1. Introduction

Part 5 of the Bill, Healthcare: Scrutiny and Improvement, describes the establishment of a new body, Healthcare Improvement Scotland (HIS). All of the current functions of NHS QIS, including those of the Scottish Health Council, will transfer into the new body together with the registration and regulation of the independent healthcare sector, including complaints in relation to the provision of an independent healthcare service. The key functions currently performed by NHS QIS are set out in the diagram below:

Assessment and measurement / scrutiny is just one element of this cycle of quality improvement and maintaining the balance between the three activities will be key to ensuring improvement across both the NHS and the independent sector. This will be a key responsibility for HIS, which will need to build confidence that its values are focused on improvement, and demonstrating the organisation’s contribution to implementation of the new NHS Quality Strategy will be critical to this.

Crucial to the functions currently fulfilled by NHS QIS is clinical buy-in. A key factor in maximising the effect and impact of guidance and standards is that these are developed with healthcare professionals, not imposed externally; likewise the process of reviews against standards is based upon peer review. This is one important aspect of the mutuality that the Government is committed to reinforcing in the NHS; it also avoids the bureaucracy and cost of recharging transactions between NHS Boards. Again there is an important balance to be struck between robust and evidence-based processes and professional expertise and involvement. We therefore strongly welcome the commitment that HIS will
remain an NHS body and the further extension of our approach to clinical engagement to the independent sector.

The creation of HIS also provides NHS QIS with the opportunity to review and refine our internal arrangements, including Board governance arrangements. This should optimise the prospect of harmonising activities, avoiding duplication, ensuring co-operation and greater efficiency.

The legislation which established NHS QIS (The NHS Quality Improvement Scotland Order 2002) no longer adequately reflects the approach to our work and the PSR Bill presents an opportunity to re-articulate the Scottish approach to quality improvement in healthcare. We welcome the opportunities for improvements in the approach to scrutiny and performance assessment in the NHS, and the opportunity for a more integrated and aligned approach across the NHS and independent sectors.

2. Commentary on Part 5 of the Bill – Healthcare: Scrutiny and Improvement

10B Principles

10B (2) states that ‘the safety and wellbeing of all persons who use services provided under the health service and independent health care services are to be protected and enhanced’. This means that HIS assumes a ‘duty of protection’ and section 10K (4) refers to the disclosure of information obtained during inspection for protecting the welfare of children or at-risk adults. Our approach to reviewing both organisations (governance) and services (clinical) optimises the level of assurance it is possible to provide. However it is important to be realistic about the absolute degree of assurance possible.

In addition, section 10D, subsection (3), refers to the liability of HIS in respect of any liabilities incurred, including for ‘negligent acts or omissions’. Consideration will need to be given to what this might mean in practice for HIS, for example, in relation to frequency and basis of inspection visits.

10C Health service functions

(1) (d) retains the functions of NHS QIS in relation to the evaluation and provision of advice, currently carried out by the Directorate of Guidance & Standards and the Scottish Medicines Consortium. Their guidance should apply across the NHS and independent sector in Scotland to ensure
consistency and equality of approach, and we welcome this opportunity for greater alignment.

Subsections (2) (a) and (b) refer to the power to assist voluntary organisations whose activities may be similar to or related to the functions of HIS. There is already considerable collaboration with the voluntary sector and this provides for it to be further strengthened. However it is important to be clear that such assistance needs to be directly related to the strategic aims of HIS and properly resourced.

Subsection (2) (c) also refers to the power to disseminate information relating to ‘the promotion and maintenance of health’. Given the remit of NHS Health, and to avoid duplication, it may be appropriate to refer to the need to work jointly in this area.

Subsection (3) (c) sets out the requirement for HIS to provide advice to Ministers. In addition, the professional integrity of HIS must be maintained by enabling the organisation to report to Ministers when issues of concern are identified as a result of inspections and other data / information-gathering activities. We therefore welcome and value the inclusion of (3) (d), the power to provide such advice to Ministers at any time.

**10E Independent health care functions**

These functions bring the risk of scrutiny distorting, perhaps even dominating, the balance of the organisation’s quality improvement activities, bearing in mind the NHS is the principle provider of healthcare in Scotland. This risk would be exacerbated if commencement orders were issued for the independent health services that are covered by the Regulation of Care (RoC) Act but not yet commenced. There must be sufficient evidence to support commencement for any additional services and there is already much work underway in assuring the quality of these services. As the RoC Act includes dentists and certain clinics it would put significant pressure on the new organisation.

We therefore welcome the intention that the existing functions of NHS QIS and the existing functions of the Care Commission in relation to the independent healthcare sector will be covered by Healthcare Improvement Scotland in the first instance. The Bill provides for additions to these functions and in our view further consideration needs to be given to their extent and timescale. The scope of services covered may also have implications for the extent to which improvement can be implemented or measured, particularly for services where there is a limited evidence base or limited impact.

**10F Meaning of “independent health care services”**
Section (2) refers to the current definition of independent clinics as including a ‘clinic…from which services are provided…by a medical practitioner or a dental practitioner’.

There is also scope for independent clinics to supply similar services involving healthcare professionals other than medical or dental practitioners. The provisions should therefore apply to all registered health professionals working in independent health services.

The definition of “independent medical agency” is unclear, particularly in terms of how this can be distinguished from an independent clinic.

The definition of an “independent hospital” is difficult to interpret, where this is collocated with an NHS hospital. It is important that there is clarity as independent healthcare is provided in increasingly innovative ways, in particular arising from “site sharing”, where both the NHS and the independent sector are working closely together, including the use of fast track diagnostic and treatment centres.

10H Standards and outcomes

Section 10H states that ‘Scottish Ministers may prepare and publish standards and outcomes’ applicable to both NHS and independent health care services. At present, any provider of independent health care services who is also providing services to NHS Boards is required to comply with relevant NHS QIS standards and we welcome the opportunity for a more integrated approach to standard setting.

Section 10H also refers to the need for consultation as appropriate and the ability to delegate this function to HIS or ‘other persons’. Consultation and co-ordination relating to the development of any standards and outcomes is vital to ensure consistency of approach and balance across quality improvement activities. We strongly support the proposal that the setting of standards is delegated to HIS to ensure continuation of the current approach being taken by NHS QIS to quality improvement in NHSScotland.

10M Inspections: reports

NHS QIS welcomes the emphasis in this section on the ability to report and make available the findings of inspections carried out by HIS, as this is a valuable requirement for an independent inspection process. While NHS QIS, and subsequently HIS, will therefore be transparent and accountable to the public and to Scottish Ministers, this does not guarantee that the findings and recommendations of reports will be able to
secure an adequate response by government and other relevant authorities as recommended by Crerar.

10N Regulations relating to inspections

We note that under 3 (e) the regulations make provision for: ‘the sharing or production of information (including health records) for the purposes of an inspection’; and for ‘interviews and examinations…which may be carried out in connection with the inspections’. These are not approaches currently employed by NHS QIS. We would strongly recommend that, for both HIS and SCWIS, any deployment of such provisions should be exceptional and underpinned by a Code of Practice. Ideally patients would give consent for access to their records for the purpose of improving healthcare.

In this section, medical records are defined, while dental records are referred to but not defined. It would be helpful to have a similar definition. We would also suggest that in 10N (4), line 3, “medical records” is replaced by “health records”.

10O Registration of independent health care services
10Q Improvement notices: independent health care services
10S Condition notices

The new arrangement enables greater use of common approaches to standards and assessment across all healthcare – whether delivered by the NHS or independently, and this is welcomed.

Section 10O sets out the responsibility of HIS for registration of independent health care services. It should be noted that NHS QIS does not currently have a registration function and that the resource implications of HIS taking on this function will require consideration.

In contrast to the other functions of HIS, each of the areas above introduces a responsibility in relation to independent healthcare services, the equivalent of which will not be applicable to NHS services, and presents a challenge in terms of ensuring a common approach. While the NHS is heavily performance managed it is not formally regulated as such, and the sanctions that can be invoked are less explicit. However while there are different sanctions, both approaches are robust and have the necessary power to address failing systems.

10Z3 Complaints about independent health care services

10Z3 states that HIS must establish a complaints procedure in relation to independent health care services (currently undertaken by the Care
Commission). This will sustain the current situation whereby NHS users of independent healthcare can complain via both the Care Commission and NHS processes. There is also a concern, as expressed in the Crerar report, that there is not a single complaints system for users of all public services.

However the introduction of the Bill gives an opportunity to standardise the approach to handling complaints and joining up learning across the NHS and independent healthcare sector, and ideally across the public sector generally.

10R Cancellation of registration

This section refers to cancellation of the registration of independent health care services. It is important that the procedures for cancellation of registration of care services regulated by SCSWIS will be exactly the same for independent health care services in HIS.

10Z Registration fees

This section refers to the ability of HIS to charge fees in respect of its registration function. This will be necessary to cover the administrative resource required to provide this function in HIS as it does in the Care Commission at present. If regulation of independent healthcare is to be extended beyond the existing arrangements, it is essential that provision is made for full cost recovery.

10Z7 Inquiries

This section includes the ability for HIS to charge the party to an inquiry for expenses incurred. It could be argued that this is not in keeping with the independent nature of HIS and it may be preferable for this function to rest with the Scottish Government i.e. once an inquiry is concluded, the Scottish Government can pursue the reimbursement of costs on behalf of the taxpayer.

10Z10 Establishment of Scottish Health Council

(2) (b) refers to the appointment by Scottish Ministers of a member of HIS to chair the Scottish Health Council, on the basis that ‘HIS may establish…a committee to be known as the Scottish Health Council’.

We welcome the opportunity presented by the Bill to more fully integrate user focus activities within HIS than has been the case to date with NHS QIS and the Council, in particular through the implementation of the Participation Standard.
If Scottish Ministers appoint a chair of the Council, this should be from the core membership of HIS with the same lines of accountability as other members and not independently accountability to the Minister as at present, to ensure a more streamlined patient focus and public involvement approach and fully integrated work programme and hence the efficiencies and economies that are a core purpose of the Bill.

3. **Additional commentary**

- **Part 6 of the Bill – Scrutiny**

  **94 Scrutiny: Duty of Co-operation**

  The introduction of the PSR Bill and the setting up of HIS and Social Care and Social Work Improvement Scotland (SCSWIS) presents a number of opportunities to strengthen and further develop our current working practices, including: the introduction of a more consistent approach to risk assessment and scrutiny of public services; improved sharing of information; and use of the Duty of Co-operation to replace the current ad-hoc joint working arrangements. NHS QIS is fully involved in the multi-agency task groups which have been established to take the project forward.

  In relation to the bodies working to the same templates and processes, ‘one size may not fit all’ and that HIS and SCSWIS will need to tailor their approaches. The opportunity to review the co-operation to ensure that the wellbeing of users is at the centre of the respective functions of HIS and SCSWIS is welcome.

- **Schedule 5A – Membership of HIS**

  The Bill proposes that HIS consists of a chair, the chair of SCSWIS, and between 10 and 13 other members, all appointed by Scottish Ministers. There is nothing in the legislation which would prevent the Minister from appointing employees of HIS and other NHS boards, but there is no requirement to do so. This alters the nature of the governing body from the current NHS QIS, and may make it easier for HIS to demonstrate its arms-length relationship from the NHS and independent sector providers.

  We note that the Chief Executive ‘must be a member of HIS’ and it is essential that this remains the case, to guide the smooth running of the organisation. The inclusion of the chair of SCSWIS on the HIS Board and vice-versa will bring an added time commitment but will strengthen governance and strategic planning for both organisations.
• **Policy Memorandum**

Within ‘Overview of policy aims’, paragraph 185, we suggest that the second bullet point should read ‘promote and support the continuous improvement of services’.

Jane Illingworth  
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