Older people in acute hospitals inspections and older people in acute care improvement programme

Strategic review group report

October 2017
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Executive summary

1. This report highlights the review process and recommendations arising from a review of the ‘older people in acute hospitals inspections and older people in acute care improvement programme’ carried out between May 2016 and May 2017.

2. Healthcare Improvement Scotland supports two programmes of work focused on improving the care of older people: the Older People in Acute Hospitals Inspection Programme (OPAH) and the Older People in Acute Care (OPAC) Improvement Programme, both of which are commissioned by the Chief Nursing Officer Directorate at Scottish Government.

3. Whilst both programmes are based in acute care, their work programmes have developed over the years to support a range of different priorities.

4. In May 2016, a multi-agency strategic review group was established by Healthcare Improvement Scotland to review both programmes with the support of the Scottish Government. The aim of the review was “to explore how Healthcare Improvement Scotland can most effectively continue to support improvement and provide assurance in older people’s care.”

5. The strategic review group was co-chaired by Heidi May, Executive Director Nursing, Midwifery and Allied Health Professionals, NHS Highland, representing the Scottish Executive Nurse Directors and Pam Whittle CBE, Chair, Scottish Health Council and Healthcare Improvement Scotland non-executive director. Membership of the group included representatives from NHS boards, third sector organisations, public partners, national bodies and Scottish Government.

6. The aim of the review process was to understand how effective the current OPAH and OPAC programmes are at enabling improvements in older people’s care. Over 200 NHS staff were interviewed as part of an independent review process and the findings from this have been used to inform the thinking of the strategic review group and its recommendations.

7. During the timespan of this review, a number of significant changes and developments have taken place in health and social care which have influenced thinking and helped to shape the review, including the development of Healthcare Improvement Scotland’s Quality of Care Approach.

8. At present, the OPAH and OPAC programmes have focused on acute hospital care. To better reflect the experience of older people in different hospital settings across Scotland, the Chief Nursing Officer has requested Healthcare Improvement Scotland to consider expanding both programmes to community hospitals and specialist dementia units. It was, therefore, decided that a review of the OPAH and OPAC programmes for expansion beyond acute care should be conducted at the same time rather than independently. Work has already started on a programme of improvement support for specialist dementia units as part of the Focus on Dementia portfolio. Work to consider the models and resources required to expand the programmes will be taken forward in collaboration with the Chief Nursing Officer Directorate and a range of stakeholders.

9. A series of 15 recommendations are outlined on pages 32 and 33 which will be taken forward by Healthcare Improvement Scotland in collaboration with a range of stakeholders. Progress against the recommendations will be overseen by Healthcare Improvement Scotland’s Quality Committee.
Introduction

10. People in Scotland are living longer. By 2037, people over the age of 65 are expected to make up a quarter of the population. In the same period, the number of people over 75 is expected to rise by 85%, with this group accounting for 8% of the whole population.

11. Of course this is really positive, but older people are more likely to be admitted to hospital than younger members of the population. Often this is as an emergency admission to an acute hospital and for some older people, hospital is not the best place to receive the care they need.

12. When older people do need hospital care, it is important that they are looked after in the environment that best meets their needs. This means that people can be cared for in a variety of settings, including acute hospitals, community hospitals or specialist dementia units, and sometimes moving between these environments as their needs change. Regardless of the setting, it is important that, where possible, older people are discharged from hospital quickly to ensure they don’t suffer unintended complications such as reduced mobility or infection.

13. In May 2016, a multi-agency strategic review group was established to look at the OPAH inspection and OPAC improvement programmes. The group was co-chaired by Heidi May, Executive Director Nursing, Midwifery and Allied Health Professionals, NHS Highland, representing the Scottish Executive Nurse Directors and Pam Whittle CBE, Chair, Scottish Health Council and Healthcare Improvement Scotland non-executive director. Membership of the group includes representatives from NHS boards, third sector organisations and Scottish Government.

14. Until now, the focus of Healthcare Improvement Scotland’s Older People in Acute Hospitals (OPAH) inspection programme and the Older People in Acute Care (OPAC) improvement programme has only been on acute hospital wards. To better reflect the experience of older people in different hospital settings, the Scottish Government asked Healthcare Improvement Scotland to consider expanding its current OPAH and OPAC programmes beyond acute care to community hospitals and specialist dementia units.

15. Within Healthcare Improvement Scotland, members of the public (public partners) contribute to, and are involved in, a range of work streams across the organisation, including OPAH inspections, OPAC improvement work and the review and the development of the Care of Older People in Hospital Standards. We are committed to ensuring that public partners have a meaningful and valuable volunteering role and the opportunity to make a difference to people’s care and experience of care in Scotland. Three public partners are members of the strategic review group, providing invaluable perspective, insight and challenge.

16. The membership and Terms of Reference for the group can be found in appendices a and b.

17. The review was conducted between May 2016 and May 2017. During this time, a number of significant changes and developments shaped the review and have influenced thinking about how future inspection activity and improvement support will be delivered, including:

- the introduction of the revised Care of Older People in Hospital Standards in June 2015
the development of the new national *Health and Social Care Standards*
the integration of health and social care
the development of the Improvement Hub (ihub) and development of an acute care portfolio
the Healthcare Improvement Scotland Quality of Care Approach
Excellence in Care – the national assurance system for the quality of nursing care, and
reviewing the methodology of the joint strategic inspection of adult and social care services.

18. The strategic review group will submit recommendations for the future approach to the Scottish Government Chief Nursing Officer Directorate (CNOD) and the Healthcare Improvement Scotland Board.
Section 1: Background to the OPAH and OPAC programmes

19. Although the OPAH and OPAC programmes are both based in acute hospitals, their work programmes have developed to support a range of different priorities. Over the last three years, there has been an increasing recognition of the benefits to the programmes working more closely together. For example, inspection findings can help to target areas for improvement support and inspectors have used the learning from improvement activities to inform priority areas for review. It was, therefore, decided that a review of the OPAH and OPAC programmes for expansion beyond acute care should be conducted at the same time rather than independently. To aid understanding of the two programmes of work and how they might be more aligned in the future, this section outlines the background to the development of the OPAH and OPAC programmes.

OPAH inspection programme

20. OPAH inspections were commissioned by the Scottish Government in 2011 following the Mental Welfare Commission for Scotland report Starved of Care, which raised concerns about the care of older people in acute hospital wards.

21. The purpose of the inspections is “...to assure and improve (where appropriate) the care of older people in acute hospitals.” When this review began in May 2016, 59 inspections had taken place. Inspections examine NHS boards’ performance against a range of standards (including Healthcare Improvement Scotland’s Care of Older People in Hospital Standards, best practice statements and other national documents relevant to the care of older people in acute hospitals. The aim of OPAH inspections is to provide public assurance that the care of older people in acute hospitals is of a high standard and to support improvement where it is needed.

22. In December 2012, a multi-agency review group chaired by Pam Whittle CBE, Chair, Scottish Health Council, was formed to review the methodology for the OPAH inspections. In November 2013, the Report on the Review of the Methodology and Process for the Inspection of the Care of Older People in Acute Hospitals, was published that made 19 recommendations across the following eight areas:

- national standards, guidance and best practice
- intelligence-led, proportionate and risk-based scrutiny
- self-assessment
- case note review
- evidence and judgement
- composition of inspection team
- structure and format of reports, and
- quality assurance of the scrutiny process.

23. The Report on the Review of the Methodology and Process for the Inspection of the Care of Older People in Acute Hospitals, referred to as the ‘Whittle Review’ identified the need for the inspection process to become more focused on outcomes for patients and the following model of inspection was introduced (see Figure 1):
24. As can be seen from Figure 1, the inspection process begins with an analysis of a range of data. This ensures that the inspection is risk based and proportionate. During the 2013 review, the self-assessment was revised to become more outcomes focused. A multidisciplinary NHS board visit was introduced, bringing a peer review element into the inspection process. The purpose of this visit was to enable a deeper conversation with the NHS board about where it was performing well and what areas it was working on to improve. Importantly, the visit gave the inspection team a sense of the local context before the unannounced inspection visit. The report template was changed to reflect the outcomes in the revised self-assessment. A range of follow-up approaches, such as meetings with NHS boards and re-inspection, have continued to assess progress against the action plans that NHS boards develop to address any areas for improvement published in the report.

25. In addition to the *Care of Older People in Hospital Standards*\(^3\), a range of other standards and good practice guidance is used to assess current practice and quality of care. These include:

- **Best Practice Statement for Working with Dependent Older People to Achieve Good Oral Health**\(^8\)
- **Best Practice Statement for Prevention and Management of Pressure Ulcers**\(^9\)
- **Food, Fluid and Nutritional Care Standards**\(^10\)
- **Complex Nutritional Care Standards**\(^11\)
- **Adults with Incapacity (Scotland) Act 2000 Part 5 – Medical treatment and research**\(^12\)
- **Standards of Care for Dementia in Scotland**\(^13\)
- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR): Integrated Adult Policy – Decision Making and Communication**\(^14\)
- **Scottish Government Health Directorate, Chief Medical Officer (CMO) (2013)18: Safer Use of Medicines - Medicines Reconciliation: Revised Definition, Goals**
The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives\textsuperscript{16}
- Generic Medical Record Keeping Standards\textsuperscript{17}, and
- Allied Health Professions (AHP) Standards\textsuperscript{18}.

**OPAC improvement programme**

26. The OPAC improvement programme has focused initially on two critical areas:

- **Frailty**– ensuring all older people admitted to hospital identified with frailty receive comprehensive geriatric assessment (CGA) within 24 hours of admission.
- **Delirium**– improving early identification, prevention and management of delirium.

27. The decision to focus on these particular areas of care was informed by a review of literature, themes emerging from the OPAH inspection reports, and an extensive period of consultation with stakeholders. The OPAC programme has addressed all three quality ambitions of safe, effective and person-centred care. It has also raised awareness of these key issues, supported staff to share experiences and learn together, and has influenced practice.

28. The programme supported local teams with testing a range of approaches to identifying and co-ordinating the care of people with frailty. *Improving the Identification and Management of Frailty: A Case Study Report of Innovation on Four Acute Sites in NHSScotland*\textsuperscript{9} gives full details of the work to identify frailty and ensure rapid Comprehensive Geriatric Assessment in four NHS boards. Potential cost savings associated with such initiatives have also been suggested.

29. The programme designed, developed and tested a range of easy-to-use, evidence-based tools and resources to assess manage and review delirium, including a delirium care bundle. It guides staff to consider triggers for delirium, investigate underlying causes, implement an appropriate management plan and engage both patients and family members. These resources have received international recognition and have been widely used to increase awareness, inform and influence education and to change practice.

30. The programme engaged with a wide range of clinicians to share learning and good practice. For example:

- continuing professional development
- accredited national and local events
- cross-site visits have been facilitated, and
- online improvement clinics, such as WebExes and conference calls have been held.

31. Feedback from NHS board colleagues indicates the value placed on these opportunities for networking, sharing learning by discussing experience and ideas, exploring examples of good practice, and identifying opportunities for improvement and solutions to challenges.
32. Learning from the experience of patients, relatives and staff has also played an important role in the programme. In addition to the emotional touch-points technique used to explore the experience of care during an episode of delirium, digital stories, video clips and staff focus groups helped NHS boards to understand and learn from patients’ and family members’ experiences.

33. Collaboration between the OPAH and OPAC programmes that relates to the care of older people has increased over the years with a commitment to share and learn from each other in order to support teams with improvement activity.

34. A number of reports19-22 exist that describe the impact of the work of OPAC, provide case studies of good practice and share data to illustrate improvements in patient outcomes that OPAC work has contributed to.
Section 2: Methodology

Aim

35. The aim of the review was “to explore how Healthcare Improvement Scotland can most effectively continue to support improvement and provide assurance in older people’s care.”

The purpose of the review

36. The purpose of the review was to:

- advise on what aspects of the OPAH and OPAC programmes are enabling and what, if any, aspects are hindering improvements in older people’s care
- advise on the extent to which the Whittle Review’s recommendations have been implemented and make recommendations on any refinements required to the current methodology to ensure we maximise impact of improvement activities
- make recommendations on the approach for extending the care of older people’s inspections into community hospitals and specialist dementia units
- advise on key areas of focus for the next phase of the OPAC programme, including the approach to be taken nationally that will best support local services to deliver sustained improvement, and
- make recommendations on how we ensure the national assurance and improvement programmes across older people in acute care, community hospitals and specialist dementia units interface effectively to maximise the drive for improvement locally.

37. These are covered in sections 3-7 of the report.

Method

38. Information to support this review was gathered from a number of stakeholders and reports, including:

- Interviews with stakeholders from across NHSScotland
- members of the strategic review group through presentations and workshops
- the Whittle Review
- *Review of the Care of Older People, Borders General Hospital, NHS Borders*\(^23\)
- *Care for Older People in Acute Hospitals, Progress Report (May 2013-July 2014)*\(^24\), and
- *NHS Lothian Hospital Based Complex Clinical Care*\(^25\).

*Interviews with stakeholders*

39. As part of the review, it was important to understand what NHS staff providing and delivering acute care to older people across NHSScotland thought about the current inspection and improvement programmes. The review needed to reflect their views on how this work should be undertaken in future and what would best support them to improve care for older people. To enable this to be done in a rigorous way within the timescale proposed for the review, the decision was taken to contract out the stakeholder interviews to a professional organisation with the time and expertise to
undertake this work and deliver a report on the outcomes to inform the review process.

40. A project specification was drawn up and put out to competitive tender and bids were assessed by a panel within Healthcare Improvement Scotland. The contract to undertake the stakeholder interviews and write a report on the findings was awarded to market research company, Blake Stevenson.

41. Blake Stevenson carried out interviews with members of senior management teams, middle managers and clinical staff providing frontline services across all 14 territorial NHS boards during late August to early October 2016. A combination of face-to-face interviews and group discussions was undertaken. Also, interviews were held with senior managers from Healthcare Improvement Scotland and with a number of national stakeholders.

42. The interviews covered the following four questions:

- What is currently working well within the OPAC and OPAH programmes?
- What differences are the programmes currently making to improve the care of older people?
- How can the programmes be enhanced to support greater improvements in the care of older people?
- How do we ensure the methodology for inspection is appropriate to the area being inspected?

43. Blake Stevenson carried out a total of 209 face-to-face and telephone interviews with key stakeholders and staff from across the 14 territorial NHS boards. Full details are presented in the final report from Blake Stevenson.

**Strategic review group**

44. The strategic review group discussed and built upon the findings of the Blake Stevenson report through a series of workshop-style meetings. Each of the meetings began with a presentation to provide context. A facilitated workshop format then followed to allow group members to debate and share their views. The workshops focused on:

- the self-assessment
- the inspection methodology
- inspection reports
- links between improvement and assurance, and
- approaches to improvement.

45. These views were collated and summarised after each meeting and used to inform the findings and recommendations of this review.

**Recommendations from the Whittle Review**

46. The strategic review group considered the extent to which the recommendations from the Whittle Review have been implemented and whether the recommendations will continue to inform the expansion of OPAH inspections beyond acute hospital care.
Review of the Care of Older People, Borders General Hospital, NHS Borders\textsuperscript{23}

47. Learning from the review of older people’s care in Borders General Hospital and the subsequent ‘after action review’ was shared with the strategic review group and helped to shape the discussion and recommendations.

Care for Older People in Acute Hospitals Progress Report: May 2013–July 2014\textsuperscript{24}

48. This overview report which commented on themes coming from inspection, and examples of where the improvement team had supported NHS boards to improve the care for older people was considered as part of the discussions on future reporting.

NHS Lothian Hospital-based Complex Clinical Care Review Report\textsuperscript{25}

49. Recommendations from this review of hospital-based complex clinical care (HBCCC) services in Edinburgh were considered by the strategic review group.

Limitations

50. It is recognised that there have been a number of limitations to the review.

Public involvement

51. Over the course of the review, the strategic review group had wide ranging discussions, including how patients and the public should be involved in the review process and implementation of the recommendations. Three public partners from Healthcare Improvement Scotland were members of the strategic review group.

52. As the purpose of the review was to establish what had worked well and what could be improved with the OPAH and OPAC programmes, it was decided that the stakeholder engagement element would be limited to people who had direct experience of the programmes. The ability to seek the views from people who had used services across NHSScotland at the time of an OPAH inspection or OPAC improvement work would have presented significant work for NHS boards and been beyond the time and financial constraints of the review. For this reason, the strategic review group agreed that the interviews would be limited to NHS staff and key stakeholders. It is recognised that this is a limitation, however, the strategic review group has asked Healthcare Improvement Scotland to continue to develop its approach to service user engagement, ensuring that it is central to the implementation of the recommendations from the review.

Stakeholder experience of OPAH/OPAC

53. It was recognised that how recently a NHS board had been inspected, and the outcome of that inspection, could influence the views of staff. The Blake Stevenson report\textsuperscript{1} contains more feedback about the inspection process than about improvement support. This reflects the higher visibility of the former and the wider involvement of managers and frontline staff in the inspection process than in improvement support. Although the OPAC programme covers all NHS boards, at the time the interviews were conducted, only staff from nine of the 14 NHS boards had direct experience of receiving improvement support through OPAC. The need for a better balance of improvement and assurance was raised by a number of respondents.
Section 3: What is working well and what could be better?

54. The first purpose of the review was to advise on what aspects of the OPAH and OPAC programmes are enabling and what, if any, aspects are hindering improvements in older people’s care. This section presents the key themes from the Blake Stevenson report and the strategic review group workshops. For ease of reading, all participants are referred to as ‘stakeholders’.

OPAH

Approach to inspection

55. The OPAH inspection programme was found to be valued across all NHS boards and there was consistency in agreement that inspection should continue. Of particular value were the NHS board visits (see paragraphs 67–68). There was also an acknowledgement that the inspection programme has continued to evolve, with many commenting that it had particularly improved in the last few years. Inspectors were found to be more approachable, supportive and unobtrusive.

56. In 2012, NHS board were advised of the first ‘round’ of announced OPAH inspections to enable them to become familiar with the inspection process. Following this, all subsequent inspections have been unannounced. In line with previous feedback, the findings from this review suggest that staff prefer unannounced inspections. This is because it removes the stress of the build-up to an approaching announced inspection, and gives a more realistic view of care delivery on any given day.

57. Feedback from stakeholders suggests that the OPAH inspections have led to practical improvements in the care of older people and have helped raise awareness of the needs of older people in acute care. Inspections sometimes highlight areas that staff are already aware of but external review can support staff to leverage change and improvement.

58. While some NHS boards found the inspection process to be targeted, relevant and focused, others felt that there was a lack of clarity about the inspection process and how each of the elements of the inspection linked to the Care of Older People in Hospitals Standards. There also appeared to be a lack of clarity as to how Healthcare Improvement Scotland inspections and improvement support link and work together.

59. The limitations of the current OPAH inspection programme, with its focus on acute care, being unable to assess the quality of care across patient pathways in different hospital settings was acknowledged; in particular, the point where people move from one service to another. Concerns were also raised about the impact that avoidable hospital admissions and delayed discharges can have on the care and experience of older people. It was felt there needed to be more emphasis from inspection and improvement on these areas.

60. There was a view that the current inspection methodology looks at the symptoms rather than root cause of why standards are not being met. If this could be improved, there may be opportunities to identify and implement longer term improvements.
61. Some felt the current outcomes-focused approach to inspection was too fragmented as it focused on single issues, such as pressure care and nutrition. There was a suggestion that a more person-centred approach to inspection could be developed.

62. The introduction of the liaison inspector role to support NHS boards was well received. In particular, it enhanced NHS boards’ understanding of the self-assessment process.

National standards, guidance and best practice

63. The first recommendation from the Whittle Review\(^7\) was to revise the *Standards for the Care of Older People in Acute Hospitals*. A multi-agency working group was convened and under the chairmanship of Dr Christine McAlpine, the *Care of Older People in Hospital Standards\(^3\)* were published. There was obvious support for the new standards. It was suggested that there could be greater transparency as to how these and a range of other standards, including the new national *Standards for Health and Social Care\(^4\)*, are used to support the inspection process.

Self-assessment and evidence

64. The current self-assessment was introduced following the Whittle Review\(^7\) where, after consultation and testing, a more outcomes-focused self-assessment was introduced. There was consensus from stakeholders, including inspectors, that completion of the self-assessment is onerous and can duplicate information submitted for other inspections. Although there is guidance on the completion of the self-assessment, and additional support from the liaison inspector is available, the amount of supporting evidence that is submitted is often in excess of what is required. It was suggested that a core data set should be considered.

65. It was also suggested that the self-assessment should follow the headings of the *Care of Older People in Hospital Standards\(^3\)*. This was because staff found it hard to evidence that they were meeting the new standards through providing evidence under the 12 outcomes contained within the self-assessment.

66. There was an overall plea for Healthcare Improvement Scotland to capture data once and use it across its work programmes to prevent NHS boards having to submit the same data repeatedly. It was suggested that a central portal where evidence could be held and updated would reduce the burden by allowing evidence to be submitted once and used across Healthcare Improvement Scotland work streams. This would also enable the self-assessment to be a ‘live’ document which could be updated regularly, further reducing the burden.

NHS board visits

67. The visits to NHS boards which took place between 2015 and 2016 were highly valued and provided a greater understanding of the context in which to set the inspection. Many of the sessions during the NHS board visit were led by clinical experts from other NHS boards. For some, at times, the process still seemed a little one-sided and staff would value more of a two-way dialogue with the clinical experts to support shared learning. Overall, involving clinical experts as part of the inspection team was valued.

68. There were a range of views as to whether improvement staff should be part of the NHS board visit and/or part of the wider inspection team. There have been occasions where staff from the OPAC team have supported the OPAH inspections but due to limited resources available, this has not always happened. More recently, improvement staff supported the review of the care of older people in Borders.
General Hospital. The learning from this review was presented and discussed at one of the strategic review group workshops. There were a number of benefits to having a member of the improvement team as part of the NHS board visit. For example, it gave improvement staff greater insight into the inspection and review process, allowed the review team to have a deeper discussion with the NHS board about their approach to improvement, and enabled the improvement team to develop a greater understanding of where they may be able to provide responsive support after the review.

**Inspection team composition**

69. A number of stakeholders commented that the focus of the current inspection programme is on nursing and they would like to see the focus shift to the wider disciplinary team. There was a strong feeling that as care is multidisciplinary, the scope of the inspection should be widened to include care that is delivered by the whole care team, including medical staff, Allied Health Professionals and social workers. This should include the inspection field work not just the NHS board visit. However, some stakeholders commented on the large size of the inspection team and this will need to be considered as part of future developments.

70. The enormous benefit to staff having the time to be part of an inspection team was recognised, both in terms of their own development and sharing learning when they returned to their substantive post.

71. However, it was also acknowledged that there could be challenges to releasing staff from NHS boards to participate in inspection, and that this is likely to be an increasing problem as budgets tighten. It was also suggested that hospitals could do more to support the multidisciplinary aspect of the inspection by not just focusing their local work on nursing in their local action plan.

72. Public partners are part of the core inspection team. Stakeholders spoke of their appreciation of this, particularly the public partner role in engaging with patients, relatives and carers to gather their views.

**Published reports**

73. There was recognition that the published inspection reports have a hugely positive impact in terms of improving care but they can also have a negative impact on staff morale when findings were not good. The impact of negative press and publicity following the publication of a report was also highlighted as having an adverse impact on staff.

74. Although recent improvements were acknowledged, some stakeholders still described an inconsistency between the verbal feedback given by the team at the end of the inspection which could be more positive than the published report. Some had a perception that generalisations were made on one or two pieces of evidence from one or two wards.

75. It was suggested by some that the report should focus on areas where there was a real lack of care. It was also suggested that the reports could distinguish ‘red line’ issues. For example, those which presented risk to safety, from those that were important but of no immediate harm to patients.

76. NHS boards appreciated the factual accuracy process. They valued the opportunity for discussion and welcomed the response from the inspection team in taking account of their comments and changing the report where this was agreed and appropriate.
77. A number of managers identified that an annual report summarising inspection findings across NHSScotland would be helpful in identifying common and regularly occurring issues. It was suggested that this could focus the work of the improvement team and encourage joint working between inspection and improvement.

78. There were mixed views as to whether a rating scale should be included in the report. The challenges of applying an overall rating scale when there is diversity of standards between wards, and where there is no regulation and associated powers was acknowledged.

79. There was consensus that reports should be open and transparent and accessible to patients and the public.

**OPAC**

**Approach**

80. Those who had experienced and received support from the OPAC team with their work to improve the care of those with delirium and frailty spoke highly of it, both in terms of the support provided and those providing it. Others spoke highly of specific support they had received around falls, food, fluid and nutrition, and using the ‘What Matters to Me’ approach. However, as highlighted in the limitations section, compared with the OPAH inspection programme, far fewer staff had an understanding, or experience, of OPAC due to the small size of the team and the improvement approach adopted which focused on working with small teams in each NHS board.

81. The gap between inspection and improvement was frequently raised, with some NHS boards commenting on the disparity of resources between the OPAH and OPAC teams.

82. Some concern was raised about the number of different improvement programmes and initiatives that NHS boards were expected to engage with. Feedback from some stakeholders suggested that clarity was needed on how different aspects of improvement support from Healthcare Improvement Scotland fit together and how the different improvement programmes linked.

83. The OPAC programme has adapted and responded to learning about ‘what works’ when it comes to improvement, recognising the importance of local context and ownership as key factors in securing sustainable improvement.

84. A ‘blended local collaborative’ approach to OPAC improvement support was tested with three NHS boards between June 2015 and August 2016. As part of this work, Healthcare Improvement Scotland provided funding for an Improvement Advisor to be part of the local NHS board team. The work sought to explore whether a different model of improvement support that took account of local context would help the alignment of improvement initiatives and facilitate a joined-up approach to improving care for older people.

85. A report published in October 2016 highlights the learning from this alternative model of improvement support for older people’s acute care. The benefits of protected time to work with staff to enable them to drive improvements locally, the opportunities for sharing, learning and networking, and the value of understanding the local context in order to build relationships and influence strategically were all highlighted as advantages to the model. In all areas, staff reported improvements in their knowledge, skills and confidence. A wide range of contextual and system factors, specifically assessing readiness for change and balancing demand with
capacity were recognised as challenges that need to be considered when planning models of improvement support.

86. This approach was supported by stakeholders who said they wanted the national team to understand and support them in their own local priorities. It was proposed that recognising and building on existing local initiatives could enhance the relationship between NHS boards and the improvement team. Also, stakeholders wanted improvement to link with inspection findings so that issues could be tackled rather than the same issues recurring at different inspections.

Local support

87. Feedback from stakeholders illustrated the variety of approaches to improvement within NHS boards. From the Blake Stevenson report\(^1\), it is evident that some NHS boards have a very clearly developed approach to quality assurance and quality improvement in place and have identified the priorities they wish to work on, while with others this was less immediately apparent.

88. Where these approaches were highly developed, NHS boards wanted Healthcare Improvement Scotland to be more aware of their local work so that the NHS boards could be supported to develop these further, and importantly, supported to share their work with others.

89. The interviews with stakeholders made clear the enormous amount of pressure in terms of capacity and staffing that NHS boards feel themselves under and that the current levels of service in some areas are unsustainable. This may impact on the approach to, and the ability to, achieve sustained improvement.

90. Support to enhance the environment for improvement, such as time for in-depth training on improvement methodology and techniques and increasing staff capacity to undertake ‘bottom-up’ improvement work, was welcomed. Some stakeholders encouraged having a senior manager or practitioner leading and/or closely involved in the work as being important for sustaining improvements.

Sharing good practice

91. Healthcare Improvement Scotland’s role in sharing and learning from good practice was welcomed. The flash reports of progress and good practice were particularly appreciated. It was found that although WebEx and online learning were seen to be important, stakeholders stressed the impact and value of face to face learning opportunities such as learning events. However, it was felt that more ‘point of care’ staff needed to be involved, not just the ‘usual [more senior] people’.

92. Some of the larger NHS boards described the challenges of sharing learning and improvements across their NHS board area. One NHS board suggested that Healthcare Improvement Scotland could have a role in supporting them to identify appropriate improvement methodologies.

Impact

93. In terms of impact, stakeholders identified that there have been benefits to working collaboratively with the OPAC team, raising the profile of delirium and frailty as critical areas of care. They reported positive improvements in the care of people with delirium and frailty.

94. Through the work of OPAC there has been an increased awareness and understanding of these issues and this has contributed to changes in behaviour and
practice, with staff being more confident and better able to identify and respond to delirium. The resources that have been developed, tested and refined in collaboration with colleagues across Scotland have been received positively and enabled staff to address challenges in practice. Staff involved in OPAC work have described the value of sharing learning with colleagues across Scotland and working together to make improvements. The collaborative approach of OPAC has helped develop thinking and practice, with data gathered by local teams showing improved outcomes for patients in areas such as falls, delirium assessment and reduced length of stay.

95. However, stakeholders also commented that attributing these improvements to the inputs of the OPAC team could be problematic as some NHS boards saw that they themselves had already initiated improvement work. The OPAC team was just one, although important, aspect of this.
Section 4: Implementation of the recommendations from the Whittle Review (2013)

96. The second purpose of the review set out to examine the extent to which the 19 recommendations from the Whittle Review had been implemented.

97. The 19 recommendations were made across the following eight areas:
   - national standards, guidance and best practice
   - intelligence-led, proportionate and risk-based scrutiny
   - self-assessment
   - case note review
   - evidence and judgement
   - composition of inspection team
   - structure and format of reports, and
   - quality assurance of the scrutiny process.

98. Overall, good progress has been made with all recommendations having been fully implemented, with the exception of the development of an Evidence and Judgement Framework to support inspection. Work has started to develop the framework. However, it is now recognised that this should be organisation-wide, not just to support inspection. It will now, therefore, be taken forward as part of the Quality of Care Approach. A number of the other recommendations from the Whittle Review will continue to be further developed as part of ongoing review and expansion of the OPAH inspection programme.
Section 5: Extending the OPAH inspections beyond acute care

99. The third purpose of the review was to make recommendations on the approach for extending the older people’s inspections into community hospitals and specialist dementia units.

Approach to inspection

100. In 2014, Healthcare Improvement Scotland was asked by Scottish Government ministers to review its current quality assurance methodologies (including inspection) with a view to designing and delivering a new approach to deliver more comprehensive reviews of the quality of care provided to the people of Scotland. In response to this we developed the quality of care approach. This is how we design our inspection and review frameworks and provide external assurance of the quality of care. The quality of care approach brings a consistency to all of our quality assurance activity by basing all of our inspections and reviews on a common quality framework and a set of fundamental principles. Implementation of the approach will ensure that all of our quality assurance activity:

- is risk-based and proportionate
- makes best use of the data and intelligence already available to us
- is focused on improved outcomes for people
- builds supportive improvement-focused relationships with service providers, and
- is seen within the context of our broader improvement support offering.

101. The new approach is timely for this review, as it provides a framework upon which the strategic review group’s recommendations for the future development of the OPAH inspections can be developed. It also fits with having a more NHS board-wide approach, inspecting (in larger NHS boards a sample of) both acute and community hospitals. This would enable a more person-centred focus to the inspections, assessing the quality of care across different points of the care pathway, particularly where people move from one hospital to another.

102. Senior managers and frontline staff expressed concern about the impact preventable hospital admission and delayed discharge can have on older people and these concerns are supported by strong evidence (www.isdscotland.org). The scope of the inspection should be widened to include preventable admission and delayed discharge and, where possible, findings should be supported by current data. The joint strategic inspection of adult services looks at preventable hospital admission and delayed discharge from a community perspective. It should be made explicit how the findings from the OPAH inspections will be informed by, and will inform, the strategic inspection of services for adults.

103. In line with the ambition of the Quality of Care Approach\(^2\), the new inspection methodology should focus on working with services to diagnose where there are issues or difficulties in initiating, sustaining and spreading improvement and thereafter work with them to design risk-based supportive interventions to support sustainable local improvement.

104. The review group identified that the current OPAH inspection tools may not be appropriate for all community hospitals and specialist dementia units. The involvement of clinical experts and public partners (particularly those who have
experience of using services) will be essential to the development and testing of new methodologies and tools. A programme of development and testing should take place across a three-year period. This should take place in two phases:

- **Phase 1**: acute and community hospitals, and
- **Phase 2**: specialist dementia units.

| 2017–2018 | Create a project plan to deliver the full expansion of OPAH inspections beyond acute hospitals (phases 1 and 2) by 2020. To include:
|           | - the agreed scope of the new inspection programme
|           | - revision of existing overarching methodology for the new OPAH inspection programme
|           | - revision of current OPAH inspection tools in line with the new approach, and
|           | - developing and testing the new inspection tools for Phase 1. |

| 2018–2019 | Roll out the new methodology to acute and community hospitals. Begin the development and testing of the new inspection tools for specialist dementia units. |

| 2019–2020 | Extend the inspection of acute and community hospitals to include specialist dementia units. |

105. During the testing phase for acute and community hospitals, **the existing OPAH inspection programme will continue**. There may be a reduced number of inspections to create the capacity for development and testing. The programme will be based on the current risk assessment of services.

**Oversight of the new approach**

106. The Quality of Care Approach² Programme Board is in place to ensure cross-organisational ownership of the development, testing and implementation of the quality of care approach. The programme board reports into the Healthcare Improvement Scotland Quality Committee. A working group will be established in partnership with a range of clinical experts and public partners to develop the older people in hospitals inspection specific work plan and oversee the development work. This will be supported by subgroups that will take forward specific areas within the methodology, for example the self-assessment. The working group will report progress against the work plan to the Quality of Care Approach² Programme Board and this will be reported in the context of the wider quality of care approach implementation to the Quality Committee.
Recommendations

1. The future expansion of OPAH inspections to community hospitals should be developed in line with the Quality of Care Approach\(^2\) and reflect the care pathway across different hospital settings. This should also include a focus on preventable hospital admission and delayed discharge.

2. The development of any new methodologies and inspection tools must involve clinical experts and public partners (particularly those who have experience of using services).

3. New methodologies should focus on supporting services to identify the root cause of problems to enable more sustainable improvements.

National standards, guidance and best practice

107. As the Care of Older People in Hospital Standards\(^3\) are adopted across all hospitals, these standards will continue to underpin the inspection programme as it expands into community hospitals. The name of the inspection programme will change (OPAH) to the Care of Older People in Hospital inspection programme. However, these will not be the only standards that hospitals will be inspected against. In addition to the existing range of standards and guidance, the new national Health and Social Care Standards\(^4\) will also be used to underpin the inspection process. The inspections will also be supported by the principles outlined in the Chief Medical Officer's Annual Report 2015-16, Realising Realistic Medicine\(^6\) ensuring that people are receiving the most appropriate, person-centred care.

Intelligence-led, proportionate, risk-based scrutiny

108. Since the Whittle Review\(^7\), the use of data and intelligence to support proportionate, evidence and risk-based inspections has continued to develop and improve. This includes a range of patient experience information such as surveys, Patient Opinion, the Scottish Public Services Ombudsman reports and complaints data. A risk assessment is carried out to help plan the inspection programme and provide a focus on key areas within each inspection.

109. Going forward, the drive to reduce the ‘data burden’ will continue. As part of Phase 1, a core data set which will support the risk assessment across acute and community hospitals should be developed. This should be a subset of the data captured for the Quality of Care Approach\(^2\) to prevent unnecessary duplication. As part of Phase 2, any additional measures should be identified to support the risk assessment and inspection of specialist dementia units.

110. In future, consideration will need to be given to the use of Excellence in Care data for external assurance.
Recommendation

4. Work should continue with Healthcare Improvement Scotland’s Data, Measurement and Business Intelligence Unit to identify key measures and information to support the expansion to community hospitals and specialist dementia units.

Self-assessment and evidence

111. One of the strongest messages from the review was to reduce the burden of the self-assessment. As part of the Quality of Care Approach\(^2\), the development and testing of a programme of organisational self-evaluation against the quality framework is now underway. The ambition in the long term is that NHS boards, and/or Health and Social Care Partnerships, will complete one self-evaluation which will cover all quality assurance activity, including the inspection of the care of older people. However, it is recognised that considerable work has yet to be undertaken in this area.

112. In preparation, and to begin the streamlining process, work has already begun to align the current OPAH self-assessment with the Quality Framework. Further development of this is required to ensure that the links to the Care of Older People in Hospital Standards\(^3\) are explicit within the self-evaluation tool. In addition, any other standards or guidance used to inform inspection will need to be clearly referenced.

Recommendations

5. Develop and test a self-assessment in line with the Quality Framework, making explicit the links to the Care of Older People in Hospital Standards\(^3\) and any other standards or guidance used to support inspection by March 2018.

6. As part of the wider Quality of Care Approach\(^2\), explore the possibility of developing a web-based portal to support self-assessment.

NHS board/Integration Joint Board visit

113. The area that received the most positive feedback from the inspection process was the NHS board visit and this should continue. However, the structure of the visit will need to be reviewed to include Integration Joint Boards as most have delegated responsibility for community hospitals.

114. In addition, the range of experts who take part in the ‘peer challenge’ part of the visit should be widened to reflect the wider scope of the new Care of Older People in Hospital inspection programme. In the future this may include social workers in addition to a wider range of healthcare professionals.

115. From the learning following the NHS Borders review\(^23\) and the feedback from the Blake Stevenson interviews, opportunities should be explored to increase the involvement of improvement expertise as part of the NHS board visit.

116. Public partners currently form part of the NHS board visit team. Building on the learning from other review visits, their role should extend from meeting representatives from NHS board public involvement structures to participating in meetings with staff, including where appropriate non-executive Board members and senior staff.
117. Although highly valued, annual NHS board visits are resource intensive. This may be more so as the scope of the programme expands, therefore careful consideration needs to be given to the frequency of NHS board/Integration Joint Board visits.

**Recommendations**

7. The NHS board/Integration Joint Board visits should be developed and tested as part of Phase 1 (acute and community hospitals).

8. The visiting team where appropriate should be widened to include multi agency expertise. The role of public partners should be extended to include meetings with senior staff and lead personnel involved in, and responsible, for public involvement. Options for the inclusion of improvement expertise to participate in NHS board/Integration Joint Board visits should be explored.

9. Frequency of NHS board/Integration Joint Board visits should be considered following evaluation of the resource requirement during the test phase.

**Inspection team composition**

118. Feedback from stakeholders strongly encouraged that the inspection team should include experts from across the multidisciplinary team.

119. With any inspection, once the scope of the inspection has been agreed, the next step is to identify who, in addition to the core team (inspectors, public partners and support staff), should be involved at each stage of the inspection process. It is, therefore, essential that the scope is clear so that the right people, with the right expertise are available at the right time in the process. This may vary slightly from inspection to inspection as the focus for each inspection will depend, to a certain extent, on what the data shows.

120. Feedback from stakeholders also identified the potential increasing risk of services being unable to release staff to support inspections which may result in a risk to the inspection programme. To minimise the risk, good forward planning and clear role descriptors will be required, as well as an outline of what benefits individual practitioners, and the service releasing them, can expect from the experience of participating in an inspection.

121. Healthcare Improvement Scotland is currently developing its **Clinical and Care Governance Framework** to provide assurance to Healthcare Improvement Scotland Board that robust clinical and care governance arrangements are in place for all its programmes of work. The framework introduces a new Clinical and Care Governance Group which will report to the Quality Committee. This group will seek the assurance that the clinical and care risks are identified, managed and acted upon for all programmes of work, including the OPAH inspection programme. This will provide a mechanism to report any clinical and care risks associated, for example, with failure to secure the required expertise for a particular inspection. It will also provide a forum to share any lessons learned.
Recommendations

10. The scope of the inspection should be clearly defined and mechanisms to secure relevant clinical expertise, and where appropriate, other expertise will be sourced from appropriate agencies, to augment the core inspection team.

11. Clear role descriptors and mechanisms should be developed and implemented to ensure, where possible, inspection forward planning supports NHS boards/Integration Joint Boards to release staff.

12. Once established, any risks to the composition of the team which may impact on the inspection process should be reported to the Healthcare Improvement Scotland Clinical and Care Governance Group.

Published reports

122. The published inspection report is a fundamental part in the inspection process. The report should provide assurance to the public and to Scottish Government ministers that the care of older people in hospitals is safe, effective and of a high standard. Any areas which do not meet the required standard should be clearly, but sensitively reported to allow improvements to be made.

123. The current report format will need to be reviewed to reflect the new scope and methodology for inspection. Feedback from stakeholders reinforced that Healthcare Improvement Scotland reports should be open, transparent and accessible. It is, therefore, important that a range of stakeholders, including the communications team are fully involved in the development of the new report. Public partners will be essential to this process.

124. There was some concern from stakeholders that the verbal feedback was, on occasion, more positive than the published report and that findings within the report were sometimes based on one or two pieces of evidence. However, people valued the factual accuracy process and this should be retained within the new methodology. In addition, further consideration should be given to the need for an Evidence and Judgement Framework as recommended in the Whittle Review. This should be developed to support the Quality of Care Approach.

125. The idea of an annual report which published an overview of inspection findings was put forward by many stakeholders. Since the inception of OPAH inspections, three overview reports have been published. In 2014, the third overview report was published as a joint report between OPAH and OPAC: Care for Older People in Acute Hospitals Progress Report: May 2013–July 2014. At the time, this was well received, with feedback suggesting that the joint report gave a more balanced view of what was working well and what areas needed to improve, rather than publishing inspection findings alone, where there is an inherent bias towards areas for improvement. Stakeholders clearly valued having a national overview report which pulled out key themes from the inspection findings. Building on the feedback from the Care for older people in acute hospitals Progress report: May 2013–July 2014, this report should be a joint report to reflect improvements made to the care for older people. It should be produced annually to coincide with the publication of the Healthcare Improvement Scotland Annual Report.
**Recommendation**

13. A report which summarises the themes from inspection and improvements made to the care of older people in hospital should be published annually in line with the Healthcare Improvement Scotland Annual Report.
Section 6: The next phase of the improvement support for the care of older people

126. The fourth purpose of the review was to advise on key areas of focus for the next phase of the OPAC improvement programme, including the approach to be taken nationally, that will best support local services to deliver sustained improvement.

Approach

127. The ihub was launched on 1 April 2016 following the integration of a range of improvement services across Scotland.

128. During 2016–2017, the ihub developed a three-year workplan to support the priorities identified by key stakeholders. These included NHS boards, Health and Social Care Partnerships, independent, third sector and housing organisations.

129. To support the effective delivery of this workplan, the ihub completed a restructure of its existing workforce to align to a range of portfolios of work such as acute care and conditions or pathway portfolios, such as dementia.

130. Underpinning these portfolios are a range of system support and enablers, including strategic planning.

131. The Acute Care Portfolio, established on 1 April 2017, brings together the improvement work which to date has been delivered through the Acute Adult and Healthcare Associated Infection (HAI) Scottish Patient Safety Programmes (SPSP) and the OPAC improvement programme. At the time of publishing this report, a process of review and redesign of acute care improvement support is being undertaken by the ihub to consider the future content of, and approach to delivering, improvement support. A steering group is working with the acute care team to support this process, building on existing knowledge, experience and expertise. Interventions and measures already available will be used wherever possible. Therefore, the main focus will be:

- agreeing the portfolio content and method of delivery
- the mix of interventions
- appropriate reliability and ‘human factors’ techniques to ensure sustainable improvement over time, and
- agreeing how best to integrate and align work across portfolios, including Focus on Dementia and Medicines.

132. By bringing these different programmes together, and working with a range of key NHS board staff and other stakeholders, there is an opportunity to build on progress, to develop better collaboration between existing areas of work, agree priority areas of focus and identify any changes to ways of working. Frailty and delirium will remain a key part of the work of the newly established Acute Care Portfolio in the ihub.

133. It is the intention that, over time, planned programmes of work such as the Acute Care Portfolio will evolve to be more locally tailored and responsive in their approach. In some areas of work this is already happening. With SPSP, priorities are now
locally determined, with the national team providing flexible improvement support in line with local priorities.

**Local improvement support**

134. During the review, stakeholders consistently asked for greater links between inspection findings and the improvement support offered by Healthcare Improvement Scotland. The ihub will develop and test the approach to planned and responsive improvement support through the newly established portfolio structure.

**Recommendation**

14. During 2017–2018, the ihub will continue to develop, test and refine its approach to responsive improvement support, including the response following older people’s inspections.

**Sharing learning**

135. The work of the Acute Care Portfolio and the wider ihub will continue to facilitate the sharing of good practice and areas of improvement within and between NHS boards.
Section 7: Closer working between assurance [inspection] and improvement

136. Lastly, the strategic review group set out to make recommendations on how we ensure the national assurance and improvement programmes across older people in acute care, community hospitals and specialist dementia units interface effectively so as to maximise the drive for improvement locally.

137. Another strong message from the review was the need for clarity, particularly on:
   - how the different improvement functions work together
   - how inspection and improvement work together, and
   - improvement expertise being part of the NHS board visit.

**Recommendation**

15. From 2017 onwards, the OPAH inspection team and ihub colleagues from the Acute Care Portfolio (and others as appropriate) will meet every three months to review the recurring themes emerging from inspections. They will agree an approach to planned improvement support for older people’s care that maximises the impact of the national resources available and considers how improvement support will be delivered.
Next steps

138. As described, there will be two parallel work streams over the course of 2017–2018 that will support the implementation of these next steps. The overarching governance for both work streams sits with the Healthcare Improvement Scotland Quality Committee. This is a subcommittee of the Healthcare Improvement Scotland Board. Progress against recommendations will be overseen by the Quality Committee.

139. The new Older People in Hospitals programme will sit within the Quality of Care Approach. This will include revising the self-assessment to reflect the Quality Framework, with an ambition to have this fully integrated into a single Quality of Care self-evaluation, over time. Work will continue to identify the most effective way for inspections to report on contextual and root cause issues, which are impacting on the quality of care and ensure that inspection findings are used to inform and focus the direction of the wider Quality of Care Approach.

140. The OPAH team will establish an implementation group with key stakeholders to take forward the development of a revised methodology and associated inspection tools. The testing of the revised methodology and tools will commence late 2017 with a view to implement the first full inspections in acute and community hospitals in April 2018. This will then be followed by the development of appropriate tools and methodology for use in specialist dementia units towards the end of 2020.

141. The Acute Care Portfolio will continue to review and redesign the improvement support offer for adult acute care.

142. This review report will be submitted to the Healthcare Improvement Scotland Board and Scottish Government in October 2017.
## Summary of recommendations

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
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References

All published references are hyperlinked.

1 Blake Stevenson, Healthcare Improvement Scotland. Review of Older People in Acute Care Improvement Programme and Older People in Acute Hospitals Inspections. 2016 [cited 13 Oct 2017]


3 Healthcare Improvement Scotland. Care of Older People in Hospital Standards. 2015 [cited 6 Oct 2017]


17 Royal College of Physicians. Generic Medical Record Keeping Standards. 2015 [cited 6 Oct 2017]
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### Appendix a: Membership of the Older People’s Care Strategic Review Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
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<tbody>
<tr>
<td>Lisa Birch</td>
<td>Programme Manager, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Penny Bond</td>
<td>Implementation &amp; Improvement Support Team Leader, Healthcare Improvement Scotland</td>
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<tr>
<td>Jane Byrne</td>
<td>Senior Programme Manager, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Beatrice Cant</td>
<td>Programme Manager, Healthcare Improvement Scotland</td>
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<tr>
<td>Lawrie Davidson</td>
<td>Head of Inspection, Care Inspectorate</td>
</tr>
<tr>
<td>Suzanne Forrest</td>
<td>Programme Director, NHS Education for Scotland</td>
</tr>
<tr>
<td>Morag Gardner</td>
<td>Associate Director of Nursing, NHS Fife</td>
</tr>
<tr>
<td>Ruth Glassborow</td>
<td>Director of Improvement Support, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Karen Goudie</td>
<td>OPAC National Clinical Lead, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Caroline Hiscox</td>
<td>Deputy Nurse Director, NHS Grampian</td>
</tr>
<tr>
<td>Margaret Hogg</td>
<td>Public Partner, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Ellen Hudson</td>
<td>Associate Director for Professional Practice, Royal College of Nursing</td>
</tr>
<tr>
<td>Lyn Irvine-Brinklow</td>
<td>Alzheimer Scotland Dementia Nurse Consultant, NHS Grampian</td>
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<tr>
<td>Christine Jess</td>
<td>Public Partner, Healthcare Improvement Scotland</td>
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<tr>
<td>Penny Leggat</td>
<td>Public Partner, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr Ajay Verma Macharouthu</td>
<td>Consultant in Liaison Psychiatry for Elderly, NHS Ayrshire &amp; Arran</td>
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<tr>
<td>Jacqueline Macrae</td>
<td>Head of Quality of Care and Interim Chief NMAHP, Healthcare Improvement Scotland</td>
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<tr>
<td>Geraldine Marsh</td>
<td>Associate Chief Nurse Older People’s Services, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Trudi Marshall</td>
<td>Nurse Consultant, Older People, NHS Lanarkshire</td>
</tr>
<tr>
<td>Heidi May (Co-chair)</td>
<td>Executive Director Nursing, Midwifery and Allied Health Professionals (representing the Scottish Executive Nurse Directors)</td>
</tr>
<tr>
<td>Christine McAlpine</td>
<td>Chair of Scottish Council, British Geriatrics Society</td>
</tr>
<tr>
<td>Fiona McCluskey</td>
<td>Assistant Chief Nurse, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Alastair McGown</td>
<td>Senior Inspector, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Gary Morrison</td>
<td>Mental Welfare Commission for Scotland</td>
</tr>
<tr>
<td>Diane Murray</td>
<td>Associate Chief Nursing Officer, Scottish Government</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
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</tr>
<tr>
<td>Rami Okasha</td>
<td>Executive Director, Care Inspectorate</td>
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<td>Jim Pearson</td>
<td>Director of Policy &amp; Research, Alzheimer Scotland</td>
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<tr>
<td>Karen Ritchie</td>
<td>Deputy Director of Evidence, Healthcare Improvement Scotland</td>
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<td>Irene Robertson</td>
<td>Inspector, Healthcare Improvement Scotland</td>
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<tr>
<td>Cesar Rodriguez</td>
<td>Associate Medical Director for Older People, NHS Tayside</td>
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<td>Ian Smith</td>
<td>Senior Inspector, Healthcare Improvement Scotland</td>
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<tr>
<td>Paul Smith</td>
<td>Associate Improvement Advisor, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Claire Sweeney</td>
<td>Director of Quality Assurance, Healthcare Improvement Scotland (until April 2017)</td>
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<tr>
<td>Alison Thomson</td>
<td>Executive Director (Nursing), Mental Welfare Commission for Scotland</td>
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<tr>
<td>Nigel Tickell</td>
<td>Programme Manager, Healthcare Improvement Scotland (until November 2016 )</td>
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<tr>
<td>Sara Twaddle</td>
<td>Director of Evidence, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Pam Whittle CBE</td>
<td>Chair, Scottish Health Council, Healthcare Improvement Scotland</td>
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<tr>
<td>June Wylie</td>
<td>Head of Improvement Support, Healthcare Improvement Scotland</td>
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<tr>
<td>Derek Young</td>
<td>Senior Policy Officer, Age Scotland</td>
</tr>
</tbody>
</table>
Appendix b: Terms of Reference of the Older People’s Care Strategic Review Group

Background

1. In July 2015, Healthcare Improvement Scotland received a new commission from the Chief Nursing Officer Directorate to continue and extend the OPAC improvement programme and OPAH inspection programme to include community hospitals and specialist dementia units. The response from Healthcare Improvement Scotland in September 2015 included a recommendation to undertake a joint review of the OPAC and OPAH programmes to explore how Healthcare Improvement Scotland can most effectively continue to support improvement and provide assurance in older people’s care.

2. The recommendation to undertake a review was approved by the Chief Nursing Officer Directorate and it was agreed that the review would take into account contextual factors, such as the publication of the revised Care of Older People in Hospital Standards\(^3\) the developing work on the Quality of Care Approach\(^2\) and the changing context of health and social care in Scotland.

Contextual factors

*Older People in Acute Hospitals inspections*

3. On 6 June 2011, the Cabinet Secretary for Health and Wellbeing announced that Healthcare Improvement Scotland would carry out a programme of inspections of services for older people in hospital with the purpose of:

- driving improvement in the care of older people, and
- providing public assurance that NHS Scotland treats older people with the respect, compassion, dignity and care that they deserve.

4. A review of the inspection process (Whittle Review\(^7\)) was undertaken in 2013. This led to a more outcomes-focused self-assessment and an inspection programme which is more risk based and proportionate. There has been greater engagement with NHS boards through pre and post-inspection visits. In addition, work has continued to align our scrutiny and improvement work, where possible, and there have been a number of examples where NHS boards have asked the OPAH and OPAC teams to jointly support them with post-inspection improvement events.

5. Since the Whittle Review\(^7\), the revised Care of Older People in Hospitals Standards\(^3\) have been published. This has led to a need to update the inspection self-assessment and inspection tools.

*Improving care for older people in acute care*

6. The OPAC improvement programme was initiated in 2012 following the launch of the OPAH inspection programme and is commissioned by the Chief Nursing Officer Directorate. The focus of the programme’s work has been on early identification and management of delirium and frailty. The improvement programme continues to build on progress in these areas and, in addition, is currently testing a blended approach to
improvement support within three NHS boards. Learning from this approach is being captured on an ongoing basis and will be shared when this work completes in September 2016.

**Internal review – scrutiny and improvement support**

7. A 90-day process was conducted by Healthcare Improvement Scotland to explore what needs to be in place for scrutiny and improvement support to operate together to maximise the benefits across healthcare in Scotland. This process identified a lack of empirical evidence regarding the benefits or otherwise of scrutiny and improvement support operating in one organisation.

**Quality of Care**

8. In the summer of 2014, the Cabinet Secretary for Health and Wellbeing announced that Healthcare Improvement Scotland would lead on developing and delivering more comprehensive reviews of the quality of healthcare provided to the people of Scotland. A report detailing the work of the design panel is available on the Healthcare Improvement Scotland website and provides an overview of the proposed ‘vision’ for the future approach whilst outlining key recommendations and next steps.

9. The approach incorporates an enhanced focus on service providers transparently self-assessing the quality of care they provide, with external, independent validation of this by Healthcare Improvement Scotland. A shared quality framework will underpin both of these activities and provide consistent guidance to services, and those externally quality assuring them, about what ‘good’ quality care looks like and how it can be evidenced. Work to translate the ‘approach’ in to a core operational methodology, with an associated set of tools that can flex to the subject and scale of the review will progress in 2016–2017.

**National improvement support for health and social care - Improvement Hub**

10. In response to the integration of health and social care services across Scotland, Healthcare Improvement Scotland has worked with a range of partners to create a new improvement resource, called the Improvement Hub (or ihub for short). This resource will support Health and Social Care Partnerships (which include health, social care, third sector, independent sector and housing organisations) and NHS boards to improve the quality of health and social care services.

11. It does this by:

   - supporting the development of cultures of continuous quality improvement so that every person working in health and social care is engaged in the work of improving their day to day practice, and
   - supporting the work to design systems, services and processes, which enable people to receive the right support and care, in the right place, at the right time whilst also reducing harm, waste, duplication, fragmentation and inappropriate variation.

12. It is recognised that in order to deliver on the above, strong and effective partnerships are required with a wide range of local and national organisations.

13. The ihub has a mixture of over 30 programmes of work that support improvements in aspects of care delivery services and the development of infrastructures and cultures which enable the work of improvement. It also has a tailored and responsive improvement support team that provides flexible improvement support to help NHS...
boards and Health and Social Care Partnerships address local priority issues. Finally, it has a small grants making arm that provides resources for organisations to test and develop approaches to improving health and social care services.

**Purpose of the review**

14. The review group has been established to advise on the next stage of development of the OPAH and OPAC programmes. In doing this it is asked to:

- advise on what aspects of the OPAH and OPAC programmes are enabling and what, if any, aspects are hindering improvements in older people’s care
- advise on the extent to which the 2013 Whittle Review recommendations have been implemented and make recommendations on any refinements required to the current methodology to ensure we maximise impact of improvement activities
- advise on key areas of focus for the next phase of the OPAC programme, including the approach to be taken nationally, that will best support local services to deliver sustained improvement
- make recommendations on the approach for extending the care of older people’s inspections into community hospitals and specialist dementia units
- make recommendations on how we ensure the national assurance and improvement programmes across older people in acute care, community hospitals and specialist dementia units interface effectively so as to maximise the drive for improvement locally, and
- carry out the review between May 2016 and November 2016.

**Relationships and reporting arrangements**

15. The review will be led by Healthcare Improvement Scotland and is supported by the Chief Nursing Officer Directorate. Progress against key milestones will be reported to the Chief Nursing Officer Directorate and through Healthcare Improvement Scotland’s Quality Committee to the Board.

16. Members are responsible for reporting on progress to their relevant stakeholder groups.

17. The review group is co-chaired by a Healthcare Improvement Scotland non-executive and a representative from the Scottish Executive Nurse Directors.

18. Membership is detailed in Appendix a of this report with project support from Healthcare Improvement Scotland.

19. Attendance at meetings by clinical experts and other external participants is by invitation from the Chairs.

20. If at any point any individual member believes they have a conflict of interest, this should be raised with the Chairs.

21. All members are required to actively participate in every meeting and carry out agreed actions.
Support

22. Support will be provided by Communications colleagues on an ‘as necessary’ basis. Outputs, including action notes and progress reports will be shared with the Healthcare Improvement Scotland Head of Communications.

23. The Administrator shall ensure that the group is provided with appropriate support to collate and circulate papers, and ensure follow-up actions are delivered. Papers will be circulated one week in advance of meetings.

Frequency

24. The group will meet monthly. Additional meetings and teleconferences will be held as necessary.

Governance arrangements

HIS Board

HIS Quality Committee

Care of Older People - Improvement & Scrutiny Review Group

Care of Older People - Improvement & Scrutiny Operational Subgroup