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Foreword

We are committed to helping healthcare providers make improvements for patients by providing: sound evidence; effective improvement support; and open, informed scrutiny. We have a statutory role to provide public assurance on the quality of services provided and this means an ever-increasing public profile for the work that we do.

As a scrutiny body of the NHS, rather than a regulator, we work closely with NHS boards to inspect and review their services and work with them to apply evidence and provide appropriate improvement support. NHS boards are accountable to Ministers and the Scottish Parliament for the performance of their services and the quality of care.

However, we are a regulator of independent healthcare services and are currently responsible for regulating independent hospitals, voluntary hospices and private psychiatric hospitals. Part of our regulation role is to undertake inspections of independent healthcare services across Scotland. If we find a service is not meeting the necessary standards, the Public Services Reform (Scotland) Act 2010 gives us powers to require the service to improve.

Scrutiny activities in relation to the Participation Standard and Major Service Change is managed and planned by the Scottish Health Council.

We are committed to ensuring that our priorities reflect the things that matter to patients and the public.

We have significant powers to inspect and scrutinise the provision of healthcare. The scrutiny of healthcare is a fundamental part of our work programme. We spend nearly £3m each year on our scrutiny and inspection work – or around one fifth of Healthcare Improvement Scotland’s budget. Each year, we publish nearly 100 inspection and review reports covering a wide range of clinical areas, such as the care of older people in acute hospitals, healthcare associated infection and individual investigations. We have a duty to ensure clarity, focus and value for money in our work.

This document sets out the areas for scrutiny and assurance in 2014-2015 led by the Scrutiny and Assurance Directorate. We highlight why these are priority areas, how they link to the NHSScotland Quality Strategy Outcomes and how we will go about our work.

Over the coming year, we are proposing to:

- further embed the patient and carer experience in our scrutiny and assurance activities to ensure we remain a listening organisation that learns from local feedback
- move towards more comprehensive assessments of the quality of healthcare
- further embed our joint work with the Care Inspectorate and other scrutiny bodies
- continue to work closely with the Evidence and Improvement Directorate to develop measures to support improvement in the quality of clinical care being delivered to patients, and
- use intelligence to determine areas for investigation and review to support improvement.

We see the coming year as an opportunity to manage a transition to a more intelligence-led approach to scrutiny and assurance and to re-align and simplify a range of activities. Our close
working with other scrutiny bodies will also be enhanced. In doing so, we will use this intelligence to guide our priorities and activities, and identify opportunities for more joint reviews.

Finally, this Scrutiny and Inspection Plan sits firmly within the broader context of our new strategy: *Driving Improvement in Healthcare*. Increasingly, Healthcare Improvement Scotland will be adopting a more integrated approach to leading and supporting scrutiny, with a particular emphasis on flexibly applying the skills and experience across the organisation and in NHS boards to assist in driving the necessary improvements in the quality of healthcare in Scotland.

Robbie Pearson
Director of Scrutiny and Assurance
1  Shaping the priorities for independent scrutiny

1.1  Building more comprehensive assessments of the quality and safety of healthcare

Healthcare Improvement Scotland is building a strong, independent and rigorous approach to scrutiny, which is leading to perceptible improvements in the quality of care.

We are approaching the third anniversary of the creation of Healthcare Improvement Scotland. Therefore this is an opportune time to take stock and to ensure a full alignment between our scrutiny activities and the 2020 Vision and the route map to achieve the vision. In particular, there is an opportunity to align and integrate scrutiny activities and to ensure a sharper focus on the overall quality of care in NHS boards, consistent with the NHSScotland Quality Strategy.

At present, it is acknowledged that there is a diverse programme of scrutiny and assurance activities. The breadth of our programme has increased in recent years. It is recognised that this brings its own complexity. There is scope to build a more cohesive, integrated and comprehensive approach to the scrutiny of healthcare in each NHS board. Such an approach would allow a marshalling of currently separate inspections and reviews into more comprehensive quality and safety assessments.

Comprehensive quality and safety assessments would also potentially cover new terrain including the workforce (such as staffing levels), leadership and patient listening exercises. They would also bring together other areas of work such as:

- an assessment of the implementation of the safety programme
- review and development of measures for clinical care
- clinical governance processes, which would include, for example, the management of adverse events
- the barriers to seamless transfer of patients from acute hospitals into the community
- unscheduled care (including A&E services); critical care
- child and maternal care
- care of older people in community hospitals inspections, and
- assessment of primary care.

The comprehensive quality and safety assessments would give a broader perspective of the quality of care afforded to patients.

In moving to this new approach, it is important that we evaluate the recent rapid review in NHS Lanarkshire and take time to consider the implications of this approach for the overall shape of scrutiny. It is unlikely that a new approach would be fully established before April 2015, but steps could be taken during 2014-2015 to further examine practical delivery. It is essential that any new model is fully aligned to our broader strategy: Driving Improvement in Healthcare.
1.2 Sharing and using intelligence to guide priorities for scrutiny

Healthcare Improvement Scotland is committed to taking a proportionate and risk-based approach to scrutiny that ultimately supports improvement in healthcare. This means that not all NHS boards and healthcare providers will receive exactly the same level of scrutiny. In time, those that are performing well are likely to receive less, and those who require more support will receive more.

Over the course of 2013-2014, we have been working with a range of organisations such as NHS National Services Scotland and Audit Scotland to consider how we can share data and information more readily. This will help us to prioritise areas that require review and support. This work has demonstrated early promise. It has shown the opportunities for information to be collected and shared that allows a fuller and more comprehensive picture of the quality of care in NHS boards. We will use this intelligence in an increasingly systematic way to inform how we deploy our resources.

In the latter part of 2013, the Scottish Government commissioned us to review the quality and safety of care in an NHS board area. This review generated a large amount of information that has been used to identify areas for improvement. The review has also given us the opportunity to reflect on the implications more generally as to how data and intelligence is used to inform scrutiny of healthcare in Scotland.

In 2014-2015, we propose to work with a range of bodies, including NHS National Services Scotland, the Care Inspectorate, NHS Education for Scotland, the Scottish Public Service Ombudsman, and Audit Scotland to establish a Healthcare Intelligence Review Group. The Group will provide a forum to share data and information to build as comprehensive a picture as possible about the quality of care in NHS boards and to use this intelligence to determine how we and our other partner organisations can work to support scrutiny and improvement. We believe, for instance, that there are greater opportunities to listen to patients and the public by sharing and using information from feedback, comments, concerns and complaints to use this information to help inform our priorities. Therefore, we will also look at the way NHS boards are complying with the Patients Rights (Scotland) Act 2011 in managing and acting on feedback comments, concerns and complaints. We envisage using this intelligence to determine independent reviews and investigations and to build more comprehensive assessments of the quality of care in NHS boards. We propose to develop these initiatives over the course of the coming year and to closely involve patients and the public in this work.
2 Improving the quality of healthcare

2.1 Care of older people in acute hospitals

In 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a programme of inspections to provide assurance that the care of older people in acute hospitals is of a high standard. In launching the programme of work, the Cabinet Secretary said: “Quality, compassionate care for older people that protects their dignity and independence, is one of the most sacred duties of any civilised society. It is something I believe we generally do well - but that is not good enough. We must do it well for every older person on every occasion, in care homes and in hospitals.”

Inspections began early in 2012 and by 31 March 2014 we will have carried out 18 announced and 6 unannounced inspections. Inspections include some, or all, of the following:

- treating older people with compassion, dignity and respect
- dementia and cognitive impairment
- nutritional care and hydration, and
- preventing and managing pressure ulcers.

In our most recent summary review report, we described the areas of good practice and the need for improvement across a wide range of priorities.

In November 2013, we published the Whittle Review Report which set out ways in which the methodology for the inspections could be improved. We intend to implement them all, and to ensure they are reflected – as appropriate – in other areas of our scrutiny work. From 1 April 2014, we propose that the revised model will build on our work to ensure that scrutiny is an integral part of the improvement cycle, but not the sole driver for improvement. We will also be broadening out the focus of our inspections to include areas such as leadership and governance arrangements.

We will increase our dialogue with NHS boards throughout the scrutiny process to ensure that we fully understand the wider context in which older people are looked after in hospital and the specific work NHS boards are undertaking to improve the care of frail older people and those with dementia.

This will include the increased use of clinical experts, for example pharmacists, doctors and nurse consultants. Before each inspection, under the leadership of the senior inspector, this ‘expert panel’ will support the inspection team with data analysis and meet with the NHS board to constructively challenge their self-assessment and improvement plans. During the inspection, most of which will be unannounced, they will act as an expert resource to the team.

We will increasingly meet with NHS boards as part of our post inspection follow-up to be assured that improvements are being made in accordance with recommendations made.

In 2014-2015, we propose to undertake 14 inspections of services for older people in acute hospitals.
2.2 Independent healthcare services

Healthcare Improvement Scotland has ongoing responsibilities in the regulation of independent healthcare services in Scotland. We are currently responsible for regulating independent hospitals, voluntary hospices and private psychiatric hospitals.

Regulation includes:

- registration which focuses on providing a licence to operate
- inspection
- complaints investigation, and
- enforcement when regulations are breached.

Part of our regulation role is to undertake inspections of independent healthcare services across Scotland. The inspections may be announced or unannounced. Our inspectors check that providers are complying with necessary standards and regulations including the following:

- the Public Services Reform Act 2010, and
- the National Care Standards, which set out standards of care that people should expect to receive from a care service.

If we find a service is not meeting the National Care Standards, the Public Services Reform (Scotland) Act 2010 gives us powers to require the service to take action and we have powers to take enforcement action.

We will produce and publish inspection reports and improvement action plans on our website approximately 6 weeks after inspections.

The Scottish Government has already consulted on the future arrangements for regulation of other independent healthcare services. We will work closely with the Scottish Government in 2014-2015 to determine their priorities for the further regulation of the independent sector including private dentistry and private ambulance providers.

In 2014-2015, we propose to inspect a minimum of 16 of the 34 independent healthcare providers.
2.3 National screening programmes

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or a condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. Many screening programmes aim to reduce death from a disease by early detection. The effectiveness of all screening programmes is based on high compliance or response to invitations to screening.

Screening has important ethical differences from clinical practice as the health service is targeting apparently healthy people. However, there are risks involved and screening cannot guarantee protection against a disease or condition. In any screening programme, there are false negatives (wrongly reported as not having the condition) and false positive results (wrongly reported as having the condition), and screening is increasingly being presented as risk reduction to emphasise this point.

Following a recent strategic review of the decision-making process for screening programmes in Scotland, the Scottish Government has determined that we will develop national standards and/or indicators for NHSScotland that reflect UK National Screening Committee standards for new and existing programmes. We will work with NHS National Services Scotland, NHS boards and the new Scottish Standing Committee for Screening to develop a robust and proportionate assurance model for screening services in Scotland. The development of new screening indicators for bowel screening and diabetic retinopathy will be taken forward in 2014-2015.

In 2014-2015, we will develop an assurance model for screening services in Scotland.

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2.4 Improving the healthcare of prisoners

Since November 2011, Healthcare Improvement Scotland has been responsible for collaborating with Her Majesty's Chief Inspector of Prisons and providing healthcare advice to prison inspections and support to the management of the Prisoner Healthcare Network. The responsibility for the inspections rests with the Chief Inspector of Prisons.

Her Majesty’s Inspectorate of Prisons has a statutory duty to inspect the condition in which prisoners are held and the treatment they receive. This includes all healthcare and substance misuse services within prisons. This links with our responsibility to support healthcare providers to deliver high quality care, and scrutinise those services to provide public assurance about the quality and safety of that care.

The programme for inspections by Her Majesty’s Inspectorate of Prisons is determined by risk assessment and need. Inspections may be announced or unannounced and result in a full range of recommendations for the Scottish Prison Service and the Scottish Government. An average of four full inspections will take place each year.

Follow-up inspections may take place with the primary objective to assess the progress made in relation to the recommendations following the previous inspection, but these can also be used if the risk assessment process indicates there are issues in particular areas.

Inspection is against a set of criteria described in Her Majesty’s Chief Inspector of Prisons for Scotland’s publication entitled ‘Standards Used in the Inspection of Prisons in Scotland’ and are presented as a set of outcomes, standards and indicators.

We will continue to work closely with Her Majesty’s Inspectorate of Prisons in providing clinical input to the health component of the scrutiny of prisoner healthcare. We will ensure that the output from such inspections informs the priorities and work of the Prison Healthcare Network.

In 2014-2015, we will support 4 full inspections and up to 4 follow-up inspections of prisons. We will also proactively follow up with host NHS boards on health-related recommendations.

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2.5 Quality of cancer care

In Scotland, Quality Performance Indicators (QPIs) have been developed to measure the quality of cancer care against the major cancers. The QPIs have been developed collaboratively with the three Regional Cancer Networks, Information Services Division (ISD) and Healthcare Improvement Scotland.¹

The overarching aim of this work is to ensure improvements in the survival and the experience of patients with cancer. Healthcare Improvement Scotland will begin a focused and proportionate programme to assess the progress of NHS boards, and regional cancer networks, in meeting the measures in the QPIs in 2014-2015.

In 2014-2015, we will assess progress against a small number of cancer QPIs as a first year of scrutiny. We will use this first year of scrutiny against the indicators to test our methodology.

3 Safer healthcare

3.1 Cleaner hospitals, reducing infections

It’s vital that patients have confidence in the quality of care and treatment they will receive if they need to go into hospital; this confidence should not be undermined by the fear of contracting an infection.

Over the past 4 years, there has been a huge effort across Scotland to help reduce healthcare associated infections. Year on year analysis comparing the most recent two years of data (October 2011 to September 2012 and October 2012 to September 2013) indicates that overall there has been a reduction in *Clostridium difficile* incident rates in both 65 and over and 15 to 64 year olds across Scotland.

HEI inspects hospitals to ensure they are clean, hygienic and patients are not at risk of getting an infection. These inspections are both announced and unannounced. This work:

- provides public assurance and protection, to help restore public trust and confidence
- contributes to the prevention and control of healthcare associated infection, and
- contributes to improvement in the healthcare environment including infection control, cleanliness and hygiene, and the broader quality improvement agenda across NHSScotland.

In the course of 2013-2014, we extended our programme of hospital inspections to community hospitals and increasingly adopted a risk-based approach to informing our inspections. We also introduced a system to prioritise requirements in our reports and NHS boards are expected to meet these timescales for improvement.

We will continue to focus on NHS boards whose hospitals present a higher risk and are most in need of support to improve the quality of their care – this may mean some inspections are longer in length. HEI will continue to respond rapidly to any emerging risks or concerns and these inspections are likely to be largely unannounced. In certain circumstances, an announced inspection may be used when it is thought to be more effective in driving improvements. Four weeks’ notice will be given for any announced inspection. Inspection reports will continue to be published on our website approximately 8 weeks after inspections.

In 2014-2015, we will conduct a minimum of 30 announced and unannounced inspections of acute and community hospitals for healthcare associated infections.

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3.2 Learning, improving and reducing risks

Since 2008, the Scottish Safety Programme has provided leadership in establishing reliably safe healthcare in the NHS in Scotland. With a range of elements now under the Scottish Safety Programme, there is scope to ensure robust and proportionate scrutiny of the implementation of the range of measures for acute adult safety. In circular CEL (2013) 19, the Scottish Government set out the need to ensure the patient safety essentials and priorities were consistently and reliably delivered by all NHS boards in Scotland. It made a commitment for proportionate, periodic, scrutiny of delivery through external review, self-assessment and other accountability methods.

We know that the NHS in Scotland already provides excellent care, but we also know that sometimes things do go wrong. Following a detailed review of NHS Ayrshire & Arran’s adverse event management in the spring of 2012, the Cabinet Secretary for Health, Wellbeing and Cities Strategy instructed Healthcare Improvement Scotland to develop a national framework and programme of review of NHS boards, aimed at supporting NHS boards to improve services by learning from adverse events.

In September 2013, we published ‘Learning from adverse events through reporting and review: a national framework for NHSScotland’ which was supported by Scottish Government circular CEL (2013) 20.²

Our national framework supports NHS boards to effectively manage adverse events, to learn from these events and allow best practice to be actively promoted across Scotland that we can continually improve the safety of our healthcare system for everyone.

The national approach provides, for the first time, a national definition of an adverse event: an event that could have caused, or did result in, harm to people or groups of people; and a framework that is applicable to clinical and non-clinical events, across specialties and services.

The framework outlines the initial actions we are leading to drive implementation of the national approach and these will continue throughout 2014-2015. This supports NHSScotland’s strategic aim of reducing avoidable harm. In the course of 2014-2015 we will be embedding this work into our wider safety improvement initiatives.

3.3 Mental health services and suicide reviews

When a suicide takes place, the effects are devastating for relatives, friends and healthcare staff involved. NHS boards need to understand what happened and learn from any lessons identified. The lessons learnt are important to improve services and help staff recognise where risk exists.

Information from the Scottish Suicide Information Database indicates that a large proportion of those who complete suicide in Scotland have made contact with NHS services. Thirty percent of people who die by suicide in Scotland have been in touch with mental health services in the previous year.

Mental health services use suicide reviews to analyse what happened and recognise what can be done to make services safer for other people at risk. The Suicide Reporting and Learning System supports NHS boards to improve the way these suicide reviews are carried out and help identify and reduce this risk. In particular, we:

- analyse mental health services’ suicide review reports and subsequent service improvement summaries to:
  - provide feedback on review processes and produce national guidance on how to improve the effectiveness of suicide reviews, and
  - identify national learning points to inform local and national service improvement
- work closely with the Mental Welfare Commission for Scotland and ensure it is notified of issues relating to the individual service user’s care or welfare
- promote peer support and sharing of experiences between people working in mental health services and key stakeholders through the Suicide Review Team Network
- provide a community of practice online resource with a focus on learning and development for staff involved in suicide reviews and who work to make mental health services safer for people at risk of suicide, and
- contribute to the implementation of the Scottish Government’s Suicide Prevention Strategy 2013-2016, including our commitment to support improvements for NHS boards that focus on areas of practice which will make mental health services safer for people at risk of suicide.

We will continue to support NHS boards through this programme of work to improve mental health services for patients at risk of suicide.

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3.4 Safer maternal and infant care

We are firmly embedding our previous scrutiny activities in this area in our Maternity and Children Quality Improvement Collaborative (MCQIC). We have a wealth of information to help us inform our work in the care of mothers and infants around the time of childbirth.

Until December 2012, Healthcare Improvement Scotland was responsible for collecting, reviewing and reporting on maternal deaths, and separately, stillbirths and infant deaths in Scotland. Information on maternal deaths was submitted by us to the UK confidential enquiry. We jointly, with Information Services Division, published an annual report on stillbirths and infant deaths entitled ‘The Scottish Perinatal and Infant Mortality and Morbidity Report’ (SPIMMR). From January 2013, all cases of maternal, stillbirth and infant death are reported directly to a consortium (MBRRACE UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) which was appointed by all four departments of health to manage the UK confidential enquiries. A Memorandum of Agreement is in place with MBRRACE to ensure Scottish data are available for local analysis to inform improvement programmes and monitor local services. Currently Healthcare Improvement Scotland is continuing to collect information and co-ordinate reviews on Sudden Unexpected Deaths in Infancy.

During 2013-2014, we are completing the 2012 reports for the Scottish Confidential Audit of Severe Maternal Morbidity (SCASMM) and the Scottish Perinatal and Infant Mortality and Morbidity schemes. Once these are published, the Reproductive Health Programme transition to MBRRACE will be completed.

We will ensure the findings from these reports are fed into the MCQIC programme of work to inform improvements in maternal and newborn care.
3.5 Investigating staff concerns

Public Concern at Work (PCaW) provides a pilot alert line for 12 months from April 2013 to all NHS staff across Scotland to allow them to seek advice about concerns they may have about the NHS. Where PCaW considers that there is a public interest and the internal process appears to have been exhausted, or the individual has sound reasons for not raising the concerns with their employer, it will direct the individual to other organisations to investigate further, which includes Healthcare Improvement Scotland.

All concerns made to Healthcare Improvement Scotland are subject to a level of assessment and investigation. The depth of the individual investigations will be determined based on:

- the risk the concern could lead to (or actual) harm of patients and/or staff, and
- the wider potential benefit (across an NHS organisation and NHSScotland) the investigation could have to enable learning that will lead to improvement from any issues that may be found.

Over the pilot period, we will continually review and refine the process of assessment and investigation to ensure that issues and concerns are appropriately resolved.

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4 Delivering more integrated care

4.1 Joint inspection of children and young people’s services in local authorities

In September 2011, the Minister for Children and Young People and the Minister for Public Health directed the Care Inspectorate to co-ordinate and lead on developing a model for the scrutiny of services for children. Ministers want a co-ordinated approach to scrutiny which:

- improves outcomes for all children and young people
- provides assurance about the cost of services for children particularly vulnerable children and young people, and
- helps to improve services and builds capacity for improvement.

Multi-agency partners have been drawn from health, social work, the Police and Education in Scotland. Healthcare Improvement Scotland is one of the partners.

The work supports the implementation of ‘Getting it right for every child’. The work will not replace existing approaches to self-evaluation and quality improvement, but will streamline the work that a range of agencies are taking forward in this area.

There will be six joint inspections of services for children within 2014-2015. Local authorities will receive a notification 12 weeks before any onsite scrutiny activity. Reporting will take place 10 weeks after inspection. Inspections will:

- be to a local authority area and the community planning partnership will be viewed as responsible for the planning and delivery of services for children in that area
- have a multi-agency and strategic approach and in so doing will not evaluate the effectiveness of individual services, but consider the effectiveness of integrated working to improve outcomes for the most vulnerable children
- report publicly on the question: How well are the lives of the most vulnerable children improving?
- be multidisciplinary and inspection teams will mirror the range of expertise required to plan and deliver successful outcomes for the most vulnerable children. This will include meeting the health needs of vulnerable children.

In 2014-2015, we will deliver, with the Care Inspectorate (as lead agency), a programme of joint inspections for children and young people’s services.
4.2 Joint inspection of adult services

Increasingly, individuals expect care to be integrated, flexible and responsive to their needs. The proposed further integration of health and social care offers an opportunity to make care more sensitive to the needs of individuals and their families.

As individuals move between care providers and care settings, we also need to ensure we have a more joined-up approach to scrutiny between Healthcare Improvement Scotland and the Care Inspectorate. We will ensure that our scrutiny work is sensitive to the pathways of care that people follow.

In the course of 2013-2014, we tested a new methodology for inspection between ourselves and the Care Inspectorate. We will consider findings from this work to inform future proportionate and risk-based scrutiny.

A similar model to the comprehensive quality and safety assessments would apply to our joint work with the Care Inspectorate. This would ensure a comprehensive approach – focusing on the strategic commissioning of services that support more people to live independent lives at home or closer to home as well as scrutinising the quality of care being delivered.

There is a substantial opportunity with the commissioning role of the new health and social care partnerships to commission services that refocus the pathway of care with more emphasis on community rather than acute inpatient care. We have the opportunity to lead on the development of clinical standards that reflect such pathways of care – especially for the care of older people and/or those with complex chronic conditions – and quality assure, through scrutiny, the delivery of better outcomes for patients, such as reducing presentation at accident and emergency departments. In providing an integrated cycle of evidence, scrutiny and improvement, we can act as a catalyst for health and social care partnerships to develop more ambitious proposals to establish more integrated intermediate care, such as step up/step down facilities.

We will ensure that the new arrangements support the direction of travel with the proposed establishment of Health and Social Care Partnerships.

In 2014-2015, we will deliver, with the Care Inspectorate, a programme of joint inspections for the care of adults. We will take into account learning from the pilot inspections.

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4.3 People with a learning disability

In June 2013, the Scottish Government published a 10-year strategy, ‘The Keys to Life’ which focuses on what needs to be done to improve the quality of life for people with a learning disability. It sets the direction for a range of public sector services including health. It is estimated that there are approximately 42,000 children and adults in Scotland with a learning disability who require support with moderate to profound learning disabilities affecting 2.7-3.8 per 1,000 of the population.

Of the 52 recommendations contained in ‘The Keys to Life’, two specifically refer to Healthcare Improvement Scotland and we will be leading on these in partnership with other key stakeholders.

- **Recommendation 8**: that by June 2015, the Care Inspectorate and Healthcare Improvement Scotland should ensure that strategic commissioning plans, processes and implementation are examined as part of ongoing scrutiny work that impacts on services for people with a learning disability.

- **Recommendation 14**: the Learning Disability Strategy Implementation Group will work with Healthcare Improvement Scotland to undertake a review of the Learning Disability Quality Indicators and Best Practice statement to ensure that they reflect the changing needs of people with learning disabilities. A review of general health services and specialist learning disability health services will be undertaken across NHS Scotland to ensure that there is full compliance with Learning Disability Quality Indicators and Best Practice statement on Promoting access to healthcare for people with a learning disability.

We are a full member of the Scottish Government’s Learning Disability Strategy Implementation Group. We are also directly contributing to two of the sub working groups relating to Health and Scrutiny and Commissioning. We are also working closely with colleagues from the Care Inspectorate to progress these recommendations.

In 2014-2015, we will work with the Scottish Government and other organisations to design the most appropriate model for scrutiny of services for people with a learning disability.
5 Safer clinical practice

5.1 Medical revalidation

In the UK, there are over 230,000 practising doctors: over 15,000 of them working in Scotland. Every doctor needs a licence to practise and these are regulated by the General Medical Council (GMC). The GMC will only renew a licence if a doctor successfully completes medical revalidation, signed off by a Responsible Officer. Medical revalidation takes place every 5 years and requires annual appraisal. The whole process aims to:

- support doctors in their professional development
- contribute to improving patient safety and quality of care, and
- sustain and improve public confidence in the medical profession.

Legislation governing medical revalidation is reserved and applies across the UK, although each of the devolved administrations has developed an implementation programme based on GMC guidance. The Scottish Government has tasked Healthcare Improvement Scotland to carry out external quality assurance of the systems healthcare organisations have in place across primary and acute care for medical revalidation, to make sure doctors are up to date and fit to practise and to address any concerns. In Scotland, the Scottish Revalidation Delivery Board will advise the UK Revalidation Programme Board which organisations, areas or sectors are ready to recommend revalidation and our work is pivotal to this.

Our external quality assurance of revalidation arrangements has three elements:

- self-assessment and supporting evidence, to be completed by every healthcare organisation in Scotland, including registered independent services
- panel review of completed self-assessments and evidence, and
- follow-up meetings with a sample of organisations to validate information and learn more about arrangements in place.

We assess whether organisations have the necessary key elements in place, focusing on:

- clinical leadership
- robust appraisal schemes – including trained appraisers, and
- good governance and business continuity systems to provide assurance that the system is working effectively and has sufficient capacity and capability.
In 2013-2014, we completed our first assessment round. The first complete round of revalidation in Scotland takes place over the next 5 years. Together with Scottish Government, NHS Education for Scotland and other key stakeholders, we will continue to provide support and guidance to organisations and Responsible Officers to make sure they are well placed to deliver this.

During 2014-2015, we will follow up on the actions we identified in our first review and continue to monitor annual appraisal rates.
5.2 Death certification

The Harold Shipman case highlighted “Major flaws in the systems that govern death registration, the prescription of controlled drugs and the monitoring of doctors” (‘Learning from Tragedy: keeping patients safe’). Over the last 3 years, Healthcare Improvement Scotland has led on providing assurance and support on controlled drugs and the monitoring of doctors. More recently, we have taken on responsibility for improved consistency, quality and accuracy of death certification, specifically in relation to providing improved public health information and strengthening clinical governance arrangements in relation to reviewing deaths.

The new Certification of Death (Scotland) Act received Royal Assent on 20 April 2011 and the new arrangements are due to commence from April 2015. The aims are to:

- introduce a single system of independent, effective scrutiny applicable to deaths that do not require a Procurator Fiscal investigation
- improve the quality and accuracy of the medical cause of death, and
- provide improved public health information and strengthened clinical governance in relation to deaths.

The new system must not impose undue delays or distress on bereaved families arranging a funeral.

Healthcare Improvement Scotland will lead the introduction of the new single system of independent scrutiny of death certificates. The new system will have a strong focus on education and training for doctors, as well as on changing the culture relating to death certification within the healthcare system in Scotland. It will also introduce real-time scrutiny of a sample of death certificates. The reviews will feed into a systematic quality improvement programme to measure quality improvements at a national level and to monitor improvements.

In 2014-2015, we will ensure the preparatory work is done to build the new system of quality assurance of death certification in Scotland.
5.3 Controlled drugs

Controlled drugs have legitimate therapeutic application. However, they also have a potential for abuse and dependence and carry an associated risk of diversion into the hands of persons other than those for whom they are prescribed.

The Controlled Drugs (Supervision of Management and Use) Regulations 2006 set out the requirements for NHS bodies and independent healthcare bodies to appoint Accountable Officers. It is the responsibility of the Accountable Officer to secure the safe management and use of controlled drugs for their organisation.

Healthcare Improvement Scotland supports the Controlled Drugs Accountable Officers Network in Scotland to improve and strengthen governance systems for the safe and effective use of controlled drugs for patients. We facilitate shared learning, intelligence and co-operation across all designated bodies to ensure the arrangements for management of controlled drugs are better co-ordinated and integrated within the overall framework for improving the quality of healthcare.

This project supports the safeguarding of patients through sharing of good practice as well as helping to detect unusual or poor clinical practice or systems, criminal activity which puts patients at risk.

During 2014-2015, we will follow up on actions identified in our baseline review. We will also continue to maintain the Scottish healthcare directory of Accountable Officers for controlled drugs.
6 Systems of governance and accreditation

6.1 Supporting good governance of the NHS in Scotland

We will work with the Scottish Government to ensure a clear and consistent approach to the scrutiny and assurance of the clinical governance of NHS boards in Scotland. In building a scrutiny framework, we will take account of the findings from the Francis Inquiry into the failings at Mid Staffordshire NHS Trust. We will learn from the approach taken through the Clinical Governance and Risk Management Standards to establish a reliable system of benchmarking and quality assurance.

In the course of 2014-2015, we will work with NHS boards and other stakeholders to test the application of a refreshed approach to scrutinising governance arrangements that support the delivery of high quality care and improved outcomes. We will ensure any arrangements complement existing scrutiny of governance arrangements in NHSScotland, and as appropriate embed them within new comprehensive quality and safety assessments.

CONTRIBUTION TO QUALITY STRATEGY OUTCOMES

- Everyone gets the best start in life, and is able to live a longer, healthier life
- People are able to live well at home or in the community
- Healthcare is safe for every person, every time
- Everyone has a positive experience of healthcare
- Staff feel supported and engaged
- The best use is made of available resources
6.2 Human tissue bank accreditation

The UK is one of the leading countries in medical research and much of this depends on using human tissue (such as blood, cells, joints). This material is donated by patients with their explicit consent, and stored and monitored in a quality-controlled environment known as a human tissue bank (or biorepository). In Scotland, this is carefully regulated using the legislation in the Human Tissue (Scotland) Act 2006. To ensure external quality assurance, the Chief Scientists Office tasked Healthcare Improvement Scotland to develop and implement an accreditation scheme for NHS human tissue banks in Scotland. The aim of this is to provide an assurance to the public that human tissue is collected, stored and used in the right way every time for improvement in healthcare. This assurance is important, partly to encourage tissue donation for further research into life-threatening disease such as cancer and partly to attract medical research which needs high quality materials.

There are four regional tissue banks in Scotland based in Grampian, Greater Glasgow and Clyde, Lothian and Tayside and each involves a close partnership between the NHS and universities. We have developed quality standards of operation (based on those used by the Human Tissue Authority elsewhere in the UK) and our accreditation scheme assesses how the tissue banks collect, store and transfer tissue for research against these standards. Tissue bank performance is assessed by multidisciplinary panels. Tissue banks are required to demonstrate that they meet the necessary standard for accreditation and have action plans in place to address any issues.

To date, three of the four regional tissue banks have achieved accreditation in 2013-2014. Accreditation is valid for 3 years and tissue banks are required to provide annual updates and notify us of any issues or concerns that may affect their status during that period. We will review and renew human tissue bank accreditation every 3 years.

In 2014-2015, we will require an update from the four tissue banks on their current status against the Healthcare Improvement Scotland quality standards of operation and on any recommended actions.
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.