Report on the review of the methodology and process for the inspection of the care of older people in acute hospitals

November 2013
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>4</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2 Progress and recommendations</td>
<td>8</td>
</tr>
<tr>
<td>Appendix 1: Summary of recommendations</td>
<td>17</td>
</tr>
<tr>
<td>Appendix 2: Review Group membership</td>
<td>19</td>
</tr>
</tbody>
</table>
Foreword

In December 2012, I was invited to chair a group to undertake a review of Healthcare Improvement Scotland’s methodology and process for the inspections of the care of older people in acute hospitals. The purpose of this report is to present the work of the group to date and to make recommendations for further development.

The breadth and complexity of this task should not be underestimated. Significant progress has been made. Nevertheless, there is still much to do.

The Review Group’s work identified eight key areas of focus, out of which, this report has made 19 recommendations about how the work should be progressed.

Pam Whittle CBE
1 Introduction

In December 2012, a group, chaired by Pam Whittle CBE, was established to undertake a review of Healthcare Improvement Scotland’s methodology and process for the inspections of the care of older people in acute hospitals. The purpose of this report is to present the work of the group to date and to make recommendations for further development.

1.1 Background

In June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. Healthcare Improvement Scotland was asked to carry out these inspections because of its experience inspecting acute hospitals throughout NHSScotland. The aim of these inspections was to provide assurance that the care of older people in acute hospitals was of a high standard and to encourage improvement where it was needed.

The scope of the inspections was to focus on the journey of care from the patient’s point of view and specifically:

- put the patient first - listen to the views of people who use services and their carers
- inspect all acute settings that care for older patients, across the range of diagnoses, and
- focus on ensuring older people are treated with the respect, compassion, dignity and care that they deserve.

Healthcare Improvement Scotland developed an inspection methodology based on the Healthcare Environment Inspectorate scrutiny model used for both announced and unannounced inspections. A number of pilot inspections were carried out between October 2011–January 2012 to test the inspection methodology.

To determine the order in which to inspect the acute hospitals, a variety of publicly available data was used, for example patient experience, complaints, Early Warning Scorecard and a variety of clinical topics.

The inspections into the care of older people in acute hospitals started in February 2012. To date, 23 inspections have been carried out and two overview reports published. The majority of inspections have been announced (where NHS boards’ receive approximately 4 weeks’ notice of an inspection) and have targeted larger acute hospitals meaning that there has been a greater focus on certain NHS boards. As the inspection activity continues, unannounced inspections have been introduced as well as a number of follow-up inspections.

1.2 Aim

The aim of this review is to ensure an inspection methodology for the care of older people in acute hospitals in NHSScotland that is consistent, objective and standardised. The review also aims to develop a methodology which aligns with those of other scrutiny bodies, to enable consistency in data collection and intelligence gathering, inspection processes and reporting.
1.3 Method

In developing the revised draft methodology, the Review Group considered a range of information including:

- the Francis Inquiry\(^1\) into the failings of Mid-Staffordshire NHS Foundation Trust
- examples of good practice such as the inspection methodology for Child Protection Services\(^2\)
- analysis of the existing older people in acute hospitals inspection reports to identify emergent themes and to consider the style and content of the reports, and
- the independent review of Healthcare Improvement Scotland’s inspection of the care of older people at Ninewells Hospital, Dundee\(^3\).

This led the Review Group to focus on 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.

In early 2013, the Review Group produced a draft document outlining a proposed revised methodology and a draft self-assessment. The Review Group set out to adopt a partnership approach to developing the methodology. Key stakeholders including NHS boards, public and partner organisations and Healthcare Improvement Scotland staff were asked to comment on this initial draft and their feedback has been incorporated into the latest version.

The Review Group will continue to engage key stakeholders and seek feedback as the methodology develops.

Involving the public in its work is an integral part of everything Healthcare Improvement Scotland does. Healthcare Improvement Scotland’s approach to public involvement is to ensure that the organisation works with patients, carers and members of the public to help it:

- learn from the experiences of patients and carer
- ensure that health services are sensitive to the needs and preferences of patients
- enable the public to review the quality of the NHS.

An event for a wider group of public partners is being arranged in the near future and further discussion is also envisaged with older people, carers and patient groups.

---

2 Child Protection Services: Findings of Joint inspections, Care Inspectorate (2012)
3 Independent Review of the Healthcare Improvement Scotland Inspection of the Care of Older People, Ninewells Hospital, Dundee (2013)
As elements of the methodology are developed, they are being tested so that identified areas for improvement can be incorporated into the process.

1.4 Overview of proposed inspection methodology

![Diagram of inspection methodology]

- **Visit to Board**
  - Expert Panel lead by Senior Inspector
- **Unannounced Inspection**
- **Integrated Cycle of Improvement**
- **Report**
- **Follow Up**
  - Improvement Plan
  - Meeting
  - Further Inspection
- **Self Assessment**
  - Standards
  - Case Note Review
  - Improvement Plan
- **Analysis of National Data**
2 Progress and recommendations

This section presents the Review Group’s progress to date on the eight areas highlighted in Section 1 and makes recommendations for further development.

2.1 National standards, guidance and best practice

The following national standards, guidance and best practice are used to underpin the inspection of the care provided to older people in acute care.

- **Adults with Incapacity (Scotland) Act 2000** Part 5 – Medical treatment and research
- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)
- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)
- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)
- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)
- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)
- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)

The review report of the Ninewells Hospital inspection recommended that the standards for best practice against which NHS boards are assessed should be updated. Stakeholder feedback during the consultation process also raised concerns that the Clinical Standards for Older People in Acute Care (2002) are now over 10 years old and may no longer reflect current practice.

There is a need, in due course, to ensure that the development of standards is consistent with the wider and separate review of national care standards which will be underpinned by a human rights approach. In the meantime, there is scope to refine and refocus the range of standards and guidelines used for the inspections into a single and comprehensive document. This would give NHS boards clarity about the areas under scrutiny.

---

4 Clinical Standards for Older People in Acute Care, Clinical Standards Board for Scotland (2002)
Recommendation

1. A working group should be established to review the current standards and quality measures used for the inspection of the care of older people in acute hospitals. This is fundamental as it underpins all other aspects of the methodology.

2.2 Intelligence-led, proportionate and risk-based scrutiny

There has been growing focus on the use of information to provide a more focused approach to scrutiny in recent years. The Crerar Review (2007)\(^5\) examined scrutiny and complaints handling in Scotland. It described a need for:

- scrutiny bodies to work closer together to develop better ways to measure and evaluate provider performance
- greater involvement of service users and the public, and
- proportionate scrutiny based on risk.

More recently, the inquiry by Sir Robert Francis into the systematic failings of Mid-Staffordshire NHS Foundation Trust reignited the emphasis that must be placed on the use of information to make better decisions about when, where and what to inspect. Although directed at the healthcare system in England, the Francis Inquiry made several recommendations that are very pertinent to scrutiny in Scotland and inspections into care of older people in acute hospitals. For example:

- it is essential that risk is routinely monitored as opposed to relying solely on self declaration
- there should be full information sharing between separate regulators, and
- patient concerns should be investigated.

Healthcare Improvement Scotland has been leading work to explore ways in which Scottish healthcare scrutiny bodies can make better use of the intelligence that they collectively hold. A group with representation from NHS Education for Scotland (NES), Audit Scotland, Scottish Government, the Care Inspectorate and Healthcare Improvement Scotland has been formed to understand what information other organisations hold and what the implications of sharing intelligence are. The Review Group has been assured there is a strong willingness within the group to share information openly and with that, accept the responsibility that action may be required.

As part of the methodology review, national data items relating to care of older people in hospital have been identified and presented in a way that inspection teams can systematically review before inspection. These information summaries have been piloted at two pre-inspection meetings and have proved helpful in identifying areas for investigation. The data items included in these summaries are based on nationally available information and presented under the main themes of the inspections into care of older people in acute hospital (dignity and respect, falls, nutrition, and pressure ulcers) and the three quality ambitions (safe, effective and person-centred).

There is a clear need for consistent national information on number of falls and pressure ulcers. It is anticipated that the Scottish Patient Safety Indicator (SPSI) will fulfil this gap. There is also a need to represent more strongly the voice of the patient in these summaries and, in particular, their experience of being treated with dignity and respect. It can be difficult to respond proportionately to patient views when expressed by only one patient. For that reason, a range of sources such as patient feedback websites, complaints and whistleblowing sources should be explored.

Healthcare Improvement Scotland is committed to taking a proportionate and risk-based approach to scrutiny. This will mean that hospitals who are performing well receive less scrutiny while those who are performing less well receive more. The Review Group believes that less frequent inspection needs to be underpinned by reliable, valid measures of quality which are objective rather than self reported (see Section 2.5). This will maintain public and stakeholder confidence in the methodology and assurance about the service provided.

While the measurement of dignity and respect, falls and nutrition is challenging, the development of a system for rating hospitals against these qualities would help ensure more frequent scrutiny was targeted appropriately.

### Recommendations

2. Information used to inform inspections' planning decisions should be continually reviewed.

3. The emphasis should be on getting patients’ feedback in line with the main themes of the inspections.

4. A systematic approach to assessing risk should be developed with the aim of targeting those presenting greater risk.

### 2.3 Self-assessment

A revised self-assessment is being developed so that NHS boards can identify strengths and areas for improvement, independent of inspection activity. The self-assessment template, based on 11 patient outcomes, aims to make the self-assessment process more focused. This will reduce the burden on NHS boards, providing them with a range of data on their performance, against the [revised] standards, from which they will produce improvement action plans.

The self-assessment tool has been piloted in NHS Borders. This involved NHS Borders completing the new template and giving feedback on how they found the process. A senior inspector then conducted a ‘baseline assessment’ of the completed template to determine how the information provided might be used to inform the inspection process. Members of the older people inspection team were then given the opportunity to comment on the self-assessment and baseline assessment.

The feedback from NHS Borders was positive:

“Overall the revised self-assessment is more concise and focused on the NHS board’s ability to demonstrate good practice. By focussing on patient outcomes and experience, it allows the opportunity to show multidisciplinary working across the wider team, both clinical and non clinical. [The self-assessment] gives NHS boards an area to highlight improvement opportunities that are either being considered for the future, or are in the early stages of development.”
The baseline assessment was found to be helpful in identifying areas of focus for inspection. However, the amount of evidence required to support the narrative given in the template remains unclear.

Stakeholders were also given the opportunity to provide feedback on the self-assessment as part of the consultation process. Again, the feedback was largely positive. However, stakeholders also identified a number of specific outcomes they felt were missing, for example dignity and respect, discharge arrangements, and environmental factors.

In relation to the specific outcomes, a number of comments were made about the wording and content. However, the main areas of contention were about specific outcomes for falls and pressure ulcers – some respondents felt that the outcomes of ‘no falls’ and ‘no pressure ulcers’ were unrealistic in the self-assessment.

Stakeholders also suggested that the self-assessment outcomes should be aligned with the 10 key actions to support the implementation of the Standards of Care for Dementia in Scotland. It was also suggested that prompts should be provided to help NHS boards identify the level of narrative and evidence required.

The self-assessment tool is being further tested in NHS Tayside as part of the process of ongoing development and refinement.

### Recommendations

1. The self-assessment outcomes should be mapped to the 10 key actions to support the implementation of the Standards of Care for Dementia in Scotland and, once reviewed, to the revised Standards for the Care of Older People in Hospital.

2. In a similar way to the Standards of Care for Dementia in Scotland, a list of the types of evidence required to support the narrative in the self-assessment, for example policy, case note review, and patient experience, should be coded and mapped to the self-assessment.

### 2.4 Case note review

Case note review has formed part of the methodology for the inspections of the care of older people in acute hospitals since the inspections began in 2012. To date, the inspections of the care of older people in acute hospitals have focused on five main themes with inspections including some, or all, of the following:

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

As part of the current inspection process, the review of patient health records provides valuable evidence to support the evaluation of standards of care in relation to the themes outlined above. However, the Review Group has identified a further two areas where review of the patient’s case notes may support the inspection process. Firstly, assessing the patient journey and, secondly, assessing the use of medication, particularly for those with dementia or delirium. The Review Group believes that adopting this approach will become even more
important as the integration of health and social care progresses and Healthcare Improvement Scotland further develops its partnership working with other scrutiny bodies.

Focusing on the patient journey will allow NHS boards to identify areas of good practice and areas for improvement in the following areas:

• the patient journey in relation to the care pathway and the identification of the rationale for any deviation
• identifying any occasions where patients have been moved for reasons other than their clinical condition and assessing the impact of those moves on outcomes
• communication
• involvement of patients and families in decision-making, and
• discharge planning.

There is also considerable evidence that the use of antipsychotic drugs is associated with significant harm in older people with dementia. Two major regulatory warnings in 2004\textsuperscript{6} and 2009\textsuperscript{7} cautioned that antipsychotics were associated with an increased risk of stroke and death in people with dementia. The 2004 warning related particularly to Risperidone and Olanzapine, whereas the 2009 warning was for all antipsychotics. As part of the case note review, two tools have been developed to assess medication: one focuses on reconciliation (ensuring that medicines prescribed on admission correspond to those that the patient was taking before admission); and the other antipsychotic medication.

The Review Group has given much consideration as to whether the case note review should form part of the self-assessment process or be part of the inspection process. The predominant view at this stage is that the revised case note review should form part of the self-assessment process and should be assured through the inspection process.

Two key questions remain to be answered.

• Firstly, will the self-assessment case note review be a ‘one off’ exercise (bearing in mind the move to more unannounced inspections), or should the case note review follow the Scottish Patient Safety Programme methodology, where NHS boards review 20 sets of case notes per month for 20 minutes against set ‘trigger tools’?
• Secondly, how will the existing case note review be extended to include the patient journey and medicines management, without moving beyond the scope of inspection which excludes the assessment of clinical decision-making?

\textsuperscript{6} Committee on Safety of Medicines. Summary of clinical trial data on cerebrovascular adverse events (CVAEs) in randomized clinical trials of risperidone conducted in patients with dementia. London: Committee on Safety of Medicines (2004)

Recommendations

7. The tools for assessing medicines reconciliation to be tested October–November 2013.

8. A case note review proforma should be developed for NHS boards to use as part of the self-assessment process. This should be aligned to the Scottish Patient Safety Programme methodology for case note review.

9. A tool for case note review is already being used in the pilot Healthcare Improvement Scotland and Care Inspectorate joint inspection of adult and children’s services. Work has begun to develop this further for use in inspections of the care of older people in acute hospitals. Once developed, the draft tool will be tested and further consideration will be given to how the inspection will use case note reviews.

2.5 Evidence and judgement

Recommendation 2 of the review report of the Ninewells Hospital inspection states that:

“HIS should ensure that a range of qualitative and quantitative evidence is deployed in such a way as to enable consistent judgements to be made within inspections. This should include clear guidelines on:

- the nature and use of different types of evidence
- the evidential criteria for making judgements.”

It is acknowledged that the current inspection process provides a very narrow view of the care of older people in acute hospitals. Consideration is being given to broadening the scope of inspection across systems and across the patient journey.

The range of evidence needed will include:

- policy and procedures
- case notes and care plans
- staff rosters
- patient feedback
- staff feedback, and
- observations of care.

For data to be robust, it must be collected in a systematic, standardised way, using appropriate tools. For this reason, work is under way to review each of the tools used, including those for case note review, observations of care and patient feedback. The Review Group believes that one of the strongest messages from the Francis Inquiry was the failure to listen to patients and carers. With this in mind, consideration is being given to how to better engage with, and listen to, patients, carers and established public involvement groups as part of the inspection process.

While a piece of evidence may at times appear to be so strong that it can stand alone, more often, evidence needs to be corroborated. An example of this would be where an inspector is told about poor practice by a third party, such as a staff member who had not directly
witnessed the practice they described. This would be considered as weak evidence and would require to be corroborated by further evidence such as documentation, further feedback from staff or patients or observation of practice.

Work has begun on the development of an evidence and judgement framework for Healthcare Improvement Scotland inspections. This will draw on good practice in other scrutiny bodies such as the Care Quality Commission. This evidence and judgement framework will support the inspection team to make decisions about the robustness of data and where corroboration is required.

In addition, and in line with Recommendation 4 of the review report of the Ninewells Hospital inspection, the evidence and judgement framework will include guidance for dealing with incidents during inspections and the escalation of any concerns.

### Recommendations

10. Extend the scope of the inspections of the care of older people in acute hospitals.

11. Review the current patient questionnaire and identify ways of better engaging with patients, carers and public involvement groups during inspections.

12. Complete the development of, and test, the new tools for data collection.

13. Develop and implement the evidence and judgement framework across all inspection teams, ensuring the framework includes clear guidance for escalation of concerns arising during inspections.

### 2.6 Composition of inspection teams

The Review Group will undertake a fundamental review of the composition of the inspection team. The group identified at an early stage the importance of external current professional advice as part of the inspection team. This was also endorsed by the Ninewells Hospital review, which recommended that inspection teams should be multidisciplinary and include, where possible, relevant clinical/subject expertise and an external observer. Particular consideration is being given to the role and numbers of clinical and public partner members of the team.

The review report of the Ninewells Hospital inspection also recommended that the duties and responsibilities of individual team members of the inspection team should be clarified, before, during and after inspection. As such, work has begun to look at the induction and ongoing support for individuals as well as reviewing communication and escalation procedures.

The Review Group has begun to consider the composition of inspection teams and the scope to include practising health professionals as clinical experts. However, the group is clear that this must not dilute the expectation that inspections will remain rigorous and independent, and that the inspectors are the experts in scrutiny.

### 2.6.1 Clinical staff supporting scrutiny

To date, 10 inspections have included a member of clinical staff on the inspection team (from an NHS board other than that being inspected). Feedback from the clinical staff team
member and inspectors confirms the main benefits include:

- greater insight into the inspection process for the clinical staff team member and the opportunity for personal development
- the opportunity for shared learning through the inspection process with the clinical Advisors identifying a number of areas where improvements could be made in their own clinical areas, and
- the contribution to the inspection team of a different perspective and challenge.

However, feedback also highlighted, in line with the Ninewells Hospital review, the need to clearly define the role of the clinical staff team member and the level of clinical ‘expertise’ they bring. While there is no doubt that having a clinical staff member on the team adds value, the level of clinical expertise, over and above that of the inspectors who have a strong clinical background, is less clear, and dependent on the area where the clinical staff team member practices.

In addition to having a clinical team member as part of the inspection team, consideration is being given to the use of clinical experts within the scrutiny process. The Review Group has identified that there may be times when having expert clinicians at consultant or specialist level (nurse, doctor or allied health professional) would greatly contribute to the inspection process.

However, it would be expensive and challenging to release senior clinicians for the whole inspection period. For this reason, consideration is being given to the implementation of a multidisciplinary ‘expert panel’ to support the inspection process. This would be led by the senior inspector and include inspectors, data analysts, clinical experts and public partners. The expert panel would support the interpretation of the national data and self-assessment evidence. It would then meet with the NHS board to discuss the self-assessment, with the clinical experts focusing on their area of expertise. The clinical experts would not undertake the actual inspection, but would be contactable for advice throughout the inspection process.

2.6.2 Public partners
Public partners play a vital role in the inspection team and this is likely to increase. As with all members of the inspection team, it is essential that public partners are prepared before undertaking inspections and are clear about their role.

The Scottish Health Council is currently leading a review and strengthening how public partners are involved and supported in Healthcare Improvement Scotland. It is also supporting the review of the inspection methodology for the care of older people in acute hospitals.

**Recommendations**

14. There needs to be a fundamental review of the roles within the inspection team based on a review of current intelligence and the focus of future inspections.

15. Continue to develop and evaluate the role of the clinical staff team member on the inspection team.

16. Develop the role of the clinical expert and expert panel.

17. Revise the role descriptor, induction programme and ongoing support for public partners and other members of inspection teams.
2.7 Structure and format of reports

The Review Group believes that the inspection reports of the care of older people in acute hospitals need to:

- be based on robust evidence
- give assurance to patients and the public
- help NHS boards to identify areas for improvement, and
- provide opportunities for sharing good practice.

Recommendation

18. A subgroup comprising representatives from the inspection team, public partners, Healthcare Improvement Scotland’s communications team, the Scottish Health Council and NHS boards should be established to develop the revised report template.

2.8 Quality assurance of the scrutiny process

The Ninewells Hospital review has highlighted the need for robust quality assurance of the scrutiny process.

Recommendation

19. Develop and implement a framework for quality assurance which will assure:
   - the integrity and impartiality of the inspection processes and inspection team
   - the consistency of application of processes and procedures, including the consistency of inspection reports, and
   - continuous improvement of the methodology.
### Appendix 1: Summary of recommendations

#### National standards, guidance and best practice

1. A working group should be established to review the current standards and quality measures used for the inspection of the care of older people in acute hospitals. This is fundamental as it underpins all other aspects of the methodology.

#### Intelligence-led, proportionate and risk-based scrutiny

2. Information used to inform inspections’ planning decisions should be continually reviewed.

3. The emphasis should be on getting patients’ feedback in line with the main themes of the inspections.

4. A systematic approach to assessing risk should be developed with the aim of targeting those presenting greater risk.

#### Self-assessment

5. The self-assessment outcomes should be mapped to the 10 key actions to support the implementation of the Standards of Care for Dementia in Scotland and, once reviewed, to the revised Standards for the Care of Older People in Hospital.

6. In a similar way to the Standards of Care for Dementia in Scotland, a list of the types of evidence required to support the narrative in the self-assessment, for example policy, case note review, and patient experience, should be coded and mapped to the self-assessment.

#### Case note review

7. The tools for assessing medicines reconciliation to be tested October–November 2013.

8. A case note review proforma should be developed for NHS boards to use as part of the self-assessment process. This should be aligned to the Scottish Patient Safety Programme methodology for case note review.

9. A tool for case note review is already being used in the pilot Healthcare Improvement Scotland and Care Inspectorate joint inspection of adult and children’s services. Work has begun to develop this further for use in inspections of the care of older people in acute hospitals. Once developed, the draft tool will be tested and further consideration be given to how the inspection will use case note reviews.
### Evidence and judgement

| 10. | Extend the scope of the inspections of the care of older people in acute hospitals. |
| 11. | Review the current patient questionnaire and identify ways of better engaging with patients, carers and public involvement groups during inspections. |
| 12. | Complete the development of, and test, the new tools for data collection. |
| 13. | Develop and implement the evidence and judgement framework across all inspection teams, ensuring the framework includes clear guidance for escalation of concerns arising during inspections. |

### Composition of inspection teams

| 14. | There needs to be a fundamental review of the numbers and roles of the inspection team based on a review of current intelligence and the focus of future inspections. |
| 15. | Continue to develop and evaluate the role of the clinical staff team member on the inspection team. |
| 16. | Develop the role of the clinical expert and expert panel. |
| 17. | Revise the role descriptor, induction programme and ongoing support for public partners and other members of inspection teams. |

### Structure and format of reports

| 18. | A subgroup comprising representatives from the inspection team, public partners, Healthcare Improvement Scotland's communications team, the Scottish Health Council and NHS boards should be established to develop the revised report template. |

### Quality assurance of the inspection process

| 19. | Develop and implement a framework for quality assurance which will assure: |
|     | - the integrity and impartiality of the inspection processes and inspection team |
|     | - the consistency of application of processes and procedures, including the consistency of inspection reports, and |
|     | - continuous improvement of the methodology. |
Appendix 2: Review Group membership

**Pam Whittle (Chair)**  
Chair, Scottish Health Council

**Jan Baird**  
Director of Community Care/Transition, NHS Highland

**Tracy Birch**  
Programme Manager, Healthcare Improvement Scotland

**Stella Clark**  
Medical Director, Primary Care, NHS Fife (representing NHSScotland Medical Directors)

**Fiona Dagge-Bell**  
Chief Nurse, Midwife and Allied Health Professional, Healthcare Improvement Scotland

**Kevin Freeman**  
Development Manager, Healthcare Improvement Scotland

**Anne Hendry**  
Consultant, NHS Lanarkshire

**Ann Holmes**  
Chief Midwifery Advisor, Chief Nursing Officer Directorate, Scottish Government

**Ellen Hudson**  
Associate Director, Royal College of Nursing

**Penny Leggat**  
Public Partner

**Jason Leitch**  
Clinical Director, Quality Unit, Scottish Government

**Jacqueline Macrae**  
Head of Quality of Care, Healthcare Improvement Scotland

**Mags McGuire**  
Executive Nurse Director, NHS Tayside (representing NHSScotland Nurse Directors)

**Laura McIver**  
Chief Pharmaceutical Advisor, Healthcare Improvement Scotland

**Hugh Masters**  
Professional Policy Lead for Care of Vulnerable Adults and Older People, Chief Nursing Officer Directorate, Scottish Government

**Ros Moore**  
Chief Nursing Officer, Scottish Government

**Robbie Pearson**  
Director of Scrutiny and Assurance, Healthcare Improvement Scotland

**Margaret Robertson**  
Public Partner
Review Group membership (continued)

**Brian Robson**  
Executive Clinical Director, Healthcare Improvement Scotland

**Ian Smith**  
Senior Inspector, Healthcare Improvement Scotland

**Jill Vickerman**  
Policy Director, Quality Unit, Scottish Government

**Sandy Watson**  
Chair, NHS Tayside

**Kathryn Wood**  
Principal Clinical Pharmacist, NHS Tayside
The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.

www.healthcareimprovementscotland.org