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Professor Craig White
Divisional Clinical Lead
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Scottish Government

Letter emailed to: Craig.White@gov.scot

Dear Craig

NHS Boards Governance Assurance Mechanisms

I refer to the Cabinet Secretary's letter of 5 September asking NHS boards to provide assurance on the mechanisms in place for reviewing complaints of professional practice and how Boards are assured of the safety and quality of the surgical practices of its employees. While the request was aimed at territorial boards, and patient-facing national boards, I thought it would be useful to provide an overview of Healthcare Improvement Scotland (HIS)'s work in these areas.

Concerns About the Quality of Healthcare

The Sharing Intelligence for Health and Care Group (SIHCG) brings together colleagues from seven national organisations to share and consider intelligence about the quality of care systems across Scotland, and published its third annual summary report in August 2018. The group now includes the Scottish Public Services Ombudsman (SPSO) and discusses quantitative analyses from Scotland-wide care datasets, including about service delivery, complaints and workforce.

HIS does have a role in responding to concerns raised about NHS services by NHSScotland employees, or referred to us by another organisation. The routes through which we are made aware of concerns include (but are not limited to):

- Referral from the National Confidential Alert Line
- Directly by a member of staff/group of staff under the Public Interest Disclosure Act
- Request from Scottish Government
- Intelligence sharing by another NHS organisation such as NHS Education Scotland
- Referral from a regulatory organisation such as General Medical Council, Nursing and Midwifery Council, General Dental Council.

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Regardless of the routes used, all concerns are subject to a level of assessment and investigation to provide assurance that concerns have been addressed. The depth of the individual investigation will be determined based on the risk the concern could lead to (or cause) harm of patients and/or staff and the wider potential learning for the NHS organisation involved and more widely across NHSScotland.

Surgical Safety and M&M Reviews

The Scottish Mortality and Morbidity Programme (SMMP) is a collaboration which aims to improve mortality and morbidity meetings and processes within NHSScotland through:

- learning and training to provide skills and support to design and run effective mortality and morbidity meetings and processes
- sharing learning across NHSScotland, and
- technology and IT systems that support mortality and morbidity processes.

Progress to date includes publication of a practice guide, delivery of undergraduate training (with plans to spread across all Universities in Scotland), and engagement with NHS boards to better understand local challenges and to provide support.

Supervision of Junior Medical Staff

As noted above, the Sharing Intelligence for Health and Care Group considers a range of intelligence for each NHS board, and this includes, from NHS Education for Scotland (NES), data from General Medical Council and NES trainee surveys.

Openness and Transparency

Being open and honest with people about their care is already a key part of existing processes such as managing adverse events and complaints handling, alongside the professional duty of candour for all health professionals.

Through the adverse events programme, HIS is supporting a cohesive approach to the reporting, management and learning from adverse events.

The Adverse Events Community of Practice website has been set up to support NHS boards to share learning for improvement following adverse events reviews. Through this website, NHS boards can use a learning summary template to share learning about service improvements following recommendations and actions that have come from adverse events reviews with potential national application.

Healthcare Improvement Scotland has also agreed with the Procurator Fiscal to share the learning points from particular reviews into deaths more widely across NHSScotland, in order to facilitate national learning and improvement through use of learning summaries. The aim of this process is to ensure that learning from death

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investigations is shared in the most efficient and effective way possible, and ensuring that this is done in collaboration with the NHS board in which the review took place.

The resources available on this community of practice for implementing and improving the management of adverse events also support organisations in carrying out the statutory duty of candour with a dedicated page and associated resources.

I hope that this information is helpful.

Yours sincerely,

Robbie Pearson
Chief Executive