Evaluation of the Sharing Intelligence for Health and Care Group

Final Report for Sharing Health and Care Group

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Executive Summary

The evaluation of the Sharing Intelligence for Health and Care Group (SIHCG, or referred to as 'the Group') has been commissioned by SIHCG and conducted over a period of three months, from December 2017 to February 2018. The key aims of the study were to assess the efficiency and effectiveness of the SIHCG in creating the desired impacts.

The evaluation applied a mixed study method including desk-based and primary research with a sample of all key stakeholders engaged in SIHCG. Four appendices provide the detailed research findings from the various fieldwork activities, which included online, telephone and face-to-face consultations with individuals and groups.

Primary research has found that most members benefit from their involvement with SIHCG by having strengthened professional relationships and building trust. Gaining knowledge and capabilities, improved awareness and an increased understanding of wider system issues and contexts were further key outcomes mentioned. At the level of the individual, SIHCG activities have led for many to an increased job satisfaction and confidence levels. While at organisational level, SIHCG activities have improved members' abilities to co-ordinate better responses to healthcare providers on a number of occasions were risks were identified.

At the side of healthcare providers, the evaluation findings indicate that the SIHCG had a positive impact with most healthcare providers gaining comfort by the provision of an external perspective on their data sets and by gaining a better awareness of other organisations. Many wished SIHCG to provide a more solution-focused approach, signposting them to good practice where other health boards had managed to overcome similar issues to theirs.

The SIHCG represents an operational and well-respected new body and its Secretariat operates to the full satisfaction of its members. Only minor areas of improvement have been suggested such as communication. In this context, the creation of better information pathways including fuller briefings from Feedback Meetings and written minutes of meetings could help improve communication and build organisational memory.

After three years of building good working relationships between its members and with healthcare providers, the Group is now in an excellent position to developing its effectiveness further through deeper data analysis and sharing of experience between members.

In terms of the Group's organisational structure, the evaluation suggests a small number of improvements due to the Group's current flat structure and lack of sub-groups. Although fully

acknowledged in its current ability to generate a meaningful and engaging debate, the Group is considered as too large to accomplish its detailed analytic tasks and, therefore, the evaluators recommend the creation of a data sub-group to add depth and time for debate. This would help extending the currently very short timeframe for discussion of data.

For example, the use of more visualisation techniques in data presentation could help the facilitation and interpretation of the collated data report and its discussion at meetings.

The provision of further guidance for healthcare providers as to how to organise/disseminate the findings from the meetings would be considered helpful by healthcare providers.

The key recommendations of the evaluation are summarised as follows:

- *Manage and maintain membership more pro-actively by re-establishing commitment, up-dating the Memorandum of Understanding, clarifying roles of individual members, and valuing their participation.*
- *Develop and apply tools to help better structure the discussion (failure path models of previous/hypothetical system failures and check point lists).*
- *Create a sub-group of data analysts that would meet before the SIHCG main meeting to undertake a more in-depth analysis of the datasets.*
- *Apply visualisation techniques during the meeting to facilitate better triangulation and identification of inter-relationships.*
- *Allow more time at meetings for sharing information between members and their skill areas for added learning and professional development.*
- *Enable healthcare providers to participate in the data sub-group or SIHCG meetings to improve a collaborative approach and better up-to-date and contextual information.*
- *Utilise existing member organisations better to present a relevant bridge through which the public can be informed and engaged with.*
- *Take minutes at SIHCG and Feedback Meetings to create a better communication path, maintain interest and engagement with SIHCG members and to create a body of organisational memory for further reference, learning and review.*
- *By building on the existing Logic Model develop a monitoring framework with a range of SMART performance indicators and targets to measure achievement.*
- *Undertake a risk assessment exercise for the SIHCG itself.*

The evaluation report finishes with the identification of four development options, based on the findings of the evaluation and in relation to the recommendations.

1. Introduction

This report presents the findings of the evaluation of the Sharing Intelligence for Health and Care Group (SIHCG, or referred to as 'the Group'). The study has been commissioned by SIHCG and conducted over a period of three months, from December 2017 to February 2018.

This Chapter sets out the background to the study, the research objectives, study method and issues, and concludes with a brief overview of the report's structure.

1.1 Background

In 2013, the Francis inquiry into serious system failures in Mid Staffordshire NHS Foundation Trust was published and highlighted the learning from previous failings. The aims of the Francis inquiry included:

"To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken".[1]

The findings from the inquiry prompted Government demands for improved systems and regulatory action in a move to prevent similar systemic failures to occur. The inquiry report made a number of recommendations designed to improve intelligence sharing within and between national agencies.

Also in Scotland high death rates and staffing problems for example at Monklands Hospital, a clostridium difficile outbreak at the Vale of Leven Hospital, and patient safety concerns in Aberdeen Royal Infirmary, informed a report from the Academy of Medical Royal Colleges and Faculties in Scotland entitled "Learning from serious failings in care" in July 2015. The report found the problems included:

- failure of clinical staff and NHS management to work together;
- leadership and accountability were often lacking; and

[1] https://www.kingsfund.org.uk/audio-video/robert-francis-lessons-stafford-presentation-slides?gclid=EAIaIQobChMI8pmL6PCs2QIV75ztCh39fw8lEAAYASABEgIRvPD_BwE

- bullying was endemic.

The report criticised a target driven culture, and stated that: "Quality care must become the primary influence on patient experience... and the primary indicator of performance".[2]

In 2016, research confirmed that inspection alone cannot achieve the required improvements to change a negative culture of care alone. For example, the Berwick Report[3] outlined ten design principles for developing a quality improvement strategy based on shared learning involving a wide range of NHS staff and outside experts, improved leadership, strategy development and ensuring that national bodies provide unified, co-ordinated support to the NHS as full participants in a single strategy. There was a strong call for creating positive work environments and for 'simplifying and clarifying supervisory and regulatory systems and fostering a culture more focused on learning and improvement and less on scrutiny, rewards and punishment'. However, the report also acknowledged that substantial and sustained commitment of time and resources will need to be allocated to achieve fundamental improvements in the quality of care and that the link to and involvement of staff is mandatory in this process to harness the motivation of staff and to bring about improvements from within.

1.2 SIHCG Formation and Purpose

As a response to the recommendations of the Mid Staffordshire inquiry and increasing warning signs in Scotland , HIS together with NES set out to address the improvement of intelligence sharing in Scotland and undertook a series of tests in 2014/15. Consequently, the Sharing Intelligence for Health and Care Group (SIHCG) was formed in April 2015 with the aim of supporting and improving the delivery of care in Scotland through sharing of intelligence between the main national agencies.

The Group's Terms of Reference outline that by bringing together the key audit, inspection and training bodies, SIHCG can provide:

- a proactive and supportive environment for collaboration and intelligence sharing;

[2] https://www.pressreader.com/uk/the-herald/20150710/281479275087297
[3] Improving quality in the English NHS – A strategy for action, February 2016 (authors: Ham, Berwick, Dixon)

- regular opportunities to build stronger working relationships and a better understanding of roles;
- a shared view of risks to quality through our collective intelligence;
- an early warning mechanism of risk about poor quality; and
- co-ordinated action to drive improvement.

The SIHCG Memorandum of Understanding states that: "The activities of the SIHCG will not interfere with the statutory roles of constituent organisations (e.g. contractual powers or regulatory responsibilities) nor will it substitute the need for individual organisations to act promptly when concerns become apparent". As such the SIHCG has a supportive and advisory capacity only.

SIHCG Membership

Currently there are seven members of the Group including: Audit Scotland, Care Inspectorate, Healthcare Improvement Scotland (including the Scottish Health Council), Mental Welfare Commission for Scotland, NHS National Services Scotland/Public Health & Intelligence; NHS Education for Scotland; and the Scottish Public Services Ombudsman (SPSO) that has recently joined the Group.

SIHCG Aims and Objectives

SIHCG aims to improve access to data and sharing of intelligence between key regulatory and other relevant bodies to:

- improve strategic vision and action planning;
- create more effective linkages between services;
- increase levels of awareness and understanding;
- joint learning, co-creation and generating new ideas;
- facilitate better synergies and delivering more complementary services;
- to implement a more fully integrated and cohesive approach and response; and
- improve the quality, prioritisation, and efficiency of service delivery across a number of activities.

By sharing and triangulating data in such way, the aim is for participating members and their organisations to benefit from an improved insight into the complexities of issues. The dialogue between the partners should lead to an improved understanding of potential areas of risk, which in turn should help improve co-ordination and respond to issues better, faster and in a more integrated manner.

There is a keen interest amongst the members of the Group to learn from each other, improve co-ordination and thereby increase the capacity of their organisations to maintain and improve the delivery of high quality health and social care.

SIHCG Key Operations

The Secretariat manages and co-ordinates the Group which comes together at six times per year in one-day sessions to collectively share information and intelligence in particular areas of interest. The Secretariat of SIHCG is provided by HIS. The Group reviews each of the 14 NHS Boards and four national patient facing Boards in Scotland (in the following referred to as 'healthcare providers') once every year, usually resulting in two to four healthcare providers being reviewed per meeting. Following the meeting, the findings of the Group are shared with the individual healthcare providers in writing and in Feedback Meetings.

In addition to annual reporting and self-assessment, SIHCG has commissioned an independent, formative evaluation study to assess its performance and impact of its sharing intelligence activities so far. This was a commitment of the SIHCG Annual Report published in 2017.

1.3 Aims of the Evaluation Study

A previous evaluability assessment that had been overseen by the SIHCG recommended that a formative and independent evaluation should be carried out, prompting the commissioning of the current study.

Focusing on processes, implementation and achievements, the evaluation focuses on the extent to which SIHCG is an effective mechanism that is creating the desired impacts. The evaluation has a particular emphasis on establishing what and how the Group could improve its operations in future.

The primary aim of the study is to:

- assess performance against the Group's aims and objectives;
- evaluate the efficiency of the existing delivery, structures and procedures of the SIHCG;
- assess the effectiveness of the existing resource allocations and anticipated timeframes for SIHCG activities;
- take into account the existing SIHCG logic model and consider how change and impact in delivery could be measured by SIHCG;
- evaluate the complementarity of SIHCG vis-à-vis other improvement activities undertaken in NHS Scotland and beyond;
- analyse the strengths, weaknesses, threats/barriers and opportunities for the Group moving forward successfully; and
- identify the options of how to refine the approach and effectiveness of the Group to impact positively and noticeably on delivery services.

Cutting across the above, the study has three distinct components, comprising:

- process evaluation (focusing on the operations, procedures and mechanisms employed by SIHCG);
- implementation evaluation (comparing the original expectations against current operations and assessing what works and what does not work and why); and
- outcomes evaluation (evaluating the performance and difference made by SIHCG including evidence of unintended outcomes).

This report presents the findings of the evaluation. The findings have been presented to the SIHCG and relevant reflections and considerations have been integrated during the final stages of report writing.

1.4 Study Method

The study applied a mixed-method approach of desk-based research and fieldwork. The method was designed to prioritise the engagement with those organisations and representatives involved in the SIHCG meetings as well as their target audience, the

healthcare providers in Scotland. The primary research included one-to-one as well as group consultations. Progress was reported regularly to the Client involving face-to-face meetings and e-mail correspondence.

The study was conducted in four stages (many of which operated in parallel):

Stage 1: Inception and Familiarisation

Stage 1 comprised the inception meeting with the SIHCG Steering Group where the detailed study method was agreed. An Inception Report was produced. This stage also included an interview with the Client/SIHCG Secretariat and participation at one of the SIHCG meetings in December 2017 as study observers.

Stage 2: Desk-based Research

The desk-based research during Stage 2 was primarily aimed at conducting a process evaluation, which included a review of relevant documentation produced by the SIHCG. In addition, a literature review provided further contextual information and was aimed to generate ideas in line with the study objectives.

Stage 3: Primary Research

Stage 3 involved the fieldwork of the evaluation and included an:

- online survey, telephone interviews, and focus groups with the SIHCG partner organisations and their staff; and
- telephone consultations with the wider stakeholders such as the NHS Boards, Special Boards and other bodies generally regarded as the target audience of the Group activities and involved in Feedback Meetings with the SIHCG.

All fieldwork material was shared with the Client for comments and feedback before the primary research commenced.

Consultations with SIHCG Partner Organisations

In addition to an online survey, the consultations and focus groups with the SIHCG partner organisations covered process, impact, as well as outcome evaluation issues

and utilised a semi-structured pro forma. The consultations were conducted either face-to-face or by telephone and covered the following topics:

- organisational background and reasons for SIHCG membership;
- objectives and expectation of SIHCG participation;
- motivation and conditions of sharing intelligence across partners;
- quality of SIHCG management, co-ordination and facilitation;
- ability to participate and share intelligence;
- satisfaction levels with communication and learning processes;
- views on the decision-making processes and actions taken so far;
- identification of critical gaps, barriers, and areas of opportunity;
- ability to implement and influence change and create impact; and
- future aspirations, areas of improvement and priorities for SIHCG.

The main aim of the Focus Groups was to assess the reach, awareness, and relevance of SIHCG activities within each partner organisation and expectations in future. The evaluation engaged with 21 representatives across five SIHCG members (in addition, the Scottish Health Council was included in the primary research as well).

Consultations with Wider Stakeholders (Healthcare Providers)

The engagement with the key target audience of SIHCG activities was essential for the evaluation to assess the outputs and results that have been achieved so far and to capture perceptions from stakeholders with regard to the effectiveness and efficiency of SIHCG activities.

The research explored questions such as:

- stakeholders' awareness of SIHCG and its actions;
- if SIHCG engagement has improved their understanding in relevant areas and/or observed any changes because of SIHCG actions;
- if they have experienced any impacts from SIHCG action and how this affected the quality of their service delivery; and

- their suggestions for improving the impact and added value of SIHCG activities?

Interviews utilised a semi-structured pro forma, which was shared with the Client before the fieldwork commenced. The evaluation conducted 15 interviews in total.

Stage 4 - Analysis

Stage 4 engaged the analysis and triangulation of all findings in the context of the key aims and objectives of the study. During this stage we also delivered a telephone review session with some of the key SIHCG organisations and a presentation of the key findings to SIHCG meeting on 15th of February 2018.

1.5 Study Issues

A delayed start of the evaluation meant that there was only a little time to set up the fieldwork before the winter holiday season in 2017. Consequently, interviews and focus groups with SIHCG member organisations and wider stakeholders stretched well into February.

The intentions of the study were to enable all SIHCG member organisations to contribute to the evaluation. However, the SPSO – although widely regarded as a highly valuable new addition to the SIHCG membership, was not included in the contact list provided to the evaluation team.

Due to a busy winter season for the NHS, it was difficult to achieve a 100% success rate in telephone interviews with stakeholders. At times, interviews were scheduled but then cancelled due to unavailability or illness, and then often not re-scheduled or made available until the post study completion stage. A small number of contacts demonstrated a certain lack of recognition of SIHCG which also led to interviews not being scheduled or signposted to staff who have never been or couldn't recall to have been involved in SIHCG activities. Nevertheless, the study managed to interview 13 stakeholders (of the originally planned 20).

The literature review was challenging. Originally planned to be UK-based, it was agreed at the Inception Meeting of the study to focus on international practice[4] as to how other organisations share intelligence across departments, sectors, etc. While our internet search found plenty of research in the area of risk-prevention, risk-

[4] The reason for this decision was that the SIHCG had previously researched similar initiatives in Wales and England before and was aware of their processes. However, the Quality and Surveillance Groups might be of interest to explore further in future studies.

management systems in health care, and data sharing, these reports related less to the actual sharing of intelligence in a partnership approach. Searches on 'risk-prevention' usually brought up articles and reports on 'risk matrices', 'risk assessment systems within a one organisational/departmental context' not in context of multiple organisations assessing risk in a joint effort. Research articles on 'Sharing of Intelligence' generally focused on computer-based systems rather than inter-organisational collaboration. The two-day allocation of study time towards the literature review was, therefore, quickly exhausted without identifying many suitable comparative examples. However, we have summarised our findings in **Appendix D** and they have provided some degree of additional perspective and ideas for the study.

1.6 Structure of the report

The remainder of this document is structured as follows:

- Chapter 2 presents the 'process/implementation evaluation' focusing on the review of the Group's operations, procedures and mechanisms;
- Chapter 3 considers the 'outcome evaluation' reviewing the performance and difference made by SIHCG. It also provides a consideration for measuring performance in future;
- Chapter 4 presents the conclusions and recommendations; and
- Chapter 5 provides a number of development options.

2. SIHCG Process/Implementation Evaluation

2.1 Introduction

Chapter 2 presents the evaluation findings from across the evaluation research, including the desk-based review of the some of the key processes of the SIHCG on the basis of a range of documents that have been made available for the evaluation team. The evaluation team was able to observe the Group during one of their meetings, which provided helpful insights into the implementation of SIHCG's key tasks and the dynamic of the Group. Relevant observations from the evaluation team are presented in blue text boxes throughout the Chapter.

Further detail from the primary research is presented in **Appendices A, B and C**.

2.2 Feedback from the rationale of SIHCG

The rationale for improving knowledge and quality of care through sharing of data, information and intelligence is widely supported by the literature. It is believed that through better contextual knowledge regulators as well as care providers improve their capabilities of better understanding the roots of problems and connections between relevant areas of concern. However, it is important to maintain sufficient clarity and focus of what is being shared and why it is being shared. Therefore, the relevance, appropriateness and comparability of the data and information shared is key to successful learning.

The majority of SIHCG members strongly support the rationale of SIHCG to help address weaknesses within the NHS system by identifying interrelationships between the various existing data sets and information sources.

Most members also confirmed that the SIHCG is particularly relevant in light of the current challenges the NHS is facing and to help prevent system failures.

In principle, consultees perceived that the SIHCG provides an appropriate vehicle and structure to demonstrate to Government that the issue of risk reduction and quality improvement is taken seriously by national care providers and regulators.

The majority of consultees confirmed the aims and objectives of the SIHCG as relevant. However, there are a number of organisations that would welcome more clarity on this.

The literature review (**Appendix D)** confirms the relevance and importance of sharing intelligence in quality improvement across practitioners. This is particularly highlighted by the study "What is the value in regulators sharing information?"[5] emphasising the extent to which regulators can achieve efficiencies in their practices of inspections and developing joint data bases.

The relevance of being inclusive when sharing initiatives is emphasised by the 'Quadruple Healthcare System' highlighting the importance of including those who are delivering the services and to focus on improving their experience of providing care so that some of the root causes of system failures (such as low morale, lack of awareness, lack of commitment, disengagement) can be addressed. The importance of focusing on frontline-workers is also emphasised briefly by the example of the National Guard Health Affairs in Saudi Arabia, as a vital means to bring about transformational change in attitude, understanding and morale.

And finally, the Toyota Model states how important 'working together' is, but also adds the importance of seeking to analyse the 'root causes' of system failure and to focus on 'identifying solutions'.

Evaluators' Comments (Rationale)

The rationale of the SIHCG in terms of the importance of sharing intelligence is strongly supported across many disciplines mainly to bring about new ideas, focus on solution oriented approaches and action planning.

Over the years, integration and inclusiveness have become strong values in sharing experience and the literature review has shown the relevance of including those who are delivering the services. At the same time, strong emphasis is given to a collaborative approach whereby solutions are to be found jointly and responsibility is shared by all, i.e. it is not about identifying who can be blamed, but how a solution can be found. The emphasis in quality improvement is clearly on solution-finding and bringing about transformational change. In this context, membership of professional

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263064/13-1166-risk-research.pdf

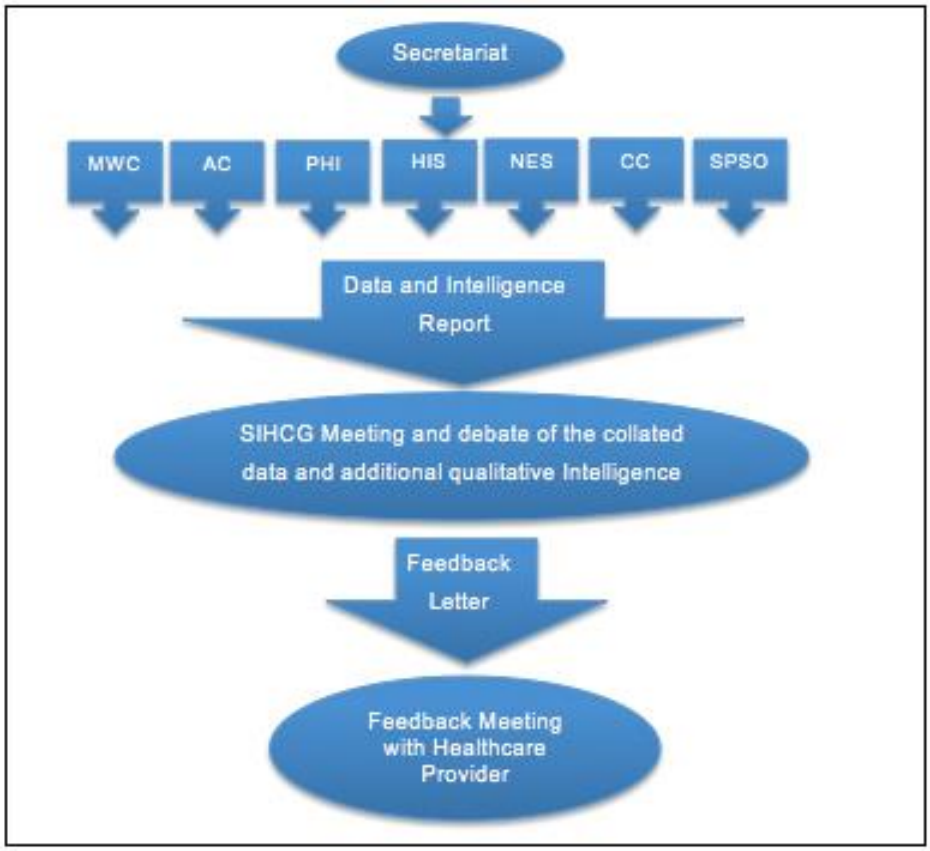
regulators such as the Midwifery and Nursing Council could be considered as worthwhile additions to SIHCG. This could enable SIHCG to build stronger links to frontline staff thereby expanding its reach regarding sharing, learning and improvement

2.3 SIHCG Basic Operating Structure

The SIHCG represents a formal group at which currently seven organisations participate to share data and intelligence on the quality and safety of health and social care services. The Group has two Co-Chairs provided by HIS and NES.

The basic organisational structure is summarised in a flow diagram as follows:

Figure 2.1: SIHCG Operational Structure



A Memorandum of Understanding is in place outlining all areas of responsibility, aims and objectives and Terms of Reference of the Group[6].

Evaluators' Comment (Operational Structure)

The operational structure of the SIHCG is very basic without any thematic or operational sub-groups, Steering Boards or such like. For a number of reasons, but specifically considering the overall number of participants at SIHCG meetings, the short time available for triangulating data, and in view of forthcoming ambitions to enlarge the themes to be incorporated by the Group (IJB's, etc.), the current, basic operational structure of the SIHCG might be considered insufficiently fit for purpose.

The structure currently represents almost a one-way system of information flow and does not provide a sufficient feedback loop of information back to the Group. Thereby, important learning from the Feedback Meetings might not be shared with SIHCG members.

In addition, the current SIHCG structure does not include provision for healthcare providers to be present at SIHCG Group meetings. While the inclusion of healthcare providers could have benefits in terms of contributing with up to date contextual information and insight, this has been debated by the Group and the decision was taken not to include them, so as not to restrict the discussion at SICHG. For some healthcare providers the current operational structure of the Group has insufficient space for collaboration between the Group members and healthcare providers.

Considering the powerful membership and high relevance of the SIHCG, it could be considered a missed opportunity that no formal structural linkage to the Scottish Government is incorporated. While it is fully acknowledged that the SIHCG seeks to be an independent group, it has the potential to take on a more defined role as a 'voice' for its member organisations thereby highlighting needs and development opportunities of the sector. The current SIHCG structure and the Annual Report itself do not sufficiently enable the Group to inform national policy.

The current operational structure has no mechanism or procedure in place to ensure that participants of SIHCG meetings share the findings of the meeting with their colleagues in their own organisations for wider learning and context. Although not

[6] The Memorandum of Understanding is due to be reviewed by the 31 of March 2018.

directly controllably by the SIHCG itself, an information flow diagram or the Memorandum of Understanding could raise awareness of this expectation.

2.4 SIHCG Secretariat

The SIHCG Secretariat is responsible for maintaining the flow of information and for co-ordinating the activities of the SIHCG, it is currently hosted by HIS. Some of its key functions, including the facilitation and attending at Feedback meetings are also supported by NES and other members of the Group. At the outset, when the Group was set up there was a suggestion that the Secretariat should rotate among partner organisations. However, so far HIS has continued to provide this role.

The Secretariat has a number of key tasks, including:

- organisation of meetings and co-ordination of members (tabling agenda's, collating information, producing material for meetings, communicating with members and care providers, arranging premises, record keeping, etc.);
- facilitation and chairing of the SIHCG meetings and the collaborative analysis of data (this is mainly done jointly between HIS and NES);
- following the SIHCG meetings, production of written documentation (Feedback Letter and PowerPoint presentation) summarising the key findings and commentary of the Group for the reviewed healthcare providers;
- arranging and facilitating Feedback Meetings with the healthcare providers (HIS, NES and other relevant members of the Group); and
- reviewing progress, managing external relationships, producing annual reports and other relevant planning documents.

Primary research indicates that members are satisfied with the level of co-ordination and the quality of outputs produced by the Secretariat including the pre-meeting documentation and Feedback Letters. The accessibility and friendliness of personnel, and the general communication between the Secretariat and the SIHCG members is also being perceived as very good.

The SIHCG has a small budget allocated for Secretariat support (involving a small team at HIS) and for evaluation purposes. If required, any additional research needs to be taken forward and/or commissioned by one of the member organisations.

The governance arrangements of the SIHCG (such as co-ordination, timing, dissemination of agenda's, organisation of meetings, etc.) were generally considered well and fit for purpose by most member organisations. Although, staffing levels for the delivery of the Secretariat function has been reported as small, particularly considering the complexity and dimension of the data gathering involved in preparing the relevant data report for each SIHCG meeting.

The templates and formats for data collation that the Secretariat requires from all member organisations have improved over time, and work is continuing on streamlining the range and type of data, which might make the range of data collected more comparable and linked-up between organisations. Many members believe that the current data sets collated could improve, particularly with regard to their effective use as 'indicators' for risk assessment.

A number of member organisations felt that the Group is lacking to some degree in addressing its own needs. This includes two areas of concern relevant to the Secretariat in facilitating:

- SIHCG should set out more clearly how it would react in case of serious problems arising in the NHS. What role would the SIHCG take on in a system failure scenario? What procedures would be in place to assist a NHS Board in serious crisis? What degree of responsibility would the Group have in not having 'seen' the warning signs across the different areas of the individual regulatory bodies?;
- the Group has little time to enable the members to share their own experience and interests with each other. Areas such as: How do the various regulators assess risk? What is considered good practice? How do the regulators judge performance? What are the different techniques applied and how can the members learn from each other in these areas?; and
- in other areas, more policy guidance would be needed to understand better how to assess the data brought to the SIHCG. For example, is it considered good to have more elderly people being cared at their home, or is it better to have more elderly people looked after in care homes?

Communication was an area for improvement according to a number of members consulted internally as well as externally. Regarding internal communications with the Group, improved prioritisation of activities and better responsiveness to members' requests were those aspects mentioned most by consultees in terms of improvements the Secretariat could address. At the same time, responsiveness levels of members to the Secretariat were also at times slow as shown by the example of the Feedback Letter. However, healthcare providers appreciated the improved communication offered to them by the Secretariat before SIHCG meetings to input contextual information to inform the discussion.

Evaluators' Comments (Secretariat)

The produced data reports as well as the Feedback Letters to healthcare providers are important documents and constitute the key documentary evidence of outputs for the Group. However, there is little documentation in terms of findings of the Group, apart from the Data Report and Feedback Letters. However, most of the triangulation and interrogation of data is undertaken verbally in meetings, therefore, minutes of SIHCG meetings as well as minutes of the Feedback Meetings with healthcare providers would provide further documentary evidence of outputs and an organisational memory of proceedings and findings adding to the transparency of the SIHCG. In this context, minutes from Feedback Meetings could be particularly useful in providing feedback to the SIHCG members for further reflection and learning how healthcare providers have reacted to the Group's findings and what they are planning to do with the information (this information is currently not shared with the Group).

As the role of the Secretariat is to organise information flow, communication and drawing up agenda's, the following additional ideas could help SIHCG members (and new staff joining the Group particularly) to maintain a high level of understanding of the Group's rationale and purpose:

- feedback from previous Feedback Meetings focusing on areas where connections between service areas have been established through the conversation with the Health Boards and where further contextual information revealed further detail (e.g. the high readmission figure at Health Trust level manifested itself in a specific department of a particular hospital, which suffered from high staff absenteeism and high stress levels amongst medical staff due to recruitment problems half a year ago – since then measures x, y,

z have been initiated by the Health Board to address the issue); and

- an additional agenda item should ensure that members of the Group are able to share their own approaches in risk assessment. For example, how does one organisation assess risk in comparison to others (i.e. thresholds of risk categories), how are value judgements made within certain areas, what is considered acceptable, what not; how do inspectors ensure they get the full story. This should include how SIHCG participants share the findings of the SIHCG meetings with their colleagues in their own organisations, including their inspectors. Relevant facilitation will be required to enable this exchange.

A number of members are concerned about the lack of clarity regarding how the SIHCG would react in times of system failure. While the Memorandum of Understanding states that legal responsibility lies with the individual regulators in their specific areas, SIHCG should have something in place to protect itself from criticism and/or be able to have a standpoint as to why the Group might have missed to see any linkages through their triangulation approach, just in case? (This point links to some recommendations of the evaluation regarding the application of more standardised methods in the triangulation of data, but also minute taking).

Further recommendations which most likely fall under the auspices of the Secretariat (currently hosted by HIS) are mentioned in the following sections as well.

2.5 Membership and Participation

Including the recently joined, SPSO, there are currently seven members of the SIHCG that contribute to providing data and intelligence before and at each SIHCG meeting.

The main interest in membership and participation included the following:

- to make best use of data and intelligence across national data providers for the purpose of improved response rates to potential risks;
- to gain a broader, contextual view of the regulatory environment;
- to ensure that one's own data are seen across the Group members;
- to support better communication and awareness across regulators; and

- to deliver a joined-up and co-ordinated service in the improvement of healthcare provision and the prevention of system failure.

Most consultees agreed that their organisation had an important role in supporting the SIHCG, and that their interest in participating had increased over the three years. At the same time, two organisations questioned their importance to some extent and felt their area of work provided little additional benefit to identifying and/or preventing any risk assessment.

Some of the newer members as well as those who weren't sure about the value of their membership, felt that the purpose of membership could be made clearer by the SIHCG, i.e. why should those round the table be interested in each other's data and intelligence? how does it all hang together? For one organisation there was also some lack of clarity as to who is a member and who isn't.

The roles and responsibilities of members include the provision and sharing of relevant data and intelligence in a responsible and secure manner, attending SIHCG meetings and assisting in the delivery the Feedback Meetings with healthcare providers. The Memorandum of Understanding also highlights their roles and responsibilities, primarily with regard to data provision and sharing of intelligence (i.e. confidentiality, data security, etc.).

Primary research findings indicate that some members would welcome more clarity about their role and responsibilities, so that greater benefit and contextual insight could be gained from attending the meetings. There was a view from some member organisations, that the Terms of Reference of the Group should be reviewed to improve the clarity and transparency of members' roles and responsibilities.

All members take part in the SIHCG meetings, many of which bring additional staff to the meetings (including data experts, inspectors, and representatives from geographic units). As such, meetings can include up to 25 senior and specialist members of staff across the organisations. According to the evaluation findings, participation levels at meetings (although generally observed as high) varied and not everyone agreed that the most appropriate individuals were involved or that the most relevant information was shared consistently.

In terms of commitment to the SIHCG, most consultees are keen and interested participants of the Group, but many noted that the current level of time and resources

required to attend six full-day meetings per year and gather all relevant data and intelligence for each meeting was the maximum of commitment they could afford.

There was widespread awareness that over the current year the Group seeks to accommodate the Integration Joint Boards (IJBs) across Scotland. However, the IJB arrangements are considered as still in progress and it was therefore too early to design an appropriate model of how SIHCG could incorporate them or establish operational linkages.

In addition to the need to involve IJBs, most members addressed the topic of public engagement as a need to be addressed by SIHCG in one way or another.

There are two agencies that are interested in joining the Group: the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) both represent professional regulators. While their membership could potentially be considered by the Group, the impression is that there are concerns that SIHCG is already a large enough group and if these two organisations would join all other professional regulators would follow seeking membership too, which would entirely exceed the capacities of the SIHCG in its current form.

A small number of healthcare providers pointed out that there should be representation from them on the SIHCG at the meetings, so that the collaborative approach of the Group would be strengthened and a link be established to provide up-to-date contextual information for the relevant discussion.

Evaluators' Comments (Membership and Participation)

The current membership is considered relevant for the purposes of the SIHCG. At the same time, the findings indicate that the relevance of membership needs to be addressed more often to ensure that members fully appreciate the value of being involved and of being important to the others. In this context, stronger emphasis should be given to explaining in more detail why sharing of data and intelligence is beneficial (i.e. not sharing for the purpose of sharing, but to identify interrelationships between the members' data, add contextual insight as to why certain data values are high/low, and to detect if certain combinations of data values and intelligence indicate a growing risk, etc.). This will also help to raise awareness of those participants who might attend the meetings more infrequently, are new to the group, or feel less engaged because of their specialist role.

While high participation numbers are a very positive sign and acknowledgement of

relevance of SIHCG to its members, there is a risk that the meetings in their current form are beginning to become too big to be effective for discussion and analysis. This is specifically relevant when considering the expansion of the Group. However, at the moment, SIHCG is considered operating at maximum capacity.

Regarding the need for public engagement/participation, consideration should be given to utilising relevant SIHCG member organisations better for this purpose. In this way, certain members could have different or added roles and responsibilities for SIHCG. For example, the Scottish Health Council as part of HIS and the Care Inspectorate could provide the necessary bridges to linking the Group to the wider public and relevant patient groups. However, should public engagement become a specific aim of the Group in future, a relevant and clear conceptual approach will need to be developed for this.

2.6 Collated Data Report for SIHCG Meetings

Before each SIHCG meeting all members are requested to prepare relevant data sets for the selected healthcare providers to be discussed at the meeting. Usually a number of staff in each organisation are tasked to gather relevant information for submission, which is experienced as a time consuming task by most members.

A small number of members have the additional challenge of bringing data together across different geographical units, as their organisation operates at local authority level and not NHS Board territorial units.

Over the last year or so, healthcare providers are invited to prepare contextual intelligence to inform the data report with an intention to provide an up-to-date insight into the current situation and to implement a collaborative and inclusive approach to SIHCG practices. This opportunity to contribute to their review by the SIHCG was appreciated by many healthcare providers.

Although the evaluators understand that the Secretariat provides guidance and templates for data gathering, the data report (which was available for the evaluators to review) presented a range of styles and preferences of data presentation across the member organisations. Some performance indicators (i.e. patient engagement) are reported by more than one organisation, some are reported over different time

periods, others as percentages others by their numerical value. At times, the individual data presentations in the report provide some introductory and summarising comment on the data sets, which helps to put the statistics into context.

Many members questioned if SIHCG is collecting the 'right' set of data, and if they or the others report the most relevant and telling data for triangulation and the identification of risks? This is a specific commitment by the SIHCG as presented in the Annual Report for 2016/17 and the evaluation team understands that work is in process seeking to identify a more concise set of data.

In terms of data presentation in the report, some organisations helpfully present their data and information in a user-friendly manner, including:

- comparative tables with data from other healthcare providers;
- graphs, trend lines and developments over time; and
- traffic light system indicating the five lowest and the five highest risk areas.

There is no analysis or cross-referencing of collated data in the data report. Triangulation and analysis is primarily undertaken at the SIHCG meeting in verbal form through discussion.

Once submitted, the Secretariat collates all contributions in a data report, whereby the contributions of each member are presented in consecutive order for each healthcare provider reviewed. The report is disseminated before the meeting to all members as pre-meeting information with the expectation that participants should have read through the report before the meeting. There was general consensus amongst consultees that the Secretariat is providing a very good service by circulating the papers well in advance of meetings providing members sufficient opportunity to review the papers in time.

Evaluators' Comments (Collated Data Report)

The collated data report presents the fundamental basis for the discussion and triangulation at the SIHCG meeting. As such it is necessary for the report to be in a user-friendly format enabling the reader to understand and appreciate the data from the other organisations as best as possible. The application of visualisation tools such as graphs and comparative data including trends over time should therefore

be part of each data set contribution. Here some member organisations already use a traffic light colouring approach (i.e. for values that vary significantly from the average in statistical terms). The evaluators consider this as a very good idea to add clarity and data accessibility for SIHCG participants (because at times it is not immediately clear in the report if a certain data value is to be interpreted as a positive or a negative).

A commentary should be provided by each member organisation in the form of an analysis of the presented data. In this context, member organisations should keep in mind that their data set is read by staff not necessarily expert in statistics or a particular area of healthcare inspection, therefore the data and the accompanying explanatory text should be written as clearly as possible for added understanding and insight as to what the listed data indicate. Although this request will add time to gathering and presenting the data, it will also impact on the efficiency of the SIHCG discussion and the ability of members to fully appreciate the data sets of their fellow members.

In view of the need to accommodate data sets from seven different organisations, a streamlining of data is considered useful by some members to focus on the most relevant data and intelligence. However, streamlining will bring the risk of losing insight and detail, which should be avoided. The current data are already at such a top level that particularly for the larger healthcare providers their ability to point to any discreet area of risk or weakness is increasingly low. It is the evaluators' believe that deeper not necessarily narrower data analysis is required to fulfil the ambitions of the SIHCG better.

2.7 SIHCG Meetings

The SIHCG meetings take place every two months (six times per year), whereby two to four healthcare providers are reviewed at each meeting (each healthcare provider is reviewed once a year).

The SIHCG meetings represent key events where members share their data and intelligence, where the analysis of the findings across the various data sources takes place (i.e. triangulation of the data information) and where members assess if there are any areas of risk or concern in respect to each healthcare provider.

The Secretariat of the SIHCG and the two Co-Chairs (HIS and NES) co-ordinate and facilitate all processes of the Group meeting. The meeting that was observed by the evaluation team was chaired well, ensuring that all organisations were encouraged to comment on certain points, leading on the key aspects of triangulation of the presented data and contributions; and asking questions to stimulate the debate and analysis by the Group. Members also feel that the chairing and facilitation of the meeting is well delivered.

As stated earlier, the meetings are generally well attended with an average of 20 people. Some organisations attend the meeting with four or more members of staff.

Primary research has shown, that some of the senior staff members see the Group as a good mechanism for professional staff development either for more junior or more specialist colleagues. It is usually the specialist staff who present their organisation's data sets and more senior members contribute at the more strategic level of the discussion. At times, data presenters leave the meeting after the discussion of 'their' relevant health provider..

The agenda of the meetings allows for some general feedback at the outset, followed by a sequence of one-hour slots allocated to each healthcare provider discussed during the day. Usually each member organisation presents a summary of their data and intelligence for five minutes, which is followed by a 20-minutes discussion, and a five-minutes conclusion session (small healthcare providers often have shorter time allocations).

Most members consider the five-minute presentation by each organisation as a very helpful feature of the meeting. At the same time, there are worries that the discussion might not go deep enough to properly 'make the most relevant connections'.

Following the individual presentations, participants contribute their reflections and observations of more contextual information, for example reporting from their previous meeting or other communication they had with the relevant healthcare provider. This includes pointing out of good practice experienced by other organisations, and references to previous meetings or contacts with the healthcare provider. This adds context and understanding. Finally, the Chair provides a short summary to conclude the review of the respective healthcare provider.

The whole day meeting focuses on the appraisal of the selected organisations and is therefore an intensive, data and information-heavy event requiring excellent

concentration skills from each participant throughout. Having said this, the level of discussion and involvement from participants is high throughout the meeting as observed by the evaluators. Participants seem familiar with the proceedings and engaged in the debate. Relevant questions are debated and there is a keen interest in identifying interrelationships between the reported information.

At the meeting, at which the evaluators have been present, apart from the graphs and data presented in the data report, data presenters did not use any visualisation techniques to support the understanding of the key points of their presentation. Similarly, no visual notes on a whiteboard or such like were taken during the analysis and discussion of the Group. Some members considered this as too informal an approach in view of the seriousness of the purpose of the Group.

Following the individual presentations from each organisation, the group discussed the emerging picture relating some of the findings to each other, raising key points of concerns and sharing observations.

Evaluators' Comments (SIHCG Meeting)

Regarding the number of member organisations and participants attending the meetings and the detailed datasets presented for analysis and discussion, a group of 20 people is considered a large group. In addition, the 20-minutes of time given for analysis and triangulation for each healthcare provider is considered as too short. Although the Group has identified a number of key risks on which members have taken action on as a result, the evaluators believe that the given timeframe for each healthcare provider should be expanded to ensure sufficient time is given for in-depth analysis and debate. This is particularly so considering the high-level data presented and the number of sectors to be triangulated.

Consideration should, therefore, be given to create a pre-meeting sub-group of data experts to interrogate the data in much more detail. This group should also be provided with the ability to break top-level data down into lower levels (for example, to track where the high number of readmissions stem from, which discipline, if there are connections to the complaints made, if there are connections to training or recruitment, etc.). Access to all available and interactive data systems should be made available to this sub-group to help the triangulation and more depth analysis.

Although the meeting is facilitated well, no summary points of the presentations nor the discussion were noted on a white board or flipchart making it more difficult for

participants to reflect, make connections, and interrogate the presented information.

The discussion does not seem to be supported by a standard set of questions, like a list of key check points to ensure that all connections and potential interrelationships are considered by the Group. Furthermore, the discussion of the presented data and intelligence is not compared or benchmarked to the data patterns of previous system failures (failure path models).

Although it is acknowledged that the Group must maintain a keen openness to new and unique situations, the lack of check points or interrogation modules leaves the discussion of the data somewhat lacking in structure and highly dependent on the participating individuals to be alert and present. There is considerable potential to improve the facilitation and support for triangulation and discussion of the group by using visualisation tools.

2.8 Feedback Letters

Following the SIHCG meeting, the Secretariat writes a Feedback Letter to each reviewed healthcare provider. After a general introduction and reminder of what the SIHCG seeks to accomplish, this Letter reports and summarises the key findings of the meeting.

Before the Letter is sent, each SIHCG member is invited to comment and add to the Letter if necessary. Although not all members provide feedback to the Secretariat, most consultees stated during the evaluation that the Letters are done well, representing a good reflection of the topics discussed in the meeting.

Many healthcare providers perceive the Feedback Letters has helpful summaries of the findings from the various regulatory bodies, but most commented that the Letters do not reveal any new information for them.

In addition to the Feedback Letters, healthcare providers receive an agenda for the Feedback Meeting, a PowerPoint presentation of the Letter, and the most recent SIHCG Annual Report.

Evaluators' Comments (Feedback Letters)

Although the discussion is engaging and focused on identifying connections and inter-relationships between the reported information, the Feedback Letters (that were

reviewed by the Evaluators) do not present this level of triangulation. The Letters rather revert back to a summarising of the findings as reported by the individual member organisations, akin (but much shorter) to the data report. As such, the Letters are limited to what the healthcare providers know / should know already, and miss adding value by sharing the intelligence that has been created during the discussion at the meeting. Therefore, the Letter should report the findings of the SIHCG, not repeat the findings of the individual regulators.

The tone of the letter seems more instructive than collaborative. The Letter explains clearly why the SIHCG would find the meeting helpful, but fails to get across more clearly why the Feedback Meeting would be of interest to the healthcare provider.

For example, benefits for the healthcare providers could be outlined in the Letter as follows:

- to jointly reflect on the issues experienced by the healthcare provider and provide an external, additional perspective on joined-up risk assessment;
- 'we are interested to know how the SIHCG could assist you in addressing the issues…';
- 'our analysis indicates that there are no major issues, but other health boards struggle in this area and would be interested in learning from your good practice / experience etc.'; and
- 'by jointly reflecting on the findings, we might be able to signpost to other health boards struggling with the same issues, or those who have managed to overcome similar issues in the past'.

2.9 Feedback Meetings

The Feedback Meetings with the relevant healthcare providers are conducted within two months following the relevant SIHCG meeting. The Secretariat organises and co-ordinates the meetings and two or three key representatives from HIS, NES and other relevant members (if appropriate) attend the meetings.

In the first year of Feedback Meetings, most healthcare providers were unsure what to expect and were at times apprehensive. Participation in the Feedback Meetings was generally understood as 'no choice' considering that seven regulatory bodies

request these meetings. However, according to most, since the first year the relationship with SIHCG has improved and after the second round of meetings, healthcare providers find the meeting increasingly useful and informative.

A small number of consultees considered that the Feedback Meetings could be more flexible, i.e. if there were no major issues identified by the SIHCG, that there was no need for the meeting.

On a small number of occasions, the evaluators found that a healthcare provider had difficulties recognising the SIHCG and remembering that they have been involved in any Feedback Meetings. However, given that the meetings only take place once a year, for one hour, the lack of recognition in a busy work environment might not necessarily be surprising.

The extent and range of people involved in the Feedback Meetings varies from one healthcare provider to the next, also depending how useful Boards find the engagement. Here it is worthwhile noting that a number of healthcare providers would appreciate better guidance from the SIHCG, who they should invite to the meeting, how they could benefit from the meetings, what the SIHCG is expecting from them and how they should disseminate or deal with the findings from the Group.

Consulted healthcare providers generally welcomed the meetings as an opportunity to reflect jointly on a range of regulatory areas. To have an external body providing its perspectives and views was appreciated by most. Many find the meetings as re-assuring and a confirmation of their own data analysis albeit that the vast majority stated that the SIHCG did not provide them with any additional insights.

According to two healthcare providers, it would be helpful if Feedback Meetings could be more suitably timed so that the SIHCG findings could inform their preparations for their Annual Reports.

Evaluators' Comments (Feedback Meetings)

The findings from healthcare providers indicate that further guidance should be provided as to who to involve in the Feedback Meetings and how best to make use and share /disseminate the SIHCG findings with a wider audience. The curiosity about who to involve included professional colleagues, Non-executive directors, as well as patients/general public (the latter more regarding the dissemination of

findings).

The agenda of Feedback Meetings should include the item: 'Progress since the last meeting' with the SIHCG, to provide a time perspective of development opening up the opportunity for further insight and learning and gathering of good practice.

As pointed out earlier, it can be considered as a missed opportunity and a gap in the provision of evidence that no minutes or similar records are taken during the Feedback Meeting and no mechanism is in place to enable those SIHCG members attending the meeting to share their findings with the rest of the SIHCG members.

2.10 Post Feedback Meetings

A number of particular examples of how SIHCG findings are being utilised by healthcare providers after the Feedback Meeting included the following:

- key contact is involving senior leadership in advance of SIHCG feedback meeting to encourage and ensure that more active dialogue with the SIHCG representatives is created;
- an additional hour was added to a Board meeting to inform as wide a range of Board members, including many executive directors and Social Care representatives, resulting in a large amount of staff attending the SIHCG feedback meeting;
- the feedback summary report is fed into the clinical meeting of the Trust;
- the findings of the feedback report were shared with the Executive Team;
- the findings are looked at and discussed in director meetings and used as a reality check;
- the findings inform existing mechanisms, they provide assurance to our Board and help us in dealing with so much data; and
- the findings of the SIHCG are split amongst the various departments to inform the development of action plans. There are also reporting mechanisms to process the findings, which we find very useful in providing an external view of our situation.

Only one organisation stated that they were not making much use of the data before or after the SIHCG meeting.

The evaluation found that there a number of healthcare providers plan to use the SIHCG findings better in future. These include:

- sharing the findings with non-Executive Directors;
- sharing their minutes of SIHCG Feedback meetings more widely to raise awareness that this 'second chamber of risk-assessment' exists at all; and
- sharing the information pack with the Governance Committee of the Trust.

Asked if the existing process was effective, many stated that the sharing of intelligence is good, but it could be better, particularly if the SIHCG findings and meeting could focus more on how the data could be utilised better and how the problems could be addressed. At the moment, many felt that the report/meeting does not contribute to finding solutions. In addition, many suggested that additional guidance as to what is expected from them and information as to how other Trusts deal with the Feedback Meetings, such as who is attending and how findings are shared would be very helpful.

2.11 SIHCG Annual Report

The recent SIHCG Summary Report for 2016-17, outlines a number of areas to be addressed over the next year, comprising:

- engagement with service provider organisations;
- better understanding of variation in data;
- supporting public engagement;
- intelligence sharing elsewhere in the British Isles; and
- evaluation.

The above objectives for 2017/18 indicate that the Group plans to intensify its reach and collaboration with a wider range of service providers (in addition to working with the NHS Boards, other stakeholders such as Integrated Authorities and Local Area Networks are to be targeted by SIHCG).

Building on the experience with data triangulation in the first three years, SIHCG plans to analyse the available data sets in more depth to identify more clearly where differences in provision exist or where data patterns suggest risks.

A number of good practice activities are also envisaged, including the consideration of involving health and social care users or their representative organisation and to increase the public focus of the SIHCG with the ambition to improve user-focus and high quality delivery. Learning from other UK nations and comparing relevant activities is also a positive step towards improving understanding and awareness.

Finally, the continuation of self-evaluation (including monitoring of progress and reflection on achievements) and the commissioning of independent, external evaluations at key stages are appropriate steps for a growing initiative keen to be an efficient and relevant group.

Evaluators' Comments:

There are a number of opportunities how the Annual Report could be expanded, so that it could present the gained knowledge of the SIHCG over the year more comprehensibly. For example, the gained intelligence inform key themes of relevance to national policy, development needs and opportunities which have been gathered through the Group's reviews and learning between each other and the healthcare providers. The Annual Report could also be a good place to highlight some of the identified good practices.

The Annual Report should be disseminated widely and at the time of publication so that this could be used to stay in touch with the healthcare providers in-between Feedback Meetings.

3. Outcome Evaluation

3.1 Introduction

Chapter 3 presents the findings from the Outcome Evaluation which focused on assessing the results that have been achieved by SIHCG so far. This includes the qualitative benefits that have been experienced by its members (at professional and organisational level) and by its stakeholders, the healthcare providers. The Chapter also presents a number of suggestions for how to potentially improve and widen the outcomes as perceived by its partners and target audience. The Chapter concludes with a section on the existing Logic Model and performance indicator set of SIHCG and how this might be able to be improved.

3.2 Main Outcomes

One of the overriding main outcomes of SIHCG is that it has created a mechanism for sharing intelligence between regulatory bodies. This was a request by Government Following the Mid Staffordshire case and the subsequent recommendations from public inquiry, the evaluation can confirm that a relevant body has now been set in place in Scotland in the form of SIHCG.

Over the last three years, SIHCG has created a membership of committed and interested group of national agencies with further agencies keen to join. The evaluation has found that most agencies benefit from SIHCG and have used the first years of collaboration and exchange to build trust and strengthen professional relationships, gaining knowledge and capabilities through improved communication and information flow between the agencies.

By sharing SIHCG findings with the healthcare providers in Scotland, the Group has widened its reach and support activities in an effort to assist and support healthcare providers in improving their understanding of risks to safety and quality and their early response capabilities. The evaluation findings indicate that the SIHCG has had a positive impact on most healthcare providers so far, but is still in progress of establishing deeper outcomes. As Figure 3.1 (in Section 3.3.2) shows, SIHCG has achieved moderately in some of its anticipated short term outcomes (such as increasing mutual understanding, collective and individual response capabilities to risks, and better informed conversations with boards), however, the evaluators

believe that the main challenge for SIHCG is the very limited engagement time it has with healthcare providers (a one hour Feedback Meeting once a year).

3.3 Benefits Experienced

3.3.1 SIHCG member organisations

Expectations

The majority of SIHCG members support the rationale of SIHCG. There was appreciation and awareness of the aims to:

- make best use of data and intelligence across national data providers and regulators for the purpose of improving patients' care and quality of health and care service delivery; and
- understand and respond better to risk and to avoid system failures.

The main expectations of SIHCG members are to:

- gain a broader view and to ensure that the data from their organisation is well disseminated and used by others thereby improving the work of partners and their own;
- foster and contribute towards a broader understanding of bringing data and intelligence together and to support better communication and awareness of each other across the national providers; and
- deliver a joined-up, co-ordinated service that can anticipate problems, alert organisations, and initiate interventions before system failure can occur.

Benefits

Most members agreed that their expectations are being met, but also acknowledged that the Group required time to build relationships and trust first. There is a general consensus that this has been accomplished well and this is regarded as a significant achievement. This provides a good basis to move forward by focusing now more on improving the effectiveness of the SIHCG in achieving outcomes.

Some organisations stated that they are benefiting hugely from their involvement in SIHCG, while others couldn't understand fully why they are invited to attend and felt

that the Group does not really relate much to their particular remits or utilise their data much in their discussion. The introduction of failure paths models and their discussion could help in this respect. For example, exploring jointly why a certain system failure had taken place and how it could have been prevented considering all areas, including complaints, staff opinion, perceptions of trainees and public engagement.

Benefits experienced at personal/professional level:

- increased understanding and awareness of other organisations (and their data) and strengthened relationships;
- increased understanding of wider system issues and context;
- improved ability to appreciate and raise questions;
- increased job satisfaction through professional debate and comparison;
- improved professional understanding and insight of approaches;
- increased awareness of the range of data; data collection methods; availability, limitations and gaps;
- improved ability to sense check and validate data; and
- increased confidence levels and interest in profession.

Benefits experienced at the level of the organisation:

- improved ability to co-ordinate responses to healthcare providers;
- improved trust and relationships among partner organisations;
- improved understanding and awareness of NHS Boards and other organisations supporting quality improvement;
- increased cross-sector understanding of practice perspective/issues and concerns;
- improved overview, comparability at a more regional/national level;
- increased assurance that work is intelligence-led;
- improved understanding of where resources should focus on;
- increased effectiveness of operations due to the collaboration; and

- improved basis for benchmarking.

Wider benefits experienced:

- created a mechanism that fulfils Government expectations/recommendations by public inquiries;
- triggering other activities and new interventions in areas of concern;
- enhanced networking, learning and development of those involved; and
- strengthened links to other NHS 'Scrutiny' Boards.

3.3.2 Healthcare providers

Expectations

Over time the awareness of what SIHCG can offer to healthcare providers has grown and is now more understood than at the outset and mostly appreciated as a helping hand, or an extra pair of eyes to support the various NHS Trusts so that important risks or connections are not missed. A number of healthcare providers perceive the support as re-assuring of their own assessment of their inspectorates' reports.

There are expectations that the Group will engage with NHS leadership to review the findings and consider ways forward and what should be done about weaknesses. The request for more comparative information, signposting to good practice and the provision of a more solution-focused approach was therefore often mentioned.

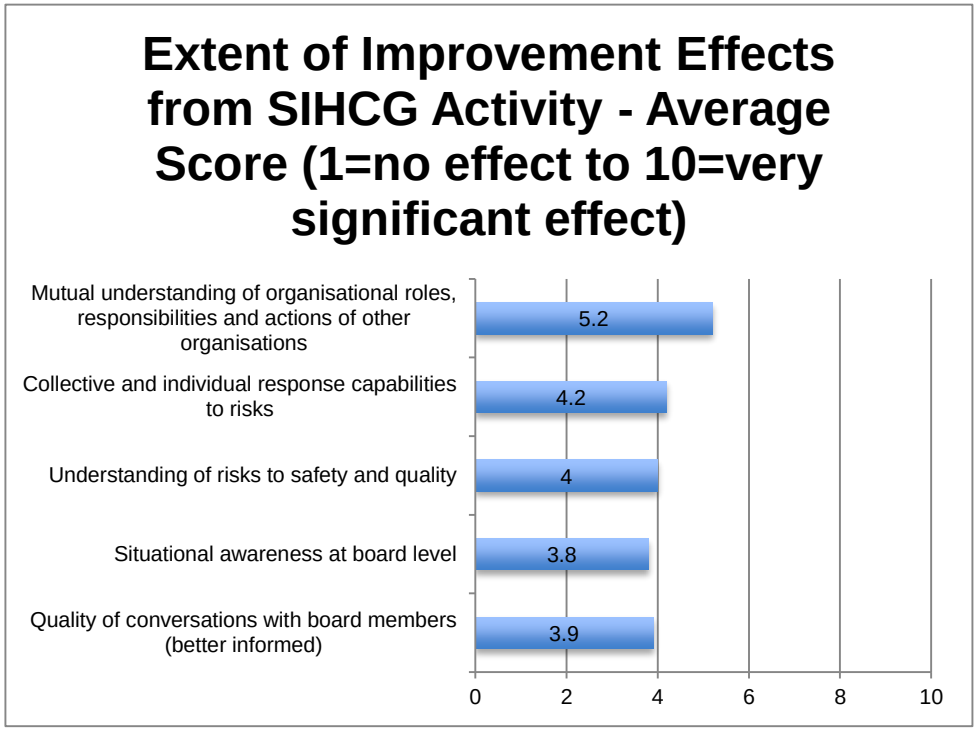
Benefits

Many healthcare providers appreciate the support provided by SIHCG which has improved communication and is perceived as an evolving and improving relationship.

Most interviewees found the process very helpful, primarily because it provides an external and overview perspective. This allows the healthcare providers to reflect on the data in a holistic manner at a given point in time. For some, the SIHCG directly informed strategic planning and action planning. However, many felt that SIHCG information could not be seen as very effective in helping to avoid system failures, as reviews were only undertaken once a year, and without direct input from the healthcare providers themselves at SIHCG meetings, the reviews were invariably lacking in up-to-date context.

In line with the short term outcomes anticipated by SIHCG, **Figure 3.1** shows the extent to which healthcare providers experienced benefits so far. Overall the indication is that improvement effects on capabilities and understanding of risks to safety and quality have only been moderate. Slightly more positive effects were gained through SIHCG engagement in the area of developing a better mutual understanding of organisational roles and responsibilities of other organisations.

Figure 3.1: Extent to which improvements have been experienced



n=10

Wider Benefits

A third of the interviewees stated that they had not (yet) experienced any wider benefits from the SIHCG report/meetings, some of which felt that they could /should do more in future to create wider benefit. This included ideas of promoting the SIHCG process more to the general public for reassurance purposes.

Others reported the following wider benefits:

- provided an additional analytical resource;
- improved joint collaborative working including in-house;

- improved contextual learning by data correlation from various sources and exploring consequences;
- gained better understanding of other NHS organisations and their interactions; and
- improved intelligence provided by an independent view point.

Some interviewees hope that in future more comparative information between them and other healthcare providers could be provided by SIHCG. This would help them to learn more and increase wider benefits.

Evaluators' Comments

The reported benefits by SIHCG members and healthcare providers reflect well the good progress made during the first three years of SIHCG: building relationships and trust and improved understanding of the wider context and organisational landscape. Over future years, the SIHCG will need to improve its effectiveness in a number of areas and it will be important to be clear about the intentions and objectives. This will include raising awareness of the kind of benefits and outcomes SIHCG seeks to achieve. This will help participants to assess progress.

3.3.3 Ensuring Benefits are Shared with a Wider Audience

To ensure that the achieved learning benefits of the exchange through intelligence will be shared with a wider audience, it is recommended to promote and put in place relevant mechanisms within each member organisation, so that gained insights will not only remain with the individuals directly participating in the exchange, but will be shared with their relevant colleagues.

This would facilitate wider learning and would inform those members of staff working at the operational level, including those who contribute to SIHCG data collection and those who actually deliver the inspections with care providers.

For example, the following procedures could be put in place to facilitate wider sharing of SIHCG learning:

- agenda item at meetings (SIHCG and feedback meetings with healthcare providers) 'feedback by participants how they have shared the findings from the last meeting with their colleagues'; and

- thematic or operational sub-groups involving staff which are not participating in the SIHCG meetings, working on selected topics.

The above would also have the advantage of opening up further levels for professional development through sharing of intelligence, experience and dissemination processes across the various SIHCG members / healthcare providers.

3.4 The SIHCG Logic Model

The existing SIHCG Logic Model is well-thought through and comprehensive, covering all key aspects and logical sequences of the rationale of SIHCG and how it is designed to bring about positive change towards ensuring quality of safety and care provision. There are only a few minor refinements to be suggested with regard to differentiating more clearly the outputs and results for the two different beneficiary groups (i.e. regulators and healthcare providers).

3.5 Monitoring Framework

At the moment, the SIHCG does not operate a monitoring framework with performance indicators and achievement targets. However, the existing SIHCG Logic Model and the benefits captured by the evaluation provide a reasonable basis to develop a set of indicators for future use, including the development of some baseline values.

In addition to a number of basic 'activity' and 'output' indicators, most achievements of the SIHCG process are of a qualitative nature and therefore less straightforward to measure and assess. On the basis of the evaluation findings, we can suggest the following set of performance indicators.

3.5.1 Quantitative Performance Indicators

The following range of performance indicators has been designed on the basis of the current range of activities undertaken by SIHCG:

- basic input indicators (could include dedicated SIHCG budgets as well as time resources such as for care providers attending feedback meetings):
    - annual SIHCG budget allocation

  - number of SIHCG member organisations
  - number of healthcare providers included in SIHCG activity
  - staff hours/salaries for SIHCG Secretariat functions
  - staff hours/salaries for attendance of meetings by SIHCG member organisation
  - staff hours/salaries for attendance of feedback meetings by care provider organisation
  - expenses incurred per year (travel, accommodation, etc.);
- basic activity indicators (including first level 'reach'):
  - number of SIHCG main meetings held per year
  - average number of participants at SIHCG main meetings per year
  - number of feedback meetings held with care providers per year
  - average number of participants from care providers at feedback meetings per year; and
- basic outputs indicators:
  - number of detailed data reports produced per year
  - number of care provider feedback reports produced
  - number of additional actions with NHS Boards carried out as a consequence of SIHCG
  - number of annual reports produced.

In terms of performance measurement, input, activity and output performance indicators are pre-dominantly of a quantitative nature, and are therefore relatively easy to measure if reporting and filing systems are in reasonable order. They can be further refined, by breaking down the data into 'type or seniority level of participant' to gain further insight into the reach of SIHCG activities.

3.5.2 Qualitative Outcomes Performance Indicators

Most of what SIHCG activity seeks to achieve is of a qualitative nature pre-dominantly based on the perceptions of the participants and beneficiaries of SIHCG activities. This includes perceived learning gain in the areas of 'improved

understanding of risks to safety and quality'; 'improved prevention capabilities'; 'better informed conversations with boards; 'increased mutual understanding of roles and responsibilities'; etc.

Across all beneficiary groups (regulators' staff and healthcare providers), SIHCG activities aim to improve the following professional areas (each of which can be refined to distinct areas of interests):

- raised awareness;
- increased learning and understanding;
- improved capabilities and skills;
- improved prevention of risk (ultimate impact indicator); and
- increased quality of service delivery (ultimate impact indicator).

For example, and in addition to those already identified in the existing SIHCG Logic Model, the following outcomes might be considered relevant for future survey activity:

- outcomes at SIHCG member level:
    - stronger relationships between members leading to better contextual knowledge
    - improved insight into how weaknesses in one area can affect risk in another area
    - increased interest in professional field (by more contextual knowledge, by making more connections)
    - improved collaborative relationships with care providers; and
- outcomes at the level of healthcare providers:
    - improved insight into how weaknesses in one area can affect risk in another area
    - increased awareness of potential solutions to address weaknesses (but this is not a distinct role of SIHCG yet)
    - improved decision-making – focus and prioritisation of action
    - improved collaborative relationships with regulators.

3.6 Performance Targets

On the basis of the Logic Model and the identification of a set of relevant and measurable performance indicators, it is recommended to set a realistic target for each performance indicator so that achievement can be measured and demonstrated.

Qualitative target setting could be undertaken in a number of ways and differentiated into different participant groups if required:

- percentage of SIHCG participants reporting a certain score in category (for example: '80% of participants reported high learning benefits'); or
- change in the average score given by the participants (for example: 'between 2017 and 2018 the average score for achieved learning benefits increased from 4.3 to 6.5 on a 'Likert scale' from 0 to 10).

Performance targets also help maintain a clear focus of SIHCG activities in line with its key aims and objectives as long as progress against targets is regularly measured and reviewed by the SIHCG partnership.

3.7 Performance Measurement and Monitoring

In terms of performance measurement, input and output indicators are predominantly of a quantitative nature and are therefore monitored via good project management records.

However, qualitative outcomes or results indicators are of an intangible nature and require different measurement techniques than quantitative indicators. A range of Incremental Change Measurement techniques are suitable to measure and visualise progress made over a given time and also facilitate target setting (baseline measurements are usually helpful in this process).

At a minimum, all indicators should be populated through survey activity once a year and analysed and put in context to the previous year's findings to assess change and progress.

Annual reporting of monitoring information should be undertaken as a minimum and to inform the production of the Annual Report.

4. Conclusions and Recommendations

4.1 Introduction

The final chapter of the evaluation report presents the conclusions of the desk-based and primary research findings. The Chapter is organised along the key study objectives as identified in the study brief. Recommendations (in blue text) are integrated into the chapter sub-sections as relevant.

4.2 Performance against aims and objectives

Since its start in 2015, the SIHCG has established a formal structure and mechanism to share intelligence of benefit to participating organisations. Considering its three years of existence, SIHCG has performed well in building a strong and growing Group of interested and committed member organisations. The rationale of the Group has been confirmed by all involved.

Currently, the Group has been successful in creating a proactive and supportive environment for collaboration and intelligence sharing creating benefits at two levels: (a) the regulatory bodies and (b) at the healthcare providers and thereby the NHS in general.

In terms of the Group's aims to enrich and improve the working relationships between regulatory bodies, and to provide each other with more context and understanding of their roles, the SIHCG has been successful in enabling this at both beneficiary levels.

In terms of the aim of the SIHCG to better identify weaknesses in quality of NHS service provision and to prevent risk of system failure across the NHS, the evaluation found that on the basis of the current level of analysis further progress and refinement is required before more added value can be created by the Group (in terms of depth of analysis and triangulation).

It is the opinion of the evaluators that the current operational structure and the available resources and time for analysis of each healthcare provider limit the potential of the Group in more fully achieving all of its aims and objectives.

Notwithstanding the very positive outcomes experienced by its participants, an annual review of each healthcare provider for one hour, it is impossible for the Group in its current format to create a mechanism capable of identifying system failures early and in a preventative capacity and is considered over-ambitious in its current format.

4.3 Efficiency of the delivery, structures and procedures

The Group's performance and efficiency, overall, can be considered as 'good work in progress'. The evaluation found that a number of improvements vis-à-vis the Group's delivery structure, its utilisation of facilitation tools for sharing intelligence, its analytic techniques, and its collaborative approach with healthcare providers could be significantly strengthened to achieve improved efficiencies.

The findings of the evaluation indicate that a number of SIHCG members and healthcare providers are not entirely clear of their roles, the purpose of their participation and expectations from them. A more frequent clarification should be provided to ensure partners of why participation is considered relevant, a confirmation that all member organisations are important to complete 'the picture' of an integrated, collaborative approach. This is particularly relevant when new member organisations join the Group and when new members of staff are introduced to the Group.

Recommendation 1: *Consideration should be given to reminding participants why their membership is important to the Group and to ensure that each participant feels valued and that he/she understands their role well so that all participants can benefit more widely from sharing intelligence.*

For sharing intelligence between SIHCG members, the existing structures and procedures are relatively effective in raising awareness of each other's roles and responsibilities. However, if more time would be created at the meetings for sharing professional experience in regulating, inspecting and risk assessing amongst members, this would add understanding and learning across the NHS regulatory field.

Recommendation 2: *Consideration should be given to allowing more time at meetings for sharing information between members and their skill areas and risk assessment approaches for added learning and professional development.*

The current flow of information represents a single-track dynamic as the SIHCG does not have mechanisms in place to allow for relevant feedback from the findings of the Feedback Meetings with healthcare providers. This would provide the SIHCG members with added insight and contextual understanding not only of how certain assumptions made by the Group were verified or negated, but also to understand better the interrelationships between certain areas which could not only be identified by data analysis and regulatory intelligence alone.

Recommendation 3: *Consideration should be given to taking minutes at Feedback Meetings and to report them back at the next SIHCG Meeting under a dedicated Agenda Heading. This should focus on how healthcare providers dealt with the Group's findings, if further context was provided, how weaknesses were addressed, how healthcare providers were planning to proceed, etc.*

The presentations of data and intelligence by each SIHCG member are verbal accounts and summaries of their data sets. Considering that there are eight such verbal mini presentations delivered to the Group without any visualisation of the data, or noting of headline findings on a whiteboard visible to all, identification of interrelationships of findings is extremely difficult. In addition, only a few organisations report on trend lines and comparative analysis which should be applied by all reporting SIHCG members.

Recommendation 4: *Consideration should be given to applying visualisation techniques during the meeting to highlight key findings and facilitate the discussion and identification of inter-relationships, conflicting data findings between data sets etc. and to make triangulation much easier.*

Although the co-ordination and chairing of SIHCG meetings is good, the discussion of the various datasets and intelligence is structured too informally. This makes the Group vulnerable in its rigour of data interrogation and dependable on individual dynamics and abilities of the participants.

Recommendation 5: *Consideration should be given to develop and apply a number of tools to help better structure the discussion. This would provide added assurance to the Group that key risk scenarios and/or models have been checked and that a standard range of standard questions have been asked. Both sets (failure path models and check point lists) should be developed on the basis of previous (as well as hypothetical) system failures. For example, what were the key failings in the Mid*

Staffordshire case, how would these have shown up in data sets? The application of a check point list and failure path models should, however, not preclude free discussion and debate of the datasets to acknowledge the uniqueness of each situation.

Neither SIHCG meetings nor Feedback Meetings are minuted. This creates a lack of evidence of the Group's outputs and learning and signifies a gap in procedures. At the moment, the main intelligence generated by the Group through discussion and triangulation remains verbal and largely unrecorded. This is regrettable as the existing documents, such as the data report and the Feedback Letters do primarily report the findings from the individual regulatory bodies/data generating members and not the triangulated intelligence generated during the meeting. The evaluators believe that there is a risk that important findings are under-recorded and remain in the heads of individual people only.

Recommendation 6: *Consideration should be given to taking minutes of SIHCG and Feedback Meetings and making them accessible to Group members on relevant cloud platforms. This will create a body of organisational memory and evidence for further reference, learning and annual review activities.*

Currently, the SIHCG understands itself as a collaborative mechanism seeking to assist healthcare providers in their early identification and handling of potential risk situations. However, healthcare providers have currently only limited opportunity to collaborate with and contribute to the Group's assessment. More collaborative input and participation by healthcare provided in SIHCG Meetings would enable the Group to directly inform the discussion with up-to-date and life context.

Recommendations 7: *Consideration should be given to enabling healthcare providers to participate in the data sub-group/SIHCG meetings for a deepened collaborative approach and improved up-date and contextual information. This could be considered as part of the suggested re-structuring of the Group. The involvement of healthcare providers could potentially be limited to the suggested data sub-group, which would still allow the SIHCG main meeting to have free debates.*

The procedures and structures of the SIHCG could be further strengthened by developing a set of risk assessments of the SIHCG itself. This would provide the Group with a clearer understanding of how it would need to act in times of crisis and/or system failure.

Recommendation 8: *Consideration should be given to undertaking a risk assessment exercise for the SIHCG itself, thereby developing a potential procedure for times of crisis.*

4.4 Effectiveness of the resource and time allocations

The evaluation findings indicate that the SIHCG is operating at its maximum capacity, with members committed to the workings of the Group, but unable to offer more resources. In light of a number of important themes to be earmarked for inclusion in 2018, such as IJBs and public engagement, and a waiting list of further regulatory bodies keen to join the Group, the SIHCG faces capacity and growth issues. Unless the Group is considering to restructure its operations, or additional resources are freed elsewhere, it is the opinion of the evaluators that the Group will be unable to consider taking on additional themes, members or other areas of responsibilities.

The capacity issues of the Group are also evident in the amount of time available for the analysis and triangulation of the various data sets for each healthcare provider, currently limited at 20 minutes of discussion. The amount of data to be reviewed and the limited time available for discussion only allows for a relatively superficial triangulation of intelligence. In addition, the number of participants at the meeting is considerable and there is a question if the diversity of participants (data specialists mixed with strategists across organisations) hinders rather than helps the discussion in light of the lack of time available and in view of the ambitions of the SIHCG.

Recommendation 9: *Consideration should be given to creating a sub-group of data analysts that would meet before the SIHCG meeting to undertake a more in-depth analysis of the datasets, including comparative analysis, trends, correlation across the sets. The sub-group would need access to interactive data systems to enable a deeper analysis of where risks might be located and for advanced level of triangulation. This would substantially help achieve more informed risk identification beyond what is already undertaken by each individual regulator.*

A small number of representatives of the data sub-group would report their findings to the SIHCG Meeting where the visualised and triangulated data sets would inform the debate at more strategic level. This new structure would reduce the number of participants at the meeting and potentially free more time for debate.

Recommendation 10: *Regarding the plan to address public engagement and participation in SIHCG proceedings, consideration should be given to utilising existing member organisations such as HIS and its Scottish Health Council to function as a relevant bridge through which the public can be informed and engaged without necessarily being directly involved in the SIHCG meetings.*

4.5 Measurability of change and impact achieved

It is evident that SIHCG has two distinct groups of beneficiaries (apart from the patients of course): the SIHCG member organisations and the healthcare providers. Both groups have quite different characteristics in relation to their experience of and with SIHCG. Whilst members join the Group voluntarily with significant scope for developing their professional expertise and insight through six full day meetings per year and data compilation tasks do undertake in-between, the healthcare providers feel requested to attend a one-hour meeting per year with no further contact in-between.

The scope of and potential for experiencing benefits is therefore quite different between the two beneficiary groups. This may also be the reason why healthcare providers wish to benefit more from their short engagement through a more solution-focused approach and signposting to good practice and comparative information.

Having said this, over the first three years of SIHCG good progress has been achieved in building trust and strengthening professional relationships across the organisational NHS landscape. This includes SIHCG member organisations as well as the healthcare providers. One of its key outcomes so far was reported as having increased the mutual understanding of each other. This had a positive effect on the increased professional development and job satisfaction of many SIHCG members.

To gain more progress in areas such as ‘improving agencies’ early response capabilities’ and ‘better understanding of risks to safety and quality’, to effectively contribute to reducing the risks of system failures, SIHCG will need to increase its operational effectiveness and depth of data analysis (as suggested earlier).

A more widely disseminated Logic Model and the development of a manageable Monitoring Framework with a selected range of performance indicators would also support the SIHCG and its beneficiary groups in gaining more clarity about what it seeks to achieve.

Recommendation 11: *Consideration should be given to developing a user-friendly and manageable monitoring framework on the basis of the existing Logic Model taking into account the various outcomes that have been captured by the evaluation. A small range of SMART performance indicators with targets and relevant monitoring and reporting procedures will also have to be designed to measure and report achievements.*

4.6 Complementarity and added value of SIHCG

The evaluation findings show that those involved in the SIHCG consider its activities as complementary to other existing initiatives. At the moment, no other organisation is providing a similar service for sharing intelligence and awareness raising in Scotland than SIHCG.

The evaluation findings further indicate that at the level of the SIHCG members and healthcare providers, the Group has added value through increased learning, better understanding of context and strengthened relationships and awareness across the field.

Also for many healthcare providers, the Feedback Session was considered a very helpful process to jointly consider regulators' findings and assess relevant actions to be taken to address these issues. The services delivered by SIHCG have added value by creating space and time for reflection.

Additional added value could be created by applying a more solution-focused approach in the Feedback Meetings, and by signposting healthcare providers to other good practice examples.

As indicated earlier, further added value for SIHCG members could be created by providing more time for participants to reflect and share experience of their own areas of work (risk assessment techniques, value judgements, identification of good practice, etc.).

4.7 Strengths, Weaknesses, Threats and Opportunities

Key Strengths	Key Weaknesses
• SIHCG has established itself as a formal structure facilitating professional exchange and awareness raising between NHS regulatory bodies and other associated organisations. • The SIHCG represents an appropriate response to the recommendations of public inquiries • The SIHCG has a unique position to gather knowledge, insight and learning across the NHS in Scotland. • SIHCG has an active and committed membership with a number of additional organisations keen to join. • Members report that professional relationships have been strengthened and improved collaboration and co-ordinated action between members. • The annual feedback meetings with healthcare providers, the SIHCG underpins and reinforces the findings of the individual regulatory bodies with the intention to support and add value by bringing key regulatory findings together in one feedback report. • Care providers perceive the particular strengths of the SIHCG to assess their individual performance from an external position, thereby offering 'another pair of eyes'.	• The time available to undertake meaningful and sufficiently in-depth analysis and triangulation is too short, missing out on adding value. • A lack of visualisation of data sets, applying a check lists and failure path models limit the ability of the Group to analyse effectively. • The level of data considered is unlikely to identify the type of risks that have caused major system failures such as in the Mid Staffordshire case. • The one-way information flow does not allow for feedback, thereby limiting the sharing of intelligence between SIHCG members. • There are no mechanisms in place to facilitate the sharing of intelligence and learning with other members of staff within member organisations as well as healthcare providers. • The existing timeframe of the Group does not allow for sufficient exchange between members and their professional challenges. • Queries evolving from the discussion of the Group cannot be taken forward due to its very limited time allocation. • Some SIHCG participants have a limited understanding of the overall rationale of the Group. • SIHCG meetings as well as Feedback meetings are not minuted,

Opportunities	Threats
• Better facilitation in the form of visualisation of the data and key points of each member's presentation (i.e. the three worst and best findings) and writing them on a whiteboard. • The identification of 'failure path models' would assist the Group in testing if the individual data scenarios of care providers are similar to any known system failure patterns. • The opportunity to re-structure the Group, so that data experts could form a data analysis sub-group that interrogates the datasets in more detail before each SIHCG meeting would have a number of advantages. • Trend analysis is important to spot growing issues over the years, and improvements. • Additional research could be undertaken by the group to 'dig deeper' into the data, i.e. to investigate where a particular 'problem' arises. • The SIHCG has a powerful image due to its membership of all key national regulators with considerable potential in terms of knowledge creation and informing policy design. • The existing Logic Model provides a good basis to develop an Evaluation and Monitoring framework to produce a more robust record of achievements.	• The Group is at its maximum capacity in terms of members, time resources and allocations and can be considered over-stretched already. • The size of Group is too large for more engaged and focussed debate and exploration. The task is very detailed data analysis, seeking to find correlations and interrelationships between different regulators' findings. • If members don't provide honest information and not all data, if members have self-interest, the whole purpose of the group becomes nil. • The Group has lot of potential and gathers a lot of knowledge and insight to expand its activity range. However, it could lose focus by serving too many purposes. • Forthcoming further ambitions, to address IJBs and public engagement may over-stretch the group. • To become more helpful for care providers, the Group will need to add new tasks • Risk that findings and learning from meetings remain un-reported and un-accessible (in case of staff turnover, for example this learning will be lost).

5. Development Options

After three years of establishing a solid structure and mechanism for intelligence sharing, it is a good time to reflect about the future. Therefore, four development options have been identified by the evaluation for consideration by SIHCG.

Option 1 – Stay as you are

Advantages: no change

Risk: sub-optimal performance of the Group's capabilities; sub-optimal positive impact on learning and risk prevention; potentially decreasing interest and engagement from care providers as no additional added value is being created.

There is no room in terms of resources to take on future challenges (for example, integration of IJBs, and public engagement).

Essential improvements:

- introduce an agenda item which reminds participants why their participation is relevant;
- streamlining and visualisation of data presentation in meetings;
- visualisation of key findings (5 best, 5 worst performing indicators reported by each SIHCG member organisation) to better identify linkages;
- correspondence to care providers articulated in a more collaborative style, reminding care providers of how they can benefit from SIHCG activity;
- in feedback meetings allow for reflection time on progress and development since the last meeting (how have problems been resolved or not); and
- provision of minutes from feedback meetings to be accessible for SIHCG members.

Consultants' view: Option 1 could be considered too resource-intensive in proportion to its perceived added value at care provider level and in relation to the impacts are actually achievable in the long-term (only one one-hour meeting per year with care providers). It might be considered too many things for too many people.

Option 2 – Focus on Triangulation

Key Assumption: Improved risk prevention can be achieved by sharing intelligence of regulatory bodies by providing improved context and understanding of how risk areas are potentially interlinked. The assumption is that there are consequential relationships and correlations between the various regulated subject areas, i.e. if A is weak the likelihood that B will suffer and also weaken is high.

Implementation Requirements:

- Refining analysis**:** A number of **'failure paths'** need to be modelled (based on known system failures), so that current data can be measured against these models (i.e. red warning in area A, combined with red warning in area B requires urgent action to prevent system failure in area C – because this combination has led to system failure in the past);

- Re-structuring of the Group: based on known system failures, the likelihood is that failures occur at the level of individuals (albeit that the root problem might be lack of finance causing support systems to fail etc.), therefore data analysis needs to reach detailed levels to meaningfully support a process of identifying risk areas (i.e. not knowing if a high level of readmissions for example occurs across all departments of the care provider or only in one particular department, reduces the informative value and intelligence of this information significantly). Therefore, more time needs to be allocated to interrogate the data sets and identify a more detailed picture of the problem at a much lower level. The Group might want to consider creating **data expert sub-groups** who have access to **smart, interactive data systems** and can interrogate the data in more detail across the various subject areas. The sub-groups should undertake these tasks before each SIHCG meeting.

- Inviting healthcare providers to join the SIHCG data sub-group This would add considerably to adding context and provide a more up-to-date account of the situation in each healthcare provider. At the same time, the invitation to attend the sub-group should be entirely voluntary and based on a fully collaborative approach, so that there is no misunderstanding such as being understood as a summoning to answer for any weaknesses.

Advantages: Much improved ability to triangulate data sets; this increased level of data triangulation and modelling correlations will substantially strengthen and refine

the current data analysis to produce more telling signs of potential risk; and create more added value for all involved.

The participating regulatory bodies would benefit from a more robust system of collaborative reassurance.

The addition of data experts (at sub-group level) and strategists (at meeting level) from the individual healthcare providers would support a collaborative approach and would provide valuable up-to-date data and contextual intelligence.

Risks: Time need to be allocated to identify 'system failure model paths', and there might be a risk not to identify all, to miss some, or to become too focused on the identified paths so that new risks and correlations might be missed (a specific agenda point at sub-group meeting level could help avoid this). The inclusion of healthcare providers could be misunderstood as a summoning to answer for shortcomings.

Resource Implications: potentially minimal, if those in sub-groups would only be represented by one rapporteur at the SIHCG meeting. This would reduce the meeting size and could have the potential to focus the debate on exploring system failure potentials at a more strategic level, i.e. what could be done to prevent or address the current situation.

Consultants' Views: through using a set of standardised failure paths, the work of the SIHCG could become more focused on a complementary area of data analysis. Furthermore, by restructuring the group through introducing data analysis and triangulation sub-groups, this would strengthening the work intensity between the data experts across the SIHCG members and would create more time at SIHCG strategic member level to consider the consequences and potential actions of what the sub-groups have identified. The truly triangulated intelligence would also be more likely considered to add value by the care providers (although their role might become more of a 'sense check' for SIHCG rather than adding new information).

Option 3 – Focus on SIHCG Member Level Only

Key Assumption: Currently, SIHCG is creating most added value and benefit at the level of SIHCG members. Only by considerably increasing the range of activities and thereby extending the remit of the SIHCG would more added value be created for care providers (i.e. solution-focused approach, signposting to good practice).

Therefore, it is reasonable to suggest that the group should focus its resources on their members. This would enable the Group to become more effective in supporting the regulatory bodies in their areas of work and provide a stronger collective re-assurance mechanism to maintain high quality of service provision at the level of regulatory bodies.

Implementation Requirements:

- a shift in perspective is required so that the main purpose of the SIHCG is for the professional enhancement of SIHCG members, to improve their quality of work through sharing of intelligence and experience (at the same time the approach in meetings could still follow a care provider by care provider structure);
- addressing all suggestions for improvement mentioned in Option 1 and Option 2 (except those regarding care providers);
- some thought needs to be given to introducing relevant new agenda items for the SIHCG meeting to provide space for cross-member sharing of experiences regarding their approaches in assessment etc.;
- minutes of SIHCG meetings should be provided at an online shared space, potentially allowing for further exchange between SIHCG members between meetings; and
- informing care providers that SIHCG support would now only be in the form of a feedback letter for them to debate internally as they feel fit, building on the example provided to them during the first two years of SIHCG implementation.

Advantages: The shift in perspective would help clarify and focus the purpose of SIHCG. This would possibly lead to an increased appreciation of the SIHCG as a learning tool/mechanism for regulatory bodies and data analysts in its own right.

Option 3 would potentially free some of the time and resources currently used for feedback meetings. It would further help to focus more intensively on additional learning opportunities and areas of joint interest of its members, such as sharing experiences and views in assessing risks (i.e. what is considered low – medium – high level of risk?), do assessments and approaches vary across the members,

could there be more efficient ways of collecting data from care providers (i.e. overlapping data sets might only need to be collected by one regulator if this is shared with others), and such like.

The refocusing on the benefits for SIHCG members would further open up debate on a number of skills levels, such as qualitative criteria assessment, data capture methods, communication with care providers, but could also lead to enhanced joined-up approaches in data capture, inspections and assessments if facilitated and addressed by the SIHCG.

Risks: As in all other options, a fundamental risk is that the learning and insights achieved at SIHCG meetings might not 'reach' those who are actually inspecting the care providers. If the findings from the SIHCG are not shared 'in-house', the effectiveness of the Group will remain a theoretical interest of a few, and will not achieve any improvement at the level of care providers.

Resource Implications: The current SIHCG resources would be cut by an estimated maximum of 36 days per year (2 days per feedback meeting for 18 care providers per year). These savings could be re-allocated to more intensive sub-group work for data experts across the members and potentially for any further joint research and learning interests of the SIHCG members.

The creation of a jointly accessible cloud space for shared access to minutes, and sharing of tools ('system failure path' models or performance measurement guides of interest to regulatory bodies).

Consultants' Views: In view of the current flow of implementation whereby the follow up of certain actions agreed with a care provider at the feedback meeting is reverted back to the individual, relevant regulatory bodies to deal with, Option 3 seems a sensible solution. While care providers might still receive a feedback letter from the observations and findings of the SIHCG discussions, how to follow this up is left in their hands and that of the regulatory bodies.

With the SIHCG in place, the care providers will receive a more rounded and insightful, integrated and holistic appreciation of arising issues by each individual regulator (as long as those undertaking the inspections are privy to and benefit from the findings of the SIHCG).

Option 4 – Focus on Solution-Focused Approach

Key Assumption: The SIHCG has a privileged position in overseeing the performance across all national health care providers by bringing together the relevant data sets of all regulatory bodies in Scotland. This provides the SIHCG with a body of knowledge and intelligence of strengths and weaknesses across the entire sector that is unique and comprehensive in scale and potential. This includes the particular potential to develop a stronger solution-focused approach in working with health care providers across Scotland, whereby SIHCG would not only identify risks by pointing out linkages and interrelationships between areas of weakness, but would pro-actively identify potential solutions as performed by other healthcare providers addressing similar weaknesses successfully before.

Although itself without enforcing powers, the SIHCG represents the combined presence of all national regulatory bodies relevant to NHS Scotland. This is a considerable force with substantial influence and a very strong image. However, at the moment, the Group uses this position exclusively to gain attention from the care providers and to reinforce the work undertaken by the individual regulatory bodies. The potential to become a 'louder voice' on behalf of the care providers and regulatory bodies and an effective 'bridge' with the Scottish Government has so far not been utilised.

Implementation Requirements: Option 4 would necessitate all improvements suggested for Option 1 and 2 and would require the following additional activities to be implemented:

- additional time allocations at sub-group level to develop comparative analysis between care providers;
- identification, capture and categorisation, and filing of good practice in a wide range of scenarios and set ups, creating an interactive log book of solutions for a comprehensive range of issues and 'system failure paths' models;
- additional staff allocations to maintain and update a good practice resource and to facilitate transfer of learning from good practice as and when required. Good practice staff need to work in close collaboration with the SIHCG at sub-group and SIHCG group level to identify appropriate matches and opportunities; and

- feedback mechanisms for good practice transfer need to be established to track progress and possibly inform new good practice cases.

Advantages: Option 4 would represent a model of excellence in collaboration and support provision between regulatory bodies and care providers. A solution-focused approach would resonate well with current development approaches, including public engagement and integrated care and health provision. SIHCG would create clear added value for its member organisations as well as for all care providers in Scotland.

Risks: A solution-focused approach, based on the identification of good practice from elsewhere is only effective if delivered in a highly bespoke and facilitated manner. Existing good practice websites tend to suffer from low up-take if not promoted intensively, and if no direct relationship can be identified early on by the site visitor, interest quickly fades. Relevance, detail and transferability are further issues, which require pro-active facilitation between recipient and good practice provider in order to be effectively addressed.

Further risks include, that the SIHCG will grow substantially in size and remit in face of the complexities of data sets and issues that are faced by care providers. It might be difficult for the SIHCG in its current set up to manage this additional workload and extended expectations.

Resource Implications: The implementation of Option 4 would require additional resources. At the level of current resources, the additional activities could not be performed. Potentially, the creation of an independent body would be more suitable to perform the role as bridging agent between regulatory bodies, care providers and the Scottish Government.

Consultants' Views: Option 4 represents the Ideal Option which would catapult the SIHCG into a model of excellence. It is undoubtedly the preferred Option, particularly as an independent organisation, but in light of its substantial resource implications over and above what is made available already for the SIHCG, has to be considered unrealistic under the current circumstances of frugal financial budgets. Having said this, the potential for this Option will continue to exist, even if the SIHCG should choose any of the other development options, and should therefore not be forgotten should a relevant opportunity arise in future.