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Dear Robbie

**Royal College of Nursing Scotland response to Healthcare Improvement Scotland's consultation on *Building a comprehensive approach to reviewing the quality of care***

The Royal College of Nursing (RCN) Scotland welcomes the opportunity to comment on Healthcare Improvement Scotland's (HIS's) proposals for its new approach to scrutiny. The RCN Scotland is a professional body and trade union for nurses and health care support workers with around 39,000 members in Scotland.

We have previously called for HIS to take a whole system approach to the diverse range of inspections it carries out<sup>1</sup>. We therefore welcome HIS's proposals to move towards a more comprehensive scrutiny model. We support the guiding principles and broad domains that underpin HIS's proposed approach. However we have concerns about the scope of this new approach and about how it will be implemented, and our comments on the consultation are focused around this.

As our feedback spans across and goes beyond the particular questions asked in the consultation paper, we have presented our comments under the headings below as opposed to in the feedback form.

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<sup>1</sup>[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/564227/RCN\\_response\\_to\\_HIS\\_scrutiny\\_and\\_inspection\\_plan\\_2014-15\\_v1.0\\_FINAL.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/564227/RCN_response_to_HIS_scrutiny_and_inspection_plan_2014-15_v1.0_FINAL.pdf)

## **1) Clarifying the purpose and scope of this new approach and HIS's role**

The way healthcare is delivered is changing rapidly. We are in the midst of health and social care integration, and more complex healthcare is increasingly being delivered in the community. In addition, there is a diverse range of organisations involved in the scrutiny and improvement of care in Scotland and their remits are evolving. Any new approach to scrutiny needs to reflect this shifting landscape and be clear of HIS's remit in relation to that of other organisations.

It is not clear whether HIS intends for this scrutiny model to apply to healthcare delivered in any setting, including community services and those delivered by independent or third sector healthcare providers. The consultation document mentions that this approach will provide an opportunity to look across different settings, however the language and emphasis within the quality framework does not reflect this, being more focused on acute services within health boards. For example, it refers to the responsibilities of health boards but not integration joint boards.

The Public Bodies (Joint Working) (Scotland) Act 2014 expands the functions of HIS and the Care Inspectorate to inspect the planning, organisation and co-ordination of services, and the effectiveness of the strategic plan, against the integration delivery principles and national health and wellbeing outcomes. It is not clear whether this model and quality framework will be the mechanism for HIS and the Care Inspectorate to fulfil their expanded role. If it is, then the links between HIS and the Care Inspectorate, and between this model and the current programme of joint inspections, need to be much more explicit. If it is not, then this needs to be made clear, along with further explanation about how HIS is going to fulfil its expanded role.

Furthermore, last year the Scottish Government consulted on proposals to revise the National Care Standards to introduce overarching quality standards that would apply to care delivered in any setting, including within the NHS. This has clear overlap with the quality framework model HIS is proposing. However it is not clear how these two approaches will fit together.

The proposals that HIS have set out are ambitious and may impact on the role of other organisations, in addition to the Care Inspectorate. For example the thematic reviews proposed may expand into the thematic reviews that bodies such as Audit Scotland or the Mental Welfare Commission produce. HIS needs to make sure that it co-ordinates with, and does not duplicate, the activity of other bodies.

We suggest that HIS clarifies the scope of its proposed model and its specific role in relation to other organisations, to help provide assurance and clarity to the public, patients and health staff about what it wants to achieve.

## **2) Ensuring a streamlined approach to scrutiny**

As well as being clear about how HIS's new model relates to the wider health and social care landscape, it also needs to be clear how it relates to its current inspection programmes, such as the inspections of older people's care, the Healthcare Environment Inspectorate and the joint inspections of older people's services. The

new model must streamline and consolidate existing standards, self-assessments and inspections into one cohesive picture, instead of duplicating activities or effort that can be seen as adding to the burden on healthcare organisations.

### **3) Transparency and consistency of approach**

HIS has stressed the importance of its approach being open and honest; and being fair, transparent and risk based. Given the scale of the proposals in HIS's new model, there will need to be a clear process for prioritising scrutiny activity in a way that is proportional and risk-based. An important part of that is being transparent about the indicators HIS will use to trigger intervention and about its internal and external escalation processes. How are these set, decided and communicated? How are issues of concern escalated to Scottish Government or to Ministers? Currently there can be confusion or conflict between the differing priorities of HIS and the Scottish Government's performance team. This transparency would help support health boards and integration joint boards to develop their own internal assurance processes. Having greater clarity and transparency around intervention pathways would also enhance public and professional confidence in HIS's ability to provide assurance that health services are well-managed, safe and fit for purpose.

The inspection process itself must be consistent and transparent. This includes having clear standards that services are measured against, having consistency between inspectors and an openness in the inspection process. Currently, for example, staff report that they may receive positive feedback from inspectors on the day of inspection and then receive negative feedback from the report itself. This can be confusing and demoralising for staff. Inspection reports need to maintain balance and proportionality. There also need to be agreed timescales and processes for publishing reports and actions, between HIS and health boards or integration joint boards. There should be learning from the current process and long timescales for the joint inspections for older people's inspections, which can limit the value of the report when it is published.

### **4) Clarity between the scrutiny and improvement functions of HIS**

Ensuring scrutiny drives improvement is an important principle of HIS's model. The improvement support of HIS will be vital to ensure the success of this new approach to scrutiny. Staff need to feel that this is being 'done with' not 'done to' them. HIS should help build improvement capacity and improvement methodology within health boards and ensure that improvement leads and processes are linked in with wider organisational structures.

However, as we have commented previously<sup>2</sup>, HIS faces a conflict with having its improvement and scrutiny functions located in the same body. There needs to be clear distinction between the two roles in order to provide public assurance that HIS's scrutiny function is independent. HIS needs to be clear how it will balance its role of providing independent assurance while still allowing scrutiny and improvement activities to support each other.

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<sup>2</sup> [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0006/564225/2014-20\\_HIS\\_Strategy\\_Consultation\\_RCN\\_response\\_FINAL\\_v1.0.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0006/564225/2014-20_HIS_Strategy_Consultation_RCN_response_FINAL_v1.0.pdf)

We support HIS's proposals to place greater emphasis on health board's own systems of assurance. This should also apply to the assurance processes that the new integration joint boards will be developing. HIS, and the new integrated improvement body, will be ideally placed to support health boards and integration joint boards to develop a consistent approach to identify early warning signs themselves, based on key aspects of the overarching quality framework. The current work around a national nursing assurance framework is directly relevant to this and must be aligned to HIS's new approach. HIS should ensure that information and data being gathered locally as part of a nursing assurance framework is acted on and underpins decision-making at a board and general management level.

Self-assessment is an important part of inspection methodology. However it can be very time-consuming and staff must have the space, time and resources to carry this out. The process must minimise the burden of self-assessment, for example by streamlining data collection and co-ordinating with the self-assessment process for other current inspection programmes. HIS should apply learning from its recent review of the self-assessment process within the older people in acute care inspections, when developing this.

## **5) Resources and workforce within HIS**

The expansion towards more comprehensive assessments of care will have resource implications for HIS. Does HIS have the resources in place needed to support and achieve this, especially as it has received no real terms increase in funding over the last two years? Given the potential stretch on resources, will moving to this model of scrutiny have any potential impact on HIS's improvement work through the re-allocation of budgets to manage a resource intensive scrutiny methodology?

The importance of a skilled workforce within HIS to support the new model is vital. HIS must make sure it has the internal capacity, skills and resources needed before starting on this new scrutiny model, or have clear mechanisms to build specialist clinical capacity from within services to enhance inspection teams. If HIS is planning to use staff from across NHS Boards to support the inspection process, there will need to be a consistent approach, training and national job profiles. The implications of this approach must be clearly outlined within both HIS and Health Board's workforce development plans. This is especially important given the current pressures health boards are facing in recruitment and retention, indicated by increased costs from bank, agency and locum staff and high vacancy rates.

With the move towards far more comprehensive reviews of quality of care, it is increasingly important that HIS has access to appropriate clinical expertise and leadership within its own board. Nursing, as the largest group in the healthcare workforce, has a huge impact on the quality of care patients receive and HIS must be able to capture the clinical expertise that nursing brings. It also needs to support nurse leaders to engage the nursing workforce to drive forward improvements to the quality of care. Given this, it is therefore surprising that HIS does not currently have a nurse on their board who would be able to provide both this vital advisory and leadership role for the nursing workforce.

## 6) Specific points about the quality framework

As outlined above, we support that HIS is looking at the wider domains that underpin quality care, particularly workforce, leadership and culture. However the quality framework as it stands is unwieldy. It needs to be implementable, with clear standards and criteria, so that staff know what is expected of them. Having clear standards and indicators would also allow benchmarking. Shifting to a more outcome-focused approach, would make the process be more meaningful, align it with the outcomes-focus of health and social care integration and help avoid it becoming just a tick-box exercise.

The quality framework also needs to be applicable across settings, particularly within community services and reflect the integration of health and social care. For example the section on governance must take into account the clinical governance responsibilities of integration joint boards, not just of health boards. HIS may find it helpful to look at a briefing the RCN has produced on clinical governance within integration joint boards<sup>3</sup>.

We are pleased that HIS has identified staffing as one of its key domains. This will need to be multi-disciplinary in its approach. From a nursing perspective, this should consider both the overall funded staffing establishment and the actual staff working on the ground. Part of this should look at the implementation of the National Workforce and Workload Planning tools for nursing, including how these are triangulated against patient acuity, professional judgement and benchmark data. Importantly the tools only look at staffing numbers not skill mix. It is vital that HIS's criteria also take into account the appropriate skill mix of staff. RCN's *Frontline First* report *Running the Red Light*<sup>4</sup> contains further information about principles of workforce planning and workforce/staffing level indicators that HIS may wish to refer to. We have also published guidance on safe staffing for older people's wards, which HIS may find helpful<sup>5</sup>. Other staffing indicators could look at staff grievances, recruitment and turnover, and sickness due to stress.

We are pleased that HIS has responded to our comments in the past and is planning to move to a more comprehensive approach to reviewing the quality of care. In the next stage of this work we suggest that HIS should shape the model to reflect the shifting landscape of health and social care; clarify and co-ordinate the scope and remit of its approach alongside its existing scrutiny activity and that of other scrutiny and improvement organisations; and ensure that the model is practical and meaningful, with staff on the ground provided with the improvement support and resources to implement it.

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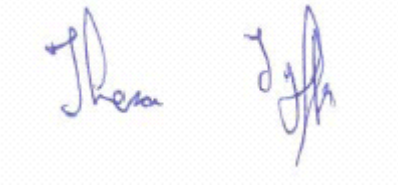
<sup>3</sup> [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0006/627648/RCN-integration-briefing-clinical-and-care-governance-v1.0.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0006/627648/RCN-integration-briefing-clinical-and-care-governance-v1.0.pdf)

<sup>4</sup> Royal College of Nursing (2013) *Frontline First* Running the Red Light. Available at: [http://royalnursing.3cdn.net/e678a38646d8d670b1\\_rdm6bgu19.pdf](http://royalnursing.3cdn.net/e678a38646d8d670b1_rdm6bgu19.pdf)

<sup>5</sup> Hayes, N and Ball, J (2012) Safe Staffing for Older People's Wards *Royal College of Nursing*. Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0009/476379/004280.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0009/476379/004280.pdf)

We are happy to be involved in further development of this work. If you would like to discuss anything further, please contact Helen Malo, Policy Officer, [helen.malo@rcn.org.uk](mailto:helen.malo@rcn.org.uk).

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Theresa Fyffe', is shown on a light grey grid background.

**Theresa Fyffe**  
**Director**