Sharing to improve

Sharing Intelligence for Health & Care Group
Summary report for 2016–2017

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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.

Contents

Foreword

"All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it." *A promise to learn – a commitment to act (2013)*[1]

The Sharing Intelligence for Health & Care Group, having now been fully functioning for two years, is enabling us to make increasingly better use of important pieces of intelligence in Scotland – with the ultimate aim of supporting improvement in the quality of health and social care.

During 2016–2017, we enhanced both our collective learning from the intelligence we share, and how we engage with NHS boards about this. This year has also seen the beginnings of engagement with Integration Authorities alongside NHS boards, as we focus on the wider agenda of integration of health and social care. We intend to deepen our intelligence and combined understanding of the integrated health and social care environment.

Triangulation of the intelligence held by six national organisations provides Scotland with a solid basis to learn about our health and social care systems, improving our understanding of how services are performing and being led.

This, our second annual summary report, describes our main achievements to date as well as where we believe we can benefit the most by refining our approach.

We also highlight some important messages about the quality of care that have featured prominently in our work. Through our work we have become aware of positive examples where services are of high quality or have improved. However, it is clear that health and social care systems across the country are experiencing enormous challenges. In particular, there is increasing demand for services and the need to redesign services, in the context of immense workforce and financial challenges. National organisations, such as those represented on the Sharing Intelligence for Health & Care Group, have a duty to be cognisant of, and responsive to, these huge challenges that local health and social care systems are facing.

We also believe there needs to be open and honest public debate about what we want these essential public services to look like in future, and the degree of change that should be anticipated and understood by those providing care and those receiving services.

Using data and intelligence wisely is necessary if we are to understand these difficult problems and engage with service providers to assist their improvement efforts. We are committed to maximising the benefits of intelligence sharing for health and social care and are optimistic that, in Scotland, we have the culture and expertise that will help us realise these benefits.

Dr Brian Robson
Co Chair of the Sharing Intelligence for Health & Care Group, Medical Director, Healthcare Improvement Scotland

Professor Stewart Irvine
Co Chair of the Sharing Intelligence for Health & Care Group, Director of Medicine & Deputy Chief Executive, NHS Education for Scotland

Key messages

About NHS boards

There is increasing demand for services and the need to redesign services, in the context of immense workforce and financial challenges.

Maintaining a strong focus on good quality care remains central, despite significant changes and pressures.

Leadership and an open culture are important drivers of change.

Positive and caring interactions between staff and patients were reported; as were cultures that are conducive to learning and improvement.

About the Group

Open and supportive relationships with the NHS boards is of importance to us, and we have tried to strengthen these relationships in the past year.

The partner organisations are now better prepared to take additional action.

Who are we and what is our aim?

The Sharing Intelligence for Health & Care Group (referred to as 'the Group') is a forum that brings together colleagues from the following six national organisations in Scotland: Audit Scotland[i], Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, and Public Health & Intelligence[ii].

Our overall aim is to support improvement in the quality of health and social care by making good use of existing data, knowledge and intelligence. Specifically, our main objective is to ensure that – where significant risks to the quality of health and social care are identified – there is prompt, proportionate, co-ordinated, and effective collaborative working between the relevant scrutiny and improvement bodies (individual partner organisations on the group also respond to risks as they arise).

In Scotland, there are a number of national organisations that, between us, hold a considerable amount of intelligence about the quality of health and social care. However, prior to April 2015, there was no ready mechanism that enabled these organisations to learn together about what this collective intelligence is telling us about the quality of care in different regions of the country. This broadly mirrored the scenario elsewhere in the United Kingdom, where a need to improve intelligence sharing between national agencies had been identified.[2] This is why, in Scotland, we decided to establish the Sharing Intelligence for Health & Care Group – and the Group has now been fully functional since April 2015.

i Including the appointed auditor.

ii Part of NHS National Services Scotland, includes Information Services Division and Health Protection Scotland

What did we do in 2016–2017?

During 2016–2017, we completed the second cycle of our programme of work. We:

- **shared intelligence about NHS board areas across Scotland**
- **met as a group to consider this collective intelligence, and**
- **engaged with the NHS boards we considered.**

The Group met six times between April 2016 and February 2017, during which we shared and considered our key pieces of data and information about 14 territorial NHS boards[iii] and four special NHS boards[iv] that provide frontline care.

What intelligence did we share and consider?

While our focus was on NHS boards, we considered some issues relating to the quality of social care as well as health care. The intelligence we shared and considered incorporated a mix of quantitative and qualitative data and examples include:

- Findings from inspections and other reviews of health and social care provider organisations.
- Quantitative analyses from Scotland-wide health and social care datasets, including on service delivery, outcomes, and workforce.
- Survey results of trainee doctors.
- Information about financial and resource management.

iii NHS Ayrshire & Arran, Borders, Dumfries & Galloway, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Highland, Lanarkshire, Lothian, Orkney, Shetland, Tayside, Western Isles.

iv Scottish Ambulance Service, State Hospitals Board for Scotland, National Waiting Times Centre, NHS 24.

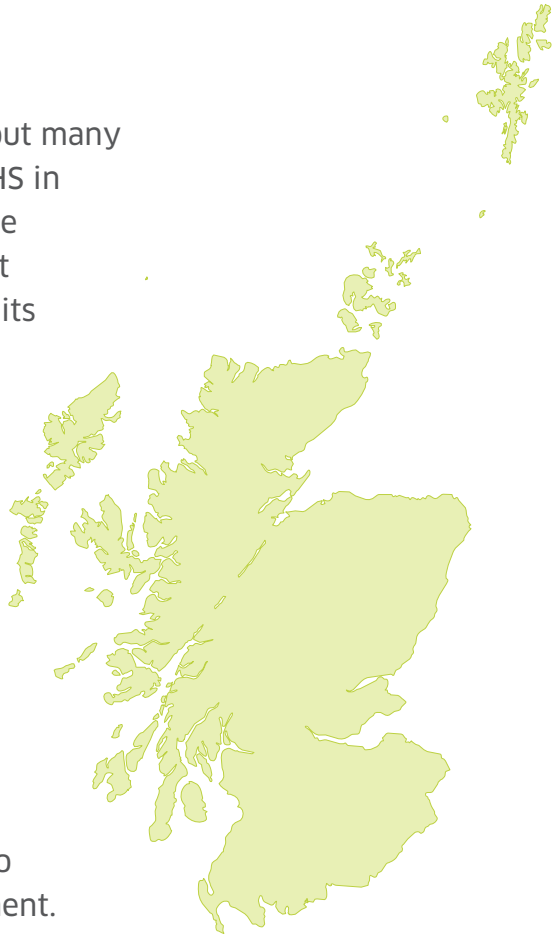
We also shared observations about engagement with NHS boards in relation to such activities. Most of the intelligence considered was already known to NHS boards, with much of this being in the public domain. The intelligence provided did not identify individual patients or service users or care professionals.

What is our relationship with the organisations we consider?

Open and supportive relationships with the NHS boards is important to us, and we have tried to strengthen these relationships in the past year. One of the principles that shapes our approach to intelligence sharing in Scotland is openness and transparency. Therefore, in 2016–2017, we shared with each NHS board the complete package of intelligence about them that we considered, together with a written summary of the main points we discussed. We also met with senior colleagues from individual NHS boards to provide feedback from our meeting and learn about key quality issues from their perspective. These meetings also included helpful consideration of the key pieces of intelligence used at both national and local level to help compare and understand how health and social care systems are evolving and working. We recognise that our focus on engaging with NHS boards needs to evolve, and we will actively consider opportunities to appropriately engage with the leadership in Integration Authorities and others as part of our approach in future.

What have we learned?

A Scotland-wide picture



We are in a privileged position of learning about many of the positive things happening across the NHS in Scotland, but also the main challenges – and we have learned more about these during the past year. As organisations with Scotland-wide remits we also have a responsibility to be cognisant of, and responsive to, these challenges – working alongside local health and social care systems and communities to tackle what might often seem like intractable problems. How we respond to key messages in the intelligence at national and regional level is a key development area for the Group.

The King's Fund[3] and the Nuffield Trust[4] have recently reported that health and social care services in England & Wales are expected to do more with less in a rapidly changing environment. This presents a major challenge to a workforce that is already under intense pressure, as it seeks to maintain and improve the quality of services – including transforming models of care. This is also the case in Scotland, as some of the partner organisations on the Group have reported previously. We continued to see much evidence of this in the intelligence we considered.

Health and social care integration

Audit Scotland[5] has already reported on some of the main challenges to be overcome if the integration of health and social care is to, in reality, transform the ways that health and social care services are delivered. We saw, for example, that Integration Authorities are still clarifying their budgets and governance arrangements, together with their comprehensive strategic plans. NHS boards, local authorities, and Integration Authorities also need to shift resources, including the workforce, towards more preventative and community–based models of care that are affordable and sustainable. Working alongside, and building capacity in, local communities is key to this. This is a huge challenge while responding to current demand and working within increasingly tight budgets. Some progress is being made in developing new models of care but, given the relatively recent formalisation of arrangements and huge pressures on services, this has yet to translate to widespread change.

Workforce challenges

All Scottish NHS boards are currently experiencing significant workforce challenges. The most common themes drawn to our attention were of high levels of vacancies in medical consultant and General Practitioner posts. To illustrate, there has been a reduction in the number of General Practitioners, and an increase in vacancies for recruitment to General Practitioner training. Contributing to these observations are large cohorts of doctors approaching retirement age in some regions, and the national shortfall in the number of younger doctors wanting to go into General Practice. Recruitment is not only a significant challenge for doctors, but also other healthcare professions (such as nurses and Allied Health Professions) – and for the social care workforce. For example, competition from other employment sectors and enhanced staff costs directly impacting on the commercial viability of care providers.

Staffing vacancies are inevitably associated with high use of temporary or locum staff which, as well as having implications for the quality of care, is often a significant factor contributing to financial pressure.

"The Commission is committed to contributing to the important work of this Group. We support the Group's ambition to reflect the integration of health and social care services and that the majority of care, treatment and support is delivered outside of hospital."

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

"The Care Inspectorate values the ability to share intelligence with a wide range of partners. Health boards play an important role in supporting healthcare provision for people who use social care services, and, in the integrated space, work with local authorities to commission and provide care in a joint way. As we build new models of scrutiny, shared intelligence is an important component of risk-based, proportionate inspection and improvement interventions. The Care Inspectorate looks forward to continue collaborating in multi-agency intelligence sharing across a variety of fora."

Rami Okasha, Executive Director of Strategy and Improvement
Care Inspectorate

For 13 of the 18 NHS boards we considered, particular workforce challenges were amongst the key points identified. For 6 of these 13 NHS boards, a reliance on the use of temporary staffing was highlighted as a particular challenge.

Successfully tackling what sometimes seem like insoluble issues affecting the workforce nationally will require effective collaborative working at local and national level, enhanced cross-sector working, and development of sustainable multi-professional models of service delivery. It is clear, however, that investment in service delivery alone will be insufficient to meet rising demand and that community mobilisation, including recognising local 'assets', third sector and community resources, will be an essential component of the future health and social care landscape. We saw little evidence of measurement of community mobilisation and it is important that in future there is intelligence on this at local and national level.

Financial pressures

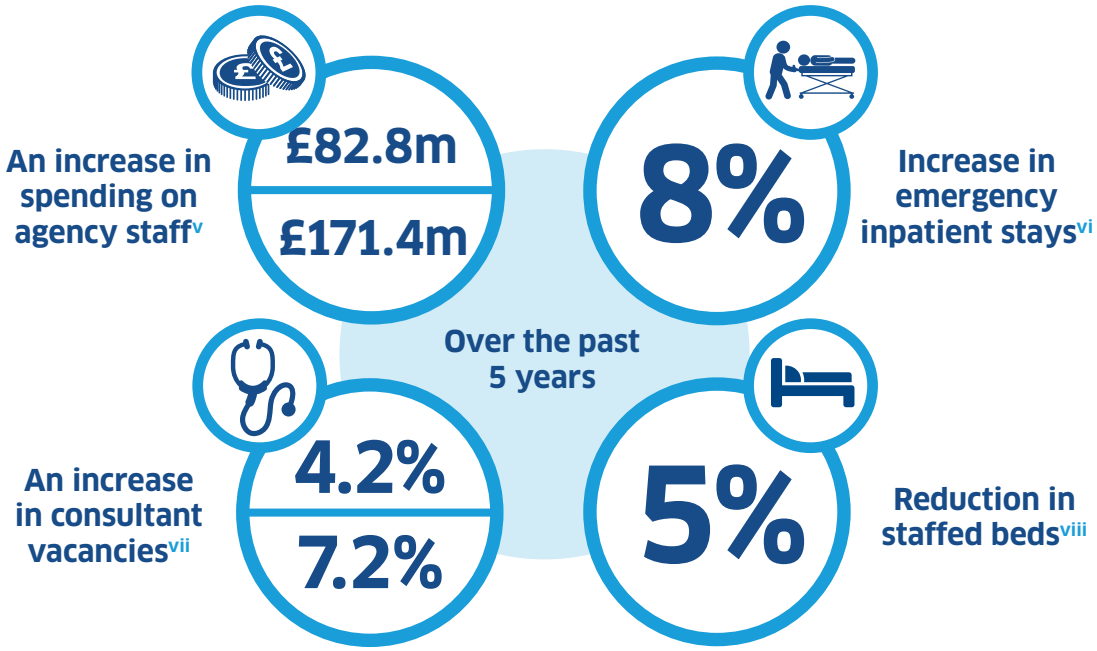
In its report *NHS in Scotland 2016*[6], Audit Scotland reported that NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many have to use short-term measures to break even. NHS boards are needing to make unprecedented levels of savings in 2016–2017 and beyond, and there is a risk that some will not be able to achieve financial balance. Financial challenges now exist very clearly across health and social care with a significant risk to quality of services and care. Similar challenges were also highlighted elsewhere in the United Kingdom including by the Care Quality Commission[7] when they reported in 2016 on the state of health and social care in England (the Care Quality Commission is the independent regulator of health and social care in England). As a group, we also believe there needs to be open and honest public debate about what we want these essential public services to look like in future.

For 8 of the 18 NHS boards we considered, we identified particular financial challenges.

For a further 6 of the 18 NHS boards, strong financial management was one of the key points the group identified.

We saw many examples where the financial and operational pressures in parts of the health and social care system had indirect or direct impact on the other, for example investing in hospital staffing necessarily impacted on the resources available for community or social care.

The following figures illustrate some of the pressures being experienced across the system. These figures focus largely on hospital-based services and only illustrate a part of the picture – and we are looking to consider such data as part of an expanded package of intelligence on primary and community health care and social care, in order to better understand how our systems are performing overall.



v Audit Scotland analysis based on review of NHS boards' annual accounts.

vi Healthcare Improvement Scotland analysis based on ISD Scotland SMR01 data.

vii Healthcare Improvement Scotland analysis based on Scottish Workforce Information Standard System (SWISS)

viii Healthcare Improvement Scotland analysis based on ISD Scotland ISD(s)1 data

Whilst there are a number of contributory factors, the overall picture is one of significant changes in service provision which, combined with intelligence about the various dimensions of quality of care provided by reviews from the various external organisations, describes a system under strain and with many traditional service models no longer fit for purpose.

Patient safety

There has been a Scotland-wide focus on improving safety since the inception of the Scottish Patient Safety Programme (SPSP) in 2008 and concerns about safety, while still significant, were not as prominent from the reviews that the Group has carried out compared with findings from the Care Quality Commission[7].

We will have an additional focus on safety during 2017–2018, including benefiting from additional information from the Scottish Patient Safety Programme (SPSP).

Primary and community care

Recent reports have highlighted the pressure on primary care services in England and Wales, and key issues include workforce shortages, unwarranted variation in the quality of care and concerns about patient safety. The majority of the intelligence that is readily available to the Group focuses on healthcare provided in hospital settings and on social care services – and we consider much more limited information about healthcare delivery in the community.

Given the volume of healthcare activity that takes place outwith hospitals, coupled with the policy drive to shift the balance of care towards preventative and community-based care, this is a key development area for the Group.

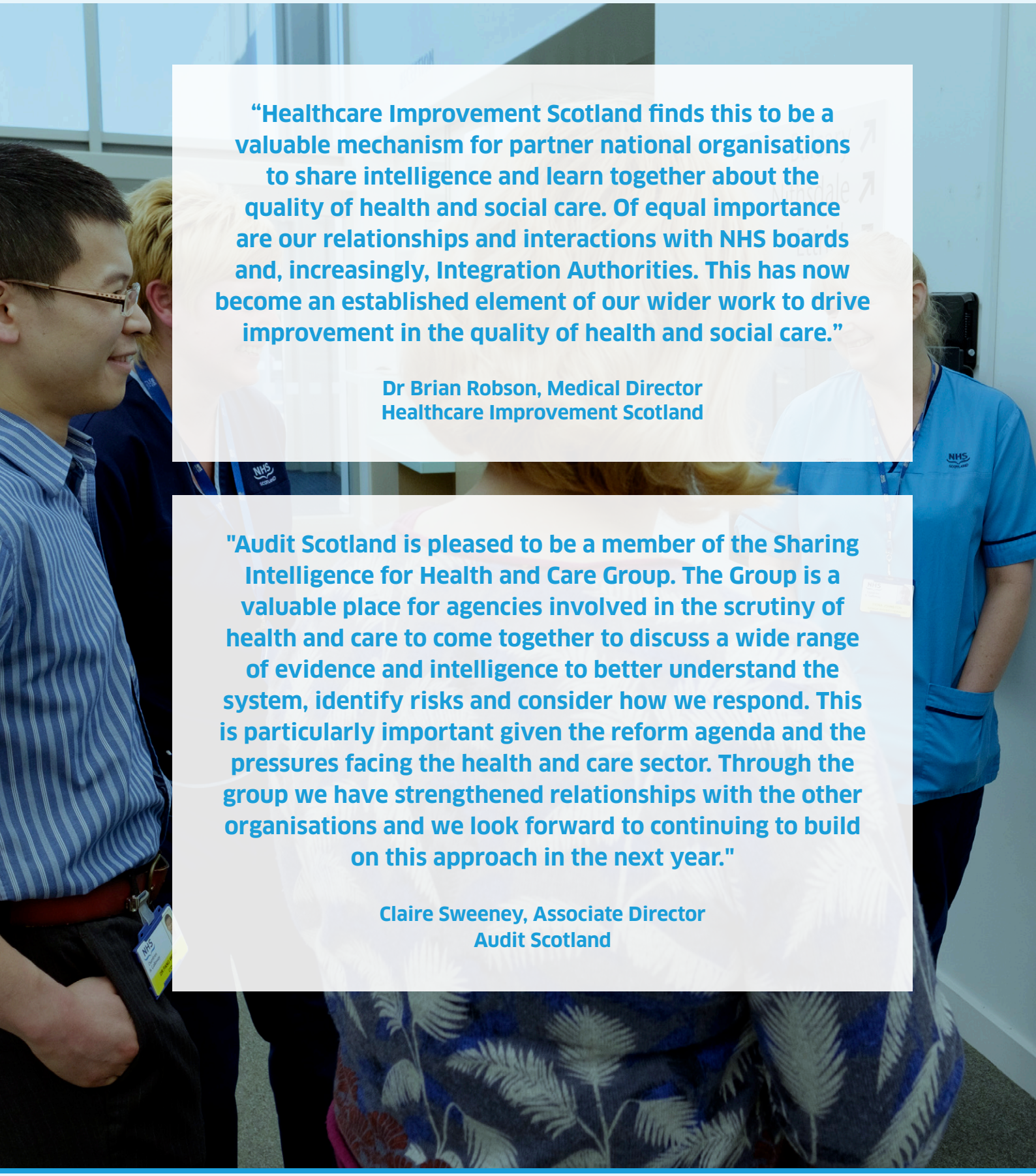
Positive findings

Some of the key themes we've identified during the past year are, however, much more positive. For example, we repeatedly heard of instances where there had been very good responses from NHS boards to the findings from external reviews, even when these sometimes drew attention to challenging issues. This is important, as leadership and an open culture are important drivers of change.

For 7 of the 18 NHS boards we considered, a positive response to the findings from external reviews or positive engagement with national organisations was amongst the key points the group identified.

We also heard that in many hospitals across Scotland the training environment for doctors in training is good, and some NHS boards have made significant improvement in the last year. We also noted examples where compliance with infection control standards has been improving. Some more illustrations of many of the positive things we learned are included below.

Positive and/or improving training environments for doctors were amongst the key points the group identified for 9 of the 16 relevant NHS boards.



"Healthcare Improvement Scotland finds this to be a valuable mechanism for partner national organisations to share intelligence and learn together about the quality of health and social care. Of equal importance are our relationships and interactions with NHS boards and, increasingly, Integration Authorities. This has now become an established element of our wider work to drive improvement in the quality of health and social care."

Dr Brian Robson, Medical Director
Healthcare Improvement Scotland

"Audit Scotland is pleased to be a member of the Sharing Intelligence for Health and Care Group. The Group is a valuable place for agencies involved in the scrutiny of health and care to come together to discuss a wide range of evidence and intelligence to better understand the system, identify risks and consider how we respond. This is particularly important given the reform agenda and the pressures facing the health and care sector. Through the group we have strengthened relationships with the other organisations and we look forward to continuing to build on this approach in the next year."

Claire Sweeney, Associate Director
Audit Scotland

A better picture of quality in individual regions

In our annual report for 2015–2016 we explained that the six partner organisations that make up the Group highlighted that this work enables all of us to acquire a more complete picture of the quality of health and social care in the different regions of Scotland. Having been in existence for a second year, during which our approach has begun to mature further, we still believe this is the case – only more so.

We consider this forum to be an essential component of Scotland's quality approach offering enhanced intelligence around services and quality of care by triangulation and better use of our combined intelligence.

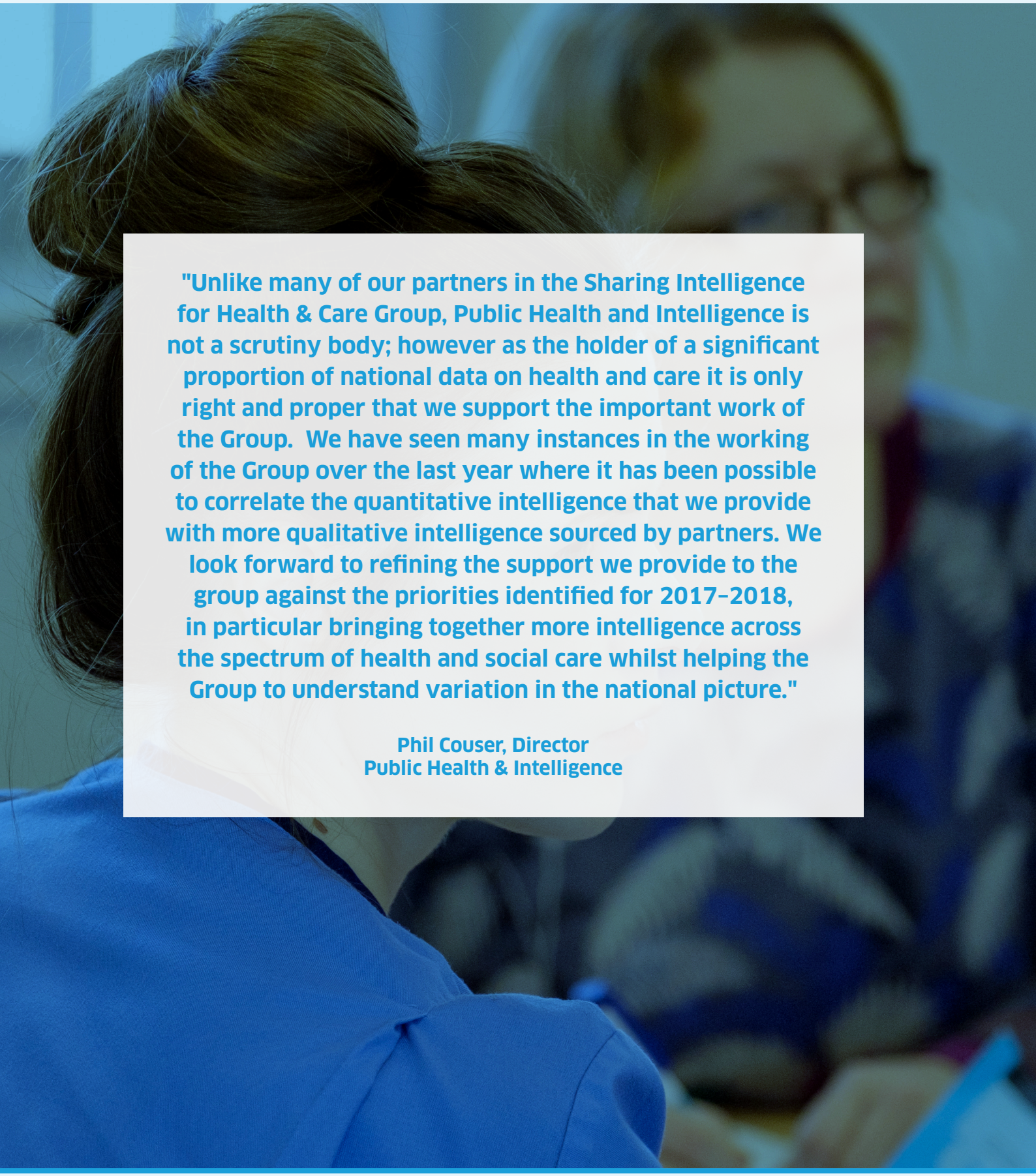
Does intelligence sharing make a difference?

To get to the heart of the matter though, what tangible difference does intelligence sharing actually make? Indeed, the Group regularly asks this 'so what?' question of ourselves.

Following our first year of operation, we reported that there were no instances where the combined intelligence resulted in the partner organisations taking action, either individually or collectively, beyond activity already planned. The partner organisations are now better prepared to take additional action, should this be merited as a result of the intelligence shared – and in 2016–2017 there were examples of this.

For one NHS board, significant concerns were raised about the medical training environment in one of its hospitals. Prior to the existence of the Group, NHS Education for Scotland and the General Medical Council would have engaged with the NHS board in question with the aim of addressing this matter – and this continues to be the case. However, the discussion between the partner agencies supported a decision by Healthcare Improvement Scotland to be proactive in working alongside this NHS board to explore the extent to which these concerns about the training environment might be a significant risk to the quality of care, and to provide additional support. In addition, NHS Education for Scotland and Healthcare Improvement Scotland established enhanced external assurance mechanisms with the aim of supporting local improvement and enabling objective evidence of improvement over time.

For a second NHS board, a number of the partner organisations on the Group raised some risks relating to the quality of care. None of these concerns were, in isolation, so great that additional urgent action was required. However, the Group agreed it would be prudent to find out more about the range of activities that various external agencies were engaged in with this NHS board – and to then explore, together with the NHS board, the specific concerns raised and whether there are opportunities to better co-ordinate and prioritise support.



"Unlike many of our partners in the Sharing Intelligence for Health & Care Group, Public Health and Intelligence is not a scrutiny body; however as the holder of a significant proportion of national data on health and care it is only right and proper that we support the important work of the Group. We have seen many instances in the working of the Group over the last year where it has been possible to correlate the quantitative intelligence that we provide with more qualitative intelligence sourced by partners. We look forward to refining the support we provide to the group against the priorities identified for 2017–2018, in particular bringing together more intelligence across the spectrum of health and social care whilst helping the Group to understand variation in the national picture."

Phil Couser, Director
Public Health & Intelligence

From the feedback meetings with NHS boards generally, it appeared that most of the key issues identified by the Group were already known locally and were being acted upon, as would be expected. 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 Group was not aware of, which is valuable for informing our work as national organisations. NHS board Chief Executives and their management teams also highlighted the potential for the concerted external opinion of the Group to identify opportunities for regional learning and working.

For every NHS board considered, we identified specific aspects that appear to be working well and continue to improve. These varied from NHS board to NHS board, and examples include:

- positive and caring interactions between staff and patients
- cultures that are conducive to learning and improvement
- integrated health and social care services that are making a real difference for children and young people
- high standards of infection control in hospital
- a supportive training environment for trainee doctors
- person-centred mental health services, and
- strong financial management in very challenging conditions.

Other benefits of our work that continue to be reported by members of the Group include getting a better shared knowledge of partner organisations' work, and building professional relationships. Although these are less tangible benefits, they are still important to us.

What are our plans for 2017–2018?

Engaging with service provider organisations

For 2017–2018, our focus will continue to be primarily at NHS board level and our rolling programme used for our first two years of operation will continue. Specifically, during 2017–2018 we will consider each territorial NHS board and relevant special NHS board. We will, however, refine our approach to reflect wider developments in the integration of health and social care. As part of this, we commit to consider how we might engage with Integration Authorities, and also to better understand how the work of the Group and the Local Area Networks might be better aligned (particularly their Shared Risk Assessment process that is applied to individual local authority areas).

Better understanding of variation in data

We have identified that the Group needs to refine its methodology to ensure we have a good awareness of intelligence from key national datasets. Specifically, we need to refine the specific metrics that we consider, and make sure we are aware of key patterns on each of these indicators – specifically, where the data for an NHS board, hospital and Health and Social Care Partnership are significantly different from the Scottish average, or where there is a significant variation over time.

Supporting public engagement

We have invited the Scottish Health Council, whose remit is to promote patient focus and public involvement, to attend two of our meetings. This is to test providing intelligence on how they have been supporting NHS boards with public engagement activities and service changes (in addition to the written information the Scottish Health Council already provides for the Group). This is also to contribute to other group discussions, particularly about the public focus of our work.

Intelligence sharing elsewhere in the British Isles

In February 2017, the Group hosted a session on intelligence sharing with colleagues from England, Wales, Northern Ireland and the Republic of Ireland. This was a valuable opportunity to learn together about some of the main cultural and logistical issues involved in intelligence sharing between national organisations within a country, and will help us build relationships with colleagues from other countries involved in such work. We believe, in Scotland, we now have a progressive mechanism in place for sharing intelligence and, as highlighted throughout this report, we are aware of the opportunities to develop this further.

Evaluation

In our inaugural summary report[8], we said that in 2016–2017 we would carry out a formative evaluation of the performance and impact of our sharing intelligence activities. We decided to first complete an evaluability assessment – this is a systematic process that helps identify whether programme evaluation is justified, feasible, and likely to provide useful information. Evaluability assessment is also used to help describe the objectives and logic of the work in question, with an aim to investigate its credibility, feasibility, sustainability and acceptability. The evaluability assessment was indeed helpful in this regard, and also recommended that it would be appropriate for a formative and independent evaluation to be carried out during 2017–2018. The findings of this evaluation will be used for the purpose of learning to inform the aims and approach of the Group from 2018–2019. There is also an intention to publish the findings of this evaluation to add to the sparse evidence and literature about intelligence sharing.

Summary of our 6 commitments for 2017–2018

We will:

- consider our collective intelligence about each NHS board area
- enhance our focus on, and engagement with, Integration Authorities
- learn more about the quality of health and social care in the community by considering additional intelligence
- test how to enhance the public voice in our work
- increase our awareness and understanding of noteworthy variation on key metrics from national datasets, and
- commission a formative and independent evaluation of our work.

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