The Sharing Intelligence for Health & Care Group Inaugural report

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Produced in partnership with: Audit Scotland, Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, and NHS National Services Scotland.

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Background

In recent years, it has become more widely recognised that sharing and acting upon data and information about the quality of care is an essential component in delivering high quality health and social care. As well as including the sharing of information at the point where care is provided, this also applies to the sharing of intelligence between national agencies. To illustrate, recommendation 35 from the Mid Staffordshire NHS Foundation Trust Public Inquiry[1] states that there should be better sharing of all intelligence between regulators which, when pieced together, would raise the level of concern. In addition, the *National Information & Intelligence Framework for Health & Social Care for Scotland: 2012-2017*[2] states that a key priority for Scotland must be to 'maximise intelligence use and impact by sharing information across sectors.'

In Scotland, there are a number of national organisations that, between us, hold a considerable amount of data and information about the quality of health and social care. However, prior to April 2015, there was no ready mechanism that enabled these organisations to draw together and consider this collective data and information. In addition, there was potential to extract more meaningful intelligence from this data and information. This meant that no one organisation had a sufficiently complete picture of the quality of health and social care, and we were not making best use of our collective intelligence to inform delivery of our distinct roles and responsibilities. In response to this scenario, the Sharing Intelligence for Health & Care Group was established to bring together a number of national bodies for the purpose of sharing and considering the intelligence we hold about the quality of health and social care.

1 Francis, R, QC. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 2: Analysis of evidence and lessons learned (part 2). London: The Stationery Office; 2013; Chapter 9, p 287.

2 *National Information and Intelligence Framework for Health and Social Care for Scotland: 2012-17*. The Scottish Government and NHS National Services Scotland. 2013.

Who we are

The Sharing Intelligence for Health & Care Group includes representation from the following six national organisations: Audit Scotland[3], Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, and Public Health & Intelligence[4]. The group provides a mechanism for these agencies to share and consider their collective data and information about health and social care providers, and have an active dialogue about the quality of health and social care. Specifically, the aims of the group are to:

- provide a forum to identify potential or actual risks to the quality of health and social care and, where necessary, initiate further action in response to these risks, and
- promote co-ordination of activity between these partner organisations, respecting the statutory responsibilities of each.

3 Including the appointed auditor
4 Public Health & Intelligence are part of NHS National Services Scotland

"The group provides a conduit for escalating statistical findings that concern us; this is important as we are not a scrutiny body. For us there is also clearly power in the group as a forum that enables us to link the statistical data that we hold on health services at a national level with other sources of intelligence in order to provide greater insight."

Phil Couser, Director, Public Health & Intelligence

"NES is the education and training body for NHS Scotland and is very aware that 'education and training is patient safety for the next 30 years.' We are responsible for managing large numbers of health professionals in training across the professions, working and learning in clinical environments. The feedback we gather from these staff provides valuable insight into the quality of the care our patients and their families receive.

Sharing our data with other organisations, who also have a pan-Scotland view of our systems of health and care, has been enormously helpful in adding value to the information we hold. This is a work in progress, but the need for better sharing of information across the healthcare system was a key finding of the report into Mid Staffordshire, and the establishment of this key forum is an important part of our response."

Stewart Irvine, Director of Medicine & Deputy Chief Executive, NHS Education for Scotland

What we did

While the concept of sharing intelligence between organisations is a simple one, putting this into practice can be more complex. Therefore, to prepare for the group 'going live' in April 2015, a series of sharing intelligence tests were carried out during 2014–2015 – with the aim of better understanding the mechanisms, benefits, risks, behaviours and governance of sharing potentially sensitive information about care provider organisations. As part of these tests, the package of data and information to be shared was developed, tested, and refined. There was also invaluable input from colleagues with expertise in information governance, particularly in the development of a Memorandum of Understanding, as well as helpful learning from other established intelligence sharing groups elsewhere in the UK.

Throughout 2015–2016, its first full year of operation, the Sharing Intelligence for Health & Care Group met six times, to share and discuss intelligence relating to 14 territorial NHS boards and two special boards that provide frontline care. We originally planned to focus, during 2015–2016, on NHS health care services in Scotland - and then extend this from April 2016 to include social care, although it transpired that there was a significant focus on social care from the very start. Both quantitative and qualitative data and information were considered, and examples include: the findings from inspections and other reviews of health and social care provider organisations; the results from surveys of doctors in training; the findings from national and local audit activity; and analyses from Scotland-wide health and social care datasets. The intelligence provided did not identify individual members of the public or care professionals.

It was important to all six partner organisations that, from the outset, NHS boards were aware of our plans to share intelligence. A presentation on this was therefore made at the NHS Chief Executives' Group meeting in March of 2015. In addition, having considered the data and information for a particular NHS board, the Co-Chairs of the Sharing Intelligence for Health & Care Group met with senior colleagues from the relevant NHS board. The key purpose of these meetings was to feed back the conclusions of the partner organisations and also to explore how NHS boards can best be involved in this work. Specifically, how can these national bodies and providers of care best work together to consider, for their mutual benefit, the key pieces of data and information about quality of care? The feedback meetings have also given us a greater shared understanding of the challenges that NHS boards face, as well as the innovations they are using to tackle these.

What we learned

The six partner organisations are unanimous that this approach to bringing together intelligence puts us all in a better position of being able to see a more complete picture of the quality of health and social care. Additional benefits identified include acquiring a greater shared knowledge of partner organisations' work, building professional relationships and more effective coordination of engagement with those organisations providing health and social care services.

During our first full year of operation, the group noted aspects of health and social care services that appear to be working well, and also areas where improvement is required. There are a number of instances where one of the partner organisations is already engaged with an NHS board about challenges to quality of care – and co-ordinating such activity has been a benefit observed during 2015–2016. However, so far there have been no instances where the combined intelligence resulted in the partner organisations taking action, either individually or collectively, beyond activity already planned. That said, should the combined intelligence raise sufficient concerns about the quality of care, partner organisations are now better prepared to take additional co-ordinated action.

From the feedback meetings with NHS boards, it appears that most of the key issues identified were already known locally and were being acted upon, as would be expected – and indeed the responsibility for tackling concerns rests primarily with the NHS boards themselves. However, the process of sharing data and information did allow a different emphasis to be placed on certain issues. Some NHS boards were also open about other challenges they were experiencing that the Sharing Intelligence for Health & Care Group was not aware of.

For every organisation considered, we identified specific aspects that appear to be working well or improving. These varied from NHS board to NHS board and included: developing a positive staff culture; positive inspections of the quality of care provided for older people in acute hospital; delivering high quality integrated health and social care for children; excellent training environments for doctors; and strong clinical and financial management.

The role and remit of the Sharing Intelligence for Health & Care Group also places us in a unique position of recognising challenges shared by a number of NHS boards across Scotland, and allows us to get a deeper understanding of the issues. We observed that a number of NHS boards are undergoing major reconfiguration of their services to reflect changing demography, integration of health and social care services and greater focus on preventative care. An area highlighted recurrently was the significant challenges that NHS boards are facing in the recruitment and retention of clinical staff. The impact of vacant clinical posts can have significant consequences across the healthcare system. Challenges in the recruitment and retention of staff can have implications for the use of locums and can have an impact on staffing budgets.

The ability of NHS boards and local authorities to jointly deliver integrated health and social care services was also of major interest to the group and we expect there to be even greater interest in this during 2016–2017. The group noted what appeared to be marked variation between regions in establishing the required governance structures in readiness to deliver high quality integrated health and social care services.

"Meeting up with colleagues from our fellow scrutiny bodies on a regular basis has been a really helpful way of sharing our information and observations on the quality of health and care across Scotland. The different perspectives we each bring to the discussions has been incredibly valuable and we gain a collective insight that we wouldn't achieve just working alone."

Angela Canning, Assistant Director, Audit Scotland

"With 14 regional NHS boards, 32 local authorities, the development of integration joint boards, and 14,000 registered care services, sharing intelligence across a range of health and social care services is an important way to inform decisions around risk, scrutiny and improvement. Providing a structured space for a wide range of partners to bring information to the table is helpful and the Care Inspectorate looks forward to playing a continued role in analysing, interpreting and using shared information for the purpose of improving the quality of care for people using services."

Rami Okasha, Executive Director of Strategy and Improvement, Care Inspectorate.

What we will do next

All partners agreed that the enhanced understanding of quality, and co-ordination of activities, made possible through the Sharing Intelligence for Health & Care Group makes it operationally essential. Therefore, the group will continue into 2016–2017 and beyond, and will focus on sustaining and evolving our processes for sharing, considering and responding to our collective intelligence on the quality of health and social care. The specific areas where the group wish to develop are described below.

During 2016–2017, we will seek to strengthen our existing mechanisms for engaging with frontline service provider organisations when considering intelligence about them. In the first instance, this will focus on enhancing our interactions with NHS boards, such as sharing with them the completed template of data and information we consider. In parallel, we aim to engage with Health and Social Care Partnerships collectively about how the group can best work with them. It is hoped that in the future, engagement will develop further so that there is an increasingly open, mature and mutually beneficial dialogue involving the Sharing Intelligence for Health and Care Group, NHS boards and Health and Social Care Partnerships.

While our communications to date have primarily been with individual NHS boards, we are also looking to forge relationships with other national bodies, including the Scottish Government, about recurring themes and issues identified through the sharing intelligence process, for example how these are fed into national policy development and national groups responsible for planning for both scrutiny and improvement activities. It is also critically important that we engage with local authority chief executives in this work.

The group also aims to establish a more robust approach for identifying areas of good practice through the sharing intelligence process and for translating this knowledge into action.

The Sharing Intelligence for Health & Care Group will also continue to review the package of data and information considered. Much of the healthcare related information shared to date focused on acute hospital care. The group will work with Public Health & Intelligence and NHS boards to identify what information is currently collected on primary and community care services and how we use this intelligence.

The experience of people using and delivering health and social care services provides important perspectives on the quality of care, and this can be a leading indicator for emerging quality issues. We will work with the Scottish Health Council, NHS boards and Health and Social Care Partnerships to identify and consider what intelligence related to patient and staff experience could most usefully be fed into our discussions. We will consider further how public representation can inform the work of the group. The group will also explore creative approaches to gathering intelligence about leadership, culture and communication.

As well as reviewing the package of data, we will make even better use of quantitative data. To do so, we will, wherever possible, strive to understand variation in data when presented over time and when comparisons are made between service providers.

In 2015–2016, we explored how the Sharing Intelligence for Health & Care Group might usefully liaise with the regulators of individual care professions, specifically in relation to intelligence about systems and services (not about individual practitioners). We will continue to look at this with the professional regulators.

Finally, in 2016–2017, we will carry out a formative evaluation of the performance and impact of our sharing intelligence activities.

"The MWC is a relatively small organisation and we need to make sure that we use our resources in the best way we can to protect and promote the rights of people with mental health problems, learning disabilities, dementia and related conditions. We need to make sure that we target our visits and other work where they are most likely to be of benefit and the information shared and discussed at the group helps us to do this.

We look forward to continuing to be involved in the work of the group and realising its full potential."

Alison Thomson, Executive Director (Nursing), Mental Welfare Commission

"It is in the public interest that, as partner agencies, we share the information we have about the quality of health and social care - and use this to make better informed decisions. We have demonstrated that we can do this in a responsible way. To maximise the value of the group, strengthening how we work together with NHS boards, health and social care partnerships and local authorities – to have a mature and mutually beneficial understanding of what the intelligence is saying – will be key."

Robbie Pearson, Acting Chief Executive, Healthcare Improvement Scotland

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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