Healthcare Improvement Scotland

Edinburgh office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.org

24 February 2023

Gillian Martin MSP
Convener, Health, Social Care and Sport Committee
The Scottish Parliament
Edinburgh
EH99 1SP

Enquiries to: Simon Watson
Direct line: 07584 484 797
Email: simon.watson3@nhs.scot

Via email to HSCS.committee@parliament.scot

Dear Convener,

Thank you for the opportunity for Healthcare Improvement Scotland (HIS) to give evidence on 7 February 2023 as part of the Committee's Stage 1 scrutiny of the Patient Safety Commissioner for Scotland Bill. We welcomed the opportunity to discuss the complexities of the safety landscape in Scotland, HIS's role therein, and considerations for further scrutiny of the Bill.

Following remarks made in the session, the Committee requested additional information on resourcing for investigatory remits, based on experience from relevant work that HIS has undertaken, as well as the work of other organisations such as the Healthcare Safety Investigation Branch (HSIB) in England.

Regarding the latter, I refer to our subsequent correspondence where we noted that we do not have specific knowledge of how the HSIB resources or undertakes their work, nor do we have a formal relationship with them, and it was confirmed that the Committee will consider whether or not to approach the HSIB for additional evidence.

Regarding insight from HIS's investigatory work, I have included additional information below.

Resourcing HIS's investigatory work

HIS is an improvement body for the NHS and integrated services, established to improve the quality and safety of healthcare for the people of Scotland. Ensuring that patients are kept safe within the healthcare setting is central to furthering improvements in the quality of patient care. We have a wide remit that is directly relevant to the proposed activities of the Patient Safety Commissioner, including providing public assurance about the quality and safety of healthcare through inspections and reviews of NHS hospitals and services, as well as regulation of independent healthcare services. Our scrutiny activity is split into 3 categories: inspection, regulation and review.

In addition to our core programme of scrutiny activity, we may also be commissioned by Scottish Government to undertake ad hoc assurance reviews in areas of emerging and urgent need. Recent examples include the Angus Health and Social Care Partnership Area – Commission for Significant Case Review Improvement Plan, the enquiry visit and follow up review of the Beatson West of Scotland Cancer Centre, and independent assurance of infection and prevention control at the Queen Elizabeth University Hospital. Examples of current work include the Review of the Management of Exclusions in Scotland's Cervical Screening Programme and the Review of Neonatal Mortality in Scotland.

NHS SCOTLAND

Taking the Review of Neonatal Mortality in Scotland for reference, HIS was asked to undertake a review with the goal of understanding any factors contributing to the national increase in neonatal mortality during 2021/22, by considering the systems, processes and governance for the delivery of neonatal care in Scotland within the scope of the review. Broadly, the review will assess and determine whether there are any themes, underlying causes or safety factors, from both a clinical and system perspective, and, if there are, will identify key learning points and make recommendations for improvements in the quality of care. The review is being conducted by an expert group, with a chair external to HIS, Dr Helen Mactier.

The resources required for this review are comprised of both internal costs, including HIS's review and programme staff time and expertise drawn on internally, as well as the costs of engaging external experts, who are reimbursed based on a clinical daily rate. It is important to note that we rely on established procedures and experience developed over time, which in situations such as these enable us to mobilise and undertake ad hoc reviews in a timely and efficient manner. Furthermore, forming a review team with appropriate knowledge and skills involves moving staff from other areas of work, requiring management of risks and consideration of impacts on other areas.

An indicative timeline of 13 months was developed for the review, to cover the establishment phase (including establishment of the internal and external team and resource requirements), followed by planning, initial assessment, fieldwork, analysis, confirming outcomes, publication, and follow up.

We identified that the following internal resources would be required:

- Senior Reviewer (0.8 WTE)
- Programme Manager (1.0 WTE)
- Project Officer (1.0 WTE)
- Administrative Officer (1.0 WTE)
- Data Analyst/Health Service Researcher (0.1 WTE)

In addition, we identified that an independent chair, 2 clinical experts, and 10 external review group members would be required to support this work. The overall costs associated with these external resources is approximately £76,000.

I hope the above is helpful, and please do not hesitate to contact us if you require further information.

Yours sincerely,

Simon Watson
Medical Director, Healthcare Improvement Scotland