

Shifting the Focus

**Leading on quality
improvement and patient
safety in community
and primary healthcare
services**

October 2007

NHS QIS is committed to equality and diversity. We have assessed this report for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For a summary of the equality and diversity impact assessment, please see our website at: www.nhshealthquality.org.

The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

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Setting the scene

In this strategy document we have used the term “community and primary healthcare services” to describe care that is given outwith the hospital setting. It is estimated that 90% of care is provided in community and primary healthcare services by a wide range of community based professionals such as independent contractors (general practitioners, pharmacists, optometrists and dentists), nurses, health visitors, physiotherapists, speech and language therapists, dieticians and podiatrists. These professionals work in partnership with colleagues in specialist services to deliver services from a range of settings including people's homes, local health centres, community clinics and GP practices. Information derived from the Information Services Division statistics estimate that in 2005 there were 27.4 million patient contacts with members of medical practices in Scotland. Of these contacts, 57% were with GPs, 24% with practice nurses, 13% with district nurses and 6% with health visitors. On average, people in Scotland visit the GP team 6 times a year.

Overarching Principles

Our community and primary healthcare work programme has been developed to foster and support quality improvement in patient care. It is:

- person-centred, working in partnership with patients, the public and carers
- aligned with the strategic direction and policy thrust of Delivering for Health
- reflective of NHS board accountability
- collaborative, involving all organisations involved in health and social care
- built on existing models, networks, expertise, intelligence and experience, and
- proportionate and risk based, taking account of the best available evidence.

Introduction

NHS boards are responsible for making sure that a full range of community and primary healthcare services are available to everyone living in the board area as well as to visitors, students and other short-term residents. Many community and primary healthcare services operate within a contractually driven environment. One of the challenges of working in such an environment is to ensure that improvements in the quality of care and patient experience carry the same importance as monitoring of volume, activity and funding. Co-ordination is complex involving both directly employed staff and contracted services working together with others to provide seamless, integrated care. The interface with social care and the voluntary sector is essential in ensuring that individuals get the care and treatment they need.

At present the only quality standards for primary care services in place are those within the different contracts for each of the four independent contractor groups. NHS QIS has published standards for the provision of safe and effective primary medical services out of hours but there are no explicit quality standards for community based services across Scotland.

To date, NHS QIS (and its predecessor organisations) has focused mainly on secondary care in a hospital setting as evidence shows that this is a high risk environment. While we have a number of projects that include community and primary care, their development has been ad hoc. In the main, we have tended to focus on the referral and discharge aspects and monitored the effectiveness of this from the perspective of secondary care.

Given the strategic direction that has been set out for Scotland in Delivering for Health, and the drive to move care from hospital settings into the community, NHS QIS is committed to reflecting this shift of focus in our work programme. Specifically, we will develop an intensive 'start up' programme of work that supports a refocus of our own agenda and underpins the work already underway in NHS boards on delivering a range of innovative and flexible local solutions against this new agenda.

We have a lot to learn and we warmly acknowledge the support, advice and expertise provided by many during the development of this strategy. We look forward to delivering against the challenging work programme we are putting in place and to working with colleagues in community and primary healthcare.

David R Steel
Chief Executive

1 Shifting the Focus

In shifting the focus of NHS QIS work more toward community and primary healthcare services our starting point was to ask key questions.

- How will NHS QIS 'add value'?
- What quality improvement activity is already underway in community and primary healthcare services?
- What opportunities are there to improve the quality of care and patient safety?
- Who do we need to work with?

1.1 How NHS QIS will 'add value' – the aims of this strategy

In supporting NHSScotland to continually improve the quality of care and treatment delivered to patients in community and primary healthcare services, we need to:

- be a trusted and credible source of knowledge about quality improvement in primary care and facilitate the link between research and delivery of care
- improve patient safety in community and primary healthcare by using available data to address variations in practice, learning from past experiences and supporting the implementation of clinical governance and risk management
- promote the best possible clinical care through the development and dissemination of clinical guidelines, standards and best practice statements
- support and encourage staff in improving services and developing their clinical practice through networks, practice development programmes and events that promote the sharing of best practice and the translation of evidence into practice
- support NHS boards in the review and monitoring of performance to determine how well NHS services are performing against the quality improvement standards set. We are continually evaluating and developing our assessment models to ensure that they are proportionate to the service being reviewed; adopt a risk-based approach; and take account of best evidence.

1.2 What quality improvement activity is already underway in primary care?

Monitoring, audit and clinical effectiveness are well-embedded in much of community and primary care and the challenge is to make sure the results of such work are used to improve the quality of care. We commissioned a mapping exercise to identify and describe:

- contract related monitoring work that NHS boards are required to carry out
- clinical effectiveness work (non contract based) that NHS boards are undertaking
- quality assurance work undertaken by other organisations and professional bodies, and
- primary care quality monitoring/quality improvement work that is already underway within NHS QIS.

Information gathered through the mapping exercise was used to guide the development of our community and primary healthcare services work programme. A summary of the community and primary healthcare services mapping exercise is included as Appendix 1. The full report is available for download from www.nhshealthquality.org

1.3 What opportunities are there to improve the quality of care?

We identified the following key opportunities that can be used to drive up the quality of care in community and primary healthcare services.

- **Delivering for Health:** The implementation and future development of the Scottish Government's long-term strategy for healthcare in Scotland is currently being taken forward through 12 separate streams of work. Of these, the workstreams designed to shift the balance of care, tackle health inequalities, develop remote and rural healthcare and improve the management of long-term conditions, are of particular relevance to the future of community and primary care. We will play an active role in these workstreams and support, as appropriate, the implementation of initiatives such as the AHP Rehabilitation Strategy, the Review of Nursing in the Community, the Community Hospitals Strategy, the Community Health Partnership (CHP) toolkit for assessing services for long-term conditions, the Scottish Patients at Risk of Re-admissions and Admissions (SPARRA) Algorithm, and Delivering Care: Enabling Health.

New contracts or arrangements for independent contractors

- **General Medical Services (GMS)** - quality has always been important with a widespread culture of clinical audit and the new GMS contract, introduced in 2004, requires services to be delivered within a Quality and Outcomes Framework (QOF). Additional/enhanced services are delivered against standards identified within the contract. NHS boards review performance against the QOF and NHS QIS in turn reviews the Boards' arrangements for doing this. We are also supporting the development of a web-based tool to allow comparative analysis of medical practice data to identify variations.
- **Dentistry** - in line with General Medical Services the new arrangements for dentistry bring an increased emphasis on quality of both process and outcomes with a requirement for quality/contract visits to all practices on a more regular basis and to a more robust format.
- **Optometry** - introduced in 2006, the new arrangements for community eyecare services require both the optometrist and the eyecare premises to be accredited. Additional services are also subject to quality standards and monitoring that need to be developed.
- **Community Pharmacy** – has a strong culture of quality improvement and the new pharmacy contract, introduced in phases from July 2006, encourages development of clinical services to complement those already available within GMS and optometry.

All four contracts share elements which reflect the principal aims of Delivering for Health, and which will be best evaluated when viewed from a patient's perspective. These elements include: improving the patient's journey and access to services; an emphasis on preventative, anticipatory healthcare; development of staff, their skills, competencies, and their capacity for teamwork; and support for infrastructure, including facilities and IT functionality.

- **Community Health Partnerships**

Following the abolition of Trusts in 2005, Boards were required to develop single system models bringing together acute and primary care services as well as explicit partnerships with local authorities. These are called Community Health Partnerships (CHPs) and there are 40 CHPs in Scotland. They are configured in a number of different ways with different strategies for engaging with social care and independent contractors. A few CHPs are described as Community Health and Care Partnerships to reflect this engagement. CHPs provide a focus for partnership working and integration

between primary care, specialist services, local authorities, the voluntary sector and other stakeholders to ensure that local population health improvement is placed at the heart of service planning and delivery. CHPs play a key role in shifting the balance of care to more local settings, and improving the health of local people. Within that policy context the specific priority areas for CHPs are:

- easing access to primary care services
- taking a systematic approach to long-term conditions
- providing anticipatory care
- supporting people at home
- avoiding hospital admissions
- identifying opportunities for more local diagnosis and treatment
- enabling appropriate discharge and rehabilitation
- improving health and tackling inequalities, and
- improving specific health outcomes.

- **Integrated care**

Delivering for Health commits NHSScotland to developing integrated care which brings together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health improvement. To the patient, it means a process of care that is seamless, smooth, and easy to navigate. To the provider, it means working with professionals from different fields and coordinating tasks and services across traditional professional boundaries. We are currently working with professionals, patients and carers to support the development of integrated care models for diabetes, unscheduled care, and mental health services. This approach builds on work already taking place through the shared services model and focuses on developing a care plan with measurable goals that is agreed by those using services and those providing them

- **The Scottish Patient Safety Alliance**

In partnership with the Scottish Government, NHS boards, Royal Colleges and professional bodies, and patients, we are taking part in a world-leading programme aimed at improving patient safety. Although focusing initially on acute care, the programme aims to promote a culture of safety across all services.

- **Information management**

eHealth can be defined as the development, application and implementation of technology to improve effectiveness in healthcare. The National eHealth Strategy identifies how IM&T can support NHSScotland

to provide efficient patient care through the development of operational, knowledge and information systems. Together with the eHealth Strategy, the National Clinical Dataset Development Programme supports clinicians to develop interoperable national data standards to facilitate the implementation of integrated care records across NHS Scotland.

Our strategic approach to shifting the focus of the NHS QIS work programme will centre initially on these areas and will build on the work already underway in NHS boards. The community and primary healthcare work programme will complement and build on the findings of the NHS QIS clinical governance and risk management review programme as well as the work of the NHS QIS clinical governance and patient safety support unit. Further details of this ongoing work is available from www.nhshealthquality.org

1.4 Who do we need to work with?

In developing and delivering our work programme for community and primary healthcare services, we will work closely with 3 key partners.

- **NHS boards**

NHS boards carry out monitoring work already and are themselves subject to scrutiny. In particular, Community Health Partnerships (CHPs) are the management groups responsible for the local delivery of services and for the integration between primary care, specialist services, local authorities and the voluntary sector. Our aim is to work with NHS boards by building on existing quality monitoring systems and concentrate on filling gaps rather than adding extra layers.

- **Healthcare professionals and their professional bodies**

The professional bodies (such as the Royal College of General Practitioners, Royal College of Nursing, Royal College of Midwives, British Medical Association, British Dental Association, Royal Pharmaceutical Society etc.) provide support and education for members through a range of quality initiatives including standards development, publication of guidelines, clinical audit and continuing professional development.

- **Patients, carers and the public**

We need to learn from the experiences and views of patients and carers and take account of the opinions of individuals from across

Scotland's diverse communities. The Public Partnership Forums that are integral to each CHP provide a useful opportunity to take this forward, as does our own Patient Focus Public Involvement (PFPI) strategy.

We will also collaborate with many other organisations in delivering the work programme, including:

- **Special Health Boards**

Working alongside NHS Education for Scotland and NHS Health Scotland in the design and commissioning of education for community and primary care staff, as well as communicating information and implementing action to improve health.

- **Information Services Division (ISD) of NHS National Services Scotland**

ISD has a major role to play in the programmes of work delivered as part of Delivering for Health. It collects NHSScotland core datasets and provides advice on how best to use information to ensure efficient and effective delivery of patient care.

- **Further and higher education institutions**

The academic community is a source of technical and evaluative expertise and leadership that NHS QIS must capitalise on. We will seek to build on and further develop the highly productive NHS/academic collaborative work that exists across Scotland.

- **Voluntary organisations**

The voluntary and community sector plays an important role in community and primary healthcare services, working alongside professionals, patients and carers. Through its engagement of volunteers and healthcare professionals, the services it provides and the support it gives to individuals and groups is highly valued.

- **Local authorities**

NHS boards work in close partnership with local authorities to make sure health and social care is provided seamlessly and to maximise the use of resources. CHPs have responsibility for developing these partnerships and it is now widely accepted that

truly holistic care includes health and social care, particularly for vulnerable groups such as children, older people and those with learning disabilities and mental health problems.

- **Other regulatory bodies**

We recognise that the strategic environment in which quality assurance organisations, inspectorates and regulators operate is complex and evolving. We want to ensure that our collaborative engagement in this field is as effective as it can be, taking account of the differing remits and statutory responsibilities of the organisations involved. Health and social services are well regulated and it is important that we use the wealth of intelligence and information collected to develop a proportionate and risk based approach to the review of services.

2 Measuring success

We will measure our progress against the outcomes described in the work programme and we will report regularly on this to services, our partner agencies and people in Scotland. As our main aim is to provide NHS boards with the support they need to improve the quality of care, we will seek feedback on whether we are achieving this and we will also commission independent evaluation of our work.

Appendix 1

Executive Summary: NHS QIS ‘Mapping Exercise’: Primary and Community Care: Monitoring and Quality Assurance

Introduction

Most healthcare is delivered in settings outside hospitals. This is described as primary and community healthcare and is provided by a wide range of community-based professionals, as well as independent contractors such as general practitioners (GPs) and community 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. A new strategic direction has now been set out for NHSScotland in Delivering for Health, which gives an enhanced and expanding role to primary care and shifts 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 undertaken, 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 NHSScotland 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 focused on four areas:

- 'Contract-related' monitoring
- Clinical Effectiveness work at NHS 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 colleagues in NHS boards and other organisations. The researcher 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 NHS 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 principal aims of Delivering for Health. These include: improving the patient's journey and access to services; an emphasis on preventative, anticipatory healthcare; development of staff, their skills, competencies, and their capacity for teamwork; and support for infrastructure, including facilities and IT functionality.

There is also a great deal 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 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, and
- updating information on current clinical effectiveness work at NHS board level and the development of a template for NHS boards to use when reporting on this.

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- in community languages.

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