Healthcare Improvement Scotland Quality Assurance and Regulation Plan 2024-2025

Updated December 2024

Our quality assurance and regulation activity is split into three categories: inspection, regulation, and review (including ad hoc investigations or reviews). We undertake these activities in a planned and proactive manner to provide public assurance on safety and quality of care and highlight areas of good practice and opportunities for learning to support ongoing improvements across the whole of Scotland.

Our plans for each programme from April 2024 to March 2025 are outlined below. This version of the plan was updated in December 2024 and reflects new assurance activity and changing priorities that have emerged since April 2024.

As a result of this additional activity and changing priorities, adjustments have been made to our assurance and regulation plan. This means some of our planned programme activities have been paused or slowed to accommodate these priority areas of work. The assurance and regulation plan is continually reviewed and may be subject to further change in response to emergent external scrutiny priorities and changing resource considerations.

An indication of the planned number of inspections and other key assurance activities are detailed below where available, however the number of planned inspections may change during the year. There are several reasons for this, including the complexity of inspections, follow-up activity that may be required in response to inspection findings, and new requests for external quality assurance in response to emergent concerns which may require the rapid redeployment of resource and reprioritisation of existing work programmes.

An asterisk * against a programme in the tables below denotes a change from the activity detailed in the plan as at March 2024.

Inspection

NHS Inspections

Our NHS Inspections currently focus on three areas - hospital inspections, mental health services inspections and the inspection of healthcare within justice.

Over the coming year we will continue our safe delivery of care methodology for inspections of NHS hospitals. We will also continue to work in collaboration with partner agencies to inspect healthcare services within prisons and police custody.

Discussions are ongoing with Scottish Government regarding the future scope of our inspections of mental health in-patient units as part of an organisation wide package of assurance, standards implementation and service reform support for mental health services. It is anticipated that this programme will recommence in autumn 2024 with a broader scope, using our safe delivery of care methodology.

During 2024-25 we also plan to develop a new programme of inspection of perinatal (maternity and neonatal) NHS services as part of a wider HIS programme of assurance, standards development, and improvement support. The initial development phase of this programme is planned to begin by the end of 2024.

All our NHS inspections will take account of and respond to the pressures being experienced across NHS Scotland that may impact on the safe delivery of care, reporting this impact on patient care through inspection reports.

Programme	**Programme Aim**	**Scrutiny body/ bodies involved**	**Inspection activity**
Hospital inspections*	To provide assurance of the safe delivery of care in NHS hospitals through targeted inspection activity that is reflective of and responsive to the evolving context of service delivery.	Healthcare Improvement Scotland	Our single and multi-site inspections will continue to be risk-based and proportionate. It is intended 11 hospital inspections will be carried out within NHS board areas between April 2024 and March 2025. Inspection reports and associated improvement action plans will be published on our website. Locations of inspections are not available as these are unannounced.

Mental health adult in-patient unit inspections*	To contribute to the safety and wellbeing of patients and service users within mental health services through targeted inspection activity that is reflective of and responsive to the evolving context of service delivery.	Healthcare Improvement Scotland	Inspection activity in 2024-2025 will recommence in autumn 2024.
Inspection of acute perinatal services*	To provide assurance of the safe delivery of perinatal services in NHS hospitals through targeted inspection activity that is reflective of and responsive to the evolving context of service delivery.	Healthcare Improvement Scotland	The inspection programme will be developed during 2024-25 by adapting and extending the existing safe delivery of care inspection methodology for NHS Hospitals.
Joint inspection of prisoner healthcare	Healthcare Improvement Scotland works with His Majesty's Inspectorate of Prisons for Scotland (HMIPS) to provide expertise to the inspection of healthcare in prisons in Scotland.	His Majesty's Inspectorate of Prisons for Scotland (lead agency) and Healthcare Improvement Scotland	Four inspections planned during 2024-2025, together with several follow up inspections.
Joint inspection of police custody centres	Healthcare Improvement Scotland works with His Majesty's Inspectorate of Constabulary for Scotland (HMICS) to provide expertise to the inspection of healthcare in police custody centres in Scotland.	His Majesty's Inspectorate of Constabulary in Scotland (lead agency) and Healthcare Improvement Scotland	Three inspections planned during 2024-2025, together with follow up inspections where required.

Multi-agency Inspections

Our strategic multi-agency inspection programmes focus on three areas - joint Inspection of adult support and protection, joint inspection of adult services and joint inspection of services for children and young people.

Phase 2 of the adult support and protection programme has been designed with a clear improvement focus. It comprises four complementary workstreams including: inspection activity; the development of a quality improvement framework which will be available for use by the sector to support multi-agency self-evaluation; progress review activity with partnerships found to have significant areas for improvement during phase 1 and focused work related to early intervention and trauma informed practice.

The joint strategic inspections of services for adults, and for children and young people, will continue with the same respective methodologies as during 2023-2024. In 2024-2025 joint inspections of adult services will focus on adults living with mental illness and their unpaid carers.

Programmes will be kept under regular review for any impacts of the reduced financial envelope and any new commissions on our ability to deliver planned work with the resources available to HIS and our partner agencies.

Programme	**Programme Aim**	**Scrutiny body/ bodies involved**	**Inspection activity**
Joint inspection of adult support and protection (phase 2)	This work seeks assurance that adults at risk of harm in Scotland are supported and protected by existing national and local adult support and protection arrangements and supports adult protection partnerships to improve.	Care Inspectorate (lead agency), Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland	Completion of two joint inspections in quarter 1 of 2024-2025 (this completes the six planned inspections of partnerships last inspected in 2017). Methodology finalisation (by spring 2024) and commencement of the programme of progress reviews and the early intervention and prevention focused work late summer 2024 (work will continue into 2025-2026).
Joint inspection of adult services (integration and outcomes)	Healthcare Improvement Scotland has a statutory responsibility to undertake joint inspections of services for adults with the Care Inspectorate.	Healthcare Improvement Scotland and Care Inspectorate	The intention is to complete up to three joint inspections of health and social care partnerships during 2024-2025. These joint inspections will focus on the effectiveness of Partnership working in creating seamless services that deliver good health

			and wellbeing outcomes for people and their unpaid carers, through the lens of different service user groups.
Joint inspection of services for children and young people	The inspection programme takes account of the experiences and outcomes of children and young people in need of care and protection by looking at the services provided for them by community planning partnerships in each of Scotland's 32 local authorities.	Care Inspectorate (lead agency), Healthcare Improvement Scotland, His Majesty's Inspectorate of Constabulary in Scotland, and Education Scotland.	The intention is to complete a minimum of three routine joint inspections of community planning partnership areas during 2024-2025 plus one thematic inspection focusing on the experiences of young people leaving care in Scotland.

Regulation

Our regulation programmes focus on delivery of all elements of our regulatory responsibilities for both independent healthcare (IHC) and Ionising Radiation (Medical Exposure) Regulations (IRMER). This includes proactive inspections, responding to notifications of incidents and enforcement activity for both programmes of work, and registration of IHC services and investigations of complaints about these registered services.

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
Ionising Radiation (Medical Exposure) Regulations (IRMER)	Through inspections and the notifications process, the aim of this work is to provide public assurance of the safe use of ionising radiation for medical exposure.	Healthcare Improvement Scotland	An inspection plan is in place to carry out at least 10 inspections. Routine inspections are announced. In addition, we will respond to all notifications (approximately 130 per year) and take forward recommendations from the Integrated Regulatory Review Service mission.
Independent Healthcare (IHC)*	Healthcare Improvement Scotland is the regulator of registered independent healthcare services in Scotland. Our regulatory functions include: • registering IHC services • proactive inspections of registered services • investigating complaints about registered IHC services • responding to notifications from IHC registered services • taking enforcement action of registered IHC services where necessary, and • continuing with development work to support the regulation of independent healthcare.	Healthcare Improvement Scotland	The planned number of inspections is IHC services for 2024/25 is 129 to take account of ongoing internal deep dive review of systems and process for the regulation of independent healthcare. The number of planned inspections may change throughout the year for a range of reasons including: • high priority reactive activity that requires resource to be diverted from planned inspections • cancelled registration of a service • follow-up inspections in response to initial inspection findings.

Review (including ad hoc investigations or reviews)

Our bespoke review programmes contribute to three key themes:

Working collaboratively to review and respond to concerns about the quality and safety of services:

- Responding to Concerns, and
- Sharing Health and Care Intelligence Network

Reviewing and improving national screening programmes and cancer services:

- External quality assurance of cancer quality performance indicators, and
- External quality assurance of national screening programmes

Reviewing and learning from adverse events, children and young people's deaths, and death certification:

- Management of adverse events
- National hub for reviewing and learning from the deaths of children and young people, and
- Death Certification Review Service

Our programmes to review and improve national screening programmes and cancer services will be redesigned to shape the future delivery of these programmes. This redesign has been paused to help accommodate the new assurance activity referenced on page 1 and will recommence later in the year.

In addition to the above review programmes, **responsive reviews** may be commissioned by Scottish Government or instigated by Healthcare Improvement Scotland to address an identified need. A new responsive review was commenced in April 2024:

- NHS Greater Glasgow and Clyde Emergency Department Review.

Working collaboratively to review and respond to concerns about the quality and safety of services

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
Responding to concerns*	Healthcare Improvement Scotland has a duty to respond to patient safety/quality of care concerns raised about NHS services by NHS Scotland employees or referred to us by another organisation. All concerns made to us are	Healthcare Improvement Scotland	Ongoing process of assessment and investigation of concerns raised. An external review of Responding to Concerns processes aimed at strengthening internal systems in relation to the

	subject to a level of assessment and investigation.		handling of quality and safety concerns brought to the attention of HIS is underway and due to report in September 2024. A revised interim process was introduced in April 2024, pending the outcome of the external review. Recommendations from the external review will be implemented in the latter half of 2024-25.
Sharing Health and Care Intelligence Network	The Sharing Health and Care Intelligence Network (SHCIN) is a mechanism that enables seven national organisations with a scrutiny, improvement, or training role at system/service level in Scotland, and nine professional regulators, to share, consider, and respond to intelligence and emerging issues that may indicate risks about health and social care systems across Scotland.	• Audit Scotland • Care Inspectorate • General Chiropractic Council • General Dental Council • General Medical Council • General Optical Council • General Osteopathic Council • General Pharmaceutical Council • Healthcare Improvement Scotland • Health & Care Professions Council • Mental Welfare Commission for Scotland • NHS Education for Scotland • Nursing and Midwifery Council • Public Health Scotland • Scottish Public Services Ombudsman • Scottish Social Services Council	The SHCIN focuses on prioritisation of emerging issues in the health and care system which supports a more agile and responsive approach, taking early action on new risks as individual network members or as a collaborative across the SHCIN. The group will meet on a quarterly basis during 2024-25, with the option to convene a review panel meeting should an emerging concern arise out with scheduled meetings.

Reviewing and improving national screening programmes and cancer services

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
External quality assurance of cancer quality performance indicators*	Undertake external quality assurance of the national cancer quality performance indicators (QPIs), provide proportionate scrutiny of performance and support service improvement.	Healthcare Improvement Scotland	The programme was due to enter a re-design phase to shape the future approach to external quality assurance of cancer services. However, due to the additional assurance priorities that have emerged in April 2024, this programme has been paused until January 2025.
Review of national screening programmes*	Work with the National Screening Oversight function, and other relevant stakeholders, to develop an approach to External Quality Assurance (EQA) of screening programmes using thematic approach and begin a test of the methodology and approach.	Healthcare Improvement Scotland	The programme was due to enter a re-design phase to shape the future approach to external assurance of national screening programmes. However, due to the additional assurance priorities that have emerged in April 2024, this programme has been paused until January 2025.

Reviewing and learning from adverse events, children and young people's deaths, and death certification

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
Management of adverse events*	Support a consistent national approach to identification, review, reporting and learning from adverse events based upon national and international good practice.	Healthcare Improvement Scotland	The revision of the Adverse Events Framework is due to be completed by December 2024. This will clearly define the role of HIS in assuring compliance with the requirements of framework. National Standardisation programme for adverse events reporting continues alongside a revised data management plan to allow for improved monitoring and targeted assurance interventions. Further development of the Adverse Events on-line community of practice along with the development of learning systems including learning summary re-design, with all NHS boards having their own area of the main hub site to share learning and other adverse events areas of interest.
National Hub for reviewing and learning from child deaths (and Sudden Unexpected Death in Infancy)	Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, co-host the National Hub for Reviewing and Learning from the Deaths of Children and Young People and aim to ensure the death of every child and young person is reviewed to an agreed minimum standard.	Healthcare Improvement Scotland and Care Inspectorate	The National Hub processes data on the deaths of children and young people, from National Records Scotland, on a weekly basis. The National Hub receives and quality assures core review data sets from NHS boards and local authorities. The work of the National Hub in 2024/25 will be shaped by the findings and recommendations in the first Data Overview Report, published in March 2024. A data management plan is being devised to improve systems for monitoring and

			responding to signals in the data.
Death Certification Review Service	The Death Certification Review Service (DCRS) provides independent scrutiny of deaths in Scotland not reported to the Procurator Fiscal with the aim of improving: • the quality and accuracy of Medical Certificates of Cause of Death (MCCDs) • public health information about causes of death in Scotland • clinical governance issues identified during the death certification review process The service is also responsible for authorising repatriation to Scotland of persons who have died abroad.	Healthcare Improvement Scotland	Review of approximately 12% of Medical Certificates of Cause of Death (MCCD). Provide advice around death certification via the DCRS enquiry line. Review all applications for repatriation to Scotland and where appropriate approve disposal.

Responsive Reviews

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
NHS Greater Glasgow and Clyde Emergency Department review*	Healthcare Improvement Scotland is undertaking an independently chaired review of the safety and quality of care within the main receiving Emergency departments in NHS Greater Glasgow and Clyde. The main aims of the work are to: • provide an evidence-based, balanced, objective and proportionate analysis of the key challenges facing the Emergency Department at the Queen Elizabeth including any wider implications for the other two main departments. • Offer support to NHS Greater Glasgow & Clyde to identify practical, evidence-based and sustainable actions that may be required to improve quality and safety. • Consider any wider evidence-based learning for Emergency Departments and NHS Boards across NHS Scotland.	Healthcare Improvement Scotland	Reporting in March 2025