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

Consultation response form

About you

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I am responding as: (mark 'x' where relevant)	Member of the public		Carer	
	Healthcare professional		Social care professional	
	Voluntary /community sector representative		Other stakeholder	x

Please return this form by **Wednesday 30 September 2015** to: hcis.QoCR@nhs.net
If you would prefer to write to us then please send your response to:

Quality of Care Review Team
Scrutiny and Assurance Directorate
Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
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Consultation questions

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?	The Royal College of Physicians of Edinburgh ("the College") agrees these are all good principles, aims or methods with international validation. The principles are suited to the needs of a rapidly changing healthcare system which needs to recognise that resources are limited and priorities will need to be regularly reviewed. However, the 9 principles and the 42 page quality framework make for a complex document; care is needed to ensure the key messages are not lost in the length and detail of the documents. It may be helpful to group the principles, sending a positive signal by positioning "patient centred" first along with "drives improvement". The principles "developed in partnership", "owned by all" and "adaptable" may be better described as method or desired outcomes.
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?	The framework should be firmly rooted in person-centred care – this is the domain that determines whether or not good care is being delivered. The other domains are subject to this, considering issues around why it is not being delivered, and how improvement will be achieved. Quality improvement cannot be achieved without patient centred care and therefore this also merits outcomes, categories and factors within the quality framework. Figure 1 on page 17 illustrates a mix of outcomes and processes within the 7 domains and includes "quality improvement" as a domain itself which is confusing when the others are important components of a quality improvement system. Quality improvement needs more prominence and should be depicted as influencing all other domains.

	Culture is all pervading and drives quality improvement and could also be better illustrated in Figure 1 (see also response to Q6). Sustainability could be considered as a domain itself, perhaps replacing the overarching quality improvement domain within Figure 1 (see also response to Q9).
Question 3: How reasonable or practical is it to assess care against the domains and categories set out in the quality framework?	It is reasonable to assess care against the domains and categories. However, some assessments will be challenging due to the lack of valid assessment tools and/or resources to capture and analyse the data. It is not clear from the proposals who will undertake the external assessments or how these assessments will take place. The proposal document indicates they will be either continuous or triggered by events but the frequency of continuous monitoring and the capacity of the system to respond to triggered assessments is unclear. It is difficult to understand how local providers or HIS/other assessors will evaluate performance if there are no clear outcome standards and much is based on process data. The College recommends that within the Quality Framework, there are a small number of sentinel standards and outcome indicators agreed for benchmarking that will be reassuring for patients and will support the targeting of inspection and review. The outcome statements within the quality framework offer a real opportunity to focus on issues that matter to patients. For example, the outcome statement for the “person centred” domain should refer to patient concerns in addition to needs preferences and values of each individual patient. There is little within the framework or the consultation document to explain the expected escalation policies to ensure self-assessed performance is reported upwards.

Question 4: Should the quality framework form a set of standards that must be met or remain a guide of best practice?	The College has received mixed views on this issue and this may be due to the terminology used within the consultation document with themes, domains, standards and best practice. Some have expressed a preference for standards as they set out clearly - for managers, clinicians and patients - what is expected of the service, while others have highlighted that targets and standards change and an inflexible framework would be difficult to maintain and therefore become increasingly unreliable, meaning a guide of best practice would be preferable. The sheer volume and level of detail within the framework makes it impractical for adoption as a set of mandatory standards. 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 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?	There was general broad support for this proposal, which would allow clarity and consistency of assessment, allow standards to be embedded in an organisation and allow comparison between health care providers and encourage sharing of good practice. As stated in response to Q4 above, this could be embedded within the framework to avoid a separate document/set of standards. It is important to avoid excessive complexity or the framework will be overlooked.

Question 6: Do you think culture underpins the domains within the quality framework and how might culture be assessed?	Culture strongly influences how services are delivered against the standards and best practice laid out in all the domains. It has a two way dynamic with the way care is delivered strongly influencing the culture of a service as was seen all too negatively in Mid Staffs when the culture became oblivious to patient care and compassion. It can lead to an upwards or downwards spiral. Those organisations/teams where there is a healthy culture and all team members, patients and service users feel they can have a say in matters and where all team members are responsive to feedback are starting from a good base to achieve better patient safety and higher standards of care. Assessing how teams communicate and how feedback from patients and service users is encouraged, facilitated and acted upon should be an important aspect of reviewing quality of care and a useful measure of culture change. Culture can be assessed with tools such as NHS staff surveys; training surveys (eg GMC trainees' survey), and recruitment and retention data (including exit interviews) along with routine, systematic feedback from all patients and service users. Health systems should be aiming for a cohesive culture and indicator data should be shared at Board level to assure those with high level responsibility that patient opinion is available and used to influence care.
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	The College agrees that routine scrutiny across these 3 levels is important and this would be consistent with other initiatives. However, it is unclear how the results of reviews at these different levels will be collated and interpreted or how the volume of external scrutiny data will be managed. It is important that these proposals are used proportionately and flexibly – externally led micro level assessment should be undertaken periodically across the service to ensure those not identified by problems benefit from external review.

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?	This need not lead to excessive numbers of reviews if random spot checks are carried out rather than a programmed methodical progression through all services and systems, wards etc. If self-assessment is working well then neither unannounced nor planned visits should present a threat. Careful coordination will be essential to avoid serious scrutiny clashes with consequent disruption to patient care.
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?	There is great potential for confusion between the 3 levels identified in Q7 above and the 4 dimensions included here; the College is unclear of the value of using both. There is a case for conducting reviews across each of these levels or dimensions, according to the immediate circumstances. However, there is no clear evidence in the consultation paper as to how any or all of these would be triggered or selected. Any review can only sample the available evidence and organisations change very slowly whereas services can grow or fail in a much shorter timeframe. The College would appreciate further clarification on how many reviews, and at what level, are projected each year, and what will be the implications for cost and timescale for both HIS and the organisation(s) under review.

Question 9: Would it be helpful to include making recommendations for service sustainability as part of the new approach?	Sustainability is critical and will be an increasing challenge over the next decade. Referring to the response to Q2 above, the College suggests that sustainability should be considered as a domain in its own right with its own outcome statement and factors. Services should be aiming for improvements in sustainability as for the other domains of good quality care. In any event, it is important that HIS addresses sustainability routinely in its assessments and recommendations and that action plans are sensitive to the workload, financial and workforce pressures on the service. This is an area where the NHS has often been deficient, with all efforts taken up in meeting the current need rather than lifting the vision to the medium term to assess sustainability.
Question 10: Will the proposals set out in the consultation document support the further integration of health and social care?	Unconvinced. Without seeing the complementary approach to be adopted by other scrutiny bodies, it is difficult to assess the effectiveness of "macro" or "thematic" reviews that cut across health and social care. Given the ambition to integrate services more closely eg in care of older patients and children, the effectiveness of this QI framework will depend critically on consistent adoption of standards, outcome indicators and data. The cultures and behaviours in health and social care can be very different and it will need senior level understanding or agreement for the proposals to make an impact. To make this framework a reality, dialogue across sectors will be important to support integration of health and social care. Ensuring that the framework includes a small subset of agreed national indicators across health and social care may support integration (see response to Q4).

Question 11: Do you feel that care will be safer and better for people as a result of the proposed changes?	Primary responsibility for improvement lies with provider organisations; scrutiny itself cannot deliver improvement. Policy leaders must support the drive to QI by addressing funding priorities, workforce challenges and data/IT system weaknesses or the proposed system of scrutiny will struggle to support local providers. If improvement in QI activity is achieved, the proposed changes will be better able to assess them but they will not, of themselves, drive the cultural, professional and financial change required to deliver improvement. The framework has to be more explicit about the responsibility for action following review; currently the balance of review and action falls on review rather than action which can delay improvement. If actions fail at provider level, this triggers more review and more action, facilitated by the same organisation (HIS). The split responsibility within HIS for scrutiny and QI, cited as a strength, worries the College as there will be a conflict for HIS in acting both as an external reviewer and QI facilitator. The Danish example continues to use an independent external scrutineer whilst focusing attention on culture change and QI. In time we may be able to move in this direction but our QI improvement system is not yet sufficiently mature. All reports (internal and external) must be documented and published for open review by patients, the public, and staff if they are to facilitate change.

Any other comments?

The College has referred in the response to Q11 above to our on-going concern about the conflict within HIS by acting as independent scrutineer and quality improvement facilitator. This is repeated here for emphasis as we believe it is critical to patient confidence in the proposed system and to developing a more positive relationship between HIS and Health Boards.

It is unclear within the papers how decisions will be made about further scrutiny or improvement support, and how proportionality and contextualisation will be applied effectively to different

providers to ensure quality of care is fairly assessed. Remote and rural services will have different solutions to service issues and the demands on services in areas of social deprivation or areas where staff shortages are prevalent will offer particular challenges. The College seeks clarity on how contextualisation will apply to the review outcomes and the proposed actions.

Surveillance of vacancy levels and recruitment process data can provide a valuable indicator of the prevailing culture and competiveness of different healthcare systems at a time of skill shortages. It will be challenging to implement the same level of quality across all NHS Scotland given differences in workforce challenges in terms of skill-mix and staff vacancies. Patients want to know who their doctor is and that they are placed in the right ward for their condition – these should be deliverable. However, safe staffing levels cannot be guaranteed in the current climate where staff shortages are endemic to some regions and have led to some remote hospitals losing approval for junior doctor educational supervision and training. Those who undertake the assessment of quality may have to contextualise their assessment within the challenges facing that hospital and against the appropriate staffing required for the quality standards to be met. It is important that Boards are challenged to address workforce issues and the teams providing care are fairly assessed given the staffing levels available to them. The Scottish Government needs to work with Health Boards to deliver effective workforce planning to ensure sustainability of services.

It is unclear from the proposals how persistent quality challenges will be resolved and where the responsibility for demanding and delivering change lies. Patient, staff and Board engagement is key and there needs to be clarity about what is expected so that all understand their role in delivering high quality care. There must be a culture of support for anyone who raises concerns and recognition for those who improve quality of care.

This is an ambitious and refreshing approach. However, if overly complex, it risks increasing the bureaucracy for all and misses an important opportunity to add emphasis to caring, compassion and kindness within the system. The quality framework and proposals risk being too detailed and complex and therefore unworkable.

Regular, routine, systematic and comprehensive feedback from all patients who wish to give it either during or as they leave care offers a real opportunity to improve patient experience and quality of care. Real time feedback to those delivering care has the potential to reinforce best practice and capture details of poor practice and near misses; the results should be published.

There is a missed opportunity within the proposed system of scrutiny and the quality framework to disseminate good practice and recognise, reward and celebrate excellence. This would help encourage an often demoralised workforce struggling to maintain services against rising demand.

There is perhaps a larger role for the Scottish Public Services Ombudsman in this quality framework as he/she performs a key role in investigating service complaints and sharing the results of his/her reviews.

A useful indicator of staff engagement in the improvement agenda could be availability and take up of CPD opportunities.

Thank you for your response.