



Primary & Community Care: Monitoring and Quality Assurance

Mapping Exercise: Working Document

Prepared by:

**Rhona Jack
24 Brown Street
Woodside
Aberdeen
AB24 4EZ**

rhonajack@drybridge.demon.co.uk

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A. Executive Summary

Introduction

Most health care is delivered in healthcare settings outside hospitals. This is described as *Primary and Community Health Care* and is provided by a wide range of community-based professionals, as well as independent contractors such as General Practitioners (GPs) and Pharmacists.

There is now good evidence that by delivering care that is local, preventative and anticipatory it is possible to reduce admissions to hospital and to involve patients more pro-actively in their care. There is also good evidence that the current model of care provided by the NHS cannot be sustained and a new strategic direction has now been set out for NHS Scotland in *Delivering for Health*, which gives an enhanced and expanding role to primary care and shifting the focus from hospital based services to those that are local and easy to access. All NHS Boards are now aligning delivery of the care they provide with this strategic direction and in order to support this, NHS Quality Improvement Scotland (NHS QIS) has committed to developing a Primary Care Work Programme that focuses on shifting the balance of care.

Development of the NHS QIS Primary Care Work Programme

It is important to build on the work already underway, particularly in relation to the many new initiatives underway in primary care. Through meetings with key stakeholders it was agreed that NHS QIS should commission work to map existing quality programmes across NHS Scotland with the aim of identifying gaps and areas where NHS QIS could add value. This report presents the findings of this mapping exercise and while it does not claim to be exhaustive, it does provide a comprehensive and cohesive picture of current quality improvement activity in primary care that will support and underpin the development of a credible quality improvement framework for primary and community healthcare in Scotland.

Methods

This Project focussed on four areas:

- 'Contract-related' monitoring
- Clinical Effectiveness work at Health Board level
- Quality assurance by NHS QIS
- Quality assurance by other organisations (including professional bodies)

The work involved reference to literature published by NHS QIS and other organisations, reference to web-based resources, and one-to-one telephone contact with collaborators in Health Boards and other organisations. The investigator was also free to define any other appropriate methods of enquiry.

Results and conclusions

This work confirmed that a very considerable amount of work is already taking place in primary and community care areas. Due to the short timescale of the project, feedback on some activity was incomplete, for example Clinical Effectiveness returns from Health Boards. However it has been confirmed that this reflects the practical difficulties in assembling a prompt response, rather than an absence of activity.

All four contracts share elements reflecting the principle aims of *Delivering for Health*. These include: improving the patient's journey and access to services; an emphasis on preventative, anticipatory health care; development of staff, their skills, competencies, and their capacity for teamwork; and support for infrastructure, including facilities and IT functionality.

There is also a lot of change underway at every level of the NHS. This includes changes to terms and conditions, changes to contracts, organisational restructure, the introduction of more robust accountability arrangements and a major programme of role extension and skills development. This presents an opportunity to build quality improvement and quality assurance into the emergent future infrastructures from the outset and meeting this challenge should be a core strategic objective for NHS QIS.

Recommendations for Further Action

As a result of this piece of work, NHS QIS has identified the following further work strands:

- Publication of the mapping report to underpin the draft NHS QIS Primary and Community Care Work Programme
- Holding a series of regional roadshows as part of consultation on the work programme. In particular, the consultation should focus on identifying those 'gap areas' identified by this work and on where NHS QIS might best 'add value'
- Exploring the value of updating this analysis regularly to reflect changes over time
- Further work on updating information on current clinical effectiveness at NHS Board level and the development of a template for NHS Boards to use when reporting on this

Malcolm Kerr

NHS Quality Improvement Scotland Clinical Advisor on Primary Care

B. Background

1 Introduction

In November 2005, the Scottish Executive Health Department (SEHD) published '*Delivering for Health*', a report that sets out a long-term programme of action for the NHS to address the changing health needs of Scotland. The emphasis is placed firmly on moving away from episodic, acute care in hospital towards anticipatory care services based on improving health and well-being, using preventative medicine and supporting self-care. The main aim is to reduce the unacceptable inequalities in healthy life expectancy across Scotland.

'*Delivering for Health*' sets out a vision of locally responsive, community-based services that is to be achieved by extending and integrating existing services. Four key challenges have been identified:

- Enabling a wider range of services to be delivered in community settings through a modern and collaborative primary care infrastructure
- Establishing a base for local diagnosis, treatment, advice and outreach in Community Health Centres
- Providing the opportunity to co-locate and more closely integrate health and social services
- Providing Community Health Partnerships (CHPs) with the tools they need to deliver a consistently good service to those most at risk in their communities.

2. NHS QIS Response

NHS Quality Improvement Scotland (NHS QIS) was set up in 2004 to lead on improving the quality of healthcare delivered by NHSScotland. To date, much of the work of NHS QIS has been in a hospital setting and the challenge now is to develop its community and primary healthcare work programme to support the NHS in the new ways of working described in *Delivering for Health*. NHS QIS is aware that there is already a lot of quality assurance and monitoring already in place in the community and primary care setting and that with the introduction of new contracts for general medical services, general dental services, optometry and community pharmacies, there is huge potential to use the information that is already being collected to improve the quality of these services. However, there is also a risk of over-regulation and duplication. Therefore NHS QIS commissioned this mapping exercise to identify:

- Contract related monitoring work that NHS Boards are required to carry out, (section B).
- Clinical effectiveness work (non contract based) that NHS Boards are undertaking, (section C).

- Quality assurance work undertaken by other organisations and professional bodies such as NHS Education, the Royal College of General Practitioners, and the Royal Pharmaceutical Society, (section D).
- Primary care quality monitoring / quality improvement work that is already underway within NHS QIS, (section E).

C. Contract related monitoring

1. General Medical Services

2. General Dental Services

3. General Optometry Services

4. General Pharmaceutical Services

1. General Medical Services

1. Introduction

Most UK general practitioners (GPs) moved to a new contract in April 2004¹. One of the aims of the contract is to recognise and remunerate GPs for the quality of care they give to patients, as well as payment related to practice list size.

NHS Boards are responsible for ensuring that the totality of funding they provide to practices is appropriate and is subject to robust contractual and performance management mechanisms.

There are two types of contract monitoring for GP practices and these are kept separate: NHS board contract monitoring; and the payments verification process.

There is also the Quality and Outcomes Framework (QOF) Review process (which includes practice visits). Its purpose is distinct from the contract review and is intended to be supportive and facilitative to drive up quality in service provision. (This also effectively replaced Practice Accreditation with effect from 1 April 2004)

2. NHS board contract monitoring - general

NHS board contract monitoring covers the whole GMS contract and not just the QOF element that is dealt with in detail in paragraph 3 below. Where possible, general contract monitoring visits are linked to QOF visits and cover staffing, premises and IT issues as well as covering the quality of services to patients.

NHS boards are required to review all practices on an **annual** basis. This work is undertaken predominantly by Practice Support Managers and is increasingly becoming a function of CHPs.

The agenda for the review covers

- past performance in relation to e.g.
 - activity levels
 - practice changes
 - Directed, National and Local Enhanced Services, (DES; NES; LES)²
- future plans

¹ Some practices are not covered by the GMS contract (such as Section 17C and 2C arrangements) but may participate in locally agreed frameworks for recognising and rewarding quality in service provision.

² Directed covers services for which NHS boards must ensure that there is alternative cover if a GP practice doesn't provide them; National covers voluntary services where the specification and level of payments are negotiated at UK level; Local covers voluntary services where the specification and level of payments are negotiated at NHS board level.

The level of evidence to support general contract monitoring can vary between NHS boards as it depends on their relationships with their GPs and how they interpret the requirement for a “high trust / low bureaucracy” approach. However, the kinds of evidence that are likely to be required are things like

- number of attendances
- whether the practice has done audits, e.g. associated with Enhanced Services; and if so, what were the key points and how are these being reflected in the future plans for practice development
- IT functionality – e.g. ability to provide performance reports
- Plans to improve accommodation to support redesigned ways of working in primary care

Another example of evidence that might be available more generally is NHS Grampian's quarterly prescribing indicators report for primary care based on PRISMs data. These cover things like cost per patient and items per 000 patients for specific drugs and they are used for benchmarking and monitoring trends in prescribing.

In addition, the SEHD Pay Modernisation Team expects NHS boards to complete an nGMS Implementation Assessment Tool at the end of each financial year for local benchmarking purposes and to drive local improvement. This can be viewed at http://www.paymodernisation.scot.nhs.uk/gms/natref/performance/docs/ngms%20imp_assess_04.xls

In summary, it covers a range of 10 strategic test questions for NHS boards to consider the extent to which they have

1. Used the contractual arrangements to modernise and integrate services rather than just as a payment mechanism for GPs
2. Used the quality framework to manage chronic disease in an integrated way
3. Used enhanced services to redesign and integrate services?
4. Reformed unscheduled care and the way it is provided, across both secondary and primary care instead of merely replacing the current OOH service
5. Used patient feedback and the flexibility in the contractual arrangements to improve patient choice and patient experience
6. Used the practice-based arrangements to develop more multidisciplinary team working and to improve skill mix
7. Used the new arrangements as a lever for recruitment and retention and improving morale in primary care
8. Used the flexibilities of primary care medical services to tackle specific local issues, support service sustainability and develop innovation in primary care
9. Used the new arrangements alongside the new consultants contract and proposals for Agenda for Change to enable pay modernisation to support service redesign
10. Implemented the change agenda in partnership with the public, area staff partnership forum, local medical / GP subcommittees and colleague agencies

Each of these is underpinned by a series of further questions and NHS boards are expected to provide brief comments in support of the score that they allocate themselves.

Using NHS Grampian as an example, the completed self-assessment for 2006 was submitted to their local Performance Governance Committee and to the Performance Directorate in SEHD. They expect the results to form part of the Accountability Review evidence.

In terms of future developments for general contract monitoring, it is likely that Regional Planning Groups will take a greater interest in monitoring the new GMS contract to ensure consistency across the region and to share learning experiences. For example, there is already a sub group working on Out of Hours models.

3. NHS board monitoring - Quality and Outcomes Framework (QOF) Review Programme

3.1 Background

The QOF was set up in April 2004 and is the mechanism that is used to monitor GP practices' achievements against a series of agreed indicators. It was set up to work on a points basis with a maximum original³ score of 1050 distributed as follows:

- Up to 550 for clinical achievement across 10 chronic disease areas
- Up to 184 for organisational achievement
- Up to 100 for patient experience
- Up to 36 for additional services
- Up to 180 to reflect the breadth of achievement across all domains.

Participation in the QOF process is voluntary but almost all practices in Scotland have chosen to be involved. Achievement was high in 2004/05 and improved in every area again in 2005/06. Across all GMS practices, 97.7% of the maximum points available were achieved and this led to £134.5m QOF related payments out of a total £642m expenditure on this service in 2005/06. This compares with 2004/05 figures which were 92.5% and £590m respectively.

3.2 Purpose

The QOF indicators aim to improve the service given to patients. In particular, clinical indicators are based on robust evidence and should, over time, lead to an improvement in the health of the population.

³ Changes to the QOF which took effect from April 2006 are described in para 3.6 below.

Table 2 - Clinical area example

Hypertension

All minimum thresholds are 25%

Indicator	Points	Maximum threshold
Records		
BP 1. The practice can produce a register of patients with established hypertension	9	
Diagnosis and initial management		
BP 2. The percentage of patients with hypertension whose notes record smoking status at least once	10	90%
BP 3. The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice has been offered at least once	10	90%
Ongoing Management		
BP 4. The percentage of patients with hypertension in which there is a record of the blood pressure in the past 9 months	20	90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in last 9 months) is 150/90 or less	56	70%

Table 3 – Non-clinical area example.

Patient experience

PE 1 Length of Consultations
<p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. [If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.]</p> <p>For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes.</p> <p>For practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p> <p style="text-align: right;">30 points</p>
PE 2 Patient Surveys
<p>The practice will have undertaken an approved patient survey each year</p> <p style="text-align: right;">40 points</p>
PE 3 Patient Survey
<p>The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate</p> <p>For practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p> <p style="text-align: right;">30 points</p>
PE 2 Patient Surveys
<p>The practice will have undertaken an approved patient survey each year</p> <p style="text-align: right;">40 points</p>
PE 3 Patient Survey
<p>The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate</p> <p style="text-align: right;">15 points</p>
PE 4 Patient Surveys
<p>The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted</p> <p style="text-align: right;">15 points</p>

3.4 QOF Data

In Scotland, the QOF data are routinely collected through the national **Quality and Outcomes Framework Management Analysis System (QMAS)** which provides practices, PCTs and Boards with objective evidence about the quality of care being provided. Practices are responsible for ensuring that their data are properly recorded - the clinical data come from the practices' clinical systems while the organisational and patient experience data are manually entered onto QMAS.

The results from QMAS are published annually by ISD – for the latest results see

http://www.isdscotland.org/isd/new2.jsp?pContentID=3973&p_applic=CCC&p_service=Content.show&

3.5 QOF Review Process

Visits are undertaken by trained QOF Reviewers and are carried out in line with the following principles

- **Robust** - to meet the needs of NHS Board's corporate governance
- **Formative** - to ensure services to patients are supported
- **Specific** - targeting areas for celebration and support in each practice
- **Efficient** - using data already available to practices and Boards
- **Fair** - the standards used are agreed nationally
- **Consistent** - all practices will be reviewed in a similar way
- **Developmental** - will look forward as well as back.

Working on behalf of the SEHD, the Winter Group recommended that QOF visits should be undertaken at a frequency determined by experience and local knowledge but as a minimum on a two yearly basis.

As with contract monitoring generally, a “high trust, low bureaucracy” approach that uses existing sources for evidence is expected to be the norm for QOF reviews. The emphasis is on self reporting and the QOF Team is not expected to undertake “intrusive verification procedures. If the QOF Review Team is concerned about payment verification, the team will report its concerns to the Board who will act accordingly.

The monitoring / QA information available to the review team is

- The outputs from QMAS
- Supplementary evidence submitted by the practice which will comprise
 - Evidence determined by the practice provided on a voluntary basis and which will vary from practice to practice – examples include their QPA submission; involvement with the Citizen's Advice Bureau; or their full patient survey not just the summary
 - “Grade A” evidence which is compulsory and should be routinely available across all practices.

Grade A evidence

This must be submitted in advance of the review visit.

2005/06	2006/07
Practice Leaflet	Practice Leaflet
Survey of notes for MED 5, MED 9 (medication review)	MED 4; MED 8
R 15, R 18 (summaries)	R 15, R 18 (summaries)
R19 (new patient summaries)	R19 (new patient summaries)
R 9 (indication for drug)	R 9 (indication for drug)
Audit of cervical smears CS 6	Audit of cervical smears CS 6
SEAs ⁵ E 2, E 7	
Access survey or statement	Access survey or statement
Consultation length statement or survey PE 1	Consultation length statement or survey PE 1
Prescribing actions MED 6, MED 10.	Prescribing actions MED 6, MED 10.
Review of complaints E 6	Review of complaints E 6
Survey report and actions PE 2, PE 3, PE 4	Survey report and actions PE 2

3.6 Current / On-going Developments

As part of the original contract negotiations, it was agreed that the contract would be reviewed for 2006/07. The key focus was to ensure that the contract continues to deliver better services for patients, whilst being fair to the profession and representing good value for public money.

The full list of changes is detailed in

<https://www.nhsemployers.org/restricted/downloads/download.asp?ref=766&hash=959a557f5f6beb411fd954f3f34b21c3>

In summary, the revised QOF now has a maximum possible QOF score of 1000 instead of 1050 and comprises:

- **the clinical domain:** coronary heart disease, heart failure, stroke and transient ischaemic attacks, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, epilepsy, hypothyroidism, cancer, palliative care, mental health, asthma, dementia, depression, chronic kidney disease, atrial fibrillation, obesity, learning disabilities, smoking (totalling 655 points)
- **the organisational domain:** records and information, information for patients, education and training, practice management, medicines management (totalling 181 points)
- **the patient experience domain:** length of consultations, patient surveys (totalling 108 points)
- **the additional services domain:** cervical screening, child health surveillance, maternity services, contraceptive services (totalling 36 points)

⁵ Significant Event Analysis

- **a holistic care payment:** based on achievement across the clinical domain (totalling 20 points)

There will also be new investment (up to £12.6m) in directed enhanced services (DEs) covering

- Cardiovascular disease risk database
- Learning disabilities
- Carers
- Cancer referral.

3.7 Other sources / useful links

<http://www.paymodernisation.scot.nhs.uk/gms/quality/index.htm>

[http://www.show.scot.nhs.uk/sehd/pca/PCA2006\(M\)09.pdf](http://www.show.scot.nhs.uk/sehd/pca/PCA2006(M)09.pdf)

<http://www.paymodernisation.scot.nhs.uk/gms/quality/docs/WinterII-Final.doc>

<http://www.bma.org/ap.nsf/Content/focusqoffeb06?OpenDocument&Highlight=2,QOF>

[http://www.show.scot.nhs.uk/sehd/pca/PCA2006\(M\)08Ann.pdf](http://www.show.scot.nhs.uk/sehd/pca/PCA2006(M)08Ann.pdf)

4. Practitioner Services Division (PSD) - Payments verification (PV) process

4.1 The Practitioner Services Division of NHS National Services Scotland is responsible for the verification and payment for treatment & services provided by NHS primary care dentists, doctors, optometrists and pharmacists.

4.2 Responsibility for payments verification rests with the NHS boards, however, they each have a service level (“partnership”) agreement with PSD.⁶ The PV team then acts as the NHS boards’ agents for the process and undertakes four levels of verification for the GMS contract

- Validation of data quality (principally CHI)
- Checking source documentation e.g. seniority and specific purpose payments
- Practice visits to check e.g. global sum opt outs; Enhanced Services; and QOF
- Activity monitoring e.g. new patient registration and temporary residents.

NHS boards receive quarterly reports from the PV Team and these are likely to be dealt with either at the Audit Committee or at the Board itself depending on local circumstances.

Full details about the mandatory and discretionary areas to be covered during a PV visit are contained in the *Payment Verification Protocol, October 2005* available from

[http://www.show.scot.nhs.uk/sehd/fpma/letters/Payment%20Verification%20Protocol HDL %202005 %2049 %20document.pdf](http://www.show.scot.nhs.uk/sehd/fpma/letters/Payment%20Verification%20Protocol%20HDL%202005%2049%20document.pdf)

⁶ In 2005/06 NHS Orkney and NHS Shetland undertook their own PV process.

The protocol requires PV visits to a random sample of between 3-5% GP practices per annum plus targeted visits if either other PV work suggests it is required or the relevant NHS board deems it necessary. These can take up to a day depending on the issue(s) and the quality of information available. Every PV visit includes a “medical adviser” who is a GP, (usually local). Where PV highlights a significant problem, this is raised with the NHS board and is referred, if appropriate to the Counter Fraud Service.

Examples of the areas covered and the evidence sought are provided in table 4 for general GMS contract monitoring and table 5 for QOF monitoring for PV purposes.

Table 4 PV checks on General GMS contract

Brief description	PV method / evidence – examples
<p>Global sum payments This is a contribution to the contractors’ costs of delivering essential & additional payments</p>	<p>Check the accuracy of data on the CHI by reviewing and reporting on e.g.</p> <ul style="list-style-type: none"> • Number of new registrations • Number of nursing / residential homes residents • Number of people > 100 years
<p>Temporary Patient Adjustment This covers the payment as part of the global sum for treatment of non registered patients – for temporary residents (TRs) or for emergency treatment (ET)</p>	<p>A 3% sample of patient details checked against CHI and reports on e.g.</p> <ul style="list-style-type: none"> • Number of TRs/ ETs seen • TR/ET trend analysis
<p>Global sum opt outs This covers deductions if the practice does not provide certain services i.e.</p> <ul style="list-style-type: none"> • OOH • Maternity • Contraceptive • Minor surgery (MS) • Immunisations / vaccinations (I/V) • Child Health surveillance • Cervical screening • TYOIP & FYOIP⁷ 	<p>No checks for OOH and maternity required.</p> <p>Examine a percentage of patient records at practice visit to establish that service has been received for maternity, MS and I/V</p> <p>For the remainder, review national call / recall systems to ensure that services are being provided.</p>
<p>Payments for a specific purpose i.e.</p> <ul style="list-style-type: none"> • Locums • Prolonged study leave • Golden hellos • Doctors retainer scheme 	<p>Check entitlements and for each group report e.g.</p> <ul style="list-style-type: none"> • Numbers entitled • % where conditions are not met • analysis of reasons for failure
<p>Adults with incapacity i.e. to provide a certificate of incapacity</p>	<p>Check number of fees paid, amount paid and analysis of outliers</p>
<p>17c Agreements i.e. locally negotiated agreements</p>	<p>NHS boards are expected review practice statistics for compliance on a quarterly basis.</p>
<p>Seniority payments These are designed to reward experience based on years of reckonable service</p>	<p>Check eligibility by reviewing length of reckonable service</p>

⁷ Two and Four Year Old Immunisation Programmes

<p>Directed Enhanced Services (DES) i.e. payments for additional services for e.g.</p> <ul style="list-style-type: none"> • Influenza / Pneumococcal infection vaccinations • Minor surgery • Violent patients 	<p>At practice visit, check the patients received the treatment. For example for “flu” - check % of the claims to ensure that the vaccination was given and the patient records to ensure that patients are in an appropriate “at risk” category and report</p> <ul style="list-style-type: none"> • number of claims • number of claims checked to CHI – verified and not verified • number of claims checked at practice visit CHI–verified and not verified etc
<p>National Enhanced Services (NES) i.e. additional services for providing specified services e.g.</p> <ul style="list-style-type: none"> • alcohol services • anti coagulant monitoring • depression • MS 	<p>At practice visits checking samples of patient records and registers and reporting e.g.</p> <ul style="list-style-type: none"> • Number of practices contracted to provide the service and number of patients receiving the service

While there is a clear separation between the PV and QOF processes, the PV team will take assurance from the QOF process in order to minimise duplication. QOF PV visits are on a (5%) sample or targeted basis and cover both clinical and non-clinical indicators.

Table 5 – PV checks on QOF

Description	Method / evidence - examples
Disease register integrity	Check reported prevalence with national and local levels taking account of practice demography
Exception coding	Check for appropriate use of these codes e.g. patient refuses vaccination / tests
Data validation for 15 indicators across 9 disease categories	Check sample with source data e.g. patient records record smoking status; BP; flu jab
Trend analysis	For example, check for BP readings for patients with CHD; stroke & TIAs; hypertension
Repeat prescribing	Check source data for 8 indicators across 5 disease categories, e.g. % of patients with CHD who are reported as taking aspirin or equivalent
Lab tests	Except for automatic downloads from lab systems, check source data for 11 indicators across 5 disease categories, e.g. % patients with CHD; stroke and diabetes whose notes record cholesterol levels over last 15 months.
Referrals	Check 5 indicators over 3 disease categories, e.g. % newly diagnosed angina sufferers referred for exercise testing
Non clinical indicators	Check written evidence but reduce burden if the practice has QPA accreditation.

4.3 In terms of future developments PV, there are a number of changes in the pipeline. For example, a QMAS co-ordinator is being sought to develop reporting, e.g. to be able to identify outliers more easily.

2. General Dental Services

1. Introduction

From 1 April 2006 a new GDS contract has been introduced in England and Wales. In Scotland, following an extensive public consultation, there has been a significant change to the existing arrangements⁸. The way in which dentists are remunerated has been modernised to reward quality by introducing a mix of payments not directly related to the item of service system; for example, increased capitation payments, allowances and re-imburements.

This has involved substantial new investment up front, for example, to improve premises and decontamination equipment as well as developing higher standards for dental practices. However, the Scottish contract also recognises the need to demonstrate improvement in return for this investment. In effect, there are three contractual and performance management mechanisms all of which will have an element of quality assurance and performance monitoring – existing local regulation (known as contract) mechanisms, (section 2); the developing modernised contract mechanisms, (section 3); and payments verification, (section 4).

SEHD published “*An action plan for improving oral health and modernising NHS dental services in Scotland*” in March 2005.⁹ Its aim was to improve oral health and accessibility of services and so to improve prevention and achieve more effective treatment. It acknowledged that patients have the right to expect high quality services delivered by a range of well-trained health professionals in premises suitable for the delivery of that care. The SEHD has therefore committed to

- supporting professionals in delivering the highest standards of oral health care, based on the primary care dental standards developed jointly by NHS Quality Improvement Scotland and the National Care Standards Committee.
- supporting dental infrastructure and premises
- providing payments to support quality through continuing professional development and audit
- ensuring that NHS Boards inspect all dental practices within a 3 year cycle.
- Introducing an "accreditation" scheme for NHS dental practices and providing support payments to practices linked to inspection and accreditation
- supporting the development of specialist skills, so that practitioners with special interests can provide community based services.
- supporting the Dental Clinical Effectiveness Programme to ensure that modernised oral health services and treatments are underpinned by evidence of effectiveness. This will build on existing published clinical standards and guidelines in dentistry and the priority for new guidelines will be

⁸ These arrangements are widely described as the dental “contract”

⁹ <http://www.scotland.gov.uk/Publications/2005/03/20871/54813>

- Dental disease in children.
- Examination and assessment of the adult patient.
- Oral health assessment.
- Emergency dental provision.
- Dental prescribing.
- Dental sedation.
- Decontamination and infection control.
- Clinical governance in dental practice.

The action plan also proposed to put in place a programme for collection and analysis of core minimum data to be a major component of the monitoring and evaluation process. In particular it envisaged that standard information would be available and reported on an annual basis covering:

- Oral health.
- NHS dental services.
- Quality and standards.
- Dental workforce.
- Patient satisfaction.

2. Local Arrangements

NHS boards are responsible for ensuring that all dental practitioners are registered on a Board list. Across Scotland there are between 900-1000 primary care practices. Of these about 300 are working in single-handed practices and they are likely to be under most pressure in terms of quality.

Every NHS board is now expected to have a Dental Practice Adviser and an inspection programme to ensure that high street dentists' premises are visited at least every 3 years¹⁰. The criteria, principles and protocols for these visits were set up to replace previous ad hoc arrangements about 5 years ago. For example, the visit should involve two or people, one of whom must be a dentist. However, it appears that such visits are in some cases not being done regularly across Scotland so it is intended to update and re-launch the inspection criteria and encourage a robust, systematic approach.

According to NES, most NHS boards now also have a facility to support Dental Primary Care Audit. Support comes in a variety of ways: most healthboards have Dental Audit Facilitators, some have funding for projects and some have both.

¹⁰ NB: some areas have had recruitment problems for these posts.

3. Quality / Performance Monitoring under the modernised regulations

3.1 Background

Monitoring systems recommended for use in dental services are still under constant development – the approach has been to invest first to help dentists modernise and then to embed performance monitoring.

3.2 Purpose

As with the other primary care contracts, the aim is to reward quality. SEHD representatives envisage a system based on self assessment with NHS boards reviewing practices on perhaps a 3 yearly basis. The results would then be performance monitored by SEHD through the Annual Review mechanisms.

3.3. Quality / performance Indicators

Current thinking at the SEHD is to base the system on 4 main domains

- Patient satisfaction – at present satisfaction questionnaires tend to be used by vocational trainees purely as an educational tool. The National Dental Advisory Committee (NDAC) is currently developing a revised model for use by all NHS practitioners / practices
- Practice quality (premises) – building on the current practice of visits, this envisages 3 yearly inspections by NHS boards to monitor progress against national standards
- Practice quality (clinical) – building on the existing system whereby Dental Reference Officers review 2-4 patients for every practitioner. The aim would be to get a better sample (e.g. focus on new practitioners and outliers thrown up by the payments verification system) and then to review the records against a “perfect examination” minimum data set.
- Development plan – the NDAC is facilitating the production of a framework for a development plan for use by all practices. It is expected to cover issues related to staff, training, premises, clinical standards and patient satisfaction.

Private dentistry is an important element of service provision in Scotland so discussions need to take place with the “Care Commission” to ensure consistency across the public and private sectors.

Discussion is also underway with NHS QIS to avoid duplication and confusion about the responsibility for developing and monitoring quality standards and guidelines, (e.g. sedation guidelines), for dentistry.

4. Payments verification process

4.1 The Practitioner Services Division of NHS National Services Scotland is responsible for the verification and payment for treatment & services provided by NHS primary care dentists, doctors, optometrists and pharmacists. The Practitioner Services (Dental) team has 5 professionally qualified dental advisers. This team operates under the aegis of the independent Scottish Dental Practice Board which has responsibility for overseeing the payments system and dealing with any disciplinary matters.

4.2 Responsibility for payments verification rests with the NHS boards, however, they each have a service level (“partnership”) agreement with PSD.¹¹ Details about the PV process are contained in the *Payment Verification Protocol, October 2005* available from <http://www.show.scot.nhs.uk/sehd/fpma/letters/Payment%20Verification%20Protocol%20HDL%202005%2049%20document.pdf>

In summary, the PV team acts as the NHS boards’ agents for the process and undertakes four levels of verification for the Dental Services contract

- Level 1: automatic 100% checks for various fees produced by the MIDAS payment system including patient details (e.g. date of birth to confirm exemption status), patient and dentists’ signatures; and duplicate claims.
- Level 2: 1% random sample of contractors based on MIDAS trend analyses covering
 - Items of service
 - Patient registration / List size
 - Level of earnings
 - Cost per claim / throughput
- Level 3: extended sample if level 2 is unsatisfactory, further checks (e.g. detailed assessment of dentist’s prescribing history) and referral of patient for clinical examination by Scottish Dental Reference Service (SDRS)
- Level 4: via SDRS random and targeted patient examinations covering approximately 3% of claims and they will check e.g.
 - patients exist
 - Registration details
 - Signatures
 - Exemption status
 - Standard of treatment

4.3 NHS boards receive quarterly reports from the PV Team and these are likely to be dealt with either at the Audit Committee or at the Board itself depending on local circumstances. Where PV highlights a significant problem, this is raised with the NHS board and is referred, if appropriate to the Counter Fraud Service.

¹¹ In 2005/06 NHS Orkney and NHS Shetland undertook their own PV process.

3. General Optometry Services

1. Introduction

The new GOS “contract” is in fact an extension to the existing arrangements brought about through a partnership agreement¹². This made a high level commitment to systematically introduce free eye checks for all before 2007. A paper exploring the options for delivering the Partnership Commitment was considered by Ministers and it was agreed to extend the scope of the previous NHS sight test to a new NHS eye examination tailor made to the needs of the patient. Provision was made within the Smoking, Health and Social Care (Scotland) Act 2005 to provide for free NHS eye examinations, including sight test where required, for all in Scotland.

The introduction of the new NHS eye examination extends the scope of GOS and, in effect produces a new set of contractual arrangements for optometrists/OMPs from April 2006.

2. Local Arrangements

From 1 April 2006, NHS boards are expected to have in place an Optometric Adviser. The job descriptions for the advisers are to be agreed locally but may include

- Service development - giving advice on
 - range, quality and coverage of GOS services.
 - GOS systems and structures
- Advice on the development of clinical governance within primary eye care services.
- Technical and clinical advice in complaints, disciplinary matters and the payment verification process
- Audit
- Dissemination of information

3. Quality / Performance Monitoring under the modernised regulations

3.1 Background

Optometrists / OMPs are required to provide a range of information, undertakings and declarations in respect of each NHS Board area where they intend to continue to provide general ophthalmic services. They are unable to provide general ophthalmic services, i.e. NHS eye examinations, if they are not included on a NHS Board’s ophthalmic list. Optometrists / OMPs are also required to demonstrate their “competency” to deliver the new NHS eye examination.

¹² A Partnership for a Better Scotland: Partnership Agreement

3.2 Purpose

As with the other primary care arrangements, the aim is to reward quality. For example, changes in the legislation allow optometrists to treat or make direct referrals to hospital, and this should reduce unnecessary referrals.

3.3. Quality / performance Indicators

Quality and performance should be improved through agreement to introduce

- new audit and practice inspection procedures
- standardised patient records to improve record keeping through the use of a minimum data set.
- a practice inspection. It will become a condition of entry to an NHS Board's ophthalmic list for new optical practices that they pass a practice inspection. NHS Boards will also be required to undertake a 3-year rolling programme of practice inspections.
- arrangements to cap the number of tests which an optometrist / OMP can undertake in a day.

SEHD will performance monitor this through the Annual Review mechanisms.

However, the details for all this still need to be worked out.

3.4 Useful sources

The background and changes to the contract are provided in SEHD letters such as

[http://www.show.scot.nhs.uk/sehd/pca/PCA2005\(O\)03.pdf](http://www.show.scot.nhs.uk/sehd/pca/PCA2005(O)03.pdf) and

[http://www.show.scot.nhs.uk/sehd/pca/PCA2006\(O\)04.pdf](http://www.show.scot.nhs.uk/sehd/pca/PCA2006(O)04.pdf)

and

<http://www.show.scot.nhs.uk/sehd/viewpublication.asp?PublicationID=1839>

4. Payments verification process

4.1 The Practitioner Services Division of NHS National Services Scotland is responsible for the verification and payment for treatment & services provided by NHS primary care dentists, doctors, optometrists and pharmacists. The PV monitoring team includes the Scottish Ophthalmic Reference Services (SORS) which is undertaken by a professionally qualified ophthalmic officer.

4.2 Responsibility for payments verification rests with the NHS boards, however, they each have a service level ("partnership") agreement with

PSD.¹³ Details about the PV process are contained in the *Payment Verification Protocol, October 2005* available from http://www.show.scot.nhs.uk/sehd/fpma/letters/Payment%20Verification%20Protocol_HDL_%202005_%2049_%20document.pdf

In summary, the PV team acts as the NHS boards' agents for the process and undertakes four levels of verification for the GOS contract

- Level 1: automatic 100% checks for various fees produced by the OPTIX payment system including patient details (e.g. date of birth to confirm exemption status), patient and practitioner signatures; and duplicate claims.
- Level 2: this concentrates on patterns of prescribing and outliers are reviewed. On a routine basis checks will include
 - Number of sight tests against vouchers issued
 - Domiciliary visits and number of tests per day
 - Cost per case

There are also ad hoc checks undertaken such as the use of early retest codes.

- Level 3: further checks on practices with high or unusual prescribing or where level 4 checks indicate there may be a problem. For example
 - Obtaining the practitioner's observations
 - Requesting record cards
 - Sending letters to specific patients

It also includes the potential for referral of patients for clinical examination by (SORS) who will check e.g.

- patients exist
- what the patient actually got
- Signatures
- Level 4: this is purely random with a 0.05% sample size, involving e.g.
 - Random requests for record cards
 - Random letters to patients, for example, to confirm that glasses were supplied.

4.3 NHS boards receive quarterly reports from the PV Team and these are likely to be dealt with either at the Audit Committee or at the Board itself depending on local circumstances. Where PV highlights a significant problem, this is raised with the NHS board and is referred, if appropriate to the Counter Fraud Service.

¹³ In 2005/06 NHS Orkney and NHS Shetland undertook their own PV process.

4. General Pharmaceutical Services

1. Introduction

The "Right Medicine; A Strategy for Pharmaceutical Care in Scotland" was published in 2002. It was well received by pharmacists as it was the first time that there had been a Scottish strategy for pharmaceutical services. Its aim was to modernise pharmacy by working with patients and health care professionals to ensure better safety and the best use of medicines. In particular, it aims to:

- Improve health – recognising that community pharmacies are at the heart of local (including deprived) communities and often the first point of contact with health services, it proposed improving links between pharmacy and public health.
- Improve access – there are approximately 1170 community pharmacies, well distributed across Scotland so it proposed making better use of them by, for example: improving out of hours services; encouraging visits to housebound people; and developing electronic prescribing and patient information sharing.
- Help patients make better use of medicines – it recognised that 94% of patients visit their community pharmacy more than once a year, so there is an opportunity to inform them about health and medicines issues.
- Service redesign – it recognised that pharmacists could play an important role in improving both the patient journey and health gain, for example, by reviewing and monitoring drug therapies.
- Improve partnership with staff – it recognised that all pharmacy related staff, (e.g. including pharmacy support staff such as pharmacy technicians) need to be fully trained with ongoing CPD, operating within good clinical governance arrangements. It therefore encouraged clinical audit, development of standards and quality improvement.

The SEHD has taken this forward with the profession by reviewing models elsewhere and by piloting proposals in Scotland prior to implementation. The most fundamental commitment was to introduce a new community pharmacy contract. Agreement has been reached to move to the new contract which has four essential services as described below and in section 4. The new contract is being phased in and should be fully implemented by 1/4/07.

The new Scottish community pharmacy contract consists of four essential services provided by all community pharmacy contractors:

- Public Health Service (PHS) - PHS encourages the pro-active involvement of community pharmacists and their staff in supporting self

care, offering suitable interventions to promote healthy lifestyles, and provision of a health promoting environment across the network of community pharmacies by participating in national and local (e.g. stop smoking) campaigns. It was introduced on 01/07/06.

- Minor Ailment Service (MAS) – MAS is the NHS management of common clinical conditions such as hay fever and head lice. It enables eligible people to register with the community pharmacy of their choice and have their common conditions treated by their community pharmacist on the NHS without the need to visit a GP. It is underpinned electronically by eMAS. It was introduced on 1/7/06.
- Acute Medication Service (AMS) – AMS is the provision of pharmaceutical services for acute episodes of care. It provides patients with access to the pharmacy of their choice for the dispensing of acute prescriptions and associated counselling and advice. It will be underpinned by the electronic transfer of prescriptions (eAMS) and is expected to be phased in by 1/4/07.
- Chronic Medication (CMS) – CMS aims to facilitate therapeutic success through the provision of a systematic approach to the pharmaceutical care for patients with long term conditions with systems in place to improve outcomes from therapy, prevent adverse drug reactions, address and prevent potential problems and provide a structured follow up intervention where necessary. It allows patients with long-term conditions to register with a community pharmacy and have their medicines supplied, monitored and reviewed over a prescribed period as part of a shared care arrangement between the patient, their GP and their pharmacist. It will be underpinned by eCMS and is expected to be phased in by 1/4/07

The agreed principles for the new contract are set out in Annex A of a SEHD letter issued on 31/7/03 which can be found at

<http://www.show.scot.nhs.uk/sehd/copy%20of%20publications/dc20030731commpharm.pdf>

The principles not only cover areas such as the efficient, effective and equitable provision of pharmaceutical services but also include that premises are fit for purpose, infrastructure (including IT) is in place and the requirement for a “high trust / low bureaucracy” approach”.

Section 2 outlines the existing legislative and funding framework; section 3 outlines the proposed new legislative framework; section 4 outlines the latest position regarding the implementation of the new contract and the proposed quality aspects under the new contract arrangements; and section 5 covers payments verification.

2. Legislative and funding framework

The intention is that new pharmaceutical care services contracts will operate under a new legislative framework. This is summarised at section 3 below. In the meantime the current provisions of the NHS Health (Scotland) Act 1978 have been used to provide for the implementation of the Minor Ailment Service and Public Health Service elements of the new contract. Also, in this transitional phase, the remuneration base on which the contract payments rest has been amended for the majority of contractors.

2.1 Existing "contract" mechanisms

The legislative and funding framework governing the relationship between NHS Boards and community pharmacies is set out in:

<http://www.scotland.gov.uk/consultations/health/mncp-02.asp>.

In summary:

- The arrangements made by Boards with community pharmacists and appliance suppliers must comply with regulations made under the 1978 Act. Those regulations (the National Health Service (Pharmaceutical Services)(Scotland) Regulations 1995 - "the 1995 Regulations") govern the selection of persons to provide pharmaceutical services and set out the terms and conditions under which those services will be provided.
- There is no formal 'contract' as such between the Board and a person or business providing pharmaceutical services in its area, except those described below under Additional Pharmaceutical Services. The role of the Board in whose area the pharmacy is located is to administer the framework set up by the 1978 Act and regulations. Nevertheless, pharmaceutical service providers are generally referred to as 'pharmacy contractors', including appliance suppliers, and the services are said to be delivered through the 'community pharmacy contract'.
- Community pharmacists and appliance suppliers with whom a Board has arranged for the provision of pharmaceutical services are included in the Board's "pharmaceutical list". An application for inclusion in the pharmaceutical list is, therefore, essentially an application to provide pharmaceutical services in the relevant Board's area.
- Although NHS Boards are responsible for arranging the provision of pharmaceutical services in their area, the community pharmacy contract under which they are delivered comprises both centrally and locally negotiated services. Consultations for the former (national contract items) are conducted between the Scottish Executive Health Department (SEHD) and the body acknowledged to represent the general body of community pharmacists in Scotland, namely the Scottish Pharmaceutical General Council (SPGC).

- The fees and allowances payable to pharmacy contractors for centrally negotiated services, and amounts they are reimbursed for certain dispensed items, are recorded in the Scottish Drug Tariff.
- The pharmaceutical services covered by the contract are:
 - Dispensing Services, i.e. the provision of proper and sufficient drugs and medicines and listed appliances ordered by a duly authorised health practitioner. This is a national contract item.
 - Additional professional services, i.e. services prescribed by Ministers. These are national contract items and detailed at regulation 4 of the 1995 Regulations and in the Scottish Drug Tariff. Currently, these services cover a range of requirements linked to the payment of a professional allowance (but not to appliance suppliers). In summary the pharmacy contractors must:
 - Set aside areas for displaying health education material
 - Provide advice and counselling to the public on medicines and appliances
 - Arrange the keeping of records of medicines supplied to NHS patients
 - Undertake clinical audit within NHSScotland structures
 - Produce a practice leaflet giving customer advice on NHS services offered
 - Additional Pharmaceutical Services – dispensing and advisory services subject to local NHS Board negotiation. These are local contract items covering services that Ministers have directed NHS Boards to negotiate, and which are listed in the Scottish Drug Tariff. These are generally referred to as ‘directed services’ and at present comprise:
 - Advisory Services to Care Homes¹⁴
 - Methadone Dispensing Services
 - Oxygen Supply Services
 - Needle Exchange Schemes
 - Disposal of Pharmaceutical Waste
 - Out of Hours Services
 - Collection and Delivery Services

Remuneration for pharmacy contractors comprises two elements, i.e. fees and allowances (including “transitional” remuneration payments) for service provision, and reimbursement for the cost of NHS drugs/appliances dispensed. The fees and allowances payable for dispensing and other services are paid by the Board on whose list the contractor is included. Payments in respect of locally negotiated services are funded from Boards’ cash limited allocations, generally referred to as ‘unified budgets’. Payments to community pharmacy contractors for nationally negotiated services are funded from a centrally held ‘global sum’ with Boards drawing down the amounts they require on a monthly basis.

¹⁴ Formerly known as Nursing Homes

The 'global sum' is determined annually through consultations between the Scottish Executive Health Department (SEHD) and the Scottish Pharmaceutical General Council. In effect it is a capped sum with any over or under payment in any one year being accounted for in the subsequent year's discussions and by appropriate adjustments to the fees and allowances scales.

The costs of drugs that the pharmacists dispense for the NHS are reimbursed by the Board with responsibility for the prescriber concerned. Whilst Boards are accountable for the payments made to community pharmacists the function of calculating and paying the amounts due is undertaken by NHS National Services Scotland on Boards' behalf.

2.2 Quality Assurance

Other than the encouragement of participation in clinical audit, the existing contract appears to have relied mainly on professional regulation and payments verification for any QA and performance monitoring. The new contract seeks to remedy this situation.

There have been elements of local QA initiatives and performance monitoring particularly for additional services, such as the provision of audit support packs. However, the extent and quality of this varies between NHS boards.

In an attempt to improve this situation, the SEHD is working with the profession to develop a standard specification for each of the new essential and additional services (see Appendix 1 for an example of the MAS service specification) and a quality outcome framework to underpin these standards.

3. New legislative framework

The Right Medicine set out the Department's strategy for modernising the way that community pharmacy services are planned and secured by NHS Boards. In 2004, the Department consulted on the legislative requirements for implementing the proposed service changes indicating that they would require a combination of both primary and secondary legislation and administrative direction.

Based on the outcome of the consultation, the primary legislative framework was put in place mainly by Part 3 of the Smoking, Health and Social Care (Scotland) Act 2005. Once implemented, its provisions will repeal sections 27 and 28 of the National Health Service (Scotland) Act 1978, which provide for the current pharmaceutical service arrangements, and allow for the introduction (at section 17) of new arrangements for the delivery of pharmaceutical care services (PCS).

In summary the provisions will introduce amongst other things:

- a duty on NHS Boards to plan and secure the provision of PCS in their respective areas, and to publish a PCS Plan against which the need for future service provision will be assessed (replacing the current control of entry arrangements to pharmaceutical lists);
- formal contract arrangements under which nationally specified 'essential' PCS will be provided;
- improved clinical governance arrangements with a new PCS performers' list with entry criteria that requires pharmacists providing PCS to produce evidence of fitness to practice.

The regulation requirements fall into two main areas, i.e. new contract and PCS planning provisions, and transitional provisions. The latter are required to bridge the substantial change process from the current service and control of entry arrangements to the new service planning and contract setting arrangements. The structure for the new PCS arrangements is such that the regulations must be laid as a complete package and work is ongoing on the transitional regulations.

Interim Arrangements

In order to implement MAS and PHS from 1 July 2006 the Department is using the existing legislative framework until the full set of new regulations are introduced. In summary, the two services will be classed as 'additional pharmaceutical services' in terms of section 27A of the 1978 Act but will for the time being operate to a national specification and remuneration rates that will be detailed in Directions (See Appendix 1).

There is also an interim transitional payment model being used.

4. Quality Assurance / Performance Monitoring under the new contract

4.1 Background

Interim arrangements have been put in place under the existing legislation to allow for some monitoring of the new services, MAS and PHS, including information on consultation rates and prescribing practice. In addition a piece of work is about to be undertaken with NES Pharmacy to develop a simulated patient model to look at the quality of MAS consultations and provide feedback on the quality of care provided. In addition guidance is being drafted for Boards on local monitoring arrangements. Work has also been carried out with the NHS Property Environment Forum to develop a set of standards for community pharmacy premises and the ePharmacy Programme is accrediting pharmacy IT systems.

4.2 Purpose

One of the aims of the new community pharmacy contract is to reward quality by developing a system along the lines of the GP Quality and Outcomes Framework (QOF). It will likely consist of a practice portfolio approach which

documents all aspects of the pharmaceutical care services provided, independent peer review and simulated patient exercises.

4.3. Quality / performance Indicators

The indicators are under development and have not yet been shared with the negotiating body so the information in paragraphs 4.3 – 4.5 should be treated as confidential at this stage.

Examples of the thinking as at July 2006 are:

- Clinical practice
- Prescribing practice
- Interventions and outcomes
- Patient experience feedback
- Record keeping
- Premises
- CPD
- Team working

4.4 Data

The data will be patient based using CHI as the unique patient indicator and will be sufficient to generate an appropriate payment. A prerequisite to all this is underpinning IT to support the administration and monitoring.

4.5 Review Process

Current thinking is that there will be input at four levels for quality assurance and performance monitoring

- SEHD to ensure national standards are set and to monitor achievement e.g. through the Annual Review process and national negotiations
- NHS NES to oversee peer review of evidence submitted by pharmacists, e.g. case studies and simulated patients
- Independent peer review of practice portfolio approach with local NHS Boards, in partnership with NES Pharmacy along with ongoing support mechanisms
- ePharmacy infrastructure for any additional associated monitoring.

The timing for these has not yet been agreed.

4.6 Current / On-going Developments

NHS boards are now required to have Directors of Pharmacy and a national group has been set up. This group is expected to have an interest in quality assurance and monitoring in future.

NHS boards have also nominated pharmacy champions (63 to date) who are committed to advising their peers about the contract and any issues relating to it, including the quality outcomes aspects.

4.7 Other sources / useful links

New community pharmacy contract web site

<http://www.communitypharmacy.scot.nhs.uk/>

e-pharmacy updates

http://www.show.scot.nhs.uk/sehd/mels/HDL2004_14.pdf

http://www.show.scot.nhs.uk/sehd/mels/HDL2005_34.pdf

Infrastructure (including IT support)

[http://www.show.scot.nhs.uk/sehd/pca/pca2005\(p\)01.pdf](http://www.show.scot.nhs.uk/sehd/pca/pca2005(p)01.pdf)

Updates on the contract

http://www.show.scot.nhs.uk/sehd/mels/HDL2004_36.pdf

[http://www.show.scot.nhs.uk/sehd/pca/pca2005\(p\)20.pdf](http://www.show.scot.nhs.uk/sehd/pca/pca2005(p)20.pdf)

[http://www.show.scot.nhs.uk/sehd/pca/pca2006\(p\)02.pdf](http://www.show.scot.nhs.uk/sehd/pca/pca2006(p)02.pdf)

[http://www.show.scot.nhs.uk/sehd/pca/pca2006\(p\)10.pdf](http://www.show.scot.nhs.uk/sehd/pca/pca2006(p)10.pdf)

5. Payments verification process

5.1 The Practitioner Services Division of NHS National Services Scotland is responsible for the verification and payment for treatment & services provided by NHS primary care dentists, doctors, optometrists and pharmacists.

5.2 Responsibility for payments verification rests with the NHS boards, however, they each have a service level (“partnership”) agreement with PSD.¹⁵ Details about the PV process are contained in the *Payment Verification Protocol, October 2005* available from

http://www.show.scot.nhs.uk/sehd/fpma/letters/Payment%20Verification%20Protocol_HDL_%202005_%2049_%20document.pdf

¹⁵ In 2005/06 NHS Orkney and NHS Shetland undertook their own PV process.

In summary, the PV team acts as the NHS boards' agents for the process and undertakes four levels of verification for the Pharmaceutical Services contract

- Level 1: automatic 100% checks for various fees produced by the payment system covering, e.g. foreign prescriptions and high GIC (gross ingredient costs), as well as manual checks for professional advice claims
- Level 2: 1% random sample of claims for the top 10 outliers identified by the Pharmacy Care Information Group, (PCIG), monthly monitoring system
- Level 3: extended sample if level 2 is unsatisfactory and clinical inspection of patient medication records
- Level 4: 1% of all pharmacies inspected annually to check e.g. claims against patient medication records

Levels 3 and 4 involve the clinical inspection of patient records.

5.3 The PCIG monthly monitoring report is provided to Prescribing Advisers / Directors of Pharmacy at NHS Boards and the PV team to follow up any outliers. The full set of performance indicators is set out in Appendix 2 and includes, for example

- % of prescriptions for which patient charges are collected
- average gross value of prescriptions
- urgent fees paid.

NB: These measure activity levels rather than the quality of clinical pharmaceutical services provided.

5.4 NHS boards receive quarterly reports from the PV Team and these are likely to be dealt with either at the Audit Committee or at the Board itself depending on local circumstances. Where PV highlights a significant problem, this is raised with the NHS board and is referred, if appropriate to the Counter Fraud Service.

5.5 The new contract is likely to require changes to the PV process but these have not yet finalised.

MINOR AILMENT SERVICE (MAS) OUTLINE SPECIFICATION

1. Background

1.1 *The Right Medicine* makes a commitment to introduce schemes between general practitioners and community pharmacists to allow patients to use their pharmacy as the first port of call for the treatment of common illnesses on the NHS.

1.2 This concept has been piloted and evaluated.

2. Aim and Objectives

2.1 The Minor Ailment Service (MAS) aims to support the provision of direct pharmaceutical care on the NHS by community pharmacists to members of the public presenting with a common illness.

2.2 The objectives for this service are to:

- improve access to consultations, advice and medicines for common illnesses;
- promote care through the community pharmacy setting;
- transfer care from GPs and nurses to pharmacists where it is appropriate;
- help address health inequalities;
- assist the primary care team to achieve their 48 hour access commitment.

3. Service Description

3.1 MAS allows individuals, who are exempt from prescription charges, to register with and use their community pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises, treats or refers the patient according to their needs.

4. Service Outline

4.1 MAS Registration and Withdrawal

4.11 Individuals who are exempt from prescription charges can register with a community pharmacy to receive the MAS.

4.12 Selection is based on the individual's exemption status.

The following persons are currently **not eligible** to register for the scheme:

- Patients not exempt from prescription charges
- Patients in possession of a pre-payment certificate
- Patients not registered with a Scottish GP
- Patients in Care Homes (Nursing and Residential Homes)
- Temporary residents

- 4.13 Individuals can only register with one pharmacy.
- 4.14 Unless an individual is transferring pharmacies or has previously withdrawn from the service, registration only needs to occur once.
- 4.15 The pharmacist registers a person via the Central Patient Registration System (CPRS) hosted at National Services Scotland using the Community Health Index (CHI) number. This, in turn, generates an electronic registration form which the patient signs declaring their reason for exemption. There is a paper registration form available for manual use in exceptional circumstances.
- 4.16 Registration is either done in advance of requiring to use the service or at the time when the service is required.
- 4.17 A check is made on each presentation that the person is still eligible for the MAS.
- 4.18 Individuals can choose to withdraw from the MAS at any point. In addition, pharmacists can withdraw an individual; this might be due to, for example, a change in their exemption status or other exceptional circumstances. CPRS withdraws patients automatically if they die or move into a care home. Registering at a pharmacy automatically withdraws the individual from a pharmacy they may have been previously registered with.
- 4.19 National and local publicity initiatives and information leaflets prepared by the Scottish Executive are used to raise public awareness of the service.
- 4.2 *Care Provision*
- 4.21 Care provided through the MAS covers the presentation, assessment and treatment of symptoms. The pharmacist assesses the patient and considers the most appropriate course/s of action, the counselling and advice needs and any requirements for follow up or referral.
- 4.22 Individuals present with a symptom or set of symptoms themselves or, occasionally, someone may present on their behalf (for example a parent for a child or a carer).
- 4.23 The pharmacist assesses the symptoms in order to collect and consider information which helps them to determine the cause and severity of the presenting condition and reflect on the most appropriate

course of action. This includes the differentiation between common illness and major disease. This helps the pharmacist to decide on the most appropriate form of action. This can be advice only, treatment or referral.

- 4.24 In some instances the only course of action required is to provide advice to a patient. This may also include aspects of healthy lifestyle advice.
- 4.25 When the pharmacist decides that the most appropriate action is to treat the presenting condition/s then they will then decide on the course of treatment they wish to recommend for the patient. They should prescribe both in line with national and local NHS prescribing policy and wherever possible on a generic basis.
- 4.26 The pharmacist will also establish the counselling and advice needs of the individual. This includes explaining to the person what to expect from their condition, what treatment is being prescribed for them, how to use that treatment, any follow up and how to avoid future episodes. This process is underpinned by the CRAG *Counselling and Advice Guidelines*.
- 4.27 The requirement to refer an individual is, in most instances, obvious when assessing the condition. Pharmacists and GPs should agree locally the circumstances when and procedure by which an individual, requiring to be seen quickly, can be referred and this should be supported using either a verbal or written referral request. People themselves may also self refer to their GP.
- 4.28 The MAS consultation enables the pharmacist to identify and agree a shared outcome or a set of outcomes with the patient. This happens as a result of the systematic approach applied to the MAS.
- 4.29 The pharmacist also considers the requirement or need for any further follow up. Follow up involves looking for signs that the condition is improving and that there is no deterioration. This is carried out by the individual with any necessary information or support provided by the pharmacist.

4.3 *Formulary*

- 4.31 There is one national formulary and it is the reference point for payment purposes for products provided under the MAS.
- 4.32 The formulary available to the pharmacist includes all Pharmacy (P) and General Sales List (GSL) medicines that are not blacklisted, dressings and appliances from Part 2 of the Drug Tariff, selected items from Part 3 of the Tariff, such as bug busting kits, and any Prescription Only Medicines (POMs) agreed suitable and which are underpinned by a series of core patient Group Direction (PGDs).

- 4.33 Pharmacists should prescribe in line with national and local NHS prescribing policy and guidance, such as local joint formularies. This includes, wherever possible, prescribing on a generic basis.

5. Administration

- 5.1 The pharmacist completes a CP2 form electronically (or under exceptional circumstances by hand using an A4 paper form) for the purpose of registering people.
- 5.2 The pharmacist also completes a CP2 form electronically (or under exceptional circumstances by hand) for each patient contact, recording whether they received a consultation, advice, a treatment or were referred to another health care professional.
- 5.3 Where appropriate, this information is annotated into the patient's medication record on the pharmacy patient medication record system.
- 5.4 In the case of adverse reactions the pharmacist will consider whether there is a need to report any adverse drug reactions to the Committee on Safety of Medicines Scotland (CSM) through the Yellow Card reporting mechanism.

6. Remuneration

- 6.1 The pharmacy contractor is remunerated for providing the MAS using a banded capitation fee.
- 6.2 The pharmacy contractor is reimbursed for any product from the national formulary supplied.
- 6.3 Drug reimbursement costs are funded through a specific MAS budget provision via the unified budget allocation at NHS Board level.

7. Supporting Good Practice

- 7.1 The MAS will be underpinned by a quality outcomes framework.
- 7.2 The MAS is subject to the same prescribing support as other clinical services.

This should be read in conjunction with the accompanying practice guidelines.

Background

The new community pharmacy contract is to be underpinned by a quality outcome framework that will ensure high standards of NHS pharmaceutical care are achieved by community pharmacy practitioners.

This will be done through a number of ways.

- SEHD will set national standards
- NES Pharmacy will set and co-ordinate case studies, simulated patients etc
- Pharmacy practitioners will develop practice portfolios
- Peer review and support by NHS Boards and NES Pharmacy
- ePharmacy infrastructure will provide additional monitoring.

Examples of areas to be covered by above include:

- Clinical practice
- Prescribing practice
- Interventions and outcomes
- Patient experience feedback
- Record keeping
- Premises
- CPD
- Team working

Pharmacy – performance indicator reports

The Primary Care Information Group (PCIG) produces monthly monitoring Performance

Indicator Reports in respect of:

- Percentage of prescriptions for which patient charges collected -
- (mean + highest & lowest %age collected – top ten);
- Average gross value of prescriptions -
- (mean + highest & lowest value reimbursed – top ten);
- Urgent fees paid -
- (mean + highest & lowest value claimed – top ten);
- No. of installment dispensing fees/100 scripts –
- (mean + highest & lowest no. claimed – top ten);
- %age of scripts with a GIC less than xxx –
- (mean + highest & lowest %age collected – top ten);
- no. of controlled drug fees/100 scripts –
- (mean + highest & lowest no. claimed – top ten);
- out of pocket expenses –
- (mean + highest & lowest value claimed – top ten);
- % age change in total no. of scripts since last month;
- %age change in the average gross value of scripts since last month;
- oxygen mileage claims by pharmacy contractors – top ten;
- total mileage claimed for oxygen delivery by pharmacy contractors – top ten.

PCIG also produce a specific set of performance indicators for dispensing doctors covering

- average value of drugs (excluding part 7 items) – Top 10
- average value of part 7 items – Top 10
- %age generic dispensing – Top & Bottom 10
- part 7 GIC as a %age of total GIC – Bottom 10
- average value of appliances – Top 10
- GIC by pay type - Scotland

D. Clinical effectiveness work (non contract based)

- NHS Ayrshire & Arran
- NHS Borders
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Highland
- NHS Shetland
- NHS 24

Examples of clinical effectiveness activity likely to impact on quality assurance and monitoring in primary and community care from a selection of NHS boards are outlined below.

NHS Ayrshire & Arran

2005/05 activity included

- Clinical Governance Action plans have been developed and agreed actions are regularly reviewed at the Ayrshire and Arran NHS Clinical Governance Committee.
- The final draft of single system Adverse Incident Guidelines is currently out for consultation
- The final draft of the single system Informed Consent Policy is currently out for consultation
- A Clinical Effectiveness Action plan has been developed and actions monitored and updated regularly.
- A single system Clinical Effectiveness Register has been developed to record Clinical Effectiveness Activity within NHS Ayrshire and Arran.
- A work plan has been developed to promote a co-ordinated approach to prioritisation, support and ongoing review to NHS Quality Improvement Standards.
- A single system flowchart has been produced to support the distribution and review of Scottish Intercollegiate Guidelines (SIGN)

During **2006/07**, activities will include a review the organisations present Clinical Governance activity against the NHS QIS Clinical Governance and Risk Standards.

NHS Borders

The programme for **2006/07** covers:

Clinical Audit Title	Standard/s
Cancer <ul style="list-style-type: none"> • Breast cancer • Colorectal cancer • Lung cancer • Ovarian cancer • Other gynaecological cancers • Upper gastro-intestinal cancer: <ul style="list-style-type: none"> ○ Oesophagogastric ○ Hepatopancreatobiliary • Head and Neck cancer 	From 2005, the maximum wait from urgent referral to treatment for all cancers is 62 days SIGN 84 Breast SIGN 67 – Colorectal Cancer SIGN 75 – Ovarian Cancer SIGN 80 – Lung Cancer

<ul style="list-style-type: none"> • Urology • Haematology 	
Surgical Site Infection Surveillance	SIGN 45 – Antibiotic Prophylaxis in Surgery CSBS (December 2001) – Health care associated infection control
Managed clinical networks	
Diabetic Audit - Scottish Diabetes Survey	NHS QIS (2004) – Diabetic retinopathy screening CSBS (2002) – Diabetes SIGN 55 – Management of diabetes
National Stroke Audit	NHS QIS (2004) – Stroke services SIGN 64 – Management of patients with stroke SIGN 78 – Dysphagia with stroke
Acute Coronary Syndrome Audit	
Hearts in the Borders Cardiac Rehabilitation Audit	SIGN 41 – Secondary prevention of CHD
Scottish Hip Fracture Audit	Hip Fracture is a ‘tracer condition’ and used to provide evidence for the standards below. CSBS (2002) – Older People in Acute Care NHS QIS (2004) – Draft standards for services used by older people SIGN 56 – Hip Fracture
Mental health	
Discharge Audits <ul style="list-style-type: none"> • Client and Carer Satisfaction • Briggs and Huntlyburn • Discharge from Teams 	NHS QIS (2001) - Schizophrenia
Psychiatric Emergency Crisis Service	
Mental Health Act Audit	
Post-natal depression	
Policies and Procedures, Clinical Risk, Complaints	
Case Note/Documentation Audit	Completion of Health Records Policy (2005)
Prescription Audit	NHS Borders Code of Practice for the control of Medicines

Pressure Care Audit	Nursing and Midwifery Practice Development guidelines
NQIS Standards/Best Practice Statements	
Scoping of Audit implications	Pregnancy and Newborn Screening (Draft Standards)
Scoping of Audit implications	Healthcare Services Used by Older People (Draft Standards)
Scoping of Audit implications	Working with older people to achieve good oral health (Best Practice Statement)

NHS Fife

- The strategy for clinical effectiveness was approved in March 2006 and is based on the criteria within the NHS QIS *Clinical Governance and Risk Management Standards*. The strategy will be delivered by
 - ensuring that prioritised, approved, co-ordinated and supported programmes of clinical effectiveness and quality improvement activity are in place within the component parts of NHS Fife that reflect the local delivery plan and the scope of services provided by NHS Fife.
 - having in place systems to provide assurance of continuous improvement in the health of the population and patient care and outcomes.
 - ensuring that clinical effectiveness and quality improvement activity is patient and carer focussed
 - ensuring that a system is in place to review, prioritise, implement and monitor national guidance and standards
- Fife is considering developing an area wide clinical effectiveness register to
 - enable clinical effectiveness facilitators to record their audit/clinical effectiveness activity
 - enable other clinical effectiveness facilitators to see an overview of projects, so that if similar work is planned, it will prevent unnecessary duplication
 - enable lessons learned from projects to be shared across NHS Fife
 - inform local and annual reports
- Waiting times data and data to monitor the quality of clinical care are available for patients diagnosed with cancer but the increasing requirement to report on waiting times has meant a reduction in time available to prepare reports on the quality of clinical care provided to patients with cancer.

- Example audits include
 - Documentation
 - Nursing Record and Documentation Project
 - Glenrothes & North East Fife CHP is undertaking a more in depth peer review audit of the patient documentation for all professional groups within the two North East Fife Localities.
 - The Mental Health Service has compiled a local Action Plan following the recommendations from the Fife-wide Audit. Local areas are currently undertaking a full baseline audit of their documentation
 - Pharmacy Led Warfarin Clinics – Dunfermline. To establish the level of compliance to the standard operating procedures that underpin the service.
 - Prostate Cancer Service - to gain the views of patients, general practitioners, District Nursing services and the staff delivering the service.
 - Boozebuster Project - to raise awareness of issues relating to underage drinking.
 - Health Visiting Service – to help health visitors adapt their service to be even more responsive to the needs of their clients
 - Diabetes – to encourage patients to manage their condition and prevent many of the complications associated with the disease.
 - Smoking Cessation - to establish the clinical and cost effectiveness of this service
 - Decontamination of Podiatry Instruments - to assess an alternative method of using sterilized instruments on the patient population by assessing the use of disposable instruments in the community and domiciliary podiatric settings
 - Men’s Health - to evaluate an event to encourage men to be more aware of their health and general lifestyle issues and now plan further initiatives.
 - Multidisciplinary Clinical Risk Assessment and Management Plan – to support the development of a more comprehensive risk assessment tool for staff involved in restraint procedures
 - Quality Impact Analysis – to improve services in Learning Disabilities
 - Discharge Evaluation - Ward 6 - to improve future discharges
 - New Mental Health Act – to support staff who need to implement the requirements of the Act.
 - Audit of Clinicians Time: Mental Health Act (Part 1)
 - Immediate Discharge Documentation Audit in Mental Health
 - Clinical Supervision to identify to what extent it is available, utilised and to highlight any obstacles to its implementation throughout the Mental health service
 - Care Programme Approach (CPA) Audit
 - Postnatal Depression Audit

- Townhill Day Hospital Carer Support - to identify levels of support throughout the three stages from diagnosis, admission to the day hospital and in preparation for the move onto other care services.
- UK Genetic Study of Mental Health - to understand why some people experience problems with their mental health.
- Breastfeeding Audit - to collect data for a breastfeeding audit on patterns of infant feeding.
- Scottish Primary Care Collaborative (SPCC) - to achieve improved access to GP and practice nurse services and secondly to improve the management of people with diabetes / COPD / hypertension
- Sleep Clinic Satisfaction Survey 2nd cycle
- Minor Injuries Audit - to look at the patients' waiting time from arrival at the department to discharge prior to and following the implementation of Emergency Nurse Practitioners.
- Coronary Heart Disease Patient Satisfaction - to evaluate the effectiveness of the CHD Clinics from the patients' perspective
- Coronary Heart Disease Audit Cycle
- Post-menopausal Bleed Audit - To ensure the recommendations in SIGN Guideline 61, 'Investigation of Post-menopausal Bleeding', were being adhered to at Forth Park Hospital, Kirkcaldy
- Dermatology Rapid Access Clinic - to determine the effectiveness of the patient's journey from initial referral, to monitor the overall clinic capacity with the introduction of a "Rapid Access Clinic" and to gauge the satisfaction of the patients attending the clinic.

NHS Forth Valley

Significant efforts have been made to develop a NHS Forth Valley Strategy for Clinical Effectiveness and detailed action and work plans. This will be implemented in 2006 and takes cognisance of the increasing emphasis placed in recent years on working seamlessly across the organization, e.g. in areas such as respiratory diseases, diabetes and epilepsy.

During 2005/06, the responsibility for determining and managing the priorities for Clinical Effectiveness (CE) rested with the Joint CHP CE Group. The clinical priorities identified this year were: Diabetes, Coronary Heart Disease, Epilepsy, Respiratory Disease, Osteoporosis, Mental Health and Cancer. Each topic has a designated clinical lead who is supported by the primary care Clinical Effectiveness Support Services (CESS). Other key topics identified as clinical priorities within the other services of the organisation included: mental health, specifically: Post Natal Depression and Schizophrenia; Learning Disabilities, Outcome Measurement within the Child and Adolescent Mental Health Service and Adult Mental Health services. Although recognised as key topics, this list is not exclusive in terms of clinical effectiveness activity as this is on-going in all areas of service provision

throughout the organisation. Action plans are monitored and progress reported at quarterly meetings of the CE sub group.

NHS Grampian

Over the last year NHS Grampian has run training courses for primary care staff such as

- A 2.5 hour session run jointly with NHS Education for Scotland aimed mainly at GPs but also open to other staff who have some experience of audit
- A two half-day course which gives participants the skills to complete an audit. An audit is carried out by each participant during the course with support from the audit facilitators.

Both of these courses have run for a number of years in NHS Grampian.

A number of projects have been carried out/or are ongoing in the last year:

- Patient Group Direction Use staff audit
- Audit of hand hygiene training in Deeside Care Homes
- Audit of condition of walking aids in Deeside Care Homes
- Audit of use of nutritional screening tools in Deeside Care Homes
- Audit of sleep clinic
- Community Mental Health Team patient satisfaction audit
- Audit of referrals to Mental Health Team
- Audit of Cardiovascular Unit discharge letter recommendations
- Audit of Community Nursing records
- Patient satisfaction with pharmacist run hypertension clinic
- Audit of serial dispensing pilot project
- Audit of Under 18s admissions to Accident and Emergency Units in Aberdeenshire for substance misuse
- Central Aberdeenshire LHCP Physiotherapy patient satisfaction questionnaire
- Audit of methadone prescribing in Grampian
- Database support to Deeside Neurological Support Services, Macmillan Workload database, Midwifery database, Minor surgery database
- Post project evaluation GP premises questionnaire
- Audit of anticoagulant therapy management guidelines
- Opinionmeters also used for a variety of patient satisfaction audits/surveys

NHS Highland

Clinical effectiveness activity – 1 April 2005 – 31 March 2006
primary care / community activity

Projects initiated within financial year.

	Title	CHP/SSU
503	Review of policies and procedures in Highland	Highland-wide
541	Evaluation of neonatal community liaison service in Highland	Highland-wide
539	Development of system for logging complaints in Highland	Highland-wide
537	Review of action learning set in Highland	Highland-wide
535	Review of continence products across Highland - patient and staff	Highland-wide
593	Audit of Implanon Removal across Highland	Highland-wide
518	Highland-wide roll-out of midwifery record keeping audit	Highland-wide
510	Food Fluid and Nutrition Highland-wide report	Highland-wide
544	Evaluation of CROCUS Child Bereavement Support Service	Highland-wide
507	Falls Prevention training needs analysis in Highland	Highland-wide
519	Nursing record keeping and care planning audit in Highland	Highland-wide
499	Evaluation of implementation of the Stroke Communication Protocol in Highland	Highland-wide
498	Podiatry record keeping in Highland	Highland-wide
492	Staff feedback on NHS Highland complaints system	Highland-wide
491	Evaluation of new pilot community nursing prescribing documentation	Highland-wide
490	Evaluation of Speech and Language Therapy pilot project	Highland-wide
488	Audit of podiatry diary returns	Highland-wide
433	Re-audit of communication for handover between Health Visitors and School Nurses in Highland	Highland-wide
432	Re-audit of communication for handover between Health Visitors and Community Midwives in Highland	Highland-wide

508	Evaluation of Occupational Health Cognitive Behaviour Therapy Programme	Highland-wide
603	Re-audit of Learning Disabilities record keeping in Community (2004/05-062)	Highland-wide
516	Falls prevention service mapping exercise in Highland	Highland-wide
599	Huntingtons Disease Family Study across Highland	Highland-wide
601	Development of Stroke Services Quality Assurance Framework	Highland-wide
571	Violence and aggression questionnaire to staff working with children	Highland-wide
598	Baby feeding audit to support the UNICEF baby friendly award across Highland	Highland-wide
570	Review of out of hours services for dental emergencies	Highland-wide
569	Review of AHP caseload and waiting times	Highland-wide
568	Minor injuries and illness services in Highland: stocktake	Highland-wide
592	Highland Joint Formulary Audit across Highland	Highland-wide
602	National Audit of SIGN 52, ADHD in Children & Young People	Highland-wide
545	Baseline review of County Hospital Invergordon Day Hospital attendances	Mid CHP
605	Re-audit of the Views of Patients on West Ness Community Nursing Service (2004/05/093)	Mid CHP
496	Midwifery workforce planning in East Highland area	Mid CHP
600	Crossroads survey of care provision in Inverness (part of 2006/07-022a R & C)	Mid CHP
329	Re-audit of nurse-led minor injuries at Ross Memorial Hospital A&E, Dingwall	Mid CHP
502	Evaluation of Alcohol Liaison Nurse post in Skye	Mid CHP
523	Patient feedback at midwifery unit, Belford	Mid CHP
505	Catheter care and pressure ulcer treatment in Skye (CARERS IN RESIDENTIAL HOMES)	Mid CHP
506	Pressure ulcers care by Community Nurses in Skye	Mid CHP
511	Re-audit of physiotherapy record keeping in East Highland	Mid CHP
504	Catheter care and pressure ulcer treatment in Skye (HOME CARERS)	Mid CHP
561	Caseload profiling for CPNs in Sutherland	North CHP

562	Evaluation of Older Adults Mental Health Support Worker post in East Sutherland + patient feedback	North CHP
563	Evaluation of Occupational Therapy Outreach Service in Sutherland	North CHP
500	Evaluation of the drop-in centre in Lochinver	North CHP
604	Audit of Once Daily Insulin in Patients with Type 2 Diabetes within North Highland CHP	North CHP
497	Review of East Sutherland "place of safety at home"	North CHP
573	Patient Feedback on Appointment System in Scourie & Kinlochbervie GP Practice	North CHP
579	Palliative Care in Caithness	North CHP
580	Myocardial Infarction Audit (WAMI), Wick	North CHP
572	Caseload profiling for unscheduled care nurses in Inverness	SE CHP
549	Evaluation of homeless centre in Academy Street, Inverness	SE CHP
524	Evaluation of neuro linguistic programming (NLP) Stroke Communication Group in Inverness	SE CHP
540	Patient feedback of community mental health in Inverness	SE CHP
548	Patient feedback for the intermediate care team in Inverness	SE CHP
379	Nutrition baseline audit in adult acute, New Craigs, Inverness (April 2005)	SE CHP
546	Review of hip fracture patients discharged to community hospitals in SE Highland	SE CHP
487	Physiotherapist patient feedback survey in Grantown on Spey	SE CHP

NHS Shetland

1. Ongoing audits & surveys (primary care)

Project Title	Aim
A review of discharge information to Primary Care.	Standards include general recording keeping quality, timeliness of receiving the discharge information for the hospital and completeness of detail for diagnosis, instructions to the GP and medications prescribed
Audit of Call to Needle times in relation to Thrombolysis (the administration of clot-	To look at the time taken for patients to be administered clot-busting drugs from the initial call for professional help (call to needle).

busting drugs (thrombolytic agents))	To look at the time taken for patients to be administered clot-busting drugs from when the patient arrives at hospital (door to needle). This piece of work is being carried out in line with national guidelines
Primary Care Counselling Using CORE-PC	The Shetland-wide counselling service was established in October 2004 – the system will provide a very comprehensive data set that enables tracking of the problems, patient characteristics, effectiveness etc
Quality and Outcome Framework	The new quality framework as part of the new GMS contract provides a framework for measuring and rewarding practices for delivering quality care against a set of nationally agreed quality standards and indicators
Scottish Primary Care Collaborative (SPCC): CHD Programme	Monthly measures will be collected and measured against nationally defined CHD indicators. Levenwick and Walls Practices are involved
Scottish Primary Care Collaborative: Diabetes Programme	Three practices are taking part, Lerwick, Bixter and Unst. The programme focuses on a review of diabetes management against a number of indicator and access to appointments

2 .Ongoing audits & surveys (primary & secondary care)

Project Title	Aim
Antenatal Visit Audit	To look at how Shetland practice compares and if we are not following the guidance why not
Baseline audit on Coshh	To ensure all areas within NHS Shetland are adhering to COSHH, keeping accurate records and carrying out risk assessments
Cancer Audit – National Data Quality Assurance Programme	NHS Shetland have been involved in this through the Information Department and will continue to do so for the foreseeable future
Delivery Notes	To look at achieving a 100% return rate on all delivery notes from all clinic areas
National Confidential Enquiry into Suicides and Homicides in Mental Health Service Patients	This is a national audit run by the University of Manchester
Quality in Dental Radiography/Radiology	To assess the quality and consistency of radiographical 'house-keeping' tasks along with a standard quality assurance program to ensure radiological exposures are minimised. Approved by NHS Education for Scotland
Staff Rehabilitation Service	To review the new trial staff service on offer, to get staff views and see if it has an impact on time taken off work

3. Planned audits & surveys (primary care)

Project Title	Aim or Background
Audit of Management of MRSA in Community	To improve management of MRSA in the community
Leg Assessment Clinic – Lerwick	To look at 5 years worth of referrals to question the idea of an ever increasing referral rate and to see if they have been able to reach the target for the frequency of repeat doppler ultrasound assessments
Peak Flow Meters – Brae Health Centre	Brae are going to contact all patients with asthma of a certain grade who recommendations suggest should have a peak flow meter at home to see if they have one and if not why
Promoting Positive Emotional Health	To look at what can be done to help children, young people, parents and staff. A small group is forming at Brae School called HIBS (Harmony in Brae School) to look at what can be done to help children, young people, parents and staff feel more happy and confident. The group has representatives from health, education and community development
Records	The District Nurses are planning an audit of the quality of their record keeping using a questionnaire based on the latest version of the NMC guidelines for Record Keeping
Repeat Prescribing in Asthma Management – Brae	Brae are looking at the repeat prescribing of salbutamol compared with the time it would last if used as prescribed. This will identify people having difficulty with their asthma and lead to a follow up consultation with the Practice Nurse

4. Planned audits & surveys (primary & secondary care)

Project Title	Aim or Background
Audit of use of Shetland NHS Board Infection Control Manual	To improve infection control within NHS Shetland
Audit of the accuracy of Pro-forma X ray reports of adult skeletal X ray referred from A & E	
Cardiac Rehabilitation	To look at the service offered to patients against recommendations
Children's Outpatient Department –users views and experiences of the Child Development Initiative	The team want to find out how the families and children feel about the CDI and if it's meeting their expectations and needs
Completed Job Requisitions	To look at what percentage of requisitions are completed correctly, particularly in relation to the decontamination of equipment before it is sent to the Medical Physics Department

Framework of maternity services in Scotland	
Needs assessment for mentors of pre-registration students	To provide support for mentors in the areas, and by a delivery method, which they have identified

5. Annual audits & surveys

Project Title	Aim
Adequacy of Cervical Smears – Scalloway	To aim for 94% adequate smears (as per cytology guidelines)
Adult Renal Services	The Renal Team has a rolling programme of audit against the QIS standards for this service
Asthma - Bixter	
Blood Pressure Audit	To monitor every patient between the ages of 20 and 74 who have not had their blood pressure checked in the last five years as part of the practice'
Diabetic Audit - Scalloway	To reach 100% in all parameters
Diabetes – Management in Primary Care – Bixter	Diabetes Management is reviewed against the clinical accord guidelines
Hypertension – Bixter	All hypertensive patients registered at Bixter have their notes reviewed annually as part of a rolling audit programme
Lithium Audit – Scalloway	The notes of patients prescribed Lithium are reviewed against 6 criteria including appropriate tests, recall, achievement of recommended ranges, if seen by a member of the Health Team in the last 6 months and documentation of the length of treatment
Patient satisfaction survey – GP Practice	Bought in service. Part of Quality and Outcomes Framework of the new GP contract. Annual.
Quality of Cervical Smears before and after the introduction of liquid based cytology – Levenwick	To audit cervical screening services in Levenwick Practice by comparing the numbers of inadequate smears
Support for the newly bereaved	The GPs, Community Nurses and Health Visitors completed a questionnaire looking at staff's ability to support these people and the use of the "Fasttrack" System.
Warfarin Audit – Scalloway	The notes of patients prescribed Warfarin are reviewed against 4 criteria: Regularity of review of blood tests Individual ranges indicated on records Results within desired range Results acted upon the day of the test

6. Completed audits - examples

Project Title	Aim or Background
A Review of Dysphagia Management in Stroke Patients	To review current practice against SIGN 78 – recommendations for Dysphagia Management
Baseline Survey of the Present Continence Service in Shetland	To establish the level of need and the current level of service provided.
Blood Pressure Control in Drug Controlled Diabetics	To review blood pressure management in diabetics
Bobath Therapy in Shetland	To find out what parents / guardians think about Bobath Therapy in Shetland. Bobath therapy is a physical therapy aimed at improving a child's posture and movement. It is used with people with a variety of impairments including children with cerebral palsy
Child Protection Audit	The Child Protection committee has engaged external auditors to review procedures
Education needs of young people with Type 1 Diabetes and their families	To define the education needs of this client group
Electronic Discharge System	A short survey to find out how GPs felt about the electronic discharge system that is being used on Ward 3.
Fissure Sealants on 1 st Permanent Molars	To assess the presence and condition of fissure sealants on 1 st permanent molars on 11 year olds to relate this to the general condition of the teeth involved. Approved by NHS Education for Scotland
Food Fluid and Nutritional Care in Hospitals	NHS QIS require an audit of standard 2 as part of this self-assessment
Palliative Care – Lerwick Health Centre	
Physiotherapy service on the Westside	A survey was sent to patients who had received treatment for back and neck related problems at Bixter Health Centre
Stroke Patients Medication Management – Hillswick	The notes of patients registered at the Hillswick Practice who have had a stroke are being reviewed against the medication section of the Scottish Stroke Audit
Suspected Heart Failure Pathway – Do we Follow the Plan?	To establish whether or not the newly developed heart failure pathway is being followed in primary care
The Use of an Early Warning System in the Early Identification of Critically Ill Patients	To determine if the use of an early warning system, as recommended by SIGN 77, will benefit Shetland patients and to identify the most suitable system
Transport Survey	To find out how patients travel to health facilities across Shetland and what difficulties they encounter
Waiting Times for Access to Services	To look at waiting times for access to clinics and services: ENT Genetics Clinic, Paediatric Clinic, Paediatric Psychology

	Paediatric Occupational Therapy, Speech and language Therapy (children and adults)
Warfarin prescribing	A pharmacy student undertook a small audit of warfarin prescribing across the Gilbert Bain Hospital as part of her course work.
Nursing documentation	To ensure record keeping is in line with NMC guidelines
Physiotherapy callouts June-Dec 2005	To raise awareness of the protocol with all involved and ensure compliance in future.

NHS 24

- Management of clinical governance
 - Adapted NHS QIS clinical governance and risk management framework and agreed strategy for use by NHS 24 and Partner Organisations, focusing on the patient journey
 - Agreed clinical audit strategy and established a National Clinical Audit Group
 - Monitored compliance via internal audit
- Management information reports / balanced scorecards
 - Performance management structures put in place in contact centres with weekly / monthly monitoring of KPIs
- Monitoring examples
 - Clinically appropriate call length
 - Consultation review
 - Processes for evaluating, disseminating and implementing best practice guidelines
 - Pharmacy audit
 - Call back risk review
- Partner Organisation links
 - Developing in-hours GP feedback
 - Review / feedback on electronic processes for handover of clinical patient data
- PFPI
 - Changed monthly telephone patient satisfaction survey to quarterly postal survey
- Risk management
 - Develop strategy and policy
 - Ensure root cause analysis training for adverse incidents.

D. Quality assurance / monitoring by NHS QIS

- 1. Best Practice Statements**
- 2. Managed Clinical networks**
- 3. Other networks / fora**
- 4. SIGN**
- 6. SMC**
- 6. Standards**
- 7. Technology Appraisal Guidance**

1. Introduction

1.1 NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHSScotland. This means improving the experiences of patients and the outcomes of their treatment while in the care of NHSScotland, for example, through

- analysing scientific evidence
- listening to the needs and preferences of patients and carers, as well as the experiences of healthcare professionals

1.2 The role of NHS QIS is to:

- Provide clear advice and guidance to NHSScotland on effective clinical practice, in order that changes can be made to the benefit of patients. The advice and guidance is based on a thorough review of the evidence available.
- Set clinical and non-clinical standards of care to help improve performance and set targets for continuous service improvement. Such standards show the public the level of care they can expect.
- Review and monitor the performance of NHSScotland to determine how well NHS services are performing against the targets that NHS QIS has set. Instances of serious service failure within NHSScotland will also be investigated by NHS QIS and recommendations made to prevent their reoccurrence.
- Support and encourage NHSScotland staff in improving services through running development programmes, publishing best practice statements and organising conferences and events that will aid the sharing of best practice.
- Promote patient safety by learning from past experiences and putting arrangements in place that will ensure that patients are safe at all times.

1.3 NHS QIS's contribution to quality assurance and performance monitoring in the NHS in Scotland is principally through its

- **Directorate of Guidance and Standards** – responsible for health services research and assessment; clinical effectiveness and coordination; and standards development
- **Directorate of Performance Assessment and Practice Development** – responsible for practice development; clinical governance support; performance assessment; and patient and public involvement.

Their functions are described more fully in Appendix 1.

1.4 In addition, NHS QIS is an umbrella for several other organisations that work to improve the quality of healthcare in Scotland. These include

- the **Scottish Medicines Consortium (SMC)** that advises NHSScotland on the clinical and cost effectiveness of: all newly licensed medicines; all new formulations of existing medicines; and all new conditions that the medicines will treat.
- the **Scottish Intercollegiate Guidelines Network (SIGN)** that aims to improve the quality of healthcare for patients by reducing variation in clinical practice and clinical outcome, through the development and dissemination of national guidelines containing recommendations for effective practice based on current evidence. Clinical guidelines provide recommendations for effective practice in the management of clinical conditions where variations in practice are known to occur and where effective care may not be delivered uniformly throughout Scotland.

Further information on these organisations is available at

<http://www.scottishmedicines.org/>

<http://www.sign.ac.uk/>

1.5 More details about NHS QIS and associated organisations' processes and outputs that support QA and monitoring, particularly in relation to primary and community care, are outlined in section 2 below.

2. Key NHS QIS Monitoring and Quality Assurance processes and outputs¹⁶

2.1. Best Practice Statements

Best Practice Statements (BPSs) provide advice and guidance to nurses, midwives and AHPs for specific health care areas. They aim to promote evidenced-based, consistent levels of health care across Scotland and are intended to be realistic but challenging. BPSs are developed through a systematic process and incorporate evidence, agreed opinion and examples of good and innovative practice. They are reviewed every 3 years.

Involvement with and implementation of BPSs are voluntary so there is no national formal review process. Some of the more recent ones include audit tools but, again, they are not formally measured in terms of impact or outcomes on a national basis. NHS boards may however reference work on and outcomes / impacts from BPSs when they are being reviewed, for example, as part of a Standards Review visit.

¹⁶ These are listed in alphabetical order.

There are over 20 BPSs in place and most of these have implications for QA and performance monitoring in primary and community care as outlined in Appendix 2.

2.2 Managed Clinical Networks (MCNs)

MCNs are groups of health professionals (eg doctors, nurses and specialists) and healthcare organisations (eg local health services, social service departments and support groups) working together to improve the treatment and care given to patients and their families in Scotland. The members of the MCN are permitted to co-ordinate their work with health professionals and organisations beyond their own Health Board or Trust.

Each network focuses on a specific condition (e.g. stroke or diabetes) or treatment for a condition (e.g. phototherapy or intravenous nutrition). The members of the MCN set targets, striving collectively to ensure that patients receive the best possible treatment regardless of where their treatment is received. MCNs can ensure that the best use is made of limited resources, improving the quality of care for patients, and easing the transitions that patients can make between their local GP, hospitals and specialist clinics. The members of an MCN can be drawn from a wide range of medical backgrounds, from general practices and hospitals, to specialist care centres and healthcare organisations. Depending on the type of network, colleagues from outside the NHS can be involved, for example social workers, educational establishments, charities and other public organisations. The networks may be organised locally, regionally or nationally, depending on the type of service being delivered. For example, if a condition is rare or a service particularly specialised then it is more likely that the MCN will be organised on a Scotland-wide basis, but if an MCN is focused on a widespread medical condition or treatment then it may operate locally in order to improve the care in that area.

NHS QIS is responsible for accrediting the Quality Assurance Framework (QAF) for each MCN, supporting them and monitoring their progress towards the completion of a robust and meaningful document.¹⁷ This role is outlined in the [Health Department Letter \(2002\) 69](#) issued by the Scottish Executive Health Department. Before the accreditation process can begin, an MCN must submit a QAF document to NHS QIS. The completed QAF will outline how the network will operate and the targets that it aims to achieve in its area of specialisation. During the drafting of this framework, NHS QIS provides support and guidance. A panel is assembled by NHS QIS to assess and approve the framework, and, the outcome of the meeting is then communicated in a formal report or letter to the Network. Endorsement of the QAF lasts for three years, at which point the MCN is required to submit an updated framework for NHS QIS to review. NHS QIS continues to provide support after the MCN is established, and monitors the network's progress against the goals and the way of working outlined in the QAF.

¹⁷ There are currently 18 MCNs in Scotland with Quality Assurance Frameworks accredited by NHS QIS – see Appendix 3

2.3 Other Networks / Fora

NHS QIS also promotes quality assurance and performance monitoring through a series of networks and fora. For example,

- AHPs Clinical Effectiveness and Practice Development Network that aims to meet the support and development needs of all AHP groups. It acts as a catalyst to encourage AHPs to provide safe and effective care that is evidence based and patient focussed across a diverse range of services in Scotland.
- Practice Development Link Nurse / Midwife Network that works closely with NHS QIS to discuss key issues relating to the practice development agenda, share information about best practice initiatives and identify priorities for the future.
- The Clinical Governance Reference Forum which aims to:
 - Support the development of clinical governance in NHSScotland
 - Advise the Chairman, Board and Executive Team of NHS QIS on strategy and activities to support and develop clinical governance
 - Represent the views of NHSScotland and related organisations on the development, implementation and evaluation of support for clinical governance
 - Advise and assist NHS QIS's Head of Clinical Governance and Patient Safety on developing collaborative approaches to clinical governance support with other 'national' organisations.

2.4 Scottish Intercollegiate Guidelines Network - Clinical guidelines

SIGN clinical guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Guidelines provide recommendations for effective practice in the management of clinical conditions where variations in practice are known to occur and where effective care may not be delivered uniformly throughout Scotland. There are many guidelines available of which SIGN estimate about 90% cover primary care, with fewer covering community care.

Most guidelines are based on a consensus of 'expert opinion' or a non-systematic review of the scientific literature. The evidence-based guidelines developed by SIGN are derived from a systematic review of the scientific evidence, and are therefore less susceptible to bias in their conclusions and recommendations.

Implementation of national clinical guidelines is the responsibility of local NHS organisations and is an essential part of clinical governance. It is acknowledged that not every guideline can be implemented immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons

for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and general practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit. Implementing the new general practice contract will provide opportunities to introduce such elements of good practice.

CRAG undertook a formal review of the implementation of SIGN Guidelines in Scotland in 2002. In summary CRAG found,

1. Targeted dissemination of guidelines to appropriate people is widespread (all acute Trusts and most primary care Trusts)
2. Two thirds of acute Trusts (67%) and over half the primary care Trusts (58%) have a **strategy** for implementing the guideline after dissemination. These strategies involved a wide range of initiatives. Multidisciplinary implementation groups with clear leadership and a link to the Trust management appear to be a common and successful model. Many Trusts are using a variety of methods for local dissemination and implementation of guidelines, including the development of local protocols. Many Trusts had a clear link to the regular clinical audit programme.
3. Implementation of SIGN guidelines is highly variable (fully, partially or not at all), and depends on a variety of circumstances. The table below illustrates progress by demonstrating the average percentage of Trusts reporting full or no implementation of the guidelines grouped as shown:

Topic	Full	Not
Cancer	34%	14%
Stroke/CHD	29%	15%
Dentistry	26%	36%
Diabetes	35%	4%
Mental Health	10%	38%
All others	23%	24%

A similar study is currently being undertaken.

2.5 Scottish Medicines Consortium

The SMC is currently undertaking an evaluation programme to demonstrate the impact and effectiveness of its advice in NHSScotland. The report is scheduled for completion in 2008 and will focus on

- Impact of SMC advice on medicines utilisation at local, regional and national level across the healthcare system including primary and secondary care.
- Evaluation of the budget impact forecasts provided as part of SMC advice with resource usage within NHS Scotland over time.

- Supporting the linkage of clinical information and medicines utilisation data. This will enable efficient monitoring of the clinical effectiveness of medicines in day to day clinical practice to include development of meaningful quality indicators of patient care.

SMC advice is regarded as "guidance" with the exception of those drugs that are classified as unique. To date SMC have only reviewed one drug that has fallen into this category. An Executive letter was issued in November 2003 NHS HDL (2003) 60¹⁸ which explains the arrangements put in place to strengthen the role of the SMC, in addition to outlining new processes to ensure the national implementation of innovative new drugs.

In addition, NHS QIS reviews NICE Multiple Technology Appraisals and decides whether the recommendations should apply in Scotland. Where NHS QIS decides that an MTA should apply in Scotland, the NICE guidance supersedes SMC advice

2.6 Standards

A major part of NHS QIS's remit is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, NHS QIS sets standards for clinical services, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service.

The standards are developed in accordance with the commitments of the *National Health Service Reform (Scotland) Act 2004* which state that, 'individual patients receive the service they need in the way most appropriate to their personal circumstances and all policy and service developments are shown not to disadvantage any of the people they serve.'

The standards are clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. The standards are:

- written in simple language and available in a variety of formats
- focused on clinical issues and include non-clinical factors that impact on the quality of care
- developed by healthcare professionals and members of the public, and consulted on widely
- regularly reviewed and revised to make sure they remain relevant and up to date
- achievable but stretching.

¹⁸ http://www.show.scot.nhs.uk/sehd/mels/hdl2003_60.pdf

NHS QIS has an annual work programme and for each project in the work programme, a group is established comprising clinical and non-clinical membership drawn from a range of backgrounds and representatives of the public to:

- oversee the development of, and consultation on, the standards and self-analysis framework
- recommend an external peer review process.

The way in which standards are developed is a key element of the quality assurance process. Project groups are expected to:

- adopt an open and inclusive process involving members of the public, voluntary organisations and healthcare professionals
- work within NHS QIS policies and procedures
- test the measurability of draft standards by undertaking pilot reviews.

The standards are supported by a self-analysis framework, which will be completed by every NHSBoard. The information contained within the self-analysis and the supporting evidence will be reviewed by NHS QIS to assist the review team to undertake a peer review visit of each NHSBoard.

A peer review team, made up of healthcare professionals and members of the public, will meet with the NHS Board to review and assess performance against the standards. The review team will reach consensus on the level of performance that an NHS Board achieves against the standards using a quality improvement scale.

NHS QIS reports the findings of the peer review for each NHS Board area, and publishes a summary of findings for NHSScotland. Assessment of performance takes place at regular intervals in order to demonstrate progress against the standards.

NHS QIS processes are subject to internal and external evaluation to help improve the quality assurance system.

Appendix 4 sets out the aims and scope of existing standards, most of which are relevant in the primary and community care environment.

2.7 Technology Appraisal Guidance

NHS Quality Improvement Scotland (NHS QIS) advises on all Technology Appraisal Guidance published by NICE after 1 May 2001. NHS QIS considers the suitability of the NICE Guidance for Scotland in the light of the following contextual differences:

- Principles and values of NHSScotland
- Epidemiology (frequency, distribution and stage at presentation)
- Structure and provision of services in Scotland
- Other implications for NHSScotland, e.g. rural issues, predicted uptake, existing advice from the Scottish Medicines Consortium.

Health professionals are expected to take due account of this advice when exercising their clinical judgement about the use of the drug or equipment under review. However, the advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patient, in consultation with the patient and/or guardian or carer.

Appendix 5 lists the topics covered and the associated standards many of which are relevant to primary and community care.

Appendix 1

NHS QIS Directorates / Units

Directorate of Guidance and Standards

- The role of the **Clinical Effectiveness Co-ordination Unit** is to commission clinical guidelines, from SIGN and other bodies, develop a strategy for clinical effectiveness/audit and commission programmes and projects to put it into effect, and to liaise with NICE to secure appropriate Scottish input to its work and dissemination of its output to NHS Scotland.
- The role of the **Health Services Research and Assessment Unit** is to assess the clinical and cost effectiveness of health interventions, to oversee the collection, analysis and publication of clinical outcome and performance data, liaising with ISD and other relevant organisations. This evidence is used by the Directorate to develop clear and measurable standards which inform NHS staff and the public as to the standards of care and service expected throughout NHSScotland.
- The role of the **Standards Development Unit** is to:
 - develop clinical and non-clinical standards ensuring consultation with stakeholders
 - develop Quality Assurance Frameworks and accreditation programmes for Managed Clinical Networks
 - liaise with other standard setting organisations eg National Care Standards Committee

Working in partnership with healthcare professionals and members of the public, NHS QIS sets standards, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are often based on the patient's journey as he or she moves through different parts of the health service. For each project in the work programme, the Standards Development Unit appoints a group comprising appropriate health care professionals and members of the public. This group will

- adopt an open and inclusive process involving members of the public, voluntary organisations and healthcare professionals
- work within NHS QIS policies and procedures
- test the measurability of draft standards by undertaking pilot reviews.

Directorate of Performance Assessment and Practice Development

- The **Clinical Governance and Patient Safety Support Unit** is responsible for
 - supporting NHSScotland in implementing clinical governance (including supporting and developing staff working in this area)
 - learning from and disseminating advice relating to adverse events and near misses (in liaison with NPSA)

- The **Performance Assessment Unit** enables NHS QIS to evaluate what NHSScotland is doing and how well services are performing against its set standards and quality indicators by
 - undertaking performance assessment of NHSScotland through
 - self-assessment
 - external review (including clinical governance, risk management and condition-specific reviews)
 - endorsing and quality assuring performance assessment of NHSScotland by others, including
 - accreditation of primary care
 - managed clinical networks

Through self-assessment, external peer review and published reports, it identifies strengths and challenges, and makes recommendations for improvement where shortcomings are noted. This process involves performance review visits and helps to make sure that services are being carried out in a safe and effective manner. The unit is also responsible for monitoring the performance of MCNs. This is achieved by means of an annual report, which is submitted to NHS QIS during the three-year accreditation period.

- **The Patient and Public Involvement Unit** is responsible for:
 - developing and overseeing implementation of the NHS QIS Patient Focus and Public Involvement (PFPI) Framework - the plan for how public involvement will be embedded in and across all business activities of NHS QIS
 - providing person-centred support to enable effective patient and public involvement in all NHS QIS business activities
 - recruiting, training and supporting lay members of project/working groups and review teams
- **The Practice Development Unit** aims to ensure that the benefits gained from excellent practice in any area, clinical or geographical, might be shared across Scotland to the benefit of patients, staff and the NHS as a whole by
 - facilitating practice development programmes
 - developing, reviewing and revising evidence-based best practice statements and working with NHSScotland to support implementation and changes in practice

- developing capacity for change and development among nurses, midwives and allied health professionals
- developing and sustaining partnerships with NHSScotland organisations and staff to promote practice development

In doing so, the Unit utilises a range of approaches to enable individuals, teams and organisations to improve the quality of health care and the patient experience in a modernising NHS. The Practice Development Unit aims to influence the culture of practice by

- Promoting & facilitating knowledge transfer
- Translating evidence into practice
- Responding to national/local healthcare priorities and
- Ensuring best practice is recognised & shared across the country

Appendix 2 – Best Practice Statements

Title	Date	Description	Scope
Ear Care	06/06	Aims to offer guidance to nursing staff with responsibility for various aspects of ear care. Uncertainties over best practice are compounded by the lack of research evidence and range of opinion relating to the delivery of care in this area.	Nursing staff working in Ear, Nose and Throat (ENT) departments and in primary care
Home oxygen therapy for children being cared for in the community	04/06	Aims to offer guidance to nurses, midwives and health visitors on best practice relating to the care of children in the community receiving home oxygen therapy. The statement does not address specific issues relating to home ventilation nor tracheostomy care.	Children from birth until transition to adult services (this varies between areas but usually occurs between 14 - 19 years of age) and therefore incorporates neonatal and community children's nursing services.
Patient Group Directions (PGD)	03/06	Aims to ensure that risks to patients receiving treatments under group protocols for supplying / administering drugs are minimised – promotes strict use of a standard template for developing PGDs.	All health care professionals who use PGDs
Management of Chronic pain (Adults)	02/06	Aims to improve the ability of the health care practitioner to differentiate between different types and causes of pain and improve pain management. Provides tools for assessing pain.	Acute and primary care nurses / AHPs
Promoting access to health care for people with learning disabilities	02/06	Aims to improve access for children, adults and older people with learning disabilities. Provides guidance and promotes induction / ongoing training to raise awareness of their needs.	All gatekeepers to NHS services including receptionists, medical secretaries, ward clerks and call handlers
Care guidance for older people – nourishment in a hospital or care home	11/05	Developed by older people and carers as part of the Involving Older People Project. They outline older people's expectations for nursing care that will ensure sufficient nourishment when older people are in a hospital or care home.	They are designed to be used by older people and their carers to make their expectations known when care is required. They complement the best practice statement, Nutrition for Physically Frail Older People, that

			was written by and for nurses, (see 05/05 below).
Continence – adults with dysfunction	11/05	Promotes a thorough assessment of continence status to ensure appropriate treatment.	Nurses, midwives and health visitors in primary and secondary care settings
Pressure ulcer prevention	11/05	Provides guidance for health care staff and carers to identify those at risk and early signs so that they can take appropriate action.	People in hospitals, care homes and at home
Maximising communication with older people - hearing	11/05	Aims to offer evidence-based nursing guidance to maximise communication with older people with hearing disability. It tackles a general failure to recognise hearing impairment as problematic for older people despite the increasing prevalence with advancing years and the tendency within the specialist literature to focus on the provision of personal hearing aids.	People in hospital, attending a day hospitals or living in care homes or at home
Pressure ulcer treatment	03/05	Aims to provide staff, patients and carers with a framework which can be used to make decisions relating to the treatment / management of pressure ulcers.	All care settings: primary, secondary and care homes
Working with dependent older people to improve physical activity	(03/05)	Aims to encourage nurses to consider how they can become significant in promoting movement and physical activity in older people.	All healthcare professionals working with older people have a responsibility to promote physical activity to maintain functional independence.
Working with dependent older people to improve oral health	05/05	Aims to bring together for nurses the existing evidence to underpin daily and continuing care of the mouth and teeth for dependent older people because good oral health is crucial to meeting fundamental human needs such as comfort, nutrition, communication and acceptable personal appearance.	Dependent older people admitted to hospital or living in a care home
Urinary Catheterisation	07/04	Reflects key principles of infection control outlined in the Standards for Healthcare Associated Infection (HAI) Infection Control (CSBS, 2001). Specific infection control issues related to catheterisation and catheter care are highlighted in Sections 2-6. Additional aspects of catheterisation and	Male / female patients in all settings

		catheter care have been identified as areas of concern by catheter users themselves; accordingly, psychological support, catheter choice and lifestyle issues are all addressed.	
Post-operative Pain management	06/04	Aims to offer guidance to nursing and midwifery staff and their colleagues on best practice relating to postoperative pain management.	Patients of all ages in surgical and day case units, and therefore incorporates paediatric and adult nursing services.
Skin care for radiotherapy patients	04/04	Aims to ensure that <ul style="list-style-type: none"> • damage is minimised as far as possible by ensuring that the best available advice is given to patients, by staff who are following evidence-based guidelines. • And where skin damage does occur, that staff offer appropriate interventions to promote healing. 	All patients receiving external beam radiotherapy are at risk of skin damage.
Management of pain in patients with cancer	04/04	Aims to provide a consistent approach by nurses and AHPs to practising pain relief to enable seamless provision of care.	Adult patients with cancer, in all care settings, who may experience pain. It therefore incorporates healthcare services in community, hospital and hospice settings.
Admission to adult mental health inpatient services	04/04	Aims to offer guidance to nurses within adult mental health acute in-patient services but the emphasis throughout is on multi-professional working and collaboration. The importance of communication, access to and the sharing of information across services and disciplines is crucial in attaining best practice for patients entering these services and is echoed throughout the statement.	Admission to adult mental health acute inpatient services.
Maternal history taking	03/04	Aims to promote good history taking, encompassing not only the physical health and past medical and surgical profile of an individual woman, but also her social circumstances, psychological wellbeing and any identified health and educational needs. Effective history taking facilitates continuity	Women in contact with maternity services

		<p>of care, thereby reducing the occurrence of avoidable harm.</p> <p>Especially relevant to midwives but also others providing maternity services</p>	
Routine examination of the newborn	03/04	Aims to ensure the professional is able to understand the relevance of the examination, examine, assess and identify normality and abnormality and be able to refer appropriately.	Focus is on midwives but is relevant for all maternity care professionals undertaking the routine examination of newborn babies
Care guidance for older people – prevention and early detection of depression	01/04	<p>Aims to offer evidence based nursing guidance on prevention and early detection of depression in older people – particularly to inform the care of older people who are moving to continuing care facilities such as community hospitals or care homes (nursing), older people awaiting hospital discharge or experiencing delayed discharge, or a comparable period of instability in their lives.</p> <p>It provides a comprehensive audit tool that users can modify to audit their own practice.</p>	Principally nurses and care teams and provides information for older people and their families.
Caring for patients with a tracheostomy	03/03	Aims to provide a consistent approach to practice to enable a seamless delivery of care to be delivered to the patient between hospital and the community.	Patients of all ages in all settings and therefore incorporates paediatric and adult nursing services in both primary and secondary care.
Nasogastric / gastrostomy tube feeding for children in the community	03/03	The aim of the statement is to offer guidance to nurses, midwives and health visitors to reduce the problems experienced by children living in the community who require home enteral tube feeding.	The statement refers to children from birth until transition to adult services (this varies between areas but usually occurs between 14 & 19 years of age) and therefore incorporates neonatal and community children's nursing services.
Home oxygen therapy for children in the community	05/02	<p>The aim of the statement is to offer guidance to nurses, midwives and health visitors covering</p> <ul style="list-style-type: none"> • initial management plan • discharge planning 	The statement refers to children from birth until transition to adult services (this varies between areas but usually occurs

		<ul style="list-style-type: none"> • risk assessment and management • information for parents / carers • provision of equipment and supplies • transport of oxygen outside the home • use of oxygen therapy at home • use of oxygen therapy outside the child's home 	between 14 - 19 years of age) and therefore incorporates neonatal and community children's nursing services.
Nutrition for physically frail older people	05/02	<p>Aims to offer guidance to nurses and care teams and provides information for older people and their families on meeting the nutritional needs of physically frail older people. It was developed and demonstrated within a community hospital and has the potential to inform the care of dependent older people who are experiencing delayed hospital discharge or who reside within the community.</p>	physically frail older people within continuing care facilities such as community hospitals, nursing homes / care homes
Nutrition – adults in hospital	05/02	<p>Aims to offer guidance to nurses, midwives and health visitors on best practice relating to nutritional assessment and referral in the care of adults in hospital covering</p> <ul style="list-style-type: none"> • admission to hospital • nursing management of nutritional care • screening and documentation • criteria for nutritional referrals • education and training 	Adults in hospital.

Appendix 3

Managed Clinical Networks (MCNs)

There are currently 18 MCNs in Scotland with Quality Assurance Frameworks accredited by NHS QIS:

- **CLEFTSIS** - a national network for the Cleft Lip and Palate Service in Scotland (www.show.scot.nhs.uk/cleftsis)
- **Stroke** – local networks have been accredited in NHS Lanarkshire, NHS Ayrshire and Arran, NHS Greater Glasgow, NHS Lothian, NHS Dumfries and Galloway, NHS Fife, NHS Tayside, NHS Western Isles
- **PhotoNet** - a national network for phototherapy treatment of common skin disorders
- **Coronary heart disease** - a local network has been accredited in NHS Dumfries and Galloway
- **Scottish home parenteral nutrition** - a national network for patients with chronic intestinal failure ([click here to visit their website](#))
- **Adult diabetes services** -a local network has been accredited in NHS Tayside
- **Epilepsy** – a regional network for epilepsy services, developed by NHS Boards in Ayrshire and Arran, Greater Glasgow and Tayside ([click here to visit their site](#)) and the Scottish Paediatric Epilepsy Network (SPEN), which operates nationally, and is organised from NHS Yorkhill.

In addition, there are three regional cancer networks:

- **SCAN** - South East Scotland cancer Network (www.scan.scot.nhs.uk)
- **WoSCAN** - West of Scotland Cancer Network
- **NoSCAN** - North of Scotland Cancer network (www.noscan.scot.nhs.uk).

Other Managed Clinical Networks have been established across NHS Scotland and are in different stages of development.

Standards

Title	Date	Description	Scope
clinical governance and risk management	10/05	Aim to support all NHS Boards to put in place the necessary systems and processes to ensure that safe, effective, patient-focused care and services are being delivered across Scotland.	<p>The scope of the standards covers all aspects of clinical governance and risk management from the perspective of patient outcomes, and incorporate the following elements:</p> <p>Standard 1 – Safe and effective care and services</p> <ul style="list-style-type: none"> • Risk management • Emergency and continuity planning • Clinical effectiveness and quality improvement <p>Standard 2 – The health, wellbeing and care experience</p> <ul style="list-style-type: none"> • Access, referral, treatment and discharge • Equality and diversity • Communication <p>Standard 3 – Assurance and accountability</p> <ul style="list-style-type: none"> • Clinical governance and quality assurance • Fitness to practice • External communication • Performance management • Information governance
pregnancy and newborn screening	10/05	Aims to identify the risk of a particular condition. Screening tests are not compulsory but are offered to help individuals	<ul style="list-style-type: none"> • all pregnant women are eligible for screening.

		make informed choices about their health and the health of their child.	<ul style="list-style-type: none"> Screening for specific conditions of all babies is offered and all results are reported to the NHS Board for input onto the department of community child health records system. In addition positive results are reported to the consultant paediatrician / audiologist, GP, and the NHS Board who will initiate treatment and/or further testing.
Maternity services	03/05	They aim to reflect best practice in the area of pre-conception services, and also incorporate key areas of the organisation and provision of maternity services, the assessment and management of risk, and the importance of good information and communication strategies.	The scope is the period of time between confirmation of pregnancy, through until the baby is 6–8 weeks old. These standards, therefore, cover pregnancy, childbirth, the postnatal period and parenthood.
The Provision of Safe and Effective Primary Medical Services Out-of-Hours	08/04	The aim is to ensure that the public can be confident that any healthcare professionals (and those providing support to them) working in the out-of-hours period will have the right training, skills and competencies to provide a service appropriate to the clinical needs of the patient in the most appropriate setting.	NHS Boards have a legal responsibility to ensure primary medical services are provided at all times, including out-of-hours. Where GPs opt out of out-of-hours provision, an NHS Board can provide the services itself through direct provision, or by entering into a contract or an agreement for services with another provider. Whatever the arrangements, the out-of-hours 'provider' (including the NHS Board if it is providing services directly) will be required,

			as a duty to meet the standards established by NHS Quality Improvement Scotland.
Diabetic Retinopathy Screening	03/04	To raise the standard of diabetes care and contribute to the development of an effective national diabetic retinopathy screening programme, and the associated national quality assurance framework and standards through an 'evolutionary' rather than a 'revolutionary' process	People with diabetes
Stroke Services: Care of the Patient in the Acute Setting.	03/04	Aims to provide measures of performance for a service providing care to stroke patients covering <ul style="list-style-type: none"> • Organisation of Hospital Stroke Services for Scotland; • Acute Stroke and Rehabilitation (Management of Patients Admitted to Hospital); • Secondary Prevention; and • Discharge. 	stroke and transient ischaemic attack (TIA)
Vascular Services: Care of the Patient with Vascular Disease.	10/03	Aims to build on existing QA work for these services covering <ul style="list-style-type: none"> • Service Provision & Multidisciplinary Care; • Primary Care & Hospital Outpatient Care: Assessment, Management & Referral; • Medical Management & Lifestyle Issues in Primary & Secondary Care; • Radiological & Surgical Interventions; • Documentation, Audit & Outcomes; and • Information, Education & Training. 	Patients with arterial, venous and lymphatic disease
Food, Fluid and Nutritional Care in Hospitals.	09/03	Aims to ensure the effective delivery of food and fluid and the provision of a high quality of nutritional care which is crucial for the well-being of patients covering <ul style="list-style-type: none"> • required strategic / coordinated approach • assessment and screening, in relation to eating, 	All hospitals

		<p>drinking and nutrition, and the subsequent care planning that is required when a person is admitted to hospital;</p> <ul style="list-style-type: none"> • the formalised mechanisms needed to actually plan and deliver food and fluid; • the subsequent provision of food and fluid directly to patients; • communication with patients about eating, drinking and nutrition; and • specific training and education requirements for staff. 	
Anaesthesia	07/03	<p>Aims to pull together the available guidelines and evidence base for anaesthesia, and to identify key indicators of anaesthesia quality covering</p> <ul style="list-style-type: none"> • Organisation of Anaesthesia Services • Preoperative Care • Intraoperative Care • Postoperative Care 	Patients requiring local, regional and general anaesthetics
Management of post mortem examinations	03/03	<p>Applies to specific areas of the post-mortem examination process and cover the following areas:</p> <ul style="list-style-type: none"> • Pathology Practice – Hospital Post-mortem Examinations • Authorisation and Information • Storage, Handling and Disposal • Record-keeping • Education 	Those requiring hospital post-mortems
Mental health quality indicators	01/03	<p>Provides framework for assessing</p> <ul style="list-style-type: none"> • Needs assessment • Delivery of care • Community health teams • Mental health day services • Clinical governance 	Patients accessing mental health services
Older people quality indicators	01/03	<p>Provides framework for assessing</p> <ul style="list-style-type: none"> • Policies – e.g. referral & discharge; rights & choice; 	Patients > 65 years and special requirements of those > 75 years

		<p>advocacy</p> <ul style="list-style-type: none"> • Management of services – e.g. liaison between NHS professionals and joint working; prescribing; transport • Service delivery – e.g. individual needs assessment and care planning; rehab; respite • Quality of life • Planning & needs assessment 	
Physical disability quality indicators	01/03	<p>Provides framework for assessing</p> <ul style="list-style-type: none"> • Promoting health & well-being e.g. disability awareness; advocacy; transport • Patient journey • Transition between services • Technology & equipment • Clinical governance • Planning 	Adults and children with physical disability in hospital and in the community
Breast Screening	12/02	<p>Aims to assess performance in</p> <ul style="list-style-type: none"> • General – i.e. management, communication, audit and confidentiality • Call-Recall and Safeguarding • The Screening Process • The Assessment Process • Surgical Referral • Cancer Yield 	Health Boards throughout Scotland where breast screening services are provided
Diabetes – 2 nd edition	10/02	<p>Aims to assess performance in specific elements of diabetes covering</p> <ul style="list-style-type: none"> • Organisation • Patient Focus • Clinical 	Health Boards throughout Scotland where diabetes services are provided
Older people in acute care	10/02	<p>Aims to scrutinise the journey of care from the patient's point of view using the most common journeys i.e.</p> <ul style="list-style-type: none"> • assessed in accident and emergency (A&E) or acute admissions units; 	All older people, in all acute care settings.

		<ul style="list-style-type: none"> • admitted to and discharged home from acute wards; and • with more complex journeys of care: post-acute rehabilitation and delayed discharge. 	
HAI – cleaning services	06/02	<p>Aims to assess to specific elements of cleaning services covering</p> <ul style="list-style-type: none"> • Accountability • Processes • Capability • Outcomes • Monitoring and Review • Audit 	Health Boards throughout Scotland where cleaning services are provided.
Specialist Palliative Care	06/02	<p>Aim to assess performance in specific elements of the service covering:</p> <ul style="list-style-type: none"> • Access to Specialist Palliative Care Services • Key Elements of Specialist Palliative Care • Managing People and Resources • Professional Education • Inter-professional Communication • Communication with Patients/Carers • Therapeutic Interventions • Patient Activity 	Hospital, community and hospice settings throughout Scotland where specialist palliative care services are provided.
Generic - reprint	03/02	<p>Aims to assess generally the steps taken to meet patients' needs and preferences and the quality of clinical care provided and covers</p> <ul style="list-style-type: none"> • patient focus • safe & effective care 	All clinical services provided by NHS Boards and Island NHS Boards in Scotland
Adult renal services	02/02	<p>Aims to assess the quality of clinical services covering</p> <ul style="list-style-type: none"> • clinical management & treatment – e.g. haemodialysis 	Hospital settings throughout Scotland for people with renal disease, with a

		<ul style="list-style-type: none"> • transplantation • patient focus – e.g. information; transport • audit 	particular focus on chronic renal failure, as this represents the vast majority of the workload in renal units.
Cervical screening	01/02	<p>Aims to assess the quality of clinical services covering</p> <ul style="list-style-type: none"> • General – i.e. screening, communication and audit • Call-recall and Failsafe • Smear-taking • Laboratory Reporting • Colposcopy <p>The standards will be used by CSBS to assess performance in these areas throughout Scotland.</p>	All service providers – including GPs
HAI – Infection control	12/01	<p>Aims to assess the quality of infection control covering</p> <ul style="list-style-type: none"> • accountability • processes – e.g. policies, procedures and guidance • capability - e.g. legislation • monitoring and review • audit • practice – i.e. hand hygiene 	Both community (including primary care) and hospital settings throughout Scotland.
Breast cancer	01/01	<p>Aims to assess services in terms of</p> <ul style="list-style-type: none"> • referral process • time to diagnosis • multidisciplinary working • support (e.g. psychiatrist / psychologist) • education & training • communication e.g. different options for treatment • audit • clinical trials • assessment & care planning • waiting time for treatment • surgical management • radiotherapy / adjuvant Systemic therapy / chemotherapy 	Patients being cared for in acute hospital setting

		<ul style="list-style-type: none"> • symptom management • drugs • equipment • outcomes 	
Colorectal cancer	01/01	Aims to assess services along the same lines as for breast cancer	Follows the patient's journey from the point of diagnosis - includes primary, secondary and tertiary care
Ovarian cancer	01/01	Aims to assess the quality of clinical services along the same lines as for breast cancer	Services provided in both community and hospital settings throughout Scotland for people with Gynaecological (Ovarian) Cancer.
Lung cancer	01/01	Aims to assess the quality of services along the same lines as for breast cancer	Services provided in both community and hospital settings throughout Scotland for people with lung cancer
schizophrenia	01/01	<p>Aims to assess the quality of services covering</p> <ul style="list-style-type: none"> • information on populations and individuals • initial diagnosis • initial / ongoing assessment & care planning • transferring care – admission and discharge • information / support to carers • prescribing • social / psychological approaches to care • misuse of alcohol / illicit drugs 	Services provided in both community and hospital settings throughout Scotland for people with schizophrenia
Secondary prevention following acute myocardial infarction	12/00	<p>to assess the quality of clinical services covering</p> <ul style="list-style-type: none"> • immediate management • prophylactic medication • risk factors • cardiovascular status • rehabilitation • discharge. 	Services provided in an acute hospital setting throughout Scotland for patients diagnosed with Acute Myocardial Infarction.

Technology Appraisal Guidance

Topic	NICE Guidance
Skin	<ul style="list-style-type: none"> • psoriasis • atopic eczema
Arthritis	<ul style="list-style-type: none"> • psoriatic arthritis • rheumatoid arthritis
Children's health	<ul style="list-style-type: none"> • conduct disorders • renal • epilepsy • chronic myeloid leukaemia • (morbid) obesity • idiopathic arthritis • rheumatoid arthritis
Cancer	<ul style="list-style-type: none"> • prostate • (advanced) colorectal • ovarian • chronic myeloid leukaemia • (aggressive) non-Hodgkin's lymphoma • breast • lymphocytic leukaemia • non small cell lung
Mental health	<ul style="list-style-type: none"> • bipolar disorder • electroconvulsive therapy • anxiety & depression • anti psychotic drugs for schizophrenia
Blood	<ul style="list-style-type: none"> • Hep B (chronic)
Heart failure	<ul style="list-style-type: none"> • Defibrillators • Statins • Pacemakers • Acute coronary syndromes
Dentistry	<ul style="list-style-type: none"> • Tooth decay
Procedures	<ul style="list-style-type: none"> • Knee joints • Laparoscopic surgery for hernia • Coronary artery stents • Fluid replacement in trauma • Myocardial perfusion scintigraphy • Glycoprotein inhibitors • Ultra sonic locating devices for placing venous catheters • arthroplasty
Vascular medicines	<ul style="list-style-type: none"> • Occlusive vascular events
Women's health	<ul style="list-style-type: none"> • Fragility fractures post menopause • Heavy menstrual bleeding • Stress incontinence • RhD-negative women
Medicines	<ul style="list-style-type: none"> • Severe sepsis • Short term management of insomnia • Chronic Hep C • Growth hormone deficiency • Influenza • Acute myocardial infarction • Crohn's disease • Multiple sclerosis
Renal	<ul style="list-style-type: none"> • Immunosuppressive therapy • End stage renal failure – home v hospital dialysis

Epilepsy	<ul style="list-style-type: none"> • New drugs for children • New drugs for adults
Screening	<ul style="list-style-type: none"> • Liquid based cytology
Older people health	<ul style="list-style-type: none"> • Macular degeneration • Alzheimer's disease
Diabetes	<ul style="list-style-type: none"> • Glitazones for type 2 • Patient education models • Subcutaneous insulin infusion • Long acting insulin analogues

E. Quality assurance by other bodies

- A. Regulators for health professionals**
- B. Professional bodies**
- C. NHS Education for Scotland (NES)**

A. The Regulators

1. General Medical Council¹⁹

The General Medical Council (GMC) registers doctors to practise medicine in the UK. Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The law gives them four main functions under the *Medical Act*:

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC is an independent body and represents a partnership between the public and the profession. This concept of 'professionally-led regulation in partnership with the public' enables the GMC to set a framework of standards and ethics that is owned by the profession while reflecting the views and expectations of the public. The values are embodied in the publication [Good Medical Practice](#), which underpins all the GMC's work.²⁰

With effect from 2005, doctors **must** be revalidated. This means they will have to prove to the GMC, every five years, that they are up to date and fit to practise; and have been practising in line with the GMC's core ethical guidance covering

- Good clinical care
- Maintaining good medical practice
- Relationships with patients
- Working with colleagues
- Teaching and training
- Probity
- Health

In terms of evidence, doctors are required to keep a folder of information, drawn from their medical practice and showing that they have been practising in accordance with the standards of competence, care and conduct set out in [Good Medical Practice](#). The GMC also requires doctors to provide evidence that they reflect on their practice, usually by means of participation in a formal appraisal process mapped onto the seven headings of Good Medical Practice and backed up by a personal development plan. The material collected for the appraisal then forms the basis for their revalidation folder. The GMC does not ask to see all folders, but it may require some doctors to submit their folders, for either decision-making or quality assurance purposes. The GMC also requires a description of each doctor's practice and certification from an appropriate person locally that there are no known concerns about their fitness to practise, health or probity.

¹⁹ <http://www.gmc-uk.org/>

²⁰ An update version of this is due to be published in November 2006 – see section 9 of this paper.

2. The Nursing and Midwifery Council (NMC)

The NMC is the regulatory body for nurses, midwives and specialist community public health nurses. Their purpose is to establish and improve standards of care in order to serve and protect the public. The key tasks of the NMC are to:

- maintain a register of qualified nurses, midwives and specialist community public health nurses
- set standards and guidelines for education, conduct, performance and ethics
- provide advice on professional standards
- consider allegations of lack of fitness to practice due to misconduct, lack of competence or ill health.

The NMC requires nurses and midwives to undertake 35 hours of CPD every 3 years in order to re-register to practice. This is called the PREP (CPD) standard. The learning must be relevant to nursing / midwifery practice and must be recorded in a personal professional profile (PPP). Practitioners are also required to comply with any request by the NMC to audit CPD. Full details are available from <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1636>

3. General Dental Council (GDC)

The GDC regulates the dental professions in the UK covering, dentists, dental hygienists and dental therapist. All these professionals must be registered with the GDC to practice in the UK. Its aim is to protect patients and promote confidence in the dental profession by

- Registering qualified professionals – it is a prosecutable offence to practice without being registered
- Setting high standards of behaviour – the GDC has issued guidance on best practice in *Standards for dental professionals*. This covers principles of ethical practice and supplementary guidance on issues such as patient consent and confidentiality
- Quality assuring dental education – the GDC publishes its requirements for the content and range of courses as well as visiting dental and other schools to ensure standards are kept.
- Ensuring dental professionals keep up to date – CPD is compulsory for dentists who must complete 250 hours over 5 years; the plan is to extend compulsory CPD to the other professionals. The GDC is also working towards a new revalidation scheme whereby dental professionals will have to demonstrate that they are fit to be on the register.
- Handling complaints

<http://www.gdc-uk.org/>

4. Royal Pharmaceutical Society of Great Britain (RPSGB)

The RPSGB is the professional and regulatory body for pharmacists in England, Scotland and Wales. All practising pharmacists must be registered with the RPSGB. It also regulates pharmacy technicians on a voluntary basis,

which is expected to become statutory under anticipated legislation. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.

As regulator of the profession, the work of the RPSGB covers

- fitness to practise standards – this involves
 - Monitoring by the Inspectorate (see below), who visit community pharmacies on a routine basis and who investigate any allegations or complaints
 - Compliance by providing written or verbal advice on the interpretation of the law and code of ethics, and by publication of decisions of the Society's Fitness to Practice Committees.
 - Enforcement by bringing proceedings against a registered pharmacist, either through the Society's fitness to practise machinery, or in the Criminal Courts.
- codes of ethics – this requires pharmacists to keep up to date with changes in pharmacy practice, the law relating to pharmacy and the knowledge and technology applicable to pharmacy, and to maintain competence and effectiveness as a practitioner. The Society recommends that pharmacists fulfil this responsibility by adopting the concept of continuing professional development (CPD) and there is a consultation currently underway to make this a mandatory requirement. CPD will include regular participation in continuing education (CE) and other activities, eg, professional audit.
- the pharmacy inspectorate - The RPSGB is unique among healthcare professions in having an Inspectorate that it maintains under Section 9 of the Poisons Act 1972, which places a duty on the Society to inspect registered retail pharmacy premises. The rationale for this is twofold: for law enforcement and the driving up of quality. Scotland has 2 inspectors who visit training pharmacies annually and others on an 18 month to 2-year cycle. They will check, for example, whether the practice is operating safe systems of working and whether standard procedures for dispensing are being followed
- complaints about pharmacists, pharmacy premises or pharmacy technicians
- disciplinaries.

The RPSGB, through its Practice and Quality Improvement directorate, actively encourages pharmacists to be involved in clinical audit as a key tool for securing a high standard of professional performance. The RPSGB has also produced a CD-ROM called [Audit to Excellence](#), which contains tools that will help pharmacists measure the quality of their pharmaceutical service and to make improvements when necessary.

<http://www.rpsgb.org.uk/>

5. General Optical Council

The GOC is the statutory body which regulates dispensing opticians and optometrists and those bodies corporate carrying on business as optometrists or dispensing opticians. The GOC's main aims are to protect the public and promote high standards of professional conduct and education amongst opticians.

Under the Opticians Act 1989 the General Optical Council registers dispensing opticians and optometrists to practise in the UK. Only those persons who have achieved adequate training and practical experience and who have achieved qualifications enabling registration may be registered to practise. A person may not practise as a dispensing optician or optometrist if he/she is not registered with the GOC. It is an offence to practise without being registered and on conviction, a fine of up to £5,000 can be imposed. Once registered, optometrists and dispensing opticians must retain their registration by renewing it annually in order to practise in the UK. An annual fee is payable to retain registration.

The education and training of optometrists and dispensing opticians is an important aspect of the GOC's work and the GOC manages all matters relating to optical training and examinations, including continuing and post qualification education. In June 2006, the GOC approved the new CET scheme principles and requirements, giving greater flexibility which will be effective from 1 January 2007. A copy of the new CET Scheme Principles and Requirements will be available on the website soon. However it is likely that this will be in line with the thinking / proposals set out in *Guidelines and principles of the GOC CET Scheme*, published in June 2004
http://www.optical.org/index_files/news_room/ed3.pdf

In summary, this says that the GOC considers that a registered dispensing optician or optometrist, as a health professional, should not be permitted to continue to practice without some regulation for updating knowledge and skills. This is particularly the case in a profession where there are technical and clinical changes and a developing scope of practice. The GOC has concluded that it should be a condition of retaining registration that dispensing opticians and optometrists should complete a prescribed minimum amount of continuing education and training within a stated period.
<http://www.optical.org/>

6. Health Professions Council (HPC)

The HPC is the regulatory body for 13 professions covering

- Arts therapists
- Biomedical scientists
- Chiropodists and podiatrists
- Clinical scientists
- Dietitians
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists

- Prosthetists and orthotists
- Radiographers
- Speech and language therapists

Under the Health Professions Order, 2001, the HPC has a right to request that each registrant undertakes CPD and keeps a written record including supporting evidence of that CPD. Learning activities must be relevant to the practitioner's current or future role and can include secondments, in-service training or reading. There is no requirement for a specific number of hours or points to be achieved.

As part of their re-registration, members are required to sign and submit a declaration that they continue to meet HPC standards so that patients can be treated lawfully, safely and effectively - the signature is legally binding. From 2008, the HPC will undertake an audit of a random sample of health professionals to ensure that its standards are being met.

In May 2006, the HPC published "*Your guide to our standards for continuing professional development*" which provides more details, see http://www.hpc-uk.org/assets/documents/100011A0Short_guide_to_CPD.doc

The HPC's standards are aimed at protecting the public and cover

- **Character** – the HPC requires information from practitioners about any criminal convictions; information from them if they have been subject to a decision by any other regulator (either a regulator in the UK of another profession, or a regulator outside the UK); and a character reference, which has been signed by someone 'of professional standing in the community'.
- **Health** – the HPC needs to be assured that they are of 'good health' ie: that their health does not impair their fitness to practise.
- **Education and training** – the HPC assesses education programmes to make sure that students meet standards of proficiency
- **Conduct performance and ethics** – this covers the kind of behaviour expected from members
- **Proficiency** - each profession has its own standards of proficiency to ensure safe and effective practice and they follow the same standard format i.e.
 - Expectations of a health professional
 - Professional autonomy and accountability
 - Professional relationships
 - Skills required for the application of practice
 - Identification / assessment of health and social care needs
 - Formulation and delivery of plans and strategies to meet health and social care needs
 - Critical evaluation of the impact / response to the registrant's actions
 - Knowledge, understanding and skills

Full details are provided at <http://www.hpc-uk.org/publications/standards/index.asp?id=52>

7. General Osteopathic Council (GosC)

The General Osteopathic Council is the regulatory body for osteopaths in the UK and practitioners must be registered with it as the title “osteopath” is protected by law. The Council’s aim is to protect the public and ensure that practitioners are practising high standards of safety and competency.

Registration requires the practitioner to

- Hold a recognised qualification in osteopathy
- Be of good character and have good health
- Be covered by professional indemnity insurance (PII).

The resultant certificate to practice is renewed annually on the basis that the candidate can produce evidence of their PII and that s/he signs a declaration that they remain fit to practice. In addition, CPD has been mandatory for osteopaths since May 2004. CPD is defined as learning that comprises practical sessions, individual study or other activities undertaken by an osteopath, that could reasonably be expected to advance his/her professional development and contribute to the development of osteopathy. Osteopaths must complete 30 hours CPD per year of which 15 hours must involve interaction with other professionals and they must make a declaration to the GOsC that they have met the CPD requirements, through the return of their Renewal of Registration forms. Members must also maintain a portfolio of their CPD.

<http://www.osteopathy.org.uk/>

8. General Chiropractic Council (GCC)

The GCC is the regulatory body for chiropractors in the UK and practitioners must be registered with it as the title is protected by law. The Council’s aim is to protect the public and ensure that practitioners are practising high standards of safety and competency.

The GCC maintains a register of those who meet their standards for training, professional skills / behaviour and health. Chiropractors need to re-register annually demonstrating that they are of good character and that they remain both physically and mentally fit to practice. In addition, since September 2004, members have been required to undertake mandatory CPD as described in

http://www.gcc-uk.org/files/link_file/CPD_Mandatory_Req.pdf

<http://www.gcc-uk.org/page.cfm>

9. General information about regulators / regulation

A message from the Regulators

The UK’s 13 Health and Social Care regulators launched a new leaflet, “*Who regulates health and social care professionals?*” in July 2006

<http://www.rpsgb.org/pdfs/regulatorsleaflet.pdf>

The future of regulation

A consultation was launched by the Department of Health on 14th July 2006 and closes on 10 November 2006, seeking views on the Chief Medical Officer's proposals in

"Good doctors, safer patients" - see

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137232&chk=KW63va

and

"The regulation of the non medical professions" published in July 2006 - see <http://www.dh.gov.uk/assetRoot/04/13/72/95/04137295.pdf>

Among the key themes raised in these reports are: changes to the governance and accountability of the professional regulator; the importance of operationalised standards against which to regulate; the appropriate legal standard of proof; the introduction of an independent adjudicator; a spectrum of revalidation across all clinical professions; and, devolution of some regulatory powers to the local level.

B. Other professional bodies

In addition to the regulators, there is a raft of other professional bodies all of which have an interest in the professional development, education and training of their members. For example, this may take the form of commissioning or delivering training or other materials to support (re) registering and continuous professional development.

1. Royal College of GPs

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the 'voice' of general practitioners on education, training and issues around standards of care for patients.

The College is involved in a range of performance monitoring and QA initiatives as outlined below. This includes working with others to develop tools and processes, providing toolkits and delivering training.

1.1 Individual GP level

The College encourages general practitioners to check their own performance and identify their good (as well as their weaker) areas and demonstrate improvement and development.

1.1.1 Scottish GP Appraisal Scheme

Appraisal is about identifying individual professional development needs and is not about performance management or quality assurance. However, it is a clearly stated aim of the appraisal scheme

for doctors working in general practice to support practitioners in their preparation for revalidation.

The RCGP worked with others (e.g. NHS Education for Scotland) to agree mechanisms for an annual appraisal scheme for GPs but has no other role in this scheme.

1.1.2 Revalidation

Revalidation is a mandatory process whereby doctors are required on a regular basis to demonstrate that they continue to be fit to practise medicine in line with the requirements of the GMC as outlined in section A of this paper.

The RCGP has produced a revalidation toolkit to help GPs record evidence in support of their revalidation. This is available to all GPs for a nominal fee. However, the College has no further role in the process – GPs submit their revalidation evidence direct to the GMC.

For each element, the toolkit sets out the criterion, the standard and the evidence required to demonstrate required performance. Table 1 sets out an example.

Table 1: Good clinical Care 1 – prescribing

Criterion	Doctor prescribes efficiently and effectively
Standard	Doctor has critically appraised his /her own prescribing, identified any need for training or to change prescribing habits and, where appropriate, has implemented changes
Evidence	For example, feedback from an appropriate source such as a prescribing adviser.

The toolkit takes account of evidence already collected to support other monitoring areas of work such as: Practice Accreditation (now overtaken by QOF); Training Practice Accreditation; Quality Practice Award and the Scottish GP Appraisal Scheme. Full details of the revalidation toolkit are available from

http://www.rcgp.org.uk/PDF/Scott_Revalidation_Booklet.pdf

A summary of the evidence required is provided in Appendix 1.

1.1.3 Membership of RCGP

There are two routes to becoming a member of the College: by sitting the membership examination or by undertaking an assessment scheme geared towards experienced GPs who can demonstrate that they provide good quality care for their patients in everyday practice. General practitioners who successfully complete either of the assessment methods for membership, pay an entrance fee to join the College, and continue to renew their annual subscription are entitled to use the designation Member of the Royal College of General Practitioners (MRCGP).

The scope of the examination covers the whole range of activities in general medical practice within the National Health Service including those areas which overlap with other disciplines and professions. The

examination is not just a test of clinical knowledge and diagnostic skills but aims to assess the candidate's ability in consulting and communication skills, in practice management, and of attitudes in areas such as ethics and medical politics.

1.2 GP Practice level

1.2.2. Practice Accreditation / QOF

The current system of Practice Accreditation (PA) ended on 31 March 2005. It had prepared practices for the organisational domain of the Quality and Outcomes Framework (QOF). The new GMS contract QOF review process has introduced routine visits to assess performance in all participating practices. Many of the organisational aspects of the QOF are based on the core elements of PA version 1A.

In order to support quality initiatives in the new contract in primary care in the future, RCGP Scotland was commissioned to train the QOF reviewers for all NHS boards. Training of reviewers started in March 2005. The College produced a handbook for trainers in April 2006 that aims to mirror the actual visit and contains guidance and sample questions to support reviewers; it also keeps the website up to date. However, it has no role in the QOF visits.

1.2.2. Quality Practice Award (QPA)

Increasingly, general practitioners are working as part of an extended practice-based team. The ability to work in an effective team can take forward the range and standards of care that a practice can offer.

QPA is a quality assurance process undertaken by practices on a voluntary basis which recognises a high standard of quality patient care delivered by every member of the practice team. Each practice is required to submit a portfolio of written evidence against 23 sets of criteria including accessibility; patient information and choice; management of chronic illness; and premises and equipment. The criteria are listed in full in Appendix 2 along with examples of the evidence required. Full details are contained in the "*The application process, criteria and user's guide*", 9th version which covers the period 1/4/06 – 31/3/07.

An assessment team - involving the team leader, a lay reviewer, a GP and a practice manager - then undertakes a full day assessment. Team members interview the practice team and inspect the premises, systems and medical records.

There is a 5 yearly review process to ensure that standards are maintained – this should be straightforward with evidence being produced as a by-product of the practice's routine procedures.

The QPA scheme requires considerable effort and is based on a pass / fail basis covering all the criteria. The College is considering whether it might be possible to introduce a phased approach.

2. The Royal College of Nursing

Involvement in quality assurance and performance monitoring is limited although RCN Scotland is keen to ensure a guaranteed minimum of 3 days per year CPD in addition to mandatory training.

<http://www.rcn.org.uk/>

3. The Royal College of Midwives

Involvement in quality assurance and performance monitoring is limited other than, for example, through participation in NHS QIS groups and the officers of the college sit on the three regional planning groups for maternity services across Scotland. Local representatives are also expected to be involved in their own areas but the view is that it is not uniform across the service.

<http://www.rcm.org.uk/>

4. Others

- British Association of Drama Therapists
<http://www.badth.org.uk/>
- British Association of Art Therapists
<http://www.baat.org/>
- Association of professional music therapists
<http://www.apmt.org/>
- Society of chiropodists & Podiatrists
<http://www.feetforlife.org/>
- Association of clinical scientists
<http://www.assclinsci.org/template.asp?pid=01>
- British Dietetic Association
<http://www.bda.uk.com/>
- Institute of Biomedical Science
<http://www.ibms.org/>
- College of Occupational Therapists
<http://www.cot.org.uk/>
- The Association of Operating Department Practitioners
<http://www.aodp.org/>
- British Orthoptic society
<http://www.orthoptics.org.uk/>
- British Paramedic Association
<http://www.britishparamedic.org/>
- Chartered Society of Physiotherapy
<http://www.csp.org.uk/>
- British Association of Prosthetists & Orthotists

- <http://www.bapo.com/>
- The Society & College of Radiographers
<http://www.sor.org/>
- The Royal College of Speech and Language Therapists
<http://www.rcslt.org/>

C. NHS Education for Scotland (NES)

NES's aim is to help provide better patient care by designing, commissioning, quality assuring and, where appropriate, providing education, training and lifelong learning for the NHS workforce in Scotland. NES is involved in a number of initiatives that impact on quality assurance and performance monitoring. The main areas relevant to primary and community care are highlighted below.

1. General Practice

1.1 GP Appraisal scheme – NES published the handbook *Appraisal for GPs working in Scotland* in 2003, <http://www.nes.scot.nhs.uk/docs/publications/gpappraisal2003.pdf>. The following evidence is used to support the scheme but it is confidential.

GP Scot 1: Appraisal Form – the form prepared by the appraisee prior to the interview which is used to inform the appraisal discussion and, ultimately, form the main record of the appraisal interview. This should be signed by the appraisee and the appraiser.

GP Scot 2: Personal Development/Action Plan – this contains the appraisee's key development objectives for the forthcoming year which are prioritised. The plan will be reviewed the following year. This should be signed by the appraisee and the appraiser.

GP Scot 3: Summary Development Plan – this is used by the appraiser to help collate, anonymously, the learning and development needs identified by appraisees. This information will be passed to the Local Appraisal Adviser who will use it to produce an annual, collated report for the Medical Director and Director of Postgraduate General Practice Education. This should be signed by the appraisee and appraiser.

GP Scot 4: GMC Summary of Interview - this is a summary of issues covered in the appraisal in the format required for the *Revalidation Folder*. This should be signed by the appraisee and appraiser.

GP Scot 5/5b: Appraisal Evaluation Forms – these are completed by the appraisee and appraiser and returned in confidence to NES for ongoing quality assurance.

Appraisal Notification Form - notification to the PCT/NHS Board that the appraisal has taken place and notification of entitlement to PGEA if appropriate. This should be signed by the appraisee and the appraiser.

1.2 GP Training Practice Scheme – any practice that wants to become accredited to offer training must

- meet the training practice criteria – these cover not only the attributes of the trainer as a doctor and as a teacher, but also include the overall practice management covering things like the records and registers, performance review and workloads. (see <http://www.nes.scot.nhs.uk/medicine/GPVT/accreditation/documents/CriteriaforApprovalofTrainingandTrainingPractices240205.doc>)
- complete a training practice profile which provides details on
 - Doctors working in the practice
 - Partners' outside commitments
 - Practice staff
 - Practice premises
 - Practice workload
 - Availability and accessibility
 - Out of hours cover
 - The practice team
 - Practice records and registers
 - Practice IT systems, library and teaching aids
 - Hospital services
 - nGMS Criteria
 - Practice developments
 - Trainer's educational profile
 - The GP Registrar
 - Summative assessment and the MRCGP
 - GP registrar training in specific areas
 - The Retainer doctor

(See :

<http://www.nes.scot.nhs.uk/medicine/GPVT/accreditation/documents/TrainingPracticeProfile220905.doc>)

Inspection visits are normally undertaken by a team of four people²¹ and take up a half-day. During the inspection visit further material must also be made available such as: all audits and the relevant data collection; all significant events; the practice leaflet; the practice formulary; a written policy of repeat prescribing and a written policy on handling controlled drugs.

2. Dentistry

2.1 NES is involved with the development and administration of continuing professional education for all members of the dental team. For example, NES is responsible for approximately 600 courses per year: 450 for GDPs and 150 for the team.

²¹ The team normally comprises a lead visitor from NES, a second visitor, a practice manager and a practice nurse.

2.2 It also administers vocational and general professional training for dental graduates, and is committed to educational research and development. New or recent graduates from UK dental schools must complete one year's programme of vocational training in order to be eligible to hold a Health Board list number. The list number allows dentists to work as associates or principals in NHS general dental practice. New graduates on training programmes are known as Vocational Dental Practitioners (VDPs). Training is centred on approved training practices with a complementary educational support programme of 30 study days.

Training practices are inspected to ensure that high standards are present and a dentist in each training practice is identified as the trainer. The trainer is expected to maintain high standards of clinical practice as well as possess an extensive postgraduate record. For example, every applicant is required to produce evidence of participation in Postgraduate Dental Education - a minimum of 15 hours per year over the previous 3 years of verifiable CPD is required. Practices wishing to become training practices get an informal "advisory" visit; this is followed up by a formal visit which lasts about an hour. The inspection team normally comprises a Vocational Training Adviser from the Region nearest to the practice and a GDP trained in the inspection process. The inspection team goes through a checklist that covers things like equipment, records, patient assessment questionnaires and health & safety²². (NB: it excludes the quality of dental care, as NES relies on the Dental Reference Officers²³ to cover this area.) Successful candidates obtain a Practice Inspection certificate which is valid for a period of 3 years. (NB: There have been some attempts to co-ordinate these inspections with Health Board Dental Practice Adviser inspections, through the Deputy CDO, but this has not progressed.)

VDPs must demonstrate 'satisfactory completion' of VT by providing 'assessment evidence' corresponding to several areas in the VT portfolio (Record of Progress and Achievement - RPA). Collectively, the evidence in the RPA should demonstrate competence in all domains of the competency document i.e. clinical, communication, professionalism and managerial, and across a wide sample of the individual competencies within each of these areas.

2.3 NES also supports audit, by promoting audit widely and by funding a small number of larger projects. NES has a number of "off the peg audits" including

- Recall procedures
- Caries guidelines
- Quality of radiography
- Medical history
- Patient satisfaction
- Oral cancer screening

In addition, NES has published several audit reports including

²² Hard copy of full checklist is available if required.

²³ See the PV element of the Contracts paper.

- Cross infection control procedures
- Antibiotic prescribing patterns

2.4 NES are also proposing to set up a system to run on-line audits for dental practitioners in primary care settings. The audit projects would be worked up in advance, hopefully on national priority topics, and be advertised in advance through magazines such as Scottish Dentist and BDA news. Background information, methods and data collection tools would be down loaded by practitioners ready to start collecting data on a particular date. Once the data is collected it would be e-mailed or posted to a central position for analysis. Results would be fed back to practitioners individually, to allow comparison with colleagues and amassed results would be posted on the website. Changes would have to be implemented individually to suit different practice circumstances, but a reporting system for changes would have to be considered for the "audit cycle" to be completed. The outcome of these audits would be

- Produce national figures for clinical effectiveness
- Start producing minimum standards for other practitioners
- Fulfil audit requirements (Clinical Governance) for practitioners who have little experience or interest in audit.
- Improve the quality of service for patients across Scotland

A "carrot" system of verifiable CPD hours would need to be considered, e.g. Submission of two rounds of data ie before and after change and a report highlighting changes made would be credited with 2 hours of verifiable CPD.

2.5 Another new initiative from NES is to help dentists develop dental practice development plans.

3. Nursing, midwifery and health visiting

3.1 The Nursing, Midwifery & Allied Health Professions Directorate of NES (NMAHP) is committed to investing in continuing professional development (CPD), enhancing the quality of educational provision, and providing services for a wide group of stakeholders in Scotland. The directions taken by the Directorate reflect the Scottish Executive Health Department's priorities and the specific needs of NHS Scotland.

3.2 NES (NMAHP) supports CPD by facilitating the development of competency frameworks, developing curriculum descriptors and pump priming the associated educational provision. For example, it has been involved in the development of new roles designed to meet NHS Scotland's Modernisation Agenda.

3.3 NES (NMAHP) is responsible for the approval and annual monitoring of all pre-registration and post-registration educational programmes for nurses and midwives in Scotland, where NES applies the NMC principles and standards.

4. Pharmacy

4.1 NES (Pharmacy) is the National UK Centre for Continuing Pharmaceutical Education in Scotland. It provides an education and training programme, which includes face-to-face courses, distance learning, video conferencing, open learning opportunities and specially commissioned courses for hospital and community pharmacists working within the NHS in Scotland, by a number of different methods to allow maximum flexibility and contact.

4.2 The RPSGB is strongly advocating CPD as described in paragraph A.4 above and NES (Pharmacy) intends to support this initiative within Scotland in various ways. The philosophy and recording of CPD will be encouraged through all distance learning resources and direct learning courses. A national course on CPD was also organised as part of the NES (Pharmacy) 2004/05 programme of events.

4.3 Pharmacists are now being recognised as public health practitioners, but their role has not yet been fully developed. Pharmacy has a significant contribution to make to public health and the new pharmacy contract will provide a framework to develop this role further so NES (Pharmacy) has produced a raft of distance learning packs covering issues such as smoking cessation, chronic respiratory disease and emergency hormonal contraceptive.

4.4 NES Pharmacy is developing a system for Significant Event Analysis (SEA) for all pharmacists in Scotland, based on a model currently used by General Medical Practitioners. All pharmacists in Scotland are being encouraged to complete and submit SEA as a tool for learning, improving patient safety and managing healthcare risk. In May 2005 NES trained pharmacists from each Scottish Health Board area to allow formation of a Peer Review Network that provides individual feedback on submitted SEA forms. Submitted SEA forms are anonymised and reviewed independently by two of the trained SEA peer reviewers. Their comments are collated and specific feedback is provided to the pharmacists with suggestions on how they may further enhance their practice. Peer reviewers review SEA from outwith their geographical area to maintain confidentiality.

5. AHPs

NES is supporting a number of initiatives for AHPs including work around practice placements for AHPs and the CPD needs of this group of professions. The CPD initiative involved the CPD Learning Needs Project which helped AHPs in each territorial health board to carry out a learning needs analysis.

6. Healthcare Scientists

The NES website refers to a project which will be developing National Occupational Standards (NOS) for approximately 40 different disciplines within the Healthcare Science workforce. These standards will be developed for practitioners working at all levels and will provide national benchmarks for competent performance within the Healthcare sector. Integral to the project

outcomes will be the development of accompanying assessment strategies, the identification of educational requirements and delivery mechanisms and the definition of a clear implementation strategy. However, no further details are available meantime.

7. The Scottish School of Primary Care (SSPC)

The SSPC is the national organisation promoting research and increasing capacity for research in primary care across Scotland. It is funded by the Scottish Executive Health Department and is a virtual school with the following main aims

- Provide high quality research evidence needed to inform decisions made by patients, practitioners, managers and policy makers.
- Increase research capacity and capability with Scotland.
- Increase the relevance and use of research-based evidence in health policy and practice.

RCGP Revalidation Toolkit – Examples of evidence

1. Good clinical care

- Prescribing - feedback from an appropriate source such as a prescribing adviser.
- Referrals – analysis of 10 anonymised referral letters that comply with specified criteria
- Review of clinical practice – list of audit activity and at least 2 clinical audit reports to which the doctor has contributed
- Drugs, equipment and emergency care - current practice accreditation certificate; significant event analysis of managing an emergency

2. Maintaining good medical practice

- Annual personal development plan and review of last year's learning activities signed by the doctor and the reviewer.

3. Relationships with patients

- Review of communication skills – patient satisfaction surveys / questionnaires
- Complaints – current practice accreditation certificate
- Removal of patients from list – current practice accreditation certificate

4. Working with colleagues

- Team working – current practice accreditation certificate
- Medical records – current practice accreditation certificate

5. Teaching and training

- Trainer approval or statement / certificate from teacher appraisal from a university department (formal teachers as opposed to occasional teachers)

6. Probity

- Standard GMC statement signed by the doctor to the effect that the doctor does not e.g. knowingly provide false certificates or seek financial gain from patients other than the normal remuneration

7. Health

- Standard GMC statement signed by the doctor to the effect that they do not e.g. ignore their own or colleagues' unsafe behaviour

Quality Practice Award (QPA) criteria and examples of evidence required.

Criteria	Examples of evidence required
Accessibility	<ul style="list-style-type: none"> Written policy regarding access to doctors, practice nurses and other health professionals Description of systems Audit results
Patient information and choice	<ul style="list-style-type: none"> Practice leaflet
Management of chronic illness	<ul style="list-style-type: none"> QMAS results Management plans to care for patients with chronic conditions
Medicines management	<ul style="list-style-type: none"> Audit of compliance with at least 1 section of the BNF Survey of medication reviews Actions agreed with prescribing adviser
Investigations	<ul style="list-style-type: none"> Description of the system for reviewing & actioning any investigation / letter Policy on how patients are informed of results of investigations
Referrals	<ul style="list-style-type: none"> Referral letters
Preventative care and health promotion	<ul style="list-style-type: none"> Copy of new patient questionnaire & protocol for new patients initial consultation Survey of patients > 45 showing that BP has been recorded in the last 5 years
Children's health	<ul style="list-style-type: none"> Examples of patient information sheets % children <6 who have completed their recommended immunisation programme
Women's health and family planning	<ul style="list-style-type: none"> written policy on cervical screening audit of inadequate smears policy for responding to requests for emergency contraception
Mental health services	<ul style="list-style-type: none"> protocol for identifying and managing post natal depression QMAS results re register for people with schizophrenia, bipolar and other psychoses
Maternity services	<ul style="list-style-type: none"> Guidelines on ante natal care and screening
Cancer services	<ul style="list-style-type: none"> QMAS results re register for cancer patients
Continued care in the home	<ul style="list-style-type: none"> Protocol for the identification of carers and a mechanism for the referral of carers who want a social services assessment
Services for people with disabilities	<ul style="list-style-type: none"> List of facilities and accessibility to practice
Minor operations	<ul style="list-style-type: none"> Practice log of minor ops complies with minimum data set
Team values	<ul style="list-style-type: none"> 2 case studies per discipline showing evidence of teamwork
Team working	<ul style="list-style-type: none"> evidence of systems to improve communication e.g. minutes / agenda of meetings
Continued professional development	<ul style="list-style-type: none"> description to confirm NMC registration has been checked / is current description of appraisal system
Patient and public involvement	<ul style="list-style-type: none"> patient survey results and methodology action plan resulting from patient survey
Clinical governance	<ul style="list-style-type: none"> audit calendar
Records, registers and computers	<ul style="list-style-type: none"> procedures for data entry written policy re back-up / storage etc of data policy on access to computerised data
Practice management	<ul style="list-style-type: none"> policies on staff employment person specifications / job descriptions policy for instrument sterilisation
Premises and equipment	<ul style="list-style-type: none"> details of system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment.

F. Conclusion

There is a considerable amount of work already taking place in primary and community care area and it looks as though NHS QIS could take some assurance from the work of others including regulators, NHS boards and NHS NSS PV teams. However, before doing so, NHS QIS should also consider the following factors

- Independence of the reviewers – the issue arises particularly when local professionals are reviewing their colleagues
- Skills of the reviewers – how are they selected, trained and appraised?
- Consistency of teams – is it just who is available on the day or has it been possible to mix and match based on skill mix, experience etc.
- Time available for review teams to absorb data submissions
- Quality of the records systems e.g. there have been particular problems extracting data from GPASS and QMAS functionality needs to be improved in some areas.
- Whether NHS boards are undertaking robust self-assessment, underpinned by sound evidence and pursuing continuous improvement on a consistent basis across Scotland.

Finally, NHS QIS needs to be aware of and monitor the outcome from the current public consultation on proposals for change in healthcare professional regulation that may have implications for the GMS, GPS, GDS and GOS contracts. The consultation was launched by the Department of Health on 14th July 2006 and closed on 10 November 2006, seeking views on the Chief Medical Officer's proposals in

1. *"Good doctors, safer patients"* - this consultation paper can be found at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137232&chk=KW63va

2. *"The regulation of the non medical professions"* published in July 2006. This can be found at <http://www.dh.gov.uk/assetRoot/04/13/72/95/04137295.pdf>

Among the key themes raised in these reports are: changes to the governance and accountability of the professional regulator; the importance of operationalised standards against which to regulate; the appropriate legal standard of proof; the introduction of an independent adjudicator; a spectrum of revalidation across all clinical professions; and, devolution of some regulatory powers to the local level.