spoke to each of the health board chief executives as well as a significant number of non-executive board members. Over the past year, there has been a game-changer in the form of the Francis report in England, which showed that when complaints are not listened to, people lose their lives and, furthermore, that non-executive and executive board members have a duty of care to individuals, including ensuring that they examine complaints. As a result, we have been working with non-executives and others to make it clear that the complaints process should be part of their governance.

I realise that I am taking the long way round to answering your question; what I am trying to say is that we recognise that this is a problem and are working with boards to ensure that they are aware of it, that they are addressing it and that there is closer and better scrutiny of any complaints that are made. The fact that year after year I am consistently upholding more than 50 per cent of health complaints that have already been through health boards is, in my view, unacceptable, and we are trying very hard to put pressure on boards and others to get that number down. We do not have many sticks, but we are trying to work with people, improve processes and ensure that there is better complaints handling and appropriate investigation of complaints. We bring people to our office to show them the standards that we apply in coming to a decision. If, when I leave office, that particular percentage is half of what it is today, I will regard that as a success.

Richard Lyle: Actually, my next question was about the very fact that you are still upholding more than 55 per cent of complaints. Obviously there are certain issues on which all boards will receive similar complaints. Are you working with each health board to target the problems that you perceive them to have, as a result of the complaints that you have received, on the assumption that if they can get rid of, say, this or that pyramid the percentage of complaints being upheld might come down?

Jim Martin: I have two points to make in that respect. First of all, the national health service in Scotland is very good at capturing whatever can be learned from the decisions that we publish and making boards aware of what has happened. Over the past 18 months, boards have taken greater cognisance of what we are doing. I am not sure whether that is down to the effect of the Francis report or boards being in a better place culturally, but it is happening.

Secondly, I think that the answer to all of this—and the question itself came up in the previous session—is that cultures take a long time to change. I am beginning to see and feel more confident that more people are recognising that it is not enough for those at the top of the organisation to say to those who work on the wards, "Get your act together and improve." Instead, they have to understand the context in which they are working, put in place the tools and training that people need in order to improve and lead by example from the top. That is how we are

going to improve things in the longer term. I do not think that you can legislate for better care; instead, it is all about the day-to-day performance of the people on the ground and the leadership that they get.

Richard Lyle: Thank you.

Malcolm Chisholm: I have a question for the ombudsman and another for the Care Inspectorate.

I listened to what the ombudsman said about the Francis report being a game-changer with regard to complaints—and perhaps wider than that—but I remember that, a year ago, he said that his predecessor had listed 10 key issues that faced the health service and made it clear that the fact that those issues had not changed raised questions about whether our regulatory model was producing improvement and operating efficiently. Mr Martin, I am encouraged by the fact that you have answered that to some extent with reference to the Francis report, but I presume that it does not cover all 10 issues that your predecessor highlighted. Given your experience, what is your more general take on the health service? Notwithstanding the comments about improvements in your previous answer, what issues are still proving to be intractable?

Jim Martin: For me, communication is the single biggest area of concern—communication between professionals and patients, between professionals and patients' families, and among professionals, by which I mean horizontally and vertically. It is about ensuring that everyone is speaking the same language and that what they are saying is understood.

When we unravel things, we will always come across cases in which someone has done something that, professionally, they perhaps should not have done. We will come across cases in which people have made errors. Underpinning most of people's discontent, though, is a lack of communication and a lack of understanding of why things went wrong.

I say often that, by and large, the people who come to me tend not to ask for money. They often ask for the chief executive's head, but what they most ask for is an explanation and an assurance that the lesson has been learned so that other people might not suffer in the same way.

The thing that I bang on about—I thank the committee for the opportunity to do it again—is that if we truly believe that the national health service should be person centred, communication is at the heart of that. My great fear is that we will say "person-centred care" so often that the phrase will carry as much weight as the phrase, "Our people are our greatest asset," which I and committee members have heard in all the presentations that we have sat through, carries. Every time I hear that phrase, I hear people in the room sigh.

We have to live and breathe person-centredness, and for me the critical element in that is communication.

Malcolm Chisholm: That was extremely helpful. Thank you.

I have a question for the Care Inspectorate. I am particularly interested in what happens during the inspection process. To some extent, that was covered in your response to the convener's initial questions. Let us look at the typical annual unannounced inspection that all care homes have had from the start—with the exception of the brief period before the 2011 announcement. I am trying to get a feel for what that inspection is like.

You said that more specialist staff have been recruited. What would be the typical staff mix during an unannounced inspection of a care home? How long would inspectors have to do the inspection, compared with in previous years? Will you clarify how many themes are covered? I am not sure whether an inspection always focuses on all four themes rather than just one.

You are still inspecting against the care standards. Can you say anything about your involvement with the development of the new care standards? Do you expect them to be significantly changed? I presume that that is still critical to the whole inspection process.

Paul Edie: You asked an interesting question, and I will get Annette Bruton to respond to the substantive points. Let me issue an invitation to committee members. If you want to shadow an inspection, please get in touch with us and we will happily set that up, so that you are more informed. I think that all members of our board have done that at some stage, and it has been a useful and interesting insight into operation on the ground.

Annette Bruton: In the inspection of a care home, we plan to cover all four quality indicators. Since 2012, we have made substantial progress on ensuring that all four quality indicators are covered in each inspection. However, some care homes require to be inspected several times in the year. When that happens, the inspection focuses on the area about which we are most concerned. For example, if we inspect care and support and participation, and participation is fine but care and support is poor, we will focus on that quality indicator for the next inspection—which might be in a few months' time, rather than a year's time. The plan is to ensure that we cover all four quality indicators in the year, but in some cases, where we have concerns about the inspection, we will focus on the area of greatest concern.

Depending on the size of the care home and what we already know about it, the initial inspection in that year could involve two, three or more staff. If it is a high-performing care home and all the evidence supports the view that it will continue to be high performing, we might have one inspector go in on an initial inspection. However, what they find might lead to a follow-up inspection, for which more inspectors would be required. If we carry out an inspection over four days with three staff—if that is what we have assessed that the care home needs—and find very serious concerns, we can ask for specialists to come in either at that point or in a couple of weeks' time. If we need a tissue viability specialist or a pharmacy specialist, we have those teams at our disposal. If we had very serious concerns, we would not leave the inspection; we would continue it and bring those specialists in, to have a more in-depth look.

There is not a single model of inspection. We have agreed with our board that across all care homes we need to apply more resources, so that bigger teams go into care homes as standard. Not only do we want the four quality themes, but, whether or not we have concerns about a care home, we want to put more resources into its inspection as standard. Any inspection is based on intelligence that we have and is a snapshot in time.

The concerns that we have about a number of care homes, which you will have read about in the press, were uncovered by an unannounced inspection. However, in the previous year those care homes had showed good signs of improvement, or we felt that they were doing well. There is a risk that things can quickly go wrong in an inspection. We need to put more staff into inspections and we are looking to see where we can make savings across the Care Inspectorate to beef up the size of teams and the depth of inspections in care homes and of care at home.

Malcolm Chisholm: You implied that specialists would come in on special cases. I suppose that my question is related to the one in six staff who have been recruited recently. I still have not got a clear picture of the background of what you might call the routine inspectors. Is there a mixture of backgrounds?

Annette Bruton: There could be a mixture of backgrounds. If the inspection was of a care home that provides a high degree of healthcare, we would want the link inspector. Every care service in the country has an allocated inspector, who will always go. They might be accompanied by other inspectors, depending on the skills mix that we need. A typical care home inspection would have people with a health background—perhaps a nursing background—and a social care background. We have a small team of healthcare professionals who provide specific advice.

I interpret your question as driving at whether everybody has a broad level of all the skills. The answer to that is yes. One of the jobs that our specialist team does is training for our staff. This week we are having a learning week for our staff. There is training for everyone—whether refresher or new training—on infection control and dementia. In a number of areas, inspectors will routinely encounter critical issues around care homes or care at home. They have training to enhance their normal professional skills.

That is a move from a more generic approach to inspection, in which somebody from an early years background could have inspected a care home if we thought that it was a low-risk service. However, because we believe that there are basic and inherent risks, we are moving people into their own specialist teams.

I hope that that has clarified the point.

Malcolm Chisholm: Thank you. That is very helpful.

The Convener: Would the renewal of national care standards help the environment that you work in? Would that provide some clarity?

Annette Bruton: Thank you for the prompt, convener. That was part of the question. We have seconded a member of staff part time into the policy team that is developing the care standards. We are keen to be fully engaged—as, indeed, are our colleagues in HIS—in developing the care standards, although the care standards sit not with the Care Inspectorate or HIS, but with the Government. Our job is to inspect against them. The care standards have stood us in good stead. However, they need to be updated and they need to be more flexible to deal with the different kinds of care that are available or which people seek now.

In the Care Inspectorate, we have a strongly held view, which is shared by the board and the staff, that Scotland should have a set of care standards with human rights at their heart and that we will be able to qualify the quantity or quality of the care once we have that framework for standards. Although the current care standards are full and technical, they do not sufficiently put to the fore people's right to manage their own care to the best of their ability and the safeguarding of their human rights. A new set of care standards would allow us to apply a stiffer test of standards and inspections.

12:15

The Convener: Why has it taken so long? The Government agreed and responded positively, as

did most people. We had care standards that were a decade old and needed to be renewed. We are a couple of years down the line. What are the barriers to confirming new national care standards?

Annette Bruton: We have the resources and we have made clear our support for the new care standards. The time that has been taken has related to establishing the policy position on the approach to the standards. I do not want to speak on behalf of Government colleagues who are responsible for developing it, but I know that work has been going on, that the group that is overseeing the review of the care standards has met and that a consultation on the approach to them is imminent.

The Convener: We cannot leave this evidence-taking session without considering the Public Bodies (Joint Working) Scotland Bill—the integration bill—on which the committee has been working and providing some scrutiny.

Mr Martin had some views—I do not know whether he has changed them—on complaints procedures and the cluttered landscape of regulators, which can become a barrier to making progress. I ask him whether those barriers are less than he originally thought or whether he is reassured by some of the Government's comments and some of the amendments that have been made to the bill.

The other question, which is for Annette Bruton, concerns the Care Inspectorate and HIS working together more effectively. Does there need to be more than just working together? Do we need some integration of those bodies?

I do not know whether there was a question or two in there, but whoever likes can answer.

Jim Martin: After that and Malcolm Chisholm's question, I am beginning to wonder whether this is an examination of whether I remember what I said at the last meeting that I attended.

My view on the matter has not changed at all. When I was here in October, I think I said that when we get to integration it is important that the people who are at the centre of it—who are often vulnerable people—have a clear pathway, that it is as simple as possible for them and that we ensure that we have aligned all the complaints processes so that we do not get ourselves tied up in bureaucratic delays or put difficult decisions to one side. An holistic view has to be taken.

I understand that, behind the scenes, there seems to be a consensus that there should be a single point of entry. I very much welcome that. However, it concerns me that it seems to be taking an awful long time to get the machinery in place beyond that. As I said earlier, if our approach is really person centred, it is important that, once we put in place measures for integration, those often vulnerable people quickly know where to go when things go wrong or when they are unhappy.

I am pleased to say that my position is consistent with what I said the last time that I came to the committee. I urge the committee and the Government to push things forward, to get a move on and to get the measures in place as quickly as possible.

Paul Edie: I shall kick off and Annette Bruton can pitch in later. Social Care and Social Work Improvement Scotland is a non-departmental public body, so we are independent of the Government, but we implement Government policy. The discussion about further integration, or formal integration, is really a party-political matter and we do not take a stance on it.

We will implement and work with whatever the Government of the day's policy is. If the Scottish Government—whoever that is—turns round and says that we must merge with HIS, we will do that. If it says that we must take on an inspection role, we will do that. If it says that we should leave things as they are, we will do that.

We would hope that when you as parliamentarians are deliberating on this, you are cognisant of the fact that the bulk of our activity is related not to adult social care but to children and families services. We inspect a broad range of services, but that is still the largest component of what we do.

Annette Bruton: I echo that point. The case for inspectorates working in a more joint and integrated way is well made. It is almost exactly a decade since the then care commission, Her Majesty's Inspectorate of Education and Healthcare Improvement Scotland's predecessor body NHS Quality Improvement Scotland demonstrated that they could come together and bring to Scotland a new approach to looking at the effectiveness of child protection, add learning into the system and work in an integrated way that would be well received by the bodies that were being expected to work together to deliver child protection, including Her Majesty's inspectorate of constabulary for Scotland. Irrespective of any structural changes around scrutiny bodies in the Scottish landscape, we have demonstrated over a decade that the integrated model can be efficacious and can deliver very well on those areas for children. We have now seen the expansion of that work into children's services.

Almost 6,000 of the 13,500 services that we inspect are children's services in one form or another. We also inspect fostering and adoption agencies, as well as a range of services for people with special needs and adults with learning

disabilities and mental health services. In integrated health and social care—which might expand later to include all those groups and indeed children—there are areas where we would hope to get the same efficacious effect from joint inspection as we have had in child protection and children's services. That includes the pathway that people need to follow—and sometimes come back down—towards supporting themselves in their own home and goes right through to acute care and older people's services in the community. When it comes to care at home, we know that the health component, the care component and the social component—the part that people's families play—are all very important.

I am trying to reassure the committee that whatever structure the Government and the Parliament want scrutiny bodies in Scotland to have, it is possible for us to work together in an integrated way. In the meantime, that is what we will do. We will try to mirror the experience that we have had of working in children's services and bring it to adult integrated services to support the transition of the Public Bodies (Joint Working) (Scotland) Bill through into an act.

The Convener: I would not expect you to defy the will of Parliament. I would not expect nurses or social workers to defy the will of Parliament, but they have views about that coming together. They face challenges or perhaps have fears about their ethos being overtaken by the ethos of others.

Given the presentations and evidence that we have had over a long period, I think that the Care Inspectorate has a clear focus. It ensures that people can complain and supports them in that process. That is not always mirrored in the health service. Sometimes someone complains and the health service just sees pound signs and gets very defensive.

It is about the good coming out of this joining together of systems, rather than one system dominating another. There is an opportunity not just for joint working but for new thinking about how we deal with people, as we treat people in the community more often. If we have difficulty in the secure setting and the home care setting, and if we have difficulty guaranteeing standards in hospitals, we will need the Care Inspectorate's ethos to be dominant—again, was there a question in there?

Paul Edie: That was going to be my question for you, convener—

The Convener: Your board has not expressed concern and is just passive in the process. Is that what you are telling us?

Paul Edie: This is a party-political issue, convener. We have discussed it, but whether things are brought together is a party-political issue. One party takes a particular stance, and our board would not feel at all comfortable involving ourselves in the debate. I am sorry if that is not the answer that you are looking for—

The Convener: You are welcome to your view, although I do not know how you arrived at it, because this is a cross-party committee and we all support the integration process and the Government's direction of travel. That is a matter of public record. We just want to ensure that the system works effectively and that people can exercise their rights. We are looking at different aspects of integration, with a view to identifying concerns. If your board does not have a view, that is fine.

Nanette Milne: Mr Martin, when you gave evidence to us last year you were a little uncertain about the impact that the Patient Rights (Scotland) Act 2011 was having. Have you firmed up your view on that?

Jim Martin: When the Scottish health council has brought together the information that all the health boards have provided on complaints and we begin to see a picture in that regard, I think that we will be able to take a clearer view on the impact of the 2011 act. Currently there is inconsistent reporting; the terminology is being taken to mean different things. I think that the health council is on top of that. I hope that this committee and other people will then have a picture of the issues that ordinary citizens across Scotland are concerned about in relation to our health boards—Paul McFadden talked about the picture in relation to local authorities. You will be able to ask more appropriate and informed questions of the NHS and boards when they appear in front of you.

We will be able to add qualitatively to the picture, on the basis of the complaints that come to us. Members should remember that according to the Scottish health council around 10,000 health complaints are made, of which about 10 per cent come to the ombudsman. That is a very high number. I hope that I will ultimately be able to tell you that the numbers are coming down. When we have all the information, I hope that we will be able to take an informed view on whether the 2011 act—or the element of it that we are considering—is effective.

Gil Paterson: I want to pick up on a couple of points. First, Richard Lyle asked about the 17 per cent increase in health complaints to the ombudsman this year, which follows a 23 per cent increase in the previous year. On the surface, that looks like really bad news. However, it could be good news, given that the public are increasingly satisfied with the health service.

In your submission, in the third paragraph under point 1, you touched on the relevance of the figures. Are they bad news or good news? Do they reflect something positive, because we have encouraged and made it easier for staff and the public to complain, or are we in for a bit of trouble, because there are problems in the health service?

12:30

Jim Martin: You must remember where my office is in the process and what I see. I see marathon runners—the people who have the stamina to come to me. The numbers that I deal with must be read alongside the number of complaints to the health service generally. If the trend continues, in two years' time health complaints will be the biggest source of complaints to my office. When I came into office four years ago I never thought that I would say that, because local authority complaints were so far ahead of health complaints.

It is a cultural thing. People are more willing to complain. The publicity around complaints, not just in Scotland but as a result of the Francis report, will have had an impact on that. When we take the figures alongside the information that the health council has and look at the trend over a period, we will be in a better position to be able to make a judgment. Those of you who know me know, I hope, that I am not usually a fence sitter. The paragraph to which you just referred is the nearest that I have ever got in my office to sitting on the fence. What I am really telling you is that I am not sure. I am watching the position closely, and I hope that the committee is doing so too.

Gil Paterson: We certainly are. Thank you for a definitive response.

I have a question for the Care Inspectorate. We very much appreciate the approach of turning up on someone's doorstep. I know from my experience in industry that the best way to see a business is to arrive unannounced. By seeing things in the raw, we can see what is going wrong and what is going right. That is the finest way to come to a judgment about whether change is needed.

You talked about changing the inspection regime slightly so that all four quality themes are considered. Has that had an impact on what goes on? Are standards improving because of the new approach to inspection? Is the situation the same as it ever was? Is it too early to tell?

Annette Bruton: We will report on that when we have a full year of inspections under the new regime under our belt. We will consider whether grades are going up or down and whether there is a trend. Two things are at work in that regard. First, our having specialist inspectors, who have high expectations and really know what they are looking for, is testing services. Secondly, if we look at more elements, those areas are more likely to be tested. Therefore, we think that our inspection regime is more testing.

I have anecdotal evidence, from speaking to our inspectors and from hearing the concerns that some service providers have raised, that our staff are being tougher on providers than they were previously. I welcome and am quite content with that. We do not want standards to drift all over the place so that people do not know what they are. We have had positive conversations with some of the provider umbrella bodies, and if providers get the message and accept that they will have to work to demonstrate that they are meeting the standard, that is positive.

We will need a full year's figures—probably two years' figures—before we are able to see whether there is a trend that justifies the conversation that we are having with providers at the moment.

Gil Paterson: Thank you.

The Convener: If there are no more questions, I thank our witnesses for attending and for their evidence.

12:33

Meeting continued in private until 12:41.

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 978-1-78392-685-5

Revised e-format available
ISBN 978-1-78392-698-5

Printed in Scotland by APS Group Scotland