Healthcare Improvement Scotland

A National Care Service for Scotland

Strategic response from Healthcare Improvement Scotland

November 2021

NHS SCOTLAND

Contents

1. Introduction

Healthcare Improvement Scotland exists to help ensure that the people of Scotland experience the best quality health and care services. We do this by drawing on a broad range of skills and experience in quality improvement, service redesign (including service design, strategic planning and commissioning), assurance and scrutiny, community engagement, intelligence gathering and evidence-based knowledge and research.

We also work in strong and effective partnerships across a broad range of organisations including the 14 territorial NHS boards, 31 Integration Authorities, NHS Education for Scotland (NES), Scottish Social Services Council (SSSC), National Services Scotland (NSS), Public Health Scotland, Improvement Service, NHS24, Care Inspectorate (CI), Coalition of Care and Support Providers in Scotland, Scottish Federation of Housing Associations, Alzheimer Scotland, VOX, Royal College of General Practitioners (RCGP), Health and Social Care Scotland and the Convention of Scottish Local Authorities (COSLA). This list is far from exhaustive, as we work with over 100 different organisations across Scotland.

Based on our broad expertise, this response seeks to provide constructive suggestions and points for consideration to support a National Care Service achieve the stated ambition of ensuring that social care is person-centred, human rights-based, and seen as an investment in society. We have focused our comments on the aspects where we believe we can add most value to the consultation proposals.

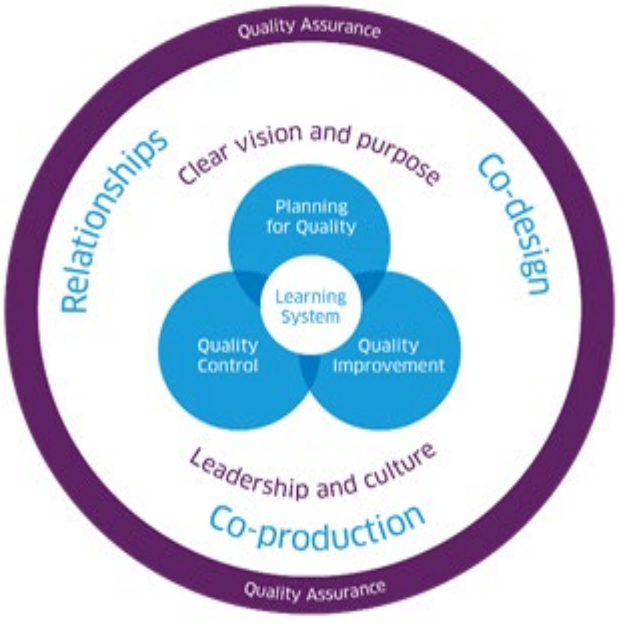
Healthcare Improvement Scotland believes that there is a substantial opportunity to adapt the current national improvement infrastructure to meet the challenges set out in the consultation document, and to ensure a flourishing and responsive National Care Service of which the people of Scotland can be proud. **As a national improvement organisation, we are committed to playing our part to leverage the necessary changes at scale and pace to achieve the improvements and ambitions for reform set out in the consultation document.**

2. Quality Management System

It is increasingly apparent that quality assurance and improvement of health and social care cannot be compartmentalised. There has been a growing recognition of the inter-dependencies and mutual support required across a complex system of care. We believe this is one of the clear lessons of the COVID-19 pandemic.

Our Quality Management System (QMS) seeks to reflect these inter-dependencies by having a common framework for quality management across health and social care. It brings together the components of quality planning, quality improvement and quality control, ensuring that they are appropriately balanced, because there is not a single or straightforward answer to sustainable improvement. Sometimes it may require an inspection to diagnose the extent of a challenge. On other occasions we may need to provide support to guide an organisation in tough times – for example, where they may understand their difficulties but not have the knowledge or skills to move forward. For others it might be about identifying that crucial piece of evidence or proven practice elsewhere that can reinforce or redefine a way forward.

The QMS approach highlights the importance of understanding and prioritising the improvement opportunities (quality planning), designing and testing solutions (quality planning and quality improvement), implementing better ways of delivering health and care services which are optimised for local contexts (quality improvement) and spreading learning at scale (learning systems). It also recognises the importance of creating the conditions for sustainable improvement by ensuring we have clear and meaningful standards and measures that enable us to assess whether we are maintaining quality (quality control and quality assurance) and whether staff at every level in the system have the skills to continuously improve (leadership and culture). Finally, the QMS is clear about the importance of co-designing and co-producing health and care services with people who need, use and deliver care. Without this broad approach there is a risk that new models and pathways will be implemented that fail to deliver the benefits, fail to adapt to changes in context, or both.



The QMS marshals the right response for the situation, leading to more effective and sustainable improvements and outcomes. That is why we believe it must be adopted at a national and a local level as a central component of the drive to creating a National Care Service.

3. Remit of the National Care Service

Our comments on the proposed remit of the National Care Service focus on where Healthcare Improvement Scotland can add most value. They are informed by our work over the last decade, and particularly by the last five years supporting improvement across integrated health and social care services.

3.1 Potential benefits of a National Care Service focused on social care

We can see the value in mirroring the NHS structures for social care by creating a parallel National Care Service. Benefits could include:

a) Staff who work in social care having a common identity as part of a National Care Service.

b) A national set of terms and conditions and common professional standards would both help with recruitment and retention. With integration in mind, we believe the option of expanding Agenda for Change to cover social care is worth considering.

c) The centralised commissioning and delivery of low-volume (and often high-cost) social care services.

d) It would open opportunities for a more co-ordinated and collaborative approach to the commissioning of third and independent sector services.

We strongly welcome the emphasis on a rights-based and participative approach to the design and monitoring of services. To ensure we consider the impact of inequalities and discrimination it is critical that mechanisms are put in place for individuals to understand their rights, appropriate advocacy and how they can realise those rights.

We are also supportive of the removal of eligibility criteria in their current form. The importance of person-centred exploratory conversations, rather than a focus on eligibility, is critical to enabling people to access the right care and support at the right time. We would suggest working with people with lived experience of social care and their families to co-design any replacement to eligibility criteria.

3.2 A National Care Service including community health services

It has become increasingly apparent during the pandemic that individuals in social care settings have a complex mix of health and social care needs. They need support from a mixture of social work, social care and a range of healthcare professionals. Further, the environments they live in need to be both homely and protective of their health.

HIS is supportive of integrated services designed to seamlessly meet the health and care needs of people. This builds on the many examples of good practice in the current Health and Social Care Partnerships and examples of successful working during the pandemic.

The consultation document states that leadership and good working relationships are key to a well-functioning integrated health and social care service, and we would agree. We would go beyond this

to state that a well-functioning service additionally needs clear lines of accountability and clinical and care governance to ensure safe and effective care, and to safeguard the staff wellbeing.

Greater clarity is needed on whether the proposed NCS and Community Health and Social Care Boards (CHSCBs) are commissioning or employing bodies or both. We believe there are risks associated with large-scale structural change at this time, but equally acknowledge that we do not wish to lose the benefits of integrated care by establishing separate health and social care silos at the local level. Our concerns are laid out as follows:

- The structural change needed to separate community health services from the NHS could detract from the vital and pressing work that needs to take place regarding social care. We believe that there is an argument to keep the NCS focused on social care, the NHS on health, and then look at embedding partnership structures at every level (from national to regional to local). This could enable delivery of integrated services designed to meet individuals' needs, maximise use of their existing assets and prioritise prevention and early intervention.
- There are risks to structurally fragmenting community health care from hospital-based health care – when there is a well-recognised need to design integrated pathways that preference prevention and early intervention.
- We also recognise the potential risks of organisational upheaval in transferring a significant percentage of the health workforce from the NHS to the NCS, creating additional anxieties for the health and care staff involved at a time when wellbeing is a major issue. This could translate to staff burnout and additional recruitment and retention difficulties, which are already a major challenge.
- We agree that there have been significant gains for residents of care homes in giving Executive Nurse Directors accountability for IPC, care assurance and workforce. We support the move to strengthen professional nursing governance in community and social care. The success of the Executive Nurse Directors and their teams in providing support to care homes required significant work to clarify roles, responsibilities and accountabilities and has been to date in the context of emergency COVID-19 measures. Significant further work is needed to ensure clear lines of governance and accountability if this role is to be extended. Key to success has been the Nurse Directors' relationships to the Chief Nursing Officer of the NHS, the Director of Public Health, and the Medical Director, and their ability to pull on the system of resources and expertise of the wider NHS. Developing Executive Nurse Director accountability outside of the current system of national and local NHS clinical and care governance would risk losing many of the benefits demonstrated during the pandemic.
- As stated in the consultation paper, multi-professional working is essential to ensure good professional and clinical and care governance. However, the role described for the Executive Nurse Director in the National Care Service and CHSCBs is in isolation of the multi-professional team. In particular, the roles of the Executive Medical Directors and the Directors of Public Health are not described nor is the relationship between the Nurse Director and Chief Social Work Officer. The role of these professionals working together has been key during the pandemic in leading the nursing, midwifery and allied health professionals (NMAHP), medical, pharmacy and public health front line teams, providing advice at the local level for the public, and in joint working with the social care in the public, third and independent sectors.
- If the NCS is to truly meet its aims, continued input from public health teams in prevention and early intervention as well as in outbreak and disease management will be needed.

Executive Medical Directors are also executive leads for pharmacy and dentistry and have similar responsibilities for these professions in the primary care, mental health and community settings as the Nurse Director has for NMAHPs. Any consideration of either structural change or commissioning should, in our view, consider the roles of all health and social care professionals in ensuring that care is rights-based, safe and effective.

- We are also concerned that moving a significant percentage of the health workforce from NHS to NCS would create unnecessary confusion for the public in terms of accessing services (i.e., they may think that since services are no longer part of NHS, they are no longer free at the point of delivery). There is also a risk that this would create public opposition that could detract from the ability to implement social care reforms in pursuit of the priorities that underpin the vision for the NCS.

3.3 Integration of health and social care alongside wider public services

The policy ambition for integrating health and social care in Scotland was *'to improve the quality and consistency of services for patients, carers, service users and their families',* providing *'seamless, joined-up quality health and social care services'*[1].

This must be non-negotiable, and the creation of the National Care Service must enable progress towards this ultimate aim. Furthermore, we need to ensure that arrangements for the local planning, commissioning and delivery of care build on learning from what has and has not worked across integration authorities. In particular, we note that there are a wide range of positive developments that have been delivered through the Integration Joint Boards (IJBs) (see the Audit Scotland report on NHS in Scotland 2019 for examples), albeit it within a context where there have continually been structural and behavioural barriers to success.

If we are to deliver on the aspirations of the Christie Report, which arguably are even more relevant today than 10 years ago, then we need to design a place-based approach for the planning, commissioning and delivery of services that recognises the need for ongoing partnership working across a range of organisations and sectors. This is essential, because individual people's needs rarely fit neatly into discrete categories such as health, social care and housing. Improving the health and wellbeing outcomes across our population requires a **joined-up approach locally (however 'local' is defined) not just between health and social care, but also involving a range of other services including vital roles for housing and education.**

We believe that there is an opportunity for the creation of a National Care Service to sit alongside a reform of arrangements for integrated planning and delivery of health and social care. In that way, the best of both worlds could be delivered: the benefits of a national approach to social care that ensures parity of approach with the NHS, alongside strengthening the local planning and delivery of integrated health and social care services within the context of enabling wider place-based transformation work.

This means that the existing partnership arrangements would need to be revised based on the learning from what has and has not worked across IJBs. From a review of the evidence, and from our experience working at a Scotland wide level across IJBs for the last six years we note:

- The vital importance of **system leadership behaviours** that enable strong and effective partnership working. The new system design must pay particular attention to how we

[1] Public Bodies (Joint Working) Scotland Bill: Policy Memorandum, 28 May 2013 (Scottish Government)

incentivise systems working. This must include attention to the targets and organisational performance management cultures that can drive leaders to focus on balancing their own budgets and meeting their own organisational performance targets even when this simply transfers costs and performance pressures to other parts of the system.

The creation of the NCS alongside the NHS means careful consideration will need to be given to national health and social care partnership arrangements, with the aim of designing an approach that enables systems leadership actions and behaviour at every level.

- The importance of investing in the time to **co-design new pathways and services with people who use and deliver services, also considering potential use of services and the wider community.** Whilst initially taking longer, this is vital to delivering sustained meaningful improvements. We welcome the emphasis on this in the consultation document, although we also note the lack of detail around how this would be achieved. We note the importance of ensuring that capacity and capability exist locally to do this and that the political will is there to ensure the necessary time is given to enable robust co-design. We think consideration should be given to embedding transformation teams which include service design, quality improvement (QI) and commissioning expertise into the local partnership structures (we have further elaborated on this in our section on Improvement Support).
- Whilst the ability to see the health and social care budget in totality is clearly vital if we are to achieve the vision of transformation, the IRASC and the NCS consultation indicate that the current approach to pooled funding at a local level is not working. We note that challenges have included:
    - Trust issues when one or both partners are applying financial savings targets to pooled budgets. These could be addressed by a centralised ring-fenced allocation to the local partnership arrangements of the funding for integrated health and social care services.
    - The practical challenges of delivering cash-releasing savings through redesign, especially where overall demand is growing and hence resources saved in one service are quickly reallocated to address other pressures in that same service. Actually moving resources around the system in this context requires a collaborative vision and commitment across all the key players alongside strong and transparent strategic and financial planning. Redesign also requires a strategic approach to workforce issues including a stronger emphasis on re-training to enable redeployment into areas struggling to recruit. Whatever arrangements are implemented to plan and deliver integrated care locally need to enable these factors to be in place.

We also note the significant challenges associated with the time delay between initiating new preventative and early intervention approaches and the point when they start to have an impact on demand further down the system. Whilst the move to three-year financial planning is a major step forward, it is not clear whether this alone will be sufficient to overcome the barriers to moving resources upstream. This is a wicked problem that every health and care system is struggling with, and it would benefit from further work to assess what other measures might help, drawing on the evidence internationally.

- We need to make sure there is sufficient senior subject matter expertise wrapped around the leadership and governance of services such as primary care, mental health, learning disability, and drug and alcohol services. We are concerned the current structures may not always enable this. Prior to COVID-19, this was flagged by senior mental health leaders at a

HIS stakeholder advisory group on mental health and has also been an issue in several NHS board-specific pieces of assurance and improvement work we have undertaken over recent years in mental health. Therefore, this is an area where we think the opportunity should be taken to explore alternative approaches to both the planning and the delivery of services.

We note that if the NCS focuses on social care, and if integration of health and social care continues to be delivered through partnership arrangements, then there will need to be a solution for the delivery of state-provided social care locally. There are a range of options for this, which could include continuing to commission it from the local authority.

We also welcome the focus in the consultation on addressing the practical arrangements that need to be in place to enable integrated delivery of services and to support a 'Getting it Right for Everyone' approach. Those include a single adult plan that is rights-based, strengths-focused and linked to the development of an integrated social care and health record. We look forward to working together with key partners, including people who need and use services, to help with the design and implementation of these person-centred improvements.

The evidence and our practical experience align; high-quality care results when we have people with the right skills and attitudes working in systems that are designed to support them to do the right thing. Therefore, any programme of change needs to focus on both process and structural solutions **and** leadership, culture, skills and relationships. This is particularly important when considering the integrated delivery of health and care services. Addressing structural barriers to joined-up delivery is a necessary but not sufficient condition for success; we must pay equal attention to leadership behaviours, culture and relationships.

Factors in relation to culture which have contributed to successful integrations across organisations include establishing and sharing of common values (Health and Social Care Alliance Scotland 2019[2]), establishing trust (CELCIS, Children in Scotland and Care Inspectorate 2018[3]), building positive relationships (Miller 2016[4]) and collaborative working (CELCIS, Children in Scotland and Care Inspectorate 2018[3]).

3.4 Children's services

We support the need for seamless, person-centred care from childhood through to adulthood, and recognise the importance of services wrapping around the whole family unit to reduce complexity and enable an integrated approach to care and support. There also needs to be a continued focus on

[2] Health and Social Care Alliance Scotland, 2019. Health and Social Care Integration. How is it for you? Views-from-the-Public-Sector
https://www.alliance-scotland.org.uk/wp-content/uploads/2019/05/Health-and-Social-Care-Integration-How-is-it-for-you-Views-from-the-Public-Sector.pdf

[3] CELCIS, Children in Scotland and Care Inspectorate, 2018. Integrating Health and Social Care in Scotland: The Impact on Children's Services. Part 1: Literature and policy review.
ttps://childreninscotland.org.uk/wp-content/uploads/2018/06/Integrating-Health-and-Social-Care-in-Scotland-The-Impact-on-Childre....pdf

[4] Miller R., 2016. Crossing the Cultural and Value Divide Between Health and Social Care. International Journal of Integrated Care;16(4):10.
Crossing the Cultural and Value Divide Between Health and Social Care (nih.gov)

the principles of improved outcomes, early intervention and prevention already established in Getting It Right For Every Child (GIRFEC) and Getting It Right For Everyone (GIRFE).

The creation of the National Care Service presents an opportunity to further strengthen effective collaboration and consistency across children's and adult services, and to review existing commissioning and delivery arrangements to help deliver a more streamlined, holistic, and rights-based approach.

However, we recognise that, to date, the development of proposals for the National Care Service have focused on considerations around adult services. We therefore believe that specific, more detailed consideration needs be given to both potential benefits and potential unintended consequences that could arise from the National Care Service encompassing children's social work and social care services before we can form an evidence-based view on this. Healthcare Improvement Scotland would be keen to input to these further discussions. The issue of maintaining investment in children's services against the future pressures of services for adults is also an ongoing concern.

4. Improvement Support

Healthcare Improvement Scotland (HIS) has a remit to support the transformation of health and social care through:

- the **redesign of clinical and care services,** and
- the development of **cultures of continuous improvement.**

We have considerable experience and expertise in the design and delivery of national improvement programmes, across both health and social care that have delivered meaningful improvements in outcomes. This includes our work:

- With the National Development Team for Inclusion (NDTi) to support implementation of community-led approaches, the impact of which included a 37% decrease in the social work waiting list, a 20% decrease in social work team caseload and up to a 107% increase in new clients receiving universal support of signposting.
- In primary care, where our work reduced GP time on correspondence management by an average of 44% and, in one practice that measured it, released an average of 6 hours per week of GP time.
- In mental health, with impacts including reduction in use of restraint by up to 57%, reduction in the percentage of patients who self-harm of up to 70% and reduction in the rates of violence of up to 78%. The impact of our work to introduce contemporary practice in mental health through the 'From Observation to Intervention' guidance has resulted in reduction of 1:1 observations by 95% and a 65% reduction in staff sickness.

We also have a strong history of successful joint working with Care Inspectorate, including our work to reduce pressure ulcers in care homes.

4.1 National Improvement Programme for social care

We support the proposal in the IRASC that a **National Improvement Programme for social care**, along the lines of the NHS Patient Safety Programme, be introduced. We also agree that **national approaches** to both improvement and innovation in social care are needed to maximise learning opportunities and create a culture of developing, testing, discussing and sharing that improves outcomes.

Building on this, HIS and the Care Inspectorate have already jointly submitted a proposal to Scottish Government and COSLA outlining how CI and HIS could co-design a **National Improvement Programme for Adult Social Care** with all relevant stakeholders, including people who need and use services. We are proposing that this moves forward in parallel to work to develop a National Care Service and that it initially focuses on the priorities recommended by the IRASC which were:

- The experience and implementation of **self-directed support** must be improved, placing at the heart of the decision-making process the needs, rights, and preferences of people using services.
- The **safety and quality of care provided in care homes** must be improved to guarantee consistent, appropriate standards of care, building on lessons from the pandemic.

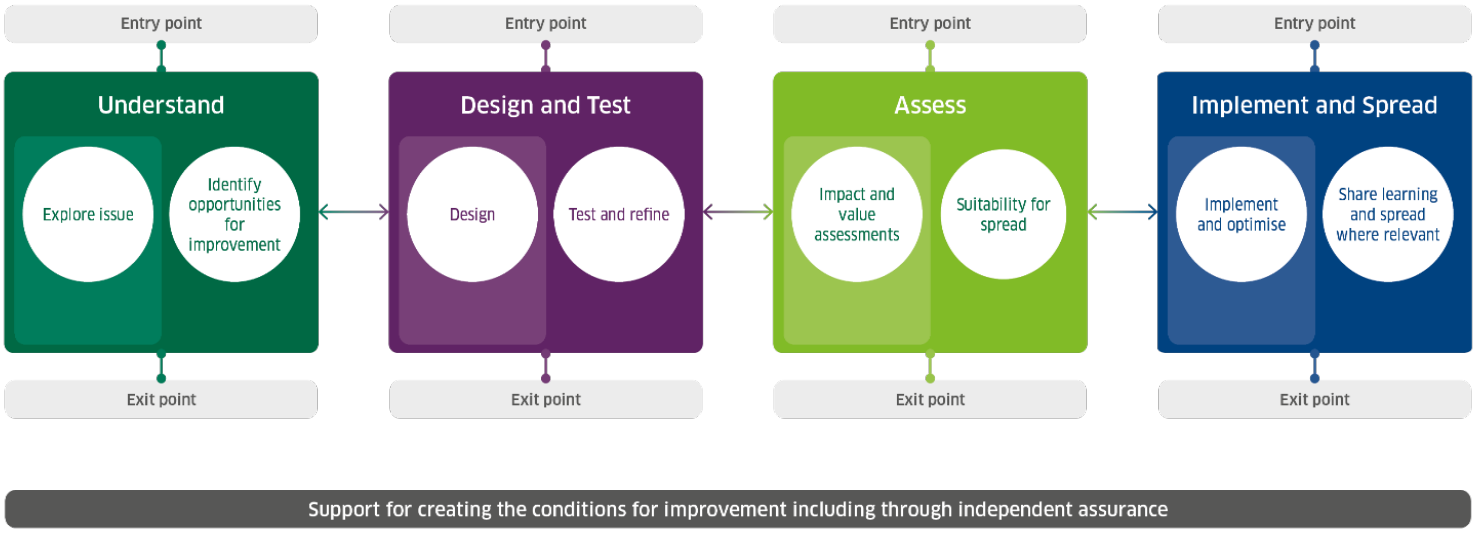
- **Commissioning and procurement processes** must be improved to provide a vehicle for raising the quality of social care support and for enhancing the working conditions and experience of the social care workforce.

We look forward to working together with a range of key partners, including individuals who need and access services, to design and deliver a national programme that will deliver measurable improvements at scale across social care in Scotland. Working together, we will ensure we build on the considerable resources, expertise and knowledge that already exists across Scotland as outlined in the next sections.

4.2 A consistent approach to Redesign and Continuous Improvement

The transformation of our health and social care system will require a mixture of large-scale redesign of services and bottom-up continuous improvement. Both require a systematic approach to ***understanding the challenge, designing solutions, testing and refining changes, assessing the impact of any change and spreading at scale.***

Fig. 1: The Scottish Redesign and Continuous Improvement Journey

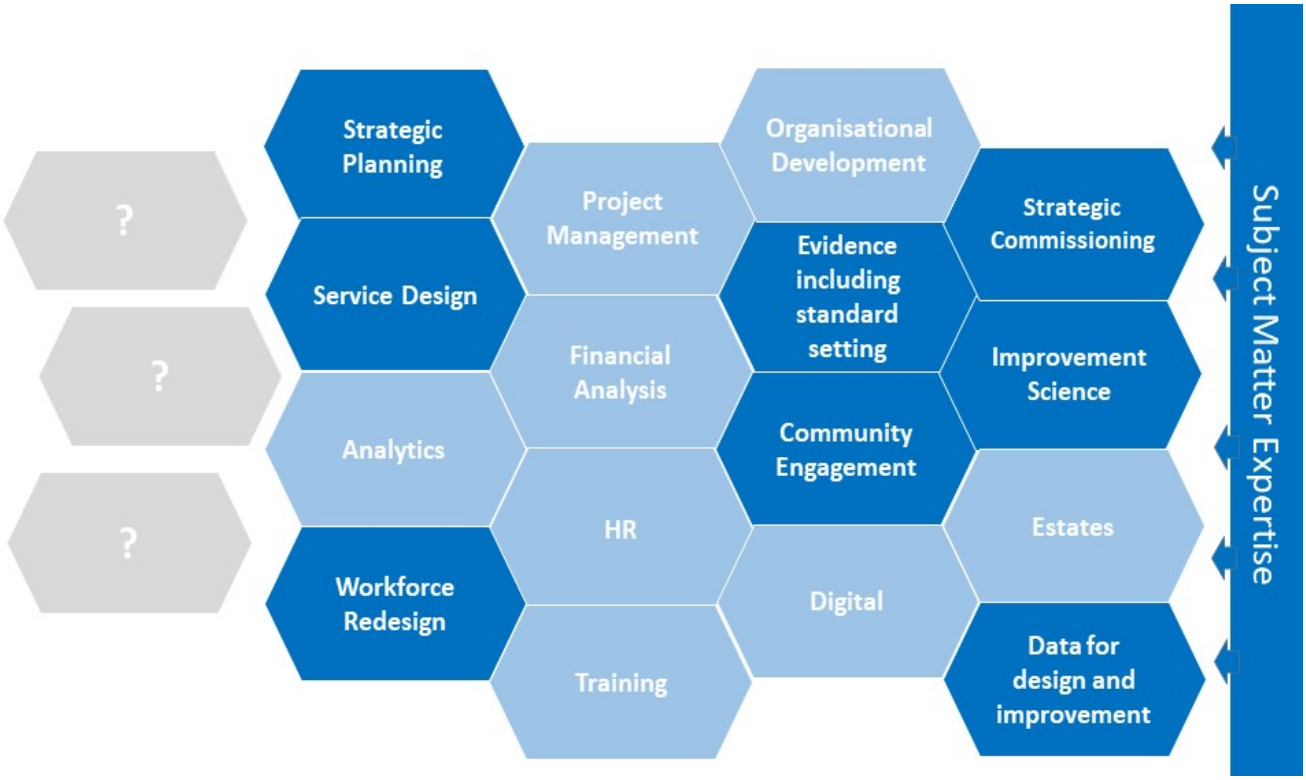


Scotland is uniquely placed across all the UK nations to move forward with a systematic approach to designing, implementing and sustaining high quality health and social care services.

- The **Scottish Approach to Service Design** provides a consistent and systematic approach to placing at the heart of any redesign work **the needs and assets of the people** who use and need services.
- The **Scottish Quality Improvement Journey** provides a consistent and systematic approach to **embedding cultures of continuous improvement** across the entire health and care system so that our entire workforce is skilled in adapting what we do, and how we do it, to better meet the needs of our populations. It also provides a critical skillset to support the implementation of new innovations and technologies, ensuring change is embedded and sustained.

- The **Scottish Quality Management System** provides a framework for ensuring a systematic approach to **managing quality** is embedded into every level of our health and social care system.
- The **Scottish Redesign and Continuous Improvement Journey** (Fig. 1) recognises that the work of redesigning services is complex and that the specific approach used must be informed by the context. Over recent years we have been advocating for the need to intentionally build and **support multidisciplinary transformation teams** that draw on a range of different skillsets, including those in the **Scottish Approach to Service Design**, the **Scottish Quality Improvement Journey** and the **Quality Management.**

Fig. 2: Composition of a multidisciplinary transformation team



The composition of a multidisciplinary transformation team should change over the life of a project to match the skills and expertise to the issues presenting at that stage.

Areas marked in dark blue in Fig. 2 indicate where Healthcare Improvement Scotland has significant experience and expertise focused on supporting redesign and improvement work across the health and social care system. Recognising that we do not have all the skills required, and the vital importance of locally led change, we work collaboratively with a wide range of partners and colleagues.

Previous successes demonstrate the potential for partners to play to their strengths in collaborating for improvement. Amongst those successes have been the HIS and CI work around reducing pressure ulcers in care homes, the HIS and Alzheimer Scotland partnership around Focus on Dementia, HIS

and NHS Education for Scotland (NES) work around Value Management and Access QI, and the most recent work between HIS, Scottish Social Services Council (SSSC), CI, NES and a range of independent and third sectors around the Essentials of Safe Care.

Therefore, we fully support the NCS consultation proposal to look at how we can *'better align the proven successful elements of improvement methodology and implementation science to provide a model that practitioners at all levels can implement as a whole rather than in parts'.* **The Redesign and Continuous Improvement Journey provides that broad model and aligns with the Scottish Approach to Service Design, the Scottish Quality Improvement Journey and the Scottish Quality Management System.**

4.3 Creating the conditions for delivering sustainable improvements in health and wellbeing outcomes

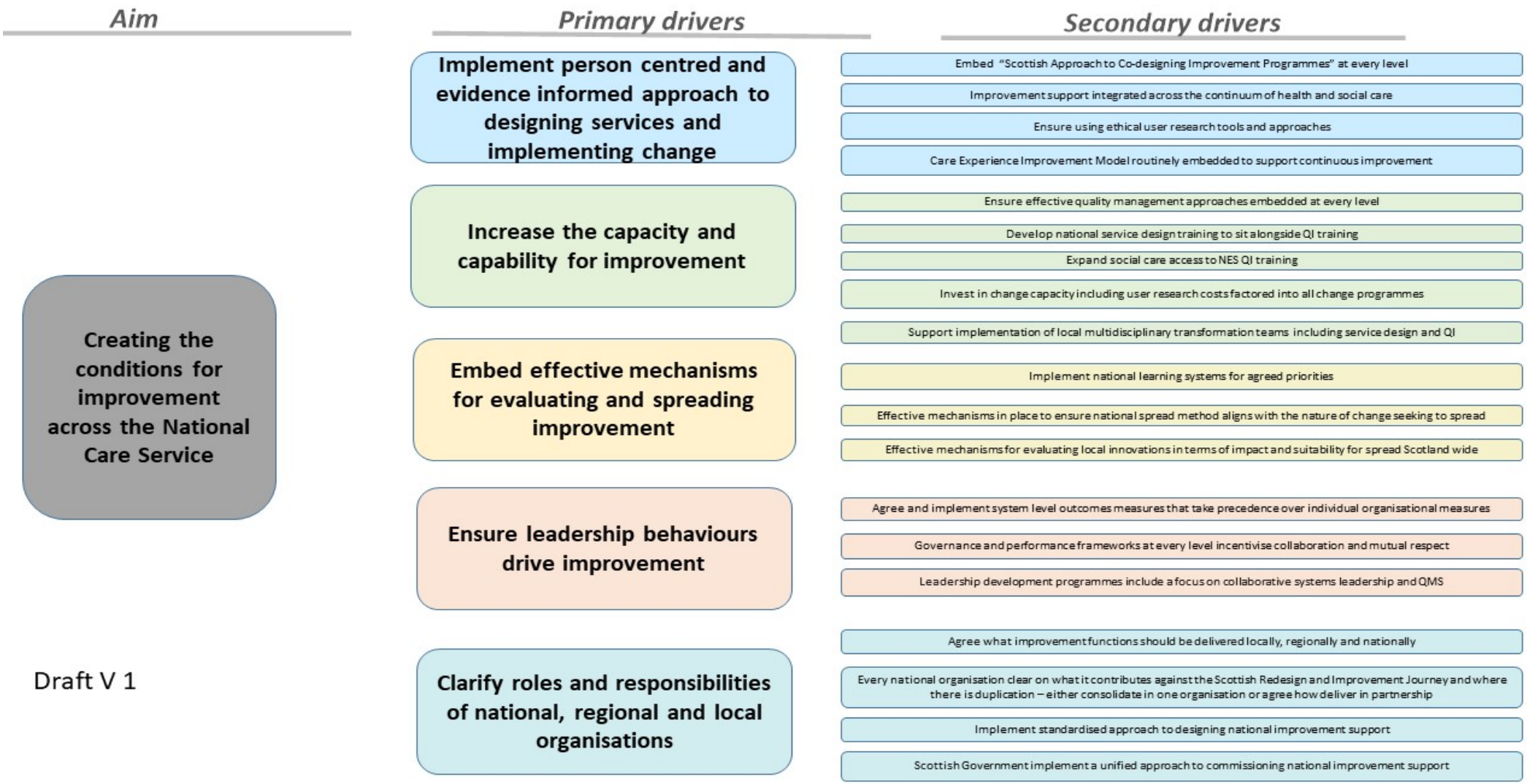
The Scottish Redesign and Continuous Improvement Journey highlights the importance of creating the conditions for successful change; **we need fertile soil for changes to flourish and deliver the desired outcomes.**

Drawing on both the evidence and our experience of over 12 years of successfully supporting the design and implementation of changes leading to improvement, creating the conditions for improvement across the National Care Service will require:

- person-centred and evidence-informed approaches to designing services and implementing change
- building improvement capacity and capability at every level, including across local systems
- effective mechanisms for evaluating and spreading improvement
- enabling leadership behaviours and cultures that drive improvement, and
- clarity on national and local organisations' roles and responsibilities

The following draft driver diagram highlights the key issues that need to be addressed to ensure the health and social care system is able to effectively undertake the practical person-centred improvement work that will ultimately deliver the changes we all aspire to see.

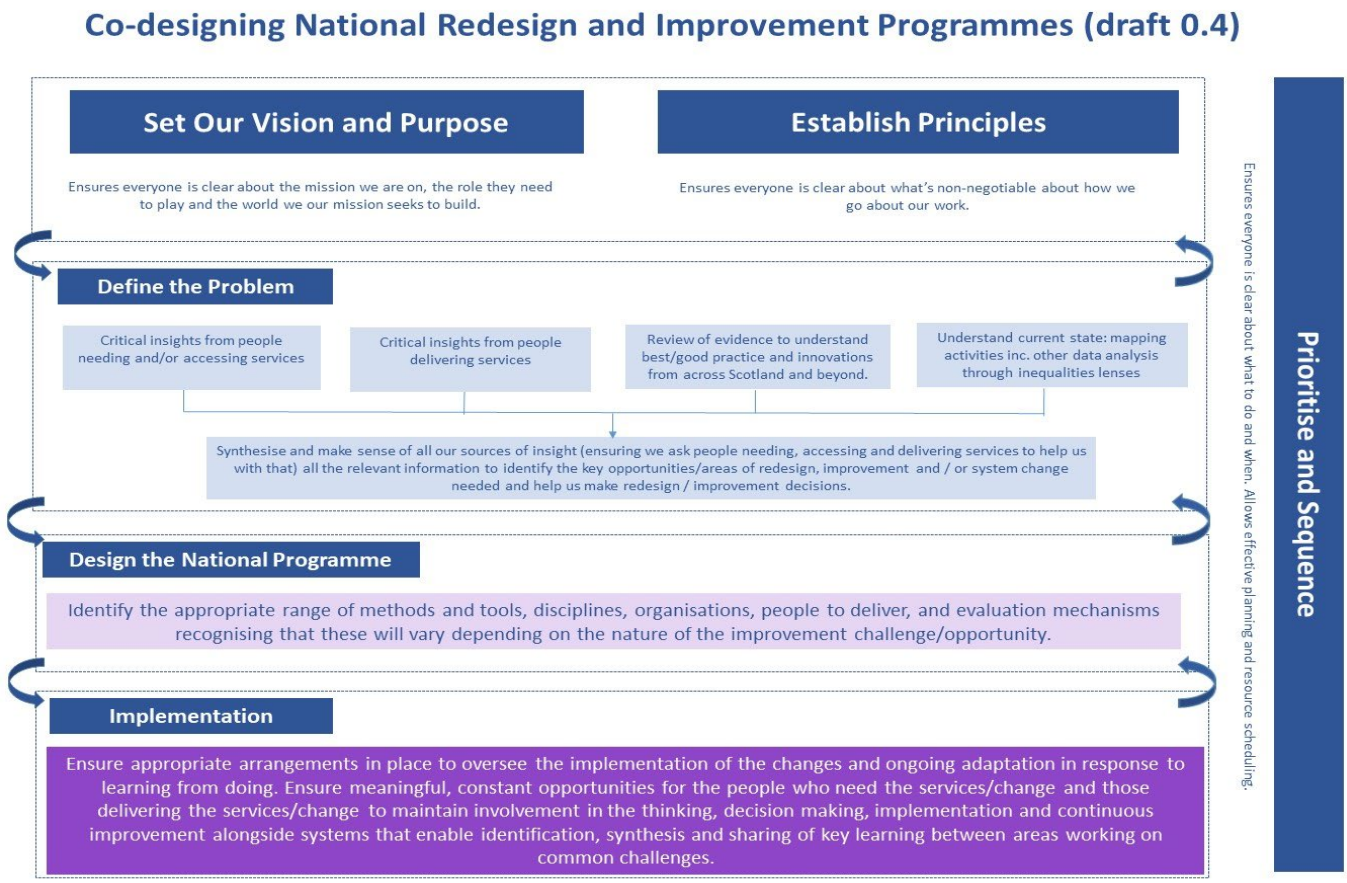
Fig. 3: Draft driver diagram highlighting the key issues that need to be addressed to ensure the health and social care system is able to effectively undertake practical person-centred improvement work.



Primary Driver 1: Person-centred and evidence-informed approaches to designing services and implementing change

Healthcare Improvement Scotland has worked with Scottish Government's Chief Design Officer to develop an approach to the design of national programmes that will ensure person-centred and evidence-informed programmes of work (Fig. 4). Both the NHS and the NCS adopting this approach would enable implementation of the vision for person-centred change.

Fig. 4: Approach to the design of national programmes developed by Healthcare Improvement Scotland and Scottish Government



However, we would go further. Our experience is that a person-centred approach to designing services that maximise individual health and wellbeing outcomes requires us to advance at pace with **place-based transformation work.** That entails recognising the vital role of housing, education, communities and transport, to name but a few sectors.

If we recognise that delivering change on this scale requires a combination of different collaborations for different issues, all aligned towards a common aim, this compels us to look at partnership approaches to the provision of improvement support.

Primary Driver 2: Building capacity and capability

In our extensive experience of leading improvement work across Scotland, the most consistent and significant barrier to progressing at pace and scale is, by far, a lack of individuals with the time and skills to do the work of change.

The Independent Review of Adult Social Care (IRASC) drew attention to the substantial investment in the improvement infrastructure in the NHS over the past decade and cited the achievements of the Scottish Patient Safety Programme (SPSP). The report from the IRASC highlighted the need to match this with similar investment in the improvement, skills and support in social care to achieve the necessary and sustainable continuous improvements required.

The report points out that it *'will require a step change in the capability of the system across the whole country, in the adoption of science-based improvement methods, and in the ability of the National Care Service to learn from success and failure – to solve problems when they are identified and to scale-up and spread promising practice much more effectively*.'

Delivering the recommendations of the IRASC will require investment in local improvement infrastructures, including an expansion of service design and quality improvement roles.

Scotland is fortunate to have a world-leading national QI training programme delivered by NHS Education for Scotland; we need to ensure that this programme has sufficient reach into social care, alongside a strategy for embedding service design skills across every level of the health and social care system.

One of the reasons for the success of the SPSP was the consistency of leadership provided through the clinical infrastructures. We need to agree what the equivalent source of consistent leadership will be within the social care sector, then ensure investment in QI training with these individuals. We may want to consider extending the Scottish Quality and Safety Fellowship[5] to the social care sector.

There also continue to be challenges in healthcare in terms of operational management buy-in to Quality Management (QM) in some areas. With the NCS, there is an opportunity to design-in up front an approach to ensuring the key operational managers in social care understand the benefits of taking a systematic approach to improvement, and there is the potential to consider a joint programme with health that would help enhance mutual understanding of roles, thus contributing to better joined-up working locally. The challenge of incorporating QM in systems which may not have experience of this methodology should not be under-estimated.

Primary Driver 3: Effective mechanisms for evaluating and spreading improvement

In Scotland we have over 12 years' experience of spreading improvements at scale across healthcare, including through implementation of the world-leading Scottish Patient Safety Programme. There are challenges in spreading improvement, and different approaches are needed for different types of change (e.g., There are challenges in spreading improvement, since different approaches are needed for different types of change (e.g., spreading a new technology such as video consultation requires a different approach to spreading a new service such as Hospital at Home).

[5] This is a highly successful programme run by NES aimed at clinical leaders in health which complements the Scottish Improvement Leaders programme.

Healthcare Improvement Scotland will work with partners to ensure this knowledge and expertise is translated into the context of the National Care Service so that we embed effective approaches to spreading good practice across Scotland.

Critical to this is the development of National Learning Systems for key priorities, which include:

- clear aims focused on improving outcomes for people needing and/or using services
- a clear theory of change and clarity on the methods being used to deliver it
- co-design and co-delivery with people who need, access and deliver services, including a focus on building the skills to design and test change
- clear roles alongside a mutual understanding and respect for each other's contributions;
- time invested in building and maintaining the relationships
- data, both qualitative and quantitative, to evidence whether changes are leading to improvements, and
- mechanisms for capturing, evaluating, synthesising and spreading learning.

It is important to note that the delivery mechanisms must not be static; they need to be regularly reviewed in light of real-time learning, recognising that, whilst our aim should be consistent, our approach to reaching it will need to adapt in response to ongoing changes in local and external contexts. The management of societal restrictions attached to COVID-19 has highlighted the vital importance of constantly reviewing what we are learning (using both quantitative and qualitative data as appropriate) and adapting responses based on that learning. At its heart, this is the QI approach: set an aim, undertake certain evidence-informed actions, collect the right data to understand what is and is not working, and adapt actions as a result of that learning. However, doing this well is dependent on having good data to aid decision making. Again, in responding to COVID-19 we have seen the importance of this and the need for a balanced scorecard of measures as working at a systems level inevitably means trade-off decisions: improvements and risks in one aspect of wellbeing set against those in another.

Any national learning system must also pay attention to the vital role of **networks and relationships.** Learning and spread are essentially social processes. We have consistently demonstrated, through our work, the value of bringing together people who are working on a common problem so that they can share experiences of what is and is not working. Once those relationships are in place, individuals are far more likely to contact and learn from each other than if we just rely on databases of good practice.

At a national level we must have in place a clear mechanism for evaluating innovations in terms of impact and suitability for national spread alongside consistent approaches to designing programmes that align with the type of innovation we are attempting to spread.

This is an example of work that lends itself to a national approach but where there is currently under-investment. HIS has an international reputation for its work evaluating the value of medicines (through the Scottish Medicines Consortium (SMC)) and technologies (through the Scottish Health Technologies Group (SHTG)). More recently, it has undertaken one-off exercises evaluating new service models around the Patient experience Anticipatory Care Planning Team (PACT) and Hospital at Home. For the former, it identified that further testing was needed prior to any decision to spread, while for the latter it highlighted there was sufficient evidence of impact to progress with a spread programme. The evidence review of Hospital at Home also pulled together key information to support spread and HIS is now working with 22 HSCPs to support implementation of Hospital at Home.

We recommend investment in developing service innovation evaluation mechanisms equivalent those of SMC and SHTG to evaluate the value and spreadability of new models of health and care. As with SMC and SHTG, this should not be a primary evaluation service; that would be a very large undertaking. Rather it would consider whether there was sufficient existing evidence to justify spread. Local systems would be expected to continue to build in evaluation of new initiatives.

We also recommend that mechanisms are put in place nationally to ensure that programmes use the most effective spread and implementation approaches, recognising that the support needed to implement a new piece of technology at the point of care delivery will look very different to the support needed to implement a new service model such as Hospital at Home. Consistently applying the approach outlined above, to co-designing redesign and improvement programmes, is a mechanism for delivering this.

Primary Driver 4: Leadership that drives improvement

The evidence is clear that integrating care at the point of delivery requires leaders across organisations to think and act differently. The King's Fund have identified these as systems leadership behaviours[6]. There is a saying in improvement – every system is designed to deliver exactly what you get. The creation of the National Care Service is an opportunity to design a system that incentivises rather than hinders collaboration and systems leadership. The new system design needs to pay particular attention to how we incentivise systems working, and this must include attention to the targets and organisational performance management cultures which can drive leaders to focus on balancing their own budgets and meeting their organisational performance targets even when this simply transfers costs and performance pressures to other parts of the system.

A meaningful set of person-centred, systems-level outcome measures is a critical area that needs a clear focus going forward. The absence of these measures means we risk continuing to incentivise silo leadership behaviours and an inappropriate focus on optimising one part of a system of care that leads to worse outcomes for the people using care. However, we are not starting from scratch, and it is important that we do not waste time reinventing wheels. Work has already started in this area around The Promise that we could learn from for adult social care, and it will also be worth revisiting work previously undertaken in adult social care around 'Talking Points'. Further, there is the work undertaken by Sir Harry Burns around targets and outcomes measures, and likely other previous work that we could draw from, including that which was previously led by Scottish Government in liaison with the International Consortium on Health Outcomes. This system-level outcomes work will then need to be complemented by key process measures that align with the outcomes but provide an earlier indication of progress.

There is also a need to invest further in leadership development programmes, with a clear focus on how we enable systems leadership behaviours alongside the technical abilities to deliver place-based transformation work.

[6] The practice of systems leadership: being comfortable with chaos, The Kings Fund and Leading for Integrated Care, The Kings Fund Nov 2019

Primary Driver 5: Clarity on the respective roles and responsibilities of the national and local organisations

Health and social care are complex, adaptive systems that do not lend themselves towards centralised control. Complexity thinking highlights that centralised control is often simply the illusion of control driven by a need to address leadership anxieties from such a complex and uncertain world, but in practice does nothing to deliver meaningful improvement in the longer term. It is vital that the NCS draws on the latest evidence and thinking about how to effectively deliver improvements within complex systems, including on the importance of embedding approaches to practical testing using data to understand whether changes are leading to improvement. We are keen to work closely with colleagues designing the NCS to enable this to happen.

At a very practical level, we need to ensure there is clarity on the work that is best delivered locally versus that which sits at a regional or national level.

As an example, it is noted that the NCS will assume responsibility for *'national workforce planning and development, data to support planning, commissioning and procurement, research to support improvement, digital enablement, and national and regional service planning.'* Local capacity and skills in these areas will be crucial. In the context of planning and commissioning, for example, relationship building at a local level is required. Our work in this area over the last couple of years has demonstrated how important this is in building trust, supporting approaches that are more creative and a move away from commissioning on a purely transactional basis. This also supports co-design at a local level.

5. Quality Assurance

Healthcare Improvement Scotland provides independent public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services and the regulation of independent healthcare services. We work in partnership with the Care Inspectorate to deliver joint inspections of health and social care services for adults, and work with the Care Inspectorate and other scrutiny partners to deliver joint inspections of services for children and young people as well as joint inspections of adult support and protection.

In addition, we carry out focused reviews of services and lead national work programmes to support the review and learning from adverse events and child deaths in Scotland, in order to share learning and drive improvements in care.

We are keen to continue to build on existing partnership working and joint inspection arrangements to play our full part in scrutinising services provided under the NCS, to provide public assurance, drive ongoing improvements in quality of care and support better outcomes for people.

Our range of quality assurance activities is centred on the principles of being:

- user-focused
- transparent and mutually supportive, yet independent
- intelligence-led and risk-based
- integrated and co-ordinated, and
- improvement-focussed.

We would highlight the following key considerations in relation to the assurance of services provided under the NCS:

- **Greater collaboration and integrated working between scrutiny and regulatory bodies, to ensure a consistent and joined-up approach reflecting the journey people take through different health and care services, with no gaps in areas of provision**

A systematic and connected approach to assurance is essential to driving and sustaining improvements in the quality of health and care and ensuring people's rights and needs are protected.

There is a need to utilise the specialist skills, knowledge and experience of relevant scrutiny and regulatory bodies in a robust and effective way. This must include the involvement of subject matter experts with the experience, credibility and understanding necessary to undertake their work. There cannot be any assurance gaps, inconsistencies or ambiguity, nor any unnecessary duplication of activities. People accessing health and care services have a right to expect regulation and scrutiny to wrap seamlessly around them and deliver a truly integrated whole-system approach to assuring safe, effective and person-centred care.

This will require more collaboration and integrated working between scrutiny bodies, including Healthcare Improvement Scotland and the Care Inspectorate, as well as other systems and health and care regulators in Scotland and across other parts of the UK. Our added value in social care has depended upon close and positive working relationships developed with the Care Inspectorate and other national bodies. Those relationships maximise the impact of the deployment of our wide-ranging expertise and skills.

Most recently, in response to the COVID-19 pandemic, we worked with Care Inspectorate to support the inspection of care homes. The Care Inspectorate acted as the lead agency, with HIS inspectors bringing expertise in relation to infection prevention and control (IPC) to help ensure key health needs were considered during this unprecedented time. There may be scope to gain further efficiency, effectiveness and economy by strengthening obligations for public bodies to co-operate to deliver change and improvement. **In this regard, there may be scope to further strengthen existing statutory duties of co-operation to support this.**

Consideration should be given to how different scrutiny and regulatory organisations can be supported to work together in a more agile and connected way. For example, there is increasing overlap and blurring of lines between the services that must be registered and regulated by either the Care Inspectorate or Healthcare Improvement Scotland, such as hospices that provide a hospice-at-home service, or care homes with hospice beds. There is also an increasing range of services being provided digitally, and those span a range of regulatory remits and have the potential to fall between the gaps if a co-ordinated approach is not taken.

A simple mechanism to undertake lawful joint inspections, with relevant inspection powers and service requirements, would ensure the focus of regulation remains on the quality of care being provided rather than on which regulator the service needs to be registered with, and would help ensure relevant assurance skills and knowledge are effectively and consistently deployed. Consistency of powers across partner agencies will also be a key consideration. This will not only help ensure consistency of process and outcomes in assuring the safety and quality of care, but also facilitate effective and efficient joint working across regulatory and scrutiny bodies.

It will be important to not only consider the regulation of individual providers and professionals, but also the wider scrutiny of integrated service provision. If community health services are part of the NCS, then there will also be a need to consider assurance not just in the context of care services, but in any community health services (such as GP services).

- **An appropriate balance between external quality assurance and internal assurance and governance mechanisms, with a focus on improvement**

The role of external assurance provided by regulation and scrutiny bodies needs to be considered in the context of a broader quality management framework that also includes internal governance and assurance. Good governance is demonstrated not only through compliance with standards, rules and regulations, but by adopting a transparent, inclusive and accountable culture within and across organisations that is focused on learning and ongoing improvement.

There is an opportunity to ensure the different assurance tools, including self-assessment, are appropriately and proportionally deployed to support ongoing improvements in the quality of care, rather than exclusively focussing on external assurance.

Our range of quality assurance activities is designed to support sustained and continuous quality improvement and we believe that there is an opportunity to build on the Quality Management System developed by HIS in order to deploy different types of internal and external assurance, or quality improvement interventions, relative to the individual service and how it is performing.

It is important that assurance activities continue to be intelligence-led and risk-based, and that they are flexible enough to support and encourage innovations and developments that will improve outcomes and care experiences.

There must also be clarity on the accountability and governance arrangements for the individuals and organisations providing care and those commissioning care, as well as a leadership culture focused on partnership working.

6. Community Engagement and Evidence

6.1 Evidence to support redesign and improvement

As the national authority for the development of evidence-based advice, guidance and standards for the health service, we believe that it is essential that the services provided by the National Care Service are evidence-based with a clear focus on improved outcomes for the people who use services.

The resources and expertise required to provide the National Care Service with a similar quality of evidence reviews, health technology appraisals, evidence-based advice, recommendations, guidelines, standards, indicators, data measurement and evaluation should be factored in from the outset.

Healthcare Improvement Scotland has in place a system that builds on expertise from Scotland and experts from around the world, to identify, develop and share evidence and to reflect the experiences and opinions of the people of Scotland. Consideration of new innovative technologies is another key area for consideration and one where we have considerable expertise. The challenges for the National Care Service will be similar to those we support NHSScotland to address - advancement in practice, sustainable service delivery and the reduction of health inequalities. A solid evidence base will be an essential factor in enabling people to make informed decisions about their care and in helping care organisations to continuously improve services.

6.2 Community Engagement

Healthcare Improvement Scotland Community Engagement (HIS-CE) ensures the meaningful involvement of people and communities in the planning and delivery of services by health boards and integration authorities. It was formerly known as the Scottish Health Council and is governed by the independent Scottish Health Council Committee, which has a chair appointed by Ministers. HIS-CE works alongside NHS boards and integration authorities and gathers the opinions and experiences of people to shape local services and influence national policy.

We have a network of staff covering health boards across Scotland, bringing experience and expertise in community engagement to support and advice to health boards on best practice for engaging with individuals and communities.

Using a range of engagement methods, we report on the opinions and experiences of people to shape policy for the Scottish Government. We collect and analyse evidence and public views through our Citizens' Panel, Citizens' Jury, Gathering Views exercises and research. Recent examples include our work to gather public views and insights on the Redesign of Urgent Care, from people living with ME, and priorities for health and social care as we move out of the pandemic.

We support the drive to reduce health inequalities by providing professionals with guidance, tools and techniques to involve people in shaping services. A particular focus is on including those often not involved in engagement initiatives.

In relation to service change, we work with NHS boards and integration authorities to ensure engagement with local communities throughout changes to services.

NHS boards have a statutory duty to involve people in designing, developing and delivering healthcare services. They must follow Scottish Government guidance on informing, engaging and consulting with local communities about changes to services, particularly where a proposed change will have a major impact, and we assess how well they have followed this guidance. We provide advice and a view about whether activity constitutes a major service change. Where this is the case, a full public consultation is required, and the final decision is subject to Ministerial approval. We assess whether a board's consultation and engagement processes have followed Scottish Government guidance and provide advice and support to boards on ensuring meaningful public engagement for all levels of proposed changes, whether major or minor.

We also co-ordinate national programmes including the Volunteering in NHSScotland Programme and What Matters to You.

We support the ambition that the National Care Service will have a clear focus on a person-centred approach and involving the people of Scotland in the design, development and delivery of support and services from the outset and on a continual basis. We suggest that the statutory duty to involve people in designing, developing and delivering healthcare services should also underpin the National Care Service.

In particular, the following activities would merit consideration:

- Revisiting the approach taken by the previous *Our Voice* initiative, which focused on engagement and impact at individual, local/regional, and national levels to improve services across health and social care partners could be an effective way forward. This would help create a shared understanding of potential impacts for service users, while providing those planning and developing the service valuable insights from those who will be affected by the new service most. HIS-CE could work with health & social care partners to revisit and repurpose the resources to determine their suitability, with a view to incorporating them within the overall engagement approach.
- HIS would also suggest that the developing Quality Framework for Community Engagement, which supports NHS boards, local authorities and integration authorities to carry out effective community engagement and demonstrate how they are meeting their statutory duties for public involvement, should also apply to the National Care Service. This would provide assurance and support around engagement activities in line with the principles set out in the Scottish Government and COSLA's Planning with People Community Engagement Guidance.