Building a comprehensive approach to reviewing the quality of care: 
Supporting the delivery of sustainable high quality services

Consultation Feedback Report

March 2016
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Executive summary

On 1 July 2015, Healthcare Improvement Scotland issued a public consultation paper. The paper set out proposals for the development and implementation of a new model for reviewing the quality of care, which will in turn support delivery of sustainable high quality services. This followed the announcement by the Cabinet Secretary for Health and Wellbeing in Scotland that Healthcare Improvement Scotland would lead on developing and delivering more comprehensive reviews of the quality of care.

The consultation process took place between 1 July and 30 September 2015. The process included:

- seeking formal written responses from stakeholders
- three focus groups with health and care professionals in Edinburgh, Elgin and Glasgow, and
- five discussion groups for members of the public in Aberdeen, Alexandria, Irvine, Orkney and Stirling, hosted and facilitated by the Scottish Health Council.

In total, we had 93 written responses and 117 individuals attended the health and care professionals’ focus groups and 34 members of the public attended the discussion groups.

The main conclusions from the consultation are listed below.

- The consultation has identified broad support for developing and implementing a quality framework that supports consistent assessment of the quality of care.
- The consultation has highlighted the need for the quality framework to be accessible for a wide range of stakeholders and to more closely reflect outcomes of care.
- The framework also needs to ensure that it sits clearly, understandably and coherently in the wider spectrum of standards.
- The consultation has elicited support for the approach, but there is a need to work through the detail of the operational model to implement the proposals.
- There is generally strong support for independent assessment of service sustainability.
- There is a need to ensure sufficient attention is focused on the future capability of organisations to improve the quality of care.
- The system needs to be weighted towards internal self-assessment, underpinned by external quality assurance, and support needs to be available to NHS boards in undertaking this.
- The model needs to fit with other elements of scrutiny in Scotland, especially any future reworking of joint inspections with the Care Inspectorate.

Healthcare Improvement Scotland will use the findings to shape the future model for reviewing the quality of care. We are committed to continuing to engage and seek further views as the proposals develop. We will work with stakeholders as we implement the new model in 2016.

A number of key recommendations and proposed ‘next steps’ to take this work forward are outlined in the Design Panel final report.

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1 [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews/qoc_reviews_consultation.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews/qoc_reviews_consultation.aspx)
2 [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews)
Background

Through the 2020 vision for health and social care and the Quality Strategy, Scotland has an explicit and ambitious commitment to providing sustainable, high quality services for the people of Scotland.

On 1 July 2015, Healthcare Improvement Scotland issued a public consultation paper, setting out proposals for developing and implementing a new model to deliver a more comprehensive approach to reviewing the quality of care, which will in turn support delivery of sustainable high quality services.

This followed the announcement by the Cabinet Secretary for Health and Wellbeing in Scotland that Healthcare Improvement Scotland would lead on developing and delivering more comprehensive reviews of the quality of care:

> “These new reviews will first and foremost focus on the quality of care. But they will add to our scrutiny regime by considering the whole system, including staff levels, and patient experience. The reviews will play an important part in ensuring that our NHS continues to be open and honest to those it serves – Scottish patients. As well as being truly open and transparent our NHS also needs to reflect on best practice and support staff to emulate success and spread good practice so that it becomes common practice everywhere.”

A Design Panel, with representatives from various health and social care organisations and members of the public, was established to help shape the new approach for reviewing the quality of care. The Design Panel developed the proposals presented in the consultation paper.

The consultation paper built upon the areas of strength within current systems and identified areas for development to support the delivery of better quality care and, ultimately, achieve better outcomes for the people of Scotland. The consultation paper highlighted the place for external scrutiny to support services in Scotland to transparently identify the gap between where they are today and where they aspire to be in the future.

Healthcare continues to adapt and evolve, with significant and successful advances in the diagnosis, treatment and rehabilitation of patients. It is also becoming more complex. Healthcare is often less about isolated episodes and more about integrated and multidisciplinary working between health and social care professionals, and increasingly with voluntary organisations.

The integration of health and social care in Scotland was in direct response to the recognition that separate systems of health and social care could no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined-up, integrated services.
The scrutiny of healthcare also needs to adjust to these changing circumstances. A major objective is to ensure even closer collaboration between scrutiny bodies in Scotland and to streamline our approach to scrutiny. Whilst the focus of this consultation document was on healthcare, there is a need to ensure, through these proposals, that we continue to work closely with the Care Inspectorate in the future design of more integrated approaches to the scrutiny of health and social care.

The consultation process took place between 1 July and 30 September 2015. The process included:

- seeking formal written responses from stakeholders
- three focus groups with health and social care professionals held in Edinburgh, Elgin and Glasgow, and
- five discussion groups hosted and facilitated by the Scottish Health Council for members of the public in Aberdeen, Alexandria, Irvine, Orkney and Stirling. A copy of the Scottish Health Council report is provided at Appendix 1.

In total, we received 93 written responses and 117 individuals attended the health and care professionals' focus groups and 34 members of the public attended the discussion groups.

The responses received as part of the consultation process have been reviewed and used to inform this report. We will use the findings to shape the future model for reviewing the quality of care. We are committed to continuing to engage and seek further views as the proposals develop. We will work with stakeholders as we implement the new model in 2016.
Summary of main themes from the consultation

A summary of the main themes arising from the consultation responses is provided below. Further details of responses against each of the 11 questions posed in the consultation paper are provided at Appendix 3. Where figures are recorded for responses, these refer to the formal written responses we received.

The guiding principles

The consultation paper set out nine guiding principles for quality of care reviews. They would guide an approach that:

- drives improvement
- is person-centred
- is open and honest
- is fair, transparent and risk based
- is flexible
- is developed in partnership
- is owned by all those involved
- is proportionate and practical, and
- is adaptable for a variety of care settings.

The majority (69%) of the responses were supportive of the guiding principles for the approach. However, a number of respondents highlighted concerns with the principles. Some noted that, although the principles were well intentioned, and there was merit in each as separate issues, it was difficult to see how they would be meaningfully applied as a whole. There were concerns about the practicalities of delivering against the principles consistently across the spectrum of scrutiny. Others noted that the principles were not necessarily ordered by importance, risking some principles being perceived as more important than they are.
The quality framework domains

The draft quality framework was developed around seven domains:

- person-centred care
- safety
- effectiveness
- leadership
- governance
- workforce, and
- quality improvement.

The majority (57%) of those who responded to the consultation felt that the domains were appropriate. Many welcomed the separate assessment of the seven domains and felt that it gave some domains, such as leadership, governance and workforce, the focus they deserve. Some respondents added other domains to the list, including timely and capacity for improvement. However, a few respondents felt that the number of domains could be reduced in order to focus on the three quality ambitions of the Quality Strategy (safe, person-centred and effective) with the other domains underpinning those ambitions. Others suggested we should use the six domains of quality defined by the Institute of Medicine of which the quality ambitions are three, and the others are efficient, timely and equitable.

Some respondents suggested that quality improvement should not be a domain in its own right but rather should run through the entire framework. Other respondents felt that some of the domains could be incorporated into other domains. For example, in contrast to others, a few respondents noted that workforce and leadership could be incorporated into a larger ‘culture’ domain. However, the majority of people (59%) agreed that culture should, and does, underpin the domains within the quality framework. Members of the public highlighted that culture was important not only within the organisation but also in the context of the individual patients and that communication underpinned everything. Most respondents recognised that culture is difficult to define or measure.

The quality framework

The intention of the framework is to provide guidance on what good quality care might look like and what evidence might be available to provide assurance of this. As part of the consultation, we asked whether the quality framework should be kept as a piece of best practice guidance or if it should be used to form a set of standards against which we could scrutinise. The responses to this question were varied, although the majority (48%) demonstrated a preference towards standards in some form. Some (28%) of those who felt that the framework should form a set of standards also felt that it should be combined with a best practice guide, although 22% of respondents were unclear whether the framework should form a set of standards or a best practice guide. Some respondents acknowledged that if this was the only set of standards against which a service may be assessed, it may be a more streamlined approach. As a set of standards, it would also add extra weight to the framework. However, a number of people pointed to the fact that this could result in duplication given the standards that already exist, the current development of the care assurance and accreditation system across nursing and midwifery services and the development of the new national care standards. This duplication could lead to an increased burden on staff as they would have to gather evidence to support the quality framework in addition to the information that is already required for existing standards and to inform improvement work. There was strong support for ensuring that the framework had a sufficiently outcomes-focused approach that would help reduce the burden of evidence gathering.
Crucially, the consultation demonstrated a need to move towards a framework that encouraged and supported a rigorous and systematic approach to internal self-assessment and quality improvement supported by external quality assurance.

Some respondents suggested other approaches for the quality framework, such as the development of key quality indicators (KQIs). This suggestion was raised a number of times at the healthcare professional focus groups and, when we asked if it would be helpful to develop a set of KQIs, 65% of respondents said it would. Respondents pointed to the flexibility of KQIs that could be based on agreed national standards.

The general perspective appeared to be that, in its current form, the framework was difficult to manage and the overall size would be off-putting to staff. One respondent noted that “...work needs to take place on the underpinning framework to try and simplify. [...] As a minimum, we need to be able to describe the interface with other agreed national frameworks around quality of care and where possible, use the same standards/indicators etc.” However, it was also recognised that the framework would support those undertaking scrutiny, including external professional experts, to maintain a consistent approach.

Responses from those outside the acute sector in NHSScotland expressed some concerns at how the framework related to them. It was felt that there was very much a focus on secondary care in the NHS and there was a need to ensure the framework was also relevant in other care settings.

**Conclusions**

- The consultation has identified broad support for developing and implementing a quality framework that supports consistent assessment of the quality of care.
- The consultation has highlighted the need for the quality framework to be accessible for a wide range of stakeholders and to more closely reflect outcomes of care.
- The framework needs to sit clearly, understandably and coherently in the wider spectrum of standards.
- The framework needs to support internal self-assessment of progress with appropriate follow-up external quality assurance.
The proposed model for quality of care reviews

The paper proposed that the new approach to quality of care reviews should have four broad dimensions:

• **Thematic Quality of Care Reviews** (thematic reviews of services across the range of providers delivering those services, or across providers in a locality such as reviews of pre-hospital care, vascular surgery, trauma, child and adolescent mental health services, clinical governance. A methodology or approach would be developed to prioritise areas/services to be reviewed along with the level of review that would yield the most benefit.)

• **Organisational Quality of Care Reviews** (reviews to assess the quality and sustainability of care at an organisational provider level as part of an ongoing or triggered approach.)

• **Service Level Review** (reviews of specific services), and

• **Point of Care Reviews or Inspections** (reviews and inspections based on intelligence received. They would cover a range of topics including, but not limited to, the care of older people across all healthcare settings, healthcare associated infection (HAI), inpatient mental healthcare).

These four dimensions would apply across three broad levels of an organisation or system of care:

• services and systems provided across a provider area, including interfaces between services, for example the interface between health and social care (macro level)

• across particular services such as care of older people, accident and emergency or primary care services (meso level), and

• at ward level, within a community setting, or any other setting with direct interaction between a care professional and the patient, service user or carer (micro level).

The majority of respondents supported the four dimensions (45%) and three levels (55%) in principle. They noted that there were similarities with our current approach to scrutiny. This led to comments on our current approach, including the difference between announced and unannounced inspection activity. During focus group discussions, those present expressed a preference for unannounced scrutiny activity, particularly due to the reduced burden on staff and the more honest impression that was given.

Although respondents noted similarities with our current approach and agreed with the new model in principle, a number also noted the proposed model was complex and confusing. One respondent highlighted that we would be assessing seven domains, across three levels with four dimensions. Respondents felt that this presented a model that would be difficult to understand at a practice level and would therefore be difficult to implement. Some also felt that the complexity of the approach could lead to an increase in bureaucracy. Others noted that simply the language used was confusing and a simpler, clearer explanation would be helpful.

A point that was raised consistently was the need to ensure effective support for internal self-assessment and continuous quality improvement, with external quality assurance as a significant opportunity to assess the progress in achieving improvement. Moreover, there was a need to ensure external quality assurance gave greater weight to assessing the capability and capacity of organisations to implement future improvements in the quality of care. Similarly, there was strong support for establishing a system that allowed for earlier flagging of concerns or difficulties rather than a later ‘crisis intervention’.
Responses to the consultation demonstrated a need to consider the balance between point of care inspections and the overall quality assurance of a system. Any new approach to scrutiny needs to be risk based and proportionate, striking the right balance between point of care inspections, external quality assurance of a system, and internal self-assessment.

The majority of respondents felt it would be helpful to assess service sustainability as part of the new approach. They felt that it was important to assess this as it is “central to the development of improvement activity moving forward.” While it was generally supported, some questioned how this would look in practice and how it would be assessed. In particular, there was a need to ensure service sustainability assessments (whether at a national, regional, or local level) had sufficient weight and credibility in arriving at their conclusions.

A particular theme that was raised was the issue of health inequalities and the extent to whether reviews would encompass this in future. This is an important point, especially when considering the establishment of health and social care partnerships.

As part of the consultation, we asked if the new proposals would support health and social care integration. The majority of respondents had mixed views on whether it would. This was largely due to the language used and the confusion around what is meant by ‘care’. The consultation paper refers to care and healthcare interchangeably. In part, this was to future proof the proposals in light of health and social care integration.

The consultation document acknowledged that there are a number of bodies with responsibility for the scrutiny of health and social care in Scotland, including Healthcare Improvement Scotland and the Care Inspectorate. Currently, we are responsible for the scrutiny of healthcare services while the Care Inspectorate is responsible for the scrutiny and regulation of care services, for example care homes, hospice at home services and childcare services. Through discussions with stakeholders and written responses, it was apparent that there was a need to be clearer about the future responsibilities of the different scrutiny bodies in relation to the spectrum of healthcare. Although we already work with the Care Inspectorate, and other scrutiny bodies, as we move further into health and social care integration, we will be working ever more closely with them.

In light of the further integration of health and social care, some attendees at the focus groups felt that it may make sense to integrate the scrutiny bodies for each sector, or at least encourage closer working, to avoid confusion. This would reduce the risk of duplicating work and reduce the potential burden on staff. There was a need to ensure absolute clarity about the balance of responsibilities between scrutiny bodies and where each body, acting in isolation or together, had the most appropriate skills or expertise.

During the consultation, some concerns were raised about how Healthcare Improvement Scotland can provide impartial scrutiny of the NHS and other healthcare providers, especially given the co-existence of improvement support and scrutiny in the same organisation. Healthcare Improvement Scotland has been undertaking work (using the Institute of Healthcare Improvement 90-day innovation process) to examine how improvement support and scrutiny can best work together to achieve improvements in the quality of care.

Some proposed that Healthcare Improvement Scotland should be formally established as an independent regulator. Some saw a need for far more robust implementation of the Health and Safety at Work Act (1974) in healthcare settings.
Conclusions

• The consultation has elicited support for the approach but there is a need to work through the detail of the operational model to implement the proposals.
• There is generally strong support for the independent assessment of service sustainability.
• There is a need to ensure sufficient attention is focused on the future capability of organisations to improve the quality of care.
• The system needs to be weighted towards internal self-assessment, underpinned by external quality assurance, and support needs to be available to NHS boards in undertaking this.
• The model needs to fit with other elements of scrutiny in Scotland, especially any future reworking of joint inspections with the Care Inspectorate.

Principles and approach: post consultation

The Design Panel has led a significant design and engagement process since its establishment in October 2014. This resulted in a consultation document that outlined, first and foremost, a proposed set of guiding principles, and four major areas of proposed change. The Design Panel has reviewed and considered the consultation feedback and the proposals have been revised, where appropriate, based on:

• what stakeholders have told us is important to them
• what stakeholders felt would be most useful, and
• what could be implemented and delivered in practical terms.

The following table includes a high level summary of our revised approach following the consultation exercise.
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<th>The consultation proposed:</th>
<th>We asked:</th>
<th>What we plan to do based on the consultation feedback:</th>
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<tr>
<td>Nine principles that would guide the approach to reviewing the quality of care.</td>
<td>Do you agree with the principles that guide our approach?</td>
<td>Adoption of these nine principles which will underpin all future work to review quality of care.</td>
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<tr>
<td>A new quality framework to underpin the assessment and improve the quality of care (with seven core domains).</td>
<td>Do you think these are the right core domains, and will the supporting detail within the quality framework support the assessment and improvement of quality care?</td>
<td>Formal adoption of the seven core domains.</td>
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<td>Increased emphasis on local systems of scrutiny and assurance.</td>
<td>How reasonable or practical is it to assess care against the domains and categories set out in the quality framework?</td>
<td>Streamlining and simplification of the quality framework to ensure accessibility and ease of use, and alignment with existing standards.</td>
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<td>Should the quality framework form a set of standards that must be met or remain a guide of best practice?</td>
<td>More emphasis within the quality framework on promoting and supporting internal self-assessment, with external validation and quality assurance of this.</td>
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<td>More comprehensive assessments of the quality of care at three broad levels (macro, meso and micro) and encompassing four broad dimensions of quality of care reviews (thematic, organisational, service level and point of care).</td>
<td>Do you think external scrutiny should focus on these three broad levels across an organisation or system of care?</td>
<td>The scrutiny dimensions will be pared back and will include intelligence-driven thematic comprehensive assessments, and point of care reviews and inspections as currently.</td>
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<td>Do you think the new approach to scrutiny should include the four dimensions of: • Thematic Quality of Care Reviews • Organisational Quality of Care Reviews • Service Level Reviews, and • Point of Care Reviews or inspections?</td>
<td>The thematic comprehensive assessments will be applied at either the macro or meso level as appropriate.</td>
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<tr>
<td>External assessments of the sustainability of care.</td>
<td>Would it be helpful to include making recommendations for service sustainability as part of the new approach?</td>
<td>Independent assessment of service sustainability will be incorporated into reviews of the quality of care.</td>
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The principles and approach as articulated above will be used to inform a suite of recommendations that were presented to the Board of Healthcare Improvement Scotland in February 2016 as part of the Design Panel final report. The recommendations will ensure coherence and alignment with other strategic developments under way or planned in Healthcare Improvement Scotland over the coming year.

In the next phase of work, Healthcare Improvement Scotland will establish an internal implementation programme board with representation from across the organisation, and an expert reference group with external membership to translate the agreed principles and approach into an operational model that can be rolled out during 2016.
Appendix 1:
Scottish Health Council consultation with members of the public

As part of the consultation process, the review team requested the Scottish Health Council, by means of use of its local office network, to host and facilitate a total of five discussion groups across Scotland to gather public feedback on the review process.

It was agreed that the format of each of these group discussions would follow the same format. They would begin with a presentation delivered by a member of the Healthcare Improvement Scotland quality of care review team. This would provide detail on the proposed framework to assess and improve the quality of care. The presentation also identified the nine guiding principles which would shape the reviews, namely that they:

- drive improvement
- are person-centred
- are open and honest
- are fair, transparent and risk based
- are flexible
- are developed in partnership
- are owned by all those involved
- are proportionate and practical, and
- are adaptable for a variety of care settings.

The presentation would be followed by a discussion session facilitated by Scottish Health Council local office staff based around a number of pre-agreed questions:

1. Are these the right principles to guide a review structure?
2. Have we identified the right areas of focus?
3. Have we identified the right categories in relation to person-centredness or are there any gaps?
4. Does the proposed model help reassure you that service providers will be reviewed effectively?
5. As a result of the proposed changes, do you feel that care will be safer and better?

Notes of each discussion session were recorded by staff before being presented as individual accounts which in turn were reviewed to identify emerging or common themes. This information was then subsequently shared with the quality of care review team to help inform the further development of the process.
Feedback from discussion groups

The Scottish Health Council organised a total of five discussion groups in Aberdeen, Alexandria, Irvine, Orkney and Stirling. A total of 34 people participated in the events to respond to a number of pre-identified questions aimed to elicit views on their opinion of a proposed framework to assess and improve the quality of care.

Question 1: Are these the right principles to guide a review structure?

There was broad general agreement across the discussion groups that the principles had been correctly identified.

There were comments suggesting possible improvement or additions such as:

- “The principle of Human Rights should perhaps also be reflected in any scrutiny approach.”
- “There should also be something about good quality, clear, effective communication.”
- “Perhaps the principle of fair, transparent and risk based should replace the word ‘risk’ with ‘safety’.”
- “The aim of the standard should be both realistic and workable.”

Question 2: Have we identified the right areas of focus?

Again after discussion there was a general agreement across the discussion groups that the model was focusing on the correct areas.

Some comments were recorded as:

- “The person in the centre is the most important area of focus. It is also important that a patient and a carer should be viewed as a single unit and not two separate beings.”
- It was noted that all of the arrows in the diagram are pointing towards the centre, “Should they not point both ways as patients should be empowered to communicate too? The arrows could be misleading and suggest that we do things to a patient rather than with them.”
- It was recognised that whilst culture was important not only within the organisation but also in the context of the individual patients, communication underpinned everything.
- There is a need to promote cultural change to support people on the front line to improve as best they can. It was felt by the group that with regards to the reasonableness and practicality of the areas of focus, that it wasn’t really the responsibility of ‘lay people’ to comment on this as they did not have the knowledge to do so.
Question 3: Have we identified the right categories in relation to person-centredness or are there any gaps?

Some of the comments are shown below.

- “Care and compassion, no doubt about it, it is necessary.”
- “Self-management, it’s not suitable for all conditions, however it can be of benefit; it can lead to peer support.” One group member spoke of being encouraged to join a self-management course and how this helped build his confidence and self-esteem.
- Equality and diversity – need to ensure that the person is treated as an individual and not just a condition. Spiritual care is important in patient recovery.
- It is important that access to independent advocacy is added to the list and again it should be stressed that good communication is vital in working together for a person-centred approach.
- A person-centred approach should be realistic and also embrace safety in an individual’s home environment.
- “Education needs to be included somewhere. Communities don’t always know how the system works.”
- Communication and feedback is important and it is also important to have representatives from Third Sector in reviews alongside professionals and members of the public.
- Measurable outcomes are missing from the documents and without these, the information is ‘waffle’. It was noted that the aim of the review is to ensure people feel the quality of care in Scotland is good. Without evidence to demonstrate this, it will be difficult to prove and therefore this is where targets can be helpful.

Question 4: Does the proposed model help reassure you that service providers will be reviewed effectively?

- Once again there was a general sense that the participants had a feeling of reassurance. However, there were a number of issues identified during discussions.
- “It is important that reviewers talk to lots of different people in the care environment and not just doctors and nurses.”
- Participants generally welcomed the principles of the new approach whilst acknowledging work was still required to build on the draft framework.
- Several areas for concern were around difficulty in taking this scrutiny approach into primary care or people’s homes. It was also acknowledged that cost could be a prohibitive factor in the scrutiny process.
- “If it works – yes”. The group felt that with the continued integration of health and social care, there was the potential for the creation of further gaps.
- The group felt the Quality of Care Review was a good step in the right direction to ensure people are not let down by services in the future.
- During discussions, it was highlighted that Healthcare Improvement Scotland currently does not carry out inspections in primary care and that it was an acute care focused organisation in terms of scrutiny. It is intended this will change as they will strive to do more in the community setting. Given that the majority of healthcare is delivered in the community, this raised the question of capacity – how do you do more with less resource?
Question 5: As a result of the proposed changes, do you feel that care will be safer and better?

There was a general hope that this would be the case and some of the points are contained below.
- “I think it’s an improvement if we can get a standard like this.”
- There was a reinforcement of the positive nature of multi-agency working and group members felt reasonably reassured that the proposed model was a step in the right direction. The model was described as having great aspirations but members reserved judgement on how wide reaching it may be in the current financial and integration climate.
- Group members felt reassured provided the model could be implemented, as planned, in the current form. There was some concern that it would be ‘watered down’ prior to implementation.

Conclusions

- It is clear from the discussions that members of the public expect continued and effective external review of care provision and that such a process should also involve public and indeed Third Sector representation where appropriate.
- Communication and feedback were themes identified at each discussion group and in particular the need for this to be clear, effective and good quality, particularly in the area of self-management when patients and carers need to properly understand the conditions they are living with. It is equally as important that when engaging with patients, carers, communities or members of the public about the design, delivery or review of healthcare services, they are provided with feedback as to how their input was used to help progress the matter.
- Another area of concern identified was the continued integration of health and social care services. It was felt that with this continued shift, there was potential for ‘gaps’ in both service delivery and service reviewing to develop and caution should be exercised to ensure this did not happen.
Appendix 2: List of respondents

The following organisations either responded to the consultation or sent representatives to a stakeholder event, or both.

- Aberdeen Council
- Aberdeen Health & Social Care Partnership
- ACCORD Hospice
- Action for Sick Children Scotland
- Age Scotland
- Alzheimer Scotland
- Ardgowan Hospice
- Ayrshire Hospice
- Audit Scotland
- British Medical Association Scotland
- Care Inspectorate
- Care Inspectorate’s Involving People Group
- Chartered Society of Physiotherapy
- Children’s Hospice Association Scotland (CHAS)
- Dartmouth Institute for Health Policy & Clinical Practice
- Diabetes Scotland
- East Dunbartonshire Health & Social Care Partnership
- Forth Valley Patient Public Panel & Public Partnership Forum
- General Medical Council
- General Pharmaceutical Council
- Golden Jubilee National Hospital
- Guild of Healthcare Pharmacists
- Healthcare Improvement Scotland
- Highland Hospice
- Inverclyde Health & Social Care Partnership
- Joint Improvement Team, Scottish Government
- Lomond Patients Group
- Marie Curie
- Moray Health & Social Care Partnership
- NHS Ayrshire & Arran
- NHS Borders
- NHS Borders Joint Associate Directors Group
- NHS Dumfries & Galloway
- NHS Education for Scotland
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Health Scotland
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS National Services Scotland
- NHS Orkney
- NHS Shetland
- NHS Tayside
- NHS24
- North Ayrshire Health & Social Care Partnership
- Nuffield Health
- Oasis Dental Care Limited
- PAMIS (Profound and Multiple Impairment Service)
- Prince & Princess of Wales Hospice
- Queen Margaret University
- Queen’s Nursing Institute Scotland
- Retired HM Inspector of Health & Safety
- Roche Products Limited
- Royal College of Anaesthetics Advisory Board for Scotland
- Royal College of General Practitioners Scotland
- Royal College of Midwives Scotland
- Royal College of Nursing Scotland
- Royal College of Physicians and Surgeons Scotland
- Royal College of Physicians of Edinburgh
- Royal College of Radiologists UK
- Royal Pharmaceutical Society
- Scottish Ambulance Service
- Scottish Health Council
- Scottish Breast Screening Programme
Five written responses were also received from carers and members of the public.
Appendix 3: Overview of responses

A total of 93 written responses to the consultation were received. Respondents were asked to note if they were responding as:

• a carer
• a healthcare professional
• a member of the public
• another stakeholder
• a social care professional, or
• a voluntary/community sector representative.

A breakdown of written responses from each group is shown below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer</td>
<td>1</td>
</tr>
<tr>
<td>Healthcare professional</td>
<td>39*</td>
</tr>
<tr>
<td>Member of the public</td>
<td>5</td>
</tr>
<tr>
<td>Other stakeholder</td>
<td>39</td>
</tr>
<tr>
<td>Social care professional</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary/community sector</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>

*four respondents noted that they were responding as both a healthcare and a social care professional.
Summary of responses

Below is a more detailed summary of the comments received, including written responses, healthcare professionals’ focus groups and public discussion groups.

Question 1:

The paper describes a number of principles that are guiding our approach; an approach that:

• drives improvement
• is person-centred
• is open and honest
• is fair, transparent and risk based
• is flexible
• is developed in partnership
• is owned by all those involved
• is proportionate and practical, and
• is adaptable for a variety of care settings.

Do you agree with the principles that guide our approach?

Response:

Yes: 64
No: 5
Unclear: 16
No response: 8

The majority (69%) of the responses were positive about the guiding principles and supportive of the approach. The principles were considered to be transferrable for both health and social care.

However, some respondents highlighted concerns with the principles. Some noted that, although the principles were well intentioned, and there was merit in each as separate issues, it was difficult to see how they would be meaningfully applied as a whole. There were also concerns about the practicalities of delivering against the principles consistently across the spectrum of scrutiny.

Some noted that the principles were not necessarily ordered by importance, risking some principles being perceived as more important than they are, while others suggested that all the principles were vital.

Some thought that the list of principles should be shortened and clarified. It was suggested that some principles could be amalgamated, for example:

• adaptability and flexibility
• transparent, open and honest, and
• risk-based and proportionate.
Others suggested additional principles such as:
• supporting health and social care integration
• sustainability
• valuing and trusting staff
• duty of candour
• regulation (and the difference from scrutiny)
• consistency and timeliness of care across Scotland, and
• opportunity for learning/recognising good practice.

Question 2:

The quality framework is based on seven domains of person-centred care, safety, effectiveness, leadership, governance, workforce and quality improvement.

Do you think these are the right core domains, and will the supporting detail within the quality framework support the assessment and improvement of quality care?

Response:

Yes: 53
No: 7
Unclear: 25
No response: 8

The majority of those who responded to the consultation felt that the domains were appropriate. Many welcomed the separate assessment of the seven domains and felt that it gave some domains, such as leadership, governance and workforce, the focus they deserve.

Some respondents added other domains to the list, including timely and capacity for improvement. However, a few respondents felt that the number of domains could be reduced in order to focus on the three quality ambitions of the Quality Strategy (safe, person-centred and effective) with the other domains underpinning those ambitions. Others suggested we should use the six domains of quality defined by the Institute of Medicine of which the quality ambitions are three, and the others are efficient, timely and equitable.

Some respondents felt that some of the domains could be incorporated into other domains. For example, a few respondents noted that workforce and leadership could be incorporated in to larger ‘culture’ domain. Others noted that quality improvement should not be a domain in its own right but rather should run through the entire framework.

While respondents felt the domains would work for both health and social care, there was concern that the framework was too healthcare focused, particularly the acute sector.
Question 3:

How reasonable or practical is it to assess care against the domains and categories set out in the quality framework?

The general perspective was that, in its current form, the framework was difficult to manage and the overall size would be off-putting to staff. One respondent noted that:

“...work needs to take place on the underpinning framework to try and simplify...As a minimum, we need to be able to describe the interface with other agreed national frameworks around quality of care and where possible, use the same standards/indicators etc.”

It was also recognised that the framework would support those undertaking scrutiny, including external professional experts, to maintain a consistent approach. It was suggested there needs to be clarity on what the grading systems are, if there are any. Alternatively, the outcomes of an inspection could be an improvement plan instead of a grade, as is already the case for inspections of NHS services.

Responses from those outside the acute sector in NHSScotland, particularly the independent healthcare sector, expressed some concerns at how the framework related to them. It was felt that there was very much a focus on acute care in the NHS and there was a need to ensure the framework was also relevant in other care settings.

Members of the public suggested that representatives from the voluntary sector should be involved in reviews alongside professionals and members of the public.

The ‘what good might look like column’ was generally deemed helpful for providers. There was a concern that only striving for ‘good’ might drive mediocrity. Some thought that the framework could be cross referenced for ease of use, and provide links to additional information.

There was strong support for ensuring that the framework had a sufficiently outcomes-based approach, which would in turn help reduce the burden of evidence gathering. Crucially, the consultation demonstrated a need to move towards a framework that encouraged and supported a rigorous and systematic approach to internal self-assessment and quality improvement, supported by external quality assurance.

Most people were supportive of the person-focused outcomes column. Some suggested that the framework could be flipped so that the outcomes are in the first column, placing the emphasis more firmly on the person-focused outcomes. However, there was concern that it would be impossible to enforce the patient responsibilities. One responding organisation suggested:

“There needs to be more balance towards the population need, and recognition of the concept that the needs of the many can outweigh the needs of the few or the one. It was felt important to promote a realisation that services may need to cater to the many rather than the individual and as a consequence there may be times when not all person centred goals can be achieved. It was also felt important that patients themselves are encouraged to understand this balance.”
Some suggested the framework must be more person-centred, for instance the person-focused outcomes in the leadership domain should be reworded. There was also debate over whether or not equality should be listed in the person-centred domain. It was suggested that patients should be asked if they are “involved to the extent they wish in decision-making.” Combining patient safety and risk enablement was also seen as a challenge.

Members of the public agreed that self-management, while not suitable for all conditions, can be of benefit and can lead to peer support. Some suggested that independent advocacy be added to the list and that education is considered as “communities don’t always know how the system works”. Members of the public also identified that the outcomes, were not all measurable and that without evidence to support the outcomes it will be difficult to demonstrate the quality of care being delivered.

Attendees at the stakeholder events recommended the development of an IT system to access and share data, and a database of common problems and solutions to help share best practice, supported by staff training. There should also be a consistent way to record information across scrutiny bodies and NHS boards so that information can be recycled for multiple scrutiny bodies rather than work being duplicated. It was felt that nationally standardised documentation could support this. To further reduce the burden on staff, respondents felt it would be helpful to use existing data, such as data gathered for improvement programmes, and the amount of information required should reflect the type or size of the review taking place.

**Question 4:**

Should the quality framework form a set of standards that must be met or remain a guide of best practice?

**Response:**

- Preference for standards: 27
- Preference for guide of best practice: 14
- Preference for a combination: 13
- Preference for guide of best practice that will become standards: 5
- Unclear: 20
- No response: 14

The intention of the framework was to provide guidance on what good quality care might look like and what evidence might be available to provide assurance of this. As part of the consultation, we asked whether the quality framework should be kept as a piece of best practice guidance or if it should be used to form a set of standards against which we could scrutinise. The responses to this question were varied.
The majority (48%) of written responses demonstrated a preference towards standards in some form. Some (28%) of those who felt that the framework should form a set of standards also felt that it should be combined with a best practice guide, although 22% of respondents were unclear whether the framework should form a set of standards or a best practice guide. Some respondents acknowledged that if this was the only set of standards against which a service may be assessed, it may be more streamlined. As a set of standards, it would also add extra weight to the framework. However, a number of people pointed to the fact that this could result in duplication given the standards that already exist: the current development of the care assurance and accreditation system across nursing and midwifery services and the development of the new national care standards. This duplication could lead to an increased burden on staff as they would have to gather evidence to support the quality framework in addition to the information that is already required for existing standards and to inform improvement work. Members of the public noted that the aim of the review is to ensure people feel the quality of care in Scotland is good. Without evidence to demonstrate this, it will be difficult to prove and therefore this is where targets can be helpful.

The mixed views are reflected in the following example responses.

“There are merits in both approaches and also potential deficits in both approaches i.e. standards bring clear consistency and conformity; however best practice potentially allows more flexibility in approaches and can evolve in light of merging evidence of improvement elsewhere.”

“There are elements of the quality framework which might be suitable for incorporation into a set of standards (eg staff demonstrating care and compassion) and other elements which might be more suitable for a guide to best practice (eg sharing learning, reducing waste). As services which are currently subject to scrutiny by both HIS and Care Inspectorate, hospices have a concern about multiple and non-aligned sets of standards.”

“I think that standards set must be met but there would be no harm in also providing a higher ‘achievable’ level as a guide of best practice.”

“Should remain as a guide of best practice, as otherwise it negates the principle of flexibility that guides your approach. This would allow for deviation from the standards where this is appropriate, with the expectation that deviations are justified.”

“Some [of our] respondents felt strongly that the quality framework should be a guide to the quality of care the NHS in Scotland expects to deliver to its patients, rather than a set of standards that must be met. It was stated in these responses that the quality framework does give some examples of ways in which organisations can demonstrate that they are providing the quality of care required, without the need for a formal set of standards that must be met. Organisations could and should be encouraged to assess performance against the framework with an action plan for improvement where required. Furthermore, some respondents reiterated their concerns that the assessment system was unlikely to be either quantifiable or comparable (for the reasons stated above) therefore, until these concerns could be addressed, the framework should be a guide. One respondent was in favour of the quality framework being used to form both a set of basic standards and also a set of guidelines to enhance development of services. The advantage of retaining some of the framework as guidance was felt to be that it was more likely to set a direction of travel within a service, whereas a set of standards could result in a loss of focus once achieved.”
“An overarching guide of good practice with relatively few standards for each domain would be preferable to ensure the framework is practical to be implemented.”

“There is perhaps a merged approach within the current model where agreed key essentials/requirements would have a standard approach but other supporting aspects/areas classed as best practice. Some areas where links are being made (for example inspections) to are mandatory so unclear how this would fit in a best practice model. As noted above if a standards approach is taken it needs to be robust and equitable and ensure that it keeps the improvement focus.”

**Question 5:**

Would it be helpful to also develop a set of consistent Key Quality Indicators against the quality framework domains for use locally and nationally?

**Response:**

Yes: 60  
No: 7  
Unclear: 9  
No response: 17

The majority of people replied that it would be helpful to have a set of consistent Key Quality Indicators against the quality framework domains for use locally and nationally, as reflected in the example comments below.

“Yes, the indicators could link to the mandatory elements of the model and could form part of a Board/local quality dashboards that could also feed into a national level. This could help Boards to track their own status and also support learning from others. There would need to be caution to ensure these indicators do not simply duplicate existing data/measures. If reliant only on a self assessment the frequency of the assessment would determine the Boards level if you like but dashboard would be more real-time.”

“Standards tend to be fixed and sometimes perceived as ‘box ticking’, and in many cases staff are not be included in their development....Key Quality Indicators (KQI) allows for flexibility and implies a spirit of improvement and dynamism. This would be a very useful approach to take. For example, the development of local indicators based on staff and patient feedback would enable organisations to proactively develop indicators in line with a change that had come from identified learning for the organisation.”

“A midway option may be preferable with the quality framework operating as a statement of good practice to guide providers and patients about what is expected, but including a small subset of essential Key Quality Indicators based on agreed national standards and for which there is national and international benchmark data. This is important to allow patients to assess the quality of the services they received and ensure ambition drives up standards.”
Question 6:

Do you think culture underpins the domains within the quality framework and how might culture be assessed?

Response:

Yes: 55
No: 5
Unclear: 16
No response: 17

The majority (59%) of people felt that culture should, and does, underpin the domains within the quality framework. Members of the public highlighted that culture was important not only within the organisation but also in the context of the individual patients and that communication underpinned everything. While it was acknowledged that culture should underpin the domains it was recognised that culture is difficult to define or measure, as highlighted through the following comments.

“Overall yes culture underpins the domains contained within the framework, this is central to the delivery of high quality, safe, effective and person centred care. Assessment of culture needs to be via various routes to meet the needs of the services, could include culture/safety climate tools, revalidation, iMatters and staff and patient experience/stories.”

“We think culture underpins both the domains and the principles of the Framework. Culture can be assessed in part by the success or otherwise a Board is having in achieving the service standards and expectations of its stakeholders. But more importantly culture (as the way we do things around here) can be measured by the eyes and ears of the organisation through for example staff surveys, patient surveys and opinions, carer feedback, patient stories, complaints, leadership or patient safety walkrounds and many more personal feedback routes.”

“Culture should underpin the framework. Experience of RCGP Quality Practice Award assessment suggested culture was effectively measured by visiting teams. Modification of questionnaires such as Safe Quest climate surveys could be used to prompt discussion and enhance insight and awareness.”

“Organisational culture is an important factor in persistently successful enterprises but that it is notoriously difficult to establish a universally applicable set of measures sufficiently robust to allow for a ‘pass mark’ to be awarded.”

“Overall yes - but the measurement of this is very difficult, there have been various strategies to attempt this in the past which have had varying degrees of success. I don't think we should become overly focused on culture measurement.”
Other suggestions were proposed for how to measure culture.

• Seek anonymous feedback so staff feel able to speak out.
• Look at staff sickness/stress absence rates.
• Find out who staff identify with, for example a ward, directorate or organisation, and develop measures around this with individualised questions for each organisation.
• Assess if there are training opportunities available to develop staff and leaders.
• Review the number of complaints made by staff as this shows that there is a good culture rather than a bad culture, because it shows that staff feel able to speak up.
• Assess whether leadership at all levels is visible, for example through leadership walkrounds or leaders speaking to families and patients to set an example.
• Ask managers or senior leaders what they worry about as this is likely to give good insight into issues within the organisation.
• Use the results of the public sector leadership review, the NES review into leadership, and evidence gathered through the safety culture tool.
• Assess if there is ownership of improvement at every level.
• Consider if there is emphasis on the sharing of good practice and achievements to spread positivity, ideas and willingness to improve.
• Ask whether staff are willing and feel able to raise concerns, whether concerns raised are followed up and if staff are informed of changes made in response to concerns. Professionals are keen to make improvements, but often worry that they will be penalised for admitting to mistakes.

While the majority of respondents felt that culture should and does underpin the domains, some raised the question of whether it is the role of Healthcare Improvement Scotland to assess this.

**Question 7:**

The paper proposes that our new approach scrutinises across different levels of an organisation or system of care.

This would be reflected at three broad levels:

• services and systems provided across a provider area, including interfaces between services, for example the interface between health and social care (macro level)
• across particular services such as care of older people, accident and emergency or primary care services (meso level), and
• at ward level, within a community setting, or any other setting with direct interaction between a care professional and the patient, service user or carer (micro level).

Do you think external scrutiny should focus on these three broad levels across an organisation or system of care?

Response:

Yes: 51
No: 6
Unclear: 19
No response: 17
Although respondents noted similarities with our current approach and agreed with the new model in principle, some respondents also found the proposed model complex and confusing. One respondent highlighted that we would be assessing seven domains, across three levels with four dimensions. Respondents felt that this presented a complex model that is difficult to understand at a practice level and would therefore be difficult to implement. Some also felt that the complexity of the approach could lead to an increase in bureaucracy. Others noted that simply the language used was confusing and a simpler, clearer explanation would be helpful.

Some respondents felt that whilst a national approach to common problems sounds ideal, one size cannot be expected to fit all contexts. It must be adaptable and proportionate, as areas such as primary care, acute care and social care are so different, and will vary geographically. Developing the model in partnership will help to ensure that the approach is adaptable and proportionate.

Care must also be taken to ensure that organisational reviews are proportionate and risk based as they could potentially pose a huge burden on providers. It would also be challenging to score organisational reviews, as areas within organisations will vary in their effectiveness.

**Question 8:**

Do you think the new approach to scrutiny should include the four dimensions of:

- Thematic Quality of Care Reviews
- Organisational Quality of Care Reviews
- Service Level Reviews, and
- Point-of-Care Reviews or inspections?

**Response:**

Yes: 42  
No: 9  
Unclear: 23  
No response: 19

The majority of respondents supported the proposed model in principle. They noted that there were similarities with our current approach to scrutiny. It was generally thought that the four dimensions needed to be simplified.

A point that was raised consistently was the need to ensure effective support for internal self-assessment and continuous quality improvement, with external quality assurance as a significant opportunity to assess the progress in achieving improvement.

Moreover, there was a need to ensure external quality assurance gave greater weight to assessing the capability and capacity of organisations to build implement future improvements in the quality of care. Similarly, there was strong support in establishing a system that allowed for earlier flagging of concerns or difficulties rather than a later ‘crisis intervention’.

Responses to the consultation demonstrated a need to consider the balance between point of care inspections and the overall quality assurance of a system. Any new approach to scrutiny needs to be risk based and proportionate, striking the right balance between point of care inspections, external quality assurance of a system, and internal self-assessment.
During focus group discussions, those present expressed a preference for unannounced scrutiny activity, particularly due to the reduced burden on staff and the more honest impression that was given. There was a strong feeling at the focus groups that there was little value in announced inspections, as any cracks in the system were plastered over. On a positive note, this means that problems are fixed, but it does not show what the normal standard is. Unannounced inspections create a lighter burden on the provider as less time is taken in preparation, and gives a more realistic idea of the culture. However, providers must know how they will be assessed. It was suggested that perhaps there could be a period of announced inspections whilst the new reviews bed in, to be replaced by unannounced inspections once providers are familiar with Quality of Care Reviews.

Thematic reviews were seen to be a valuable idea. However the timing of them would need to be considered in terms of:

- capacity in organisations being reviewed
- requests for information from NHS National Services Scotland
- co-ordinate with other review organisations, and
- avoid replication of existing work.

To add value, scrutiny must result in improvement and the sharing of best practice. This would also make inspections appear less punitive and improve the relationship between providers and Healthcare Improvement Scotland.

“If leaders support the new system and are willing to report issues then there will be less fear of bad reports, and therefore a more open and honest culture. Inspection reports should stress examples of best practice to safeguard staff morale and provide public assurance. Leaders must also learn from what goes right and share good news stories. Ultimately reform has to come from within. Culture cannot be forced.”

**Question 9:**

Would it be helpful to include making recommendations for service sustainability as part of the new approach?

Response:

**Yes:** 51
**No:** 9
**Unclear:** 14
**No response:** 19

The majority of respondents felt it would be helpful to assess service sustainability as part of the new approach. They felt that it was important to assess this as “It is central to the development of improvement activity moving forward.” While it was generally supported, some questioned how this would look in practice and how it would be assessed. In particular, there was a need to ensure service sustainability assessments (whether at a national, regional, or local level) had sufficient weight and credibility in arriving at their conclusions.

However, respondents noted that a firm definition of sustainability must be provided before it can be measured. Some attendees at the focus groups thought that it would be useful for standards to be set around sustainability, and that it was a good – if challenging – ambition. However, there was a risk that most sustainability issues would come down to lack of finance.
It was proposed that there must be more joint working throughout the NHS if it were to be sustainable. This would also include integration between scrutiny bodies to ensure they too were sustainable organisations.

“This is absolutely key for driving improvement. We have to find a way to independently review and comment on the sustainability of the current system design. Otherwise we are in danger of critiquing the problems without supporting Boards to address root cause issues around the design of services. Where the root cause lies outwith the boards control there will need to be a mechanism to escalate to the Scottish Government or other bodies who will accept their role in making changes to support the service to create the conditions for improvement. Access to improvement support will be important and this will need to be considered not just for national improvement support but also the ability of the service to harness its own internal improvement support.”

Question 10:

Will the proposals set out in the consultation document support the further integration of health and social care?

Response:

Yes: 29
No: 19
Unclear: 26
No response: 19

The majority of respondents had mixed views on whether the new proposals would support health and social care integration. This was largely due to the language used and the confusion around what is meant by ‘care’. The consultation paper refers to care and healthcare interchangeably. In part, this was to future proof the proposals in light of health and social care integration.

There are a number of bodies with responsibility for the scrutiny of health and social care in Scotland, including Healthcare Improvement Scotland and the Care Inspectorate. Currently, we are responsible for the scrutiny of healthcare services, while the Care Inspectorate is responsible for the scrutiny and regulation of care services, for example care homes, hospice at home services and childcare services. Through discussions with stakeholders and written responses, it was apparent that there was a need to be clearer about the future responsibilities of the different scrutiny bodies in relation to the spectrum of healthcare. Although we already work with the Care Inspectorate, and other scrutiny bodies, as we move further into health and social care integration, we will be working more closely with them.

In light of the further integration of health and social care, some attendees at the focus groups felt that it may make sense to integrate the scrutiny bodies for each sector, or at least encourage closer working, to avoid confusion. This would reduce the risk of duplicating work and reduce the potential burden on staff. It was suggested that scrutiny bodies should share information and use the same assessment framework. This would create less of a scrutiny burden for providers and assessors, and a lesser financial burden on the tax payer. It was also suggested there is a need to ensure absolute clarity about the balance of responsibilities between scrutiny bodies and where each body, acting in isolation or together, had the most appropriate skills or expertise.
Several attendees from the stakeholder events thought that there should be more integration between primary and secondary healthcare before integration with social care and the third sector could be successful.

The example comments below demonstrate the range of views.

“Difficult to know at this stage. Service could suffer from different scrutiny bodies using a range of approaches. Need to simplify the landscape wherever possible to ensure that scarce resources are being used to deliver and improve the service and not on responding to the needs of multiple external bodies.”

“The proposals in the consultation document do not address or support the integration of health and social care. The scope of the proposed review is significantly limited by failing to adequately reflect the integration of health and social care. To ensure a person-centred and flexible approach that places people at the heart, all aspects of a person’s care must be taken into consideration. For example, we often hear of delayed discharges from hospitals due to social care arrangements. One of the guiding principles cited is that the approach will be developed in partnership, promoting ownership and commitment for improvement within and across providers. To achieve whole-scale system improvements that are meaningful to people, there needs to be a system of review that takes into account the entire patient journey. This should take into account both primary and secondary care, social care and services provided by the third and independent sectors. We believe that a single regulator or review approach should be introduced to reflect both health and social care within the same framework.”

“Unable to definitively respond YES/NO. The potential is there to provide a common purpose or aim. However, uncertain how joined up and integrated the framework is. There are some concerns that historically scrutiny bodies do not talk to each other and tend to work in silos. A joint approach should have been taken in development of proposal presented. It needs to drive cultural change across different organisations, not just in health. This could prove challenging in respect of governance while health and social care remain under the control of different cabinet secretaries and government departments.”

“It is not clear whether these proposals will support the further integration of health and social care, but we are not clear that they are designed to. Rather, we believe that these proposals can better support the scrutiny of integrated health and social care provision. With effective collaboration and strong partnership working, the proposals will help clarify and add value to Healthcare Improvement Scotland’s and the Care Inspectorate’s working arrangements across a multi-agency, multi-disciplinary scrutiny and improvement landscape. The evidence base around the seven domains is not influenced by a social care perspective, and the four dimensions have been (understandably) designed from a health, mainly NHS, perspective. In this context, we consider it important that consideration is given to a closer alignment between the proposals and the National Health and Wellbeing Outcomes, and those parts of the new national care standards which are designed to apply across health and social care.”
**Question 11:**

Do you feel that care will be safer and better for people as a result of the proposed changes?

Response:

- **Yes:** 27
- **No:** 11
- **Unclear:** 38
- **No response:** 17

The majority of respondents were uncertain about whether care would be safer and better for people as a result of the proposed changes, as demonstrated in the following example replies.

“As long as the standards are implemented and assessed equitably, care should be safer and should improve. It is important that lack of resources is not constantly used as an excuse for not implementing the standards, though. Where resource is lacking, additional funding may be required. We have doubts, however, that the time and resources required for these processes is currently built into service design. Collection of data to meet the standards must not be too onerous, as patient care will suffer if too much staff time is spent preparing paperwork instead of looking after patients.”

“In theory care should be safer, but this may depend on the ability of services to adapt to recommendations, re-design, and receive and be receptive to improvement support. Such changes can take time and evaluating short, medium and long term outcomes should be built in as a key part of the methodology.”

“While the proposed quality framework has the potential to improve the quality and safety of healthcare systems, it is unclear that it will improve the patient experience of care. The integration of health and social care aims at improving people’s wellbeing and providing seamless services across health and social care. This review process, focused solely on healthcare does not represent the context of care in Scotland and does not adequately take into account the patient experience of services. To achieve whole-scale system improvements that are meaningful to people, there needs to be a system of review that takes into account the entire patient journey. This should take into account both primary and secondary care, social care and services provided by the third and independent sectors.”

“We are unsure if this would lead to safer and better care, as although it would provide a very thorough, robust approach to assessing care, this does not necessarily mean that care will improve. Although recognition is the first requirement for change/improvement, further support would be required to implement these changes into practice ... It would be useful to have a national database of service self-assessment, so services can see which domains they need to be working on and benchmark themselves against other services.”

“The new proposed approach brings a new dynamic moving away from solely focusing on quantitative measures. This will provide the platform for more constructive two way conversations between those who are providing the care and those who scrutinise. This needs to be balanced with additional pressure / burden this process may add on clinical teams.”

Members of the public were more hopeful that the Quality of Care Reviews would bring about safer and better care – “I think it’s an improvement if we can get a standard like this” – although there was some concern that the framework would be ‘watered down’ prior to implementation.
The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.

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