

Delivering Quality in Primary Care Progress Report

implementing the Healthcare Quality Strategy
for NHSScotland

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Contents

	Page
1. Chairman's introduction	2
2. Context	4
3. Overarching considerations, priorities and challenges ahead	7
4. Progress so far	17
5. Conclusion	35
6. Annex A	37
7. Annex B	39



1. Chairman's introduction



In August 2010, following earlier publication of the *NHSScotland Quality Strategy*¹, the *Delivering Quality in Primary Care Action Plan*² was published. It identified a shared focus on priorities and a strategic direction for the development of primary care in Scotland. The plan made a commitment to a set of key enabling national level actions which were seen as most likely to make the biggest impact on improving quality in primary care. In order to promote progress, a Delivering Quality in Primary Care (DQPC) steering group was established.

As chairman of the DQPC steering group, I have been grateful for the time, enthusiastic participation and professional expertise that individual members have brought to this work and for the supporting secretariat. In driving forward the actions, one of our main concerns has been how to ensure that the key contribution of primary care is sufficiently recognised and that the independent primary care contractors are full partners in that progress. We have recognised that professional leadership is key to the successful implementation of the plan, working in partnership with the Scottish Government, NHS Boards and other agencies.

I believe the DQPC steering group has exemplified a mutual, collaborative NHSScotland working together towards a common aim. This short report is a description, in practical terms, of actions that have been taken to begin the journey of turning our vision for primary care into reality. It sets these actions in the context of the work of the Quality Alliance Board³ and its National Quality Delivery Groups, framing them alongside existing initiatives. Inevitably, this report cannot do ample justice to the myriad of endeavours that are presently underway to improve quality in primary care services for patients throughout Scotland. In particular, it does not seek to elaborate on the respective roles of individual health professional groups, which are continuing to evolve rapidly as new models of care are developed.

The Delivering Quality in Primary Care Action Plan set in train a plan which aspires for long-term sustainable improvement of quality in primary care in Scotland. In the short term, we envisage that the DQPC steering group will continue to act as a reference group to promote the development of the actions in the DQPC plan. In the longer term, the Scottish Government's National Quality Strategy Delivery Group structures will take forward any specific actions for primary care.



Sir Lewis Ritchie

- 1 The Healthcare Quality Strategy for NHSScotland, Scottish Government, May 2010, <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality>
- 2 Delivering Quality in Primary Care Action Plan, Scottish Government, August 2010, <http://www.scotland.gov.uk/Resource/Doc/321597/0103382.pdf>
- 3 <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/QAB>



2. Context



The Delivering Quality in Primary Care process began in Autumn 2009. It is recognised that the scale of the challenge across the NHS in Scotland is rapidly escalating: an increase in the proportion of the population who are living longer with multiple long-term conditions, public health imperatives including reducing health inequalities, new technologies and tight financial constraints. NHS Board Chief Executives came to the view that primary care – where 90% of NHS patient contact begins and ends – should be at the heart of meeting these challenges. Importantly, engaging with all health professionals would be key to achieving this. The vital role of primary care professionals in the planning and delivery of high quality, appropriate, sustainable care also lies at the heart of the Scottish Government's recently published consultation on proposals for integration of health and social care⁴.

This renewed engagement was met with enthusiasm and through a planned series of regional events, welcome dialogue with primary care practitioners took place. Discussion was based around the key themes of the emerging Quality Strategy (safe, person-centred, effective care). From the constructive and enthusiastic participation there emerged three high-level messages:

- Health professionals had enthusiasm to engage and work together;
- Acknowledgment that finances were a key challenge but not insurmountable; and
- Raising and sustaining quality was the prime motivator for action.

There was a focus in the process on taking action: what were the key steps which would make the biggest difference? The output of this engagement and discussions was set out in the Delivering Quality in Primary Care (DQPC) Action Plan which was launched in August 2010 by the Cabinet Secretary. This was not a separate strategy, but articulation of the Quality Strategy for primary care. In that context the DQPC Action Plan set out the strategic direction for primary care as follows:

- Care will be increasingly integrated, provided in a joined-up way to meet the needs of the whole person;
- The people of Scotland will be increasingly empowered to play a full part in the management of their health;
- Care will be clinically effective and safe, delivered in the most appropriate way, within clear, agreed pathways; and
- Primary care will play a full part in helping the healthcare system as a whole make the best use of scarce public resources.

4 Integration of Adult Health and Social Care in Scotland, Scottish Government May 2012 www.scotland.gov.uk/Publications/2012/05/6469

The actions themselves are listed at Annex B and progress on these actions are covered in section 4. The plan stressed, in addition, two overarching themes about the way in which business was to be done:

- Ensuring that primary care plays its full part in the work of the NHS; and
- Engaging with independent contractors who constitute such a large proportion of primary care practitioners as full partners in service and policy developments.

The Delivering Quality in Primary Care Steering Group was set up under the Chairmanship of Sir Lewis Ritchie in October 2010. Its principal role was to monitor and drive implementation of the national actions and recommend any new actions which would help deliver the vision. The members of the group are set out at Annex A.



3. Overarching considerations, priorities and challenges ahead

Overarching considerations

This report takes stock of progress of which we are aware in the key areas identified. In almost every case this is being taken forward by others and many of the developments had their genesis before we started our work. However, we hope this report helps to highlight what is being achieved across the country by dint of active engagement with practitioners and a firm focus on quality.

Progress so far

The Steering Group is pleased to note that good progress is being made in each of the areas identified by practitioners and others who contributed to the DQPC process.

The fuller story is told in section 4. While it might seem unfair to pick out particular examples – we would draw particular attention to the excellent work on *patient safety in primary care*⁵, developing and making widely available the *productive general practice*⁶ tool, *leadership*⁷, *integrating eye care*⁸, rolling out *Childsmile*⁹, *the emergency care and key information summaries*¹⁰ and on steps such as the *Links project*¹¹ aiming to help tackle Scotland's health inequalities.

The combination of new national actions and effective local activity throughout the country is gratifying and reflects a renewed sense of energy and purpose in primary care. Moreover the group has had the sense that the 11 areas of national activity and indeed the two overarching themes (the central role of primary care and the need for strong, productive relations with independent contractors) remain entirely appropriate.

Challenges ahead

The task is, however, far from over. Since the creation of the Action Plan, and the establishment of the Steering Group, the challenges which both were intended to meet have undoubtedly grown. We are clearer than ever before about the scale of the challenges facing the NHS in Scotland, and its partners in local government and the third and independent sectors, in terms of public health, demographic change and financial challenge.

5 http://www.healthcareimprovementscotland.org/programmes/patient_safety/patient_safety_in_primary_care.aspx

6 http://www.institute.nhs.uk/productive_general_practice/general/productive_general_practice_homepage.html

7 [http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/leadership-and-management-\(lamp\).aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/leadership-and-management-(lamp).aspx)

8 [www.sehd.scot.nhs.uk/pca/PCA2011\(O\)02.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2011(O)02.pdf)

9 <http://www.child-smile.org.uk/>

10 <http://www.scimp.scot.nhs.uk/care-summaries/kis>

11 <http://www.scotland.gov.uk/Publications/2012/05/1043>

We welcome the articulation by the Scottish Government of a “20:20 Vision”¹² for sustainable high quality healthcare and in particular its straightforward recognition that healthcare cannot carry on being provided as it always has been. We strongly support the vision’s emphasis on anticipation, prevention and a shift towards more care at home or closer to home. These are also the priorities articulated in the Scottish Government’s proposals for integration of adult health and social care.

Keeping our eyes on the medium-term goal – the 20:20 Vision – is vital. But in doing so we must also act with urgency. Patients, practitioners, families and carers are already feeling today the impact of the challenges articulated.

The DQPC approach has been characterised by a focus on coming together to agree on practical actions which will make a difference. Faced with the enormity of the challenge, both in scale and complexity, we have sought to try to make sense of a crowded landscape and to tease out tangible actions to take us forward. In that same spirit, the DQPC steering group has set out below those areas we believe to be the most pressing to continue to address. Whilst it will be for the Scottish Government National Quality Strategy Delivery Groups to fine-tune, prioritise and progress the actions needed to move forward these challenges, **in our view these priorities should include an immediate focus on person-centred care, telehealth and telecare developments and access to meaningful primary care data.**

High-level priorities

People at the centre

In all our efforts to provide focus and to make sense of the complex system we work in, we have returned time and again to the fundamental point that it is not inputs and activity which matter most, nor indeed progress on particular conditions or systems, but rather the overall outcomes for individuals and for their family and carers. **In all our activity we must never lose sight of the need to nurture, value and develop the essential patient facing role of clinicians.** It is also about only pursuing particular “improvements” if, taken in the round, they are of net benefit to the individual.

We welcome the endorsement of supported self-management and person-centred care. It is important that these values, attitudes and behaviours continue to be articulated and demonstrated at all levels. In many senses they are as old as the professions we represent. But if pursued vigorously and resolutely they will represent a significant paradigm shift. It is important that we continue to engage patients, carers and practitioners about what this will mean for them on a day-by-day basis.

12 <http://www.knowledge.scot.nhs.uk/scln/resources-library/resource-detail.aspx?id=4002697>

To make progress in this area we expect to see:

National Quality Delivery Groups –

- Giving priority, pace and energy to the newly-launched person-centred programme;
- Ensuring that accountability frameworks and the quality measurement framework focus on the meaningful as well as the measurable, taking forward work to develop and spread approaches and tools that facilitate holistic care and shared decision making;
- Sense checking other interventions – policies, guidelines, improvements, publications etc. – to ensure they enhance and do not cut across this approach. This should be the key litmus test for steps to integrate health and social care.

NHS Boards –

- Creating the conditions and a culture that empowers patients and staff and puts patients and carers at the centre;
- Giving priority and building local leadership and improvement capacity and capability to drive improvement in person-centred care.

The Professions –

- Ensuring curricula for undergraduate and postgraduate education and training give sufficient attention to this area;
- Embedding person-centred practice within the professional development and regulatory frameworks for all primary care contractors.

Telehealth and telecare developments

Faced with new challenges we need to be quicker to adopt new solutions. We consider that the pace and determination with which we adopt innovation will go a long way to determining the success of our response to the challenges we face. This is true for both clinical innovation and technological advances. Technology itself will not deliver better quality, it is an enabler for service redesign and quality improvement. Targeted appropriately and with the right safeguards in place the use of technology such as telehealth and telecare solutions may liberate capacity to target resources to other priority areas of the system. Used creatively, it should maximise vital face-to-face care, and enable greater choice and access for individuals.

This is not primarily about resources for telehealth. It will ultimately require a cultural shift – both professional and public acceptance that this technology should be part of the bigger picture of healthcare delivery enabling greater participation and wellbeing. This will not be straightforward. It will require consistent messaging, explanation and powerful examples of stories that illustrate the transformative potential of technology on outcomes for all.

To make progress in this area we expect to see:

National Quality Delivery Groups -

- Systematically considering telehealth and telecare solutions to enable progress in each of our quality programmes in order to deliver safe, effective and person-centred care in a way that is both sustainable and value for money;
- Giving priority to the appropriate use of this technology as an enabler in anticipatory care planning.

NHS Boards -

- Continuing to engage and work collaboratively with NHS 24 and Scottish Centre for Telehealth and Telecare (SCTT);
- Systematically considering telehealth and telecare solutions in local service redesign;
- Engaging with health professionals on barriers to deploying this technology including issues of data security and confidentiality;
- Ensuring that eHealth leads work closely with NHS 24 and the Scottish Government to explore and spread more widely the use of telecare/telehealth solutions in the primary care setting.

The Professions -

- Engaging constructively with colleagues to identify the opportunities from telehealth and telecare for each of the professions;
- Involving professional champions to help others understand and seek to overcome the barriers to adoption and spread of the technology.

Access to and intelligent use of data

Quality data are central to providing quality care for patients. Best use of data supports clinical care, and promotes excellence in quality improvement at all levels. Such data are essential to underpin clinical governance, for the planning and commissioning of new services and to inform research and development activities. Research provides the essential new knowledge required to improve health outcomes and reduce inequalities. It is vital – particularly when resources are under pressure – in helping our health systems to identify new and better ways of preventing, diagnosing and managing diseases in a clinically and cost-effective way. Relevant research can also make an important contribution in meeting the challenges of Delivering Quality in Primary Care.

In the past, whilst there are rich sources of data in primary care, NHSScotland national datasets have predominately been used in secondary care and public health. This has been changing in recent years, most notably with the creation of PRISMS¹³ to make prescribing data more accessible, and with the quality data derived from the Quality and Outcomes Framework (QOF)¹⁴ payment system. However, the uses of these datasets are constrained, since they are typically aggregated data at practice level, whereas assessing the quality of care beyond the current QOF measures reported usually requires patient level data.

13 <http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/PRISMS/>

14 The Quality and Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices.

General Practice clinical IT systems are the single largest, richest and most consistently recorded source of electronic clinical data at patient level anywhere in NHSScotland but the data are fragmented across more than one thousand general practice systems. The potential of these data will therefore only be realised when a robust national mechanism is established, allowing appropriate access for a range of users and uses. This will require clinical leadership, clarity about how data will be used and for what purposes and, crucially, evidence that practices and patients will benefit from data sharing. The data we use must be meaningful, proportionate and designed to drive quality improvement and sharing of good practice.

In the context of adult health and social care integration it is even more important that we are clear about the purpose, process and governance mechanisms for data sharing and that we make significant progress in this area during 2012 and beyond.

To make progress in this area we expect to see:

The Scottish Government –

- Developing and implementing over the next year a strategic approach to primary care data extraction and uses;
- Ensuring the approach simplifies the information landscape and avoids proliferation of datasets;
- Chief Scientist Office continuing to encourage and support primary care research via the Scottish School of Primary Care and the Scottish Primary Care Research Network to support the ambitions of Delivering Quality in Primary Care.

NHS Boards –

- Engaging proactively in this process, resisting the temptation to add complexity at local levels;
- Developing in collaboration national datasets which will allow Boards to compare key performance indicators helping to share good practice and reduce unwarranted variation.

The Professions –

- Engaging constructively with each of the professions on the use of data;
- Using professional champions to help others understand and seek to overcome the barriers to primary care data extraction and use;
- Agreeing the parameters and use of common data sets for each profession;
- Agreeing the governance principles to be applied in any data extraction process.

Other priorities

Partnerships/relationships

To sustain quality and reliably deliver good outcomes we need to be innovative about how we organise ourselves and, crucially, how we develop and nurture new relationships. This is most clearly relevant to integrating health and social care; but it is also about finding new, tangible and sustainable ways of achieving the elusive integration of the whole health system. The Scottish Government's proposals for integrating health and social care acknowledge the need to make progress on integration within health, as well as between health and social care and working more collaboratively with partners from the third and independent sectors.

Within primary care itself, we acknowledge the ongoing task of finding fresh ways of achieving well-integrated primary care teams. Systems as they stand, including the arrangements for the governance and reward of staff, in part mitigate against the teamwork that is required to deliver the 20:20 Vision and to improve health and reduce inequalities. The complexity of interactions required to deliver high quality care will always require continuous nurturing of relationships, close collaboration and co-operation.

In our view there is a particular urgency to address the interface between community nursing and general practice ensuring that structural boundaries are not barriers to collaborative working.

To make progress in this area we expect to see:

National Quality Delivery Groups -

- Developing explicit plans for engaging primary care practitioners in the new arrangements designed to deliver adult health and social care integration;
- Continuing to put every effort into ensuring that interventions in the service both support collaboration and are themselves well coordinated;
- Considering how to promote optimal collaboration in any new developments, including contractual change.

NHS Boards -

- Working with partners to strengthen links in their area between community nursing and general practice to ensure that primary care teams operate to the benefit of patient care;
- Building on the learning and relationships from whole system working facilitated through the quality and productivity indicators introduced into the QOF in 2011/12¹⁵;
- Fully involving primary care professionals and staff working in community hospital settings in the arrangements to implement locality planning.

15 Details of QOF for 2011/12 can be found at: <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF2011-12.aspx>

The Professions –

- Maintaining local planning, quality improvement, learning forums and other mechanisms whereby all four independent contractors can continue to share good practice and reach joint decisions;
- Testing action learning approaches to promote collaborative practice;
- Building leadership capacity and capability through national and local leadership development.

Sharing good practice and reducing unwarranted variation

As we break new ground in how we deliver healthcare in Scotland we need to be more systematic about identifying what is good, sharing it amongst ourselves and spreading the activity to scale. Of course we need to promote local solutions that meet local needs and are locally owned and adopted, but we are not such a large nation that we cannot spread quickly and effectively good approaches and interventions that will work throughout Scotland.

To make progress in this area we expect to see:

National Quality Delivery Groups –

- Identifying solutions which have been tested and refined and are ready to spread with speed to scale. These include the patient safety in primary care programme, ALISS¹⁶ (access to local information to support self management), anticipatory care planning and medication reviews for polypharmacy;
- Mapping and aligning quality improvement activity in primary care to optimise a cohesive approach, release capacity and maximise impact of improvement;
- Promoting dialogue which provides opportunity for shared learning;
- Commissioning a database designed to capture and promote excellence in primary care.

NHS Boards –

- Prioritising improvement resources to support primary care teams to deliver high quality safe, effective and person-centred care that takes us towards the 20:20 Vision.

The Professions –

- Thinking creatively to establish and maintain processes for peer to peer support and challenge and share good practice.

Workforce

Throughout, the DQPC Action Plan has sought to engage and mobilise the workforce around quality. A key aim has always been to release the energy, creativity and dedication of primary care practitioners. We need a comprehensive workforce development strategy and a set of actions, enabling supports and measures, including education, practice development, career paths and succession planning which ensure that we continue to have the right capacity and skill mix of high quality effective, and capable, practitioners.

To make progress in this area we expect to see:

National Quality Delivery Groups -

- Ensuring that both the Workforce Development Strategy and the Leadership Strategy take full account of current primary care issues and responds to the challenges of the 20:20 Vision. We believe the vision points to the urgent need both for increased capacity, in a variety of forms, in primary and community care and for better use of existing capacity;
- Ensuring robust datasets are in place to inform such strategies.

NHS Boards -

- Engage appropriately with NHS Education for Scotland (NES) primary care educational activities both at regional and national level;
- Creating a culture that fosters innovation, recognises commitment, and nurtures team working;
- Being innovative in use of technology, shared learning opportunities and clinical skills development to build an integrated workforce that is fit for the future;
- Maximising opportunities for dialogue with staff and seeking feedback to continuously improve both the quality of care and the staff experience.

The Professions -

- Working constructively to ensure that with the right safeguards in place comprehensive data are available to inform workforce discussions and decisions in order to optimise quality and productivity;
- Promoting professionalism, excellence and leadership development within all our contractor professions.

Whole system working

The sense of urgency – that things cannot carry on as before – is relevant throughout the health and social care system. This has particular implications for primary care. It remains our belief that primary care occupies a pivotal role, at the interface between different parts of the health system and between health and social care. We welcome the moves towards a more whole system approach to healthcare, working collectively to deliver the best quality outcomes for the people of Scotland. However, we believe more needs to be done including in NHS Boards. There are many different practical ways in which this needs to be articulated. The proposals for locality planning that form part of the Scottish Government’s consultation on integration of adult health and social care offer an opportunity to build upon, discuss and develop this important strand of improvement.

It is our hope that, going forward, there will be a greater focus on effective integration of care among all elements of health and social care services.

To make progress in this area we expect to see:

National Quality Delivery Groups –

- Developing mechanisms within the NHS Board annual accountability process which ensures that the themes in the DQPC Action Plan and highlighted within this document feature in Boards’ local development plans and improvement activity;
- Enabling the Primary Care Strategic Forum to make a key contribution to achieving whole system working;
- Ensuring the Quality Measurement Framework¹⁷ reflects in full the role of primary care, including through appropriate HEAT targets (for example those being developed on discharge data and the outcomes for integration) and in other ways.

NHS Boards –

- Strengthening links between primary care and secondary care and whole system Managed Clinical Networks to ensure a whole pathway approach to service planning, delivery and quality improvement;
- Building on the learning and relationships from whole system working facilitated through the quality and productivity indicators introduced into the QOF in 2011/12;
- Fully involving primary care professionals and staff working in community hospital settings in the arrangements to implement locality planning for health and social care.

The Professions –

- Contributing constructively to opportunities for shared learning, interdisciplinary practice and integrated team working;
- Seeking opportunities to engage with, and better understand, the contribution of local community and third-sector resources to support health and wellbeing.

¹⁷ <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/measuringquality>

4. Progress so far



This report takes stock of progress of which we are aware in the key areas identified. Each of the primary care provider groups, and the professions within them, have their own unique contribution to the national quality agenda shaped by their scope of professional practice and their distinct contractual frameworks for service provision. Whilst this has its benefits around designing and shaping services, it presents challenges in areas such as collaborative and partnership working between professions.

There are national work programmes covering, for example, general dental service and NHS pharmaceutical care – some of which is described throughout the key sections to this report. These work programmes are underpinned by the three main quality ambitions of the Healthcare Quality Strategy for NHSScotland – that is care that is person-centred, safe and effective to every patient every time. The contribution of these individual work programmes will have a prominent place in determining the way forward for the primary care team as whole.

Progress in each of the action areas as at the time of this report (June 2012) is summarised below. Two overarching points need to be borne in mind in considering this analysis:

- While a national action plan and strategic policy are necessary to provide direction, effective local delivery by all stakeholders is key for success. We have not attempted in this report to capture the full extent of such local activity;
- In most of these areas this is a snap shot of the progress made thus far – there is still much to do.

1. Work with the independent contractors on proposals for ensuring that all the contracts are better able to support the delivery of quality care.

A number of national level actions have taken place in support of the desire to work better with the independent contractors ensuring that contracts developed better support the delivery of quality care. These national level actions include:

New **Quality and Productivity indicators** which were agreed nationally and included in the GP contract in 2011/12. These focused on prescribing, emergency admissions and outpatient referrals by GPs. In Scotland we have agreed with the profession the continuation of part of the prescribing element of these indicators into 2012/13, given their discontinuation at a UK level. For 2012/13, new Accident and Emergency indicators have been agreed. These aim to reduce avoidable A&E attendance.

The Cabinet Secretary for Health, Wellbeing and Cities Strategy has signalled her intention to move to a more **Scottish-focused GP contract**. Preliminary discussion on the scope of this has begun with the Scottish General Practitioners Council (SGPC). The intention is to reflect Scottish health priorities and issues within the quality and outcomes framework indicators. Simultaneously the Scottish Government will be looking ahead to the vision for general practice in 2020, involving a wide range of stakeholders in coming to a view.

For 2012/13 changes have been introduced to the **Scottish Enhanced Services Programme** (SESP) to enhance local autonomy and the sustainability of the services its supports. To allow flexibility for delivery SESP funding will no longer be restricted to general medical practice

but can be delivered throughout primary care services. This will provide greater discretion for Boards to consider how spend under SESP will assist primary care in delivering the aims of the Quality Strategy with focus on rebalancing care, support and service provision towards anticipatory care and preventative services.

The Tobacco and Primary Medical Services (Scotland) Act (2010) introduced a power for Scottish Ministers to make regulations to prescribe healthcare professionals (other than medical practitioners) as eligible to enter into GMS contracts with Health Boards. The effect is to allow the possibility, if thought necessary, of future changes to the list of those eligible to hold a GMS contract. The regulations will be able to limit the class of healthcare professional, for example, to nurses only. The RCN is undertaking a piece of work with current associate nurse partners to identify lessons learned in Scotland so far.

A **Dental Practice Quality Framework**, has been developed by the Chief Dental Officer & Dentistry Division of the Scottish Government in partnership with stakeholders, the aim of the framework is to ensure that:

- Patients would have improved oral health through a positive experience of dentistry and would receive evidence-based dental care in a safe clinical environment;
- The dental team would feel involved and supported in their clinical work and would reflect on and improve their professional practice;
- The NHS would be assured that the dental practice was “fit for purpose”, delivered care which was tailored to the individual patient’s need, could demonstrate improved oral health for the patient and makes best use of available resources.

The framework has identified dental practice quality indicators and associated outcome measures, many of which are currently in place or could be in place with minimal additional cost or effort on the part of dental contractors.

Discussion of the implementation phase is underway with stakeholders. It is hoped that several of the quality indicators and outcome measures will be available for report by the end of the year, including a website for patients to obtain information about their dentist and dental practice.

However, this will be the start of the improvement journey for primary care dentistry and not the end point. More challenging dental practice quality outcome measures will be identified in the medium and longer term which would more clearly demonstrate that a dental practice is delivering a quality dental service and contributing to oral health improvement. These could include Patient Reported Outcome Measures (PROMs) and the use of an Oral Health Assessment framework.

It should be recognised that dental practices are currently at different stages of readiness to satisfy more challenging dental practice quality outcome measures. Practices will need varying degrees of support from a range of sources in order to demonstrate improvement in support of the Quality Ambitions.

The NHS (General Ophthalmic Services) (Scotland) Regulations 2006, which set down the mandatory tests and procedures as well as patient specific tests and procedures, are kept under review and amended as and when required. Recent guidance was issued which clarified the frequency of **NHS eye examinations**. To support this individual optometrists/ophthalmic

medical practitioners (OMPs) will be provided with practice profiles data on their patterns of eye examinations, together with comparable practices in order to spread best practice. Other relevant data are being developed to ensure optometrists/OMPs have available to them information to form the basis of clinician to clinician discussions on parameters relevant to quality of care.

The Right Medicine (2002)¹⁸ set out the strategy for modernising and strengthening the role of pharmacists to deliver improved services to the public and patients. Over the last 10 years the Scottish Government has worked with its key stakeholders to modernise the way in which NHS pharmaceutical services in the community are provided and to make them more relevant to the needs of NHS services.

Since 2006 a more service-based approach to pharmaceutical care services has been developed and gradually introduced as part of a long-term strategy to move community pharmacists away from a focus purely on the dispensing of prescriptions to the provision of person-centred care as part of the wider primary care team.

This new service-based approach has been introduced through a phased implementation programme and covers four core services: **Minor Ailment Service** (MAS), **Public Health Service** (PHS), **Acute Medication Service** (AMS) and **Chronic Medication Service** (CMS). Together these services play an important part in shifting the balance of care by:

- Improving access for the public as they do not need an appointment to see their pharmacist for a consultation;
- Decreasing unnecessary workload on GP and nursing colleagues therefore freeing up their time to see patients with more serious complaints;
- Improving health outcomes and minimising adverse events from medicines;
- Helping to address health inequalities; and
- Making better use of the workforce by more fully utilising the skills of community pharmacists.

Building on these service developments, the Scottish Government aims to facilitate further shifts towards person-centred, safe and effective care which is fully integrated with the wider healthcare team across community and specialist settings.

An **ePharmacy Programme** provides the technology support to underpin the new community pharmacy services. It also supplies the platform for Practitioner Services Division (PSD) to modernise the way in which it remunerates and reimburses community pharmacy contractors as part of the ePay Programme. In turn, this provides better and quicker information to Information Services Division (ISD) which can be used for both reviewing and planning NHS services.

The ePharmacy Programme has introduced electronic support for patient registration, electronic transfer of prescriptions (ETP) including electronic claiming and pharmaceutical care planning. ETP improves patient safety through the assurance of patient and medication item selection, provides electronic prescribing, dispensing and claiming information that will allow Scotland to take a leading position in supporting research and development and improves information governance arrangements within the NHS. A central feature of the ePharmacy Programme is to promote better communication between community pharmacists and general practitioners.

18 <http://www.scotland.gov.uk/Publications/2002/02/10633/File-1>

2. Improve access for patients.

Effective primary care services are the foundation of the NHS in Scotland. Excellent access to these services therefore is a key ingredient of high quality healthcare and are crucial in ensuring patients are at the heart of how services are designed and provided. The more effectively access is managed, the better the outcome, the better the impact on the NHS as a whole and, crucially, the better the patient's experience of care. National activity to support better access to services includes:

The Scottish Government in collaboration with stakeholders through the SGPC, has produced guidance aimed at improving access to primary care services, particularly those of GP practices. The Royal College of General Practitioners (Scotland) (RCGP), in consultation with a range of key stakeholders, has developed a fit for purpose **best practice access toolkit** that can help those practices for whom access is a problem to improve access levels equivalent to that already enjoyed by many patients in Scotland. The toolkit follows a medical model which is familiar to practices. It describes the symptoms that exist when access is a problem, how to accurately diagnose the level of access present in a practice and gives advice on how to treat access problems where they exist. The best practice access toolkit has been rolled out to all NHS Boards across Scotland and will support Boards to assist those practices with the greatest challenges.

The **directed enhanced service (DES) for extended hours** has been extended, giving incentive and increased flexibility to practices in how they deliver extended hours in the best interests of their patients. The new **Quality and Productivity (QP) indicators** for 2012/13 which aim to reduce avoidable **Accident and Emergency (A&E)** attendances will help practices assess if the level of access to clinical staff in the practice is appropriate in light of the patterns on accident and emergency attendance.

There has been continued progress on improving access to NHS dentistry through a variety of means such as improved premises and workforce. The **Scottish Dental Access Initiative** has been targeted on those limited areas of the country where there continues to be issues with dental access.

Following a review of community hospitals the Scottish Government has produced the **Community Hospital Strategy Refresh**. This strategy refresh develops the work started by the *Developing Community Hospitals: a Strategy for Scotland* (2006)¹⁹ by providing a new direction and fresh focus. The strategy delivers a bright vision for the future development of community hospitals through:

- Ensuring that people who utilise community hospitals are the centre of care pathways;
- Providing provision for the development of the workforce in community hospitals; and
- Identifying how community hospitals can be developed to better provide for local communities.

The Scottish Government will be promoting the development of community hospitals and community hospital staff through the creation of an **Improvement Network** and a short-life working group. The Improvement Network will be developed in collaboration with community hospitals and hosted by NHS Education for Scotland (NES). It will provide a portal for development opportunities for community hospital staff. The working group will provide support for the development of the clinical side of community hospitals.

19 <http://www.scotland.gov.uk/Publications/2006/12/18142322/0>

In addition to the working group and the improvement network, a set of actions has been drawn together in this strategy that will be taken forward by NHS Boards. The outcomes of these actions will provide the blueprints for NHS Boards and community health partnerships to not only develop modern, locally sustainable community hospital services that are responsive to local community needs; but to also provide community hospitals with the resources to fulfil a valuable role in a modern Scottish health and social care service.

The **Minor Ailment Service** (MAS) has played an important part in opening up access in primary care in recent years; it supports the provision of direct pharmaceutical care within the NHS by community pharmacists.

MAS enables people who are eligible to register with the community pharmacy of their choice for the consultation and treatment of common conditions without the need to visit their GP. Under the service, the pharmacist advises, treats or refers the patient according to their needs.

The service which has been rolled out across Scotland is particularly valued by patients and NHS 24 in the Out of Hours period. Most recent figures show that there are some 840,000 patients registered with MAS. It is estimated that, on average, there are over 11,500 consultations a day in Scotland where a pharmacist advises on, or treats, minor ailments.

3. **Develop and implement a patient safety programme for primary care.**

Healthcare Improvement Scotland's (HIS) development of the **Patient Safety in Primary Care** (PSPC) **programme** objective is to reduce the number of events which could cause avoidable harm to people from healthcare delivered in any primary care setting. They aim to do this by aligning and integrating learning from existing improvement programmes and engaging primary care professionals and other stakeholders in the development, application and roll out of the programme.

The programme is being developed around four work streams:

Safer medicines: including the prescribing and monitoring of high-risk medications avoiding harmful co-prescribing.

Safe and effective patient care across the interface by focusing on:

- Developing reliable systems for medication reconciliation in the community when a patient has been discharged from hospital;
- Improving shared care of patients attending outpatient clinics by reliably implementing recommendations made after clinic attendance;
- The reliable and safe management of test results; and
- Implementing care bundles to ensure reliable care for patients with long-term conditions, such as congestive heart failure (CHF) and pressure ulcers.

Reduce healthcare associated infections in the community, for example develop community-based interventions to improve antimicrobial prescribing and promote hand hygiene.

Leadership and culture using trigger tools (structured case note reviews), safety climate surveys and significant event analysis (SEAs).

HIS is revising the enhanced service specifications for Anticoagulation and Near Patient Testing. These new specifications will include Board and practice level measures that will be used to help demonstrate improvement in safe care. HIS are also developing tools and spreadsheets to capture data that will support the roll out of this enhanced service.

4. Ensure we have in place an up-to-date, agreed suite of care pathways.

The agreement and implementation of care pathways has been a priority issue for the NHS in Scotland for some time. National activity in this includes:

The GMS contract for 2011/12 included new **Quality and Productivity Indicators** under which GPs signed up to three pathways for each of **outpatient referrals and emergency admissions**. The aim of which is to reduce emergency admissions and variation in referrals. While the choice of pathways were made at the NHS Board level to reflect local priorities, the following high-level pathways were developed as **national care pathways**, based on current priorities:

Referrals:

Orthopaedics: hand, knee and back pain.

Dermatology: skin lesions and acne.

Neurology: headache.

Endoscopy: dyspepsia.

Imaging: brain.

Emergency admissions: falls, adult respiratory disease and heart failure.

For each of these HIS, the Scottish Government Quality and Efficiency Support Team (QuEST) and others prepared high-level pathways, guidance notes and updated versions of priority condition-specific pathways. Practice reports will be evaluated to assess the outcomes achieved.

Additionally, through a short-life task and finish group **unscheduled care pathways** for people with long-term conditions were considered and a **set of transferable principles** developed which could be applied across a range of common presentations. The focus of this work was on the group of older people who present to unscheduled care with a fall or as a result of a frailty syndrome such as increased confusion or reduced mobility, both of which are common presentations of patients who are frequent callers to the ambulance service. These presentations will inevitably require further assessment, early intervention, treatment or adjustment of care and support. The result of this work is a series of recommendations which aim to deliver redesign pathways and which:

- Identify opportunities to improve/redesign aspects of the existing pathway;
- Develop a common triage/initial assessment tool for use in the home;
- Consider the role of robust and responsive clinical decision support for practitioners; and
- Describe the anticipated benefits for patients, practitioners and for the system.

Implemented, it is hoped that these recommendations will see more people supported at home and fewer unnecessarily taken to hospital after a fall or minor illness and an increased rate of referrals to the appropriate community-based services.

5. Develop, as part of the quality measurement framework, national quality indicators for the delivery of primary medical services Out of Hours.

National quality indicators will support the delivery of consistent care, allow comparison between different NHS Board areas, and enable continuous improvement within local primary care Out of Hours services. The aim is to improve the quality of care provided so that:

- People have the best possible experience of their local primary care Out of Hours service;
- People receive an accurate assessment of their immediate problem;
- People needing a home visit are seen without undue delay;
- People receive the correct treatment and/or care from their primary care Out of Hours service; and
- Information about a person's Out of Hours consultation is available to their own primary care and, if necessary, hospital staff at the time of the person's treatment.

Draft quality indicators have been agreed and were published in Summer 2011. The testing phase of the indicators is underway (September 2011 to June 2012) in NHS Greater Glasgow & Clyde and NHS Highland to determine how the draft quality indicators can be measured and monitored to improve the quality of services, identify the changes that may be required to improve the quality of services, and test these on a small scale before wider roll out across other NHS Boards.

Additionally, the 2011/12 **patient experience survey** included, for the first time, questions about **Out of Hours services** which will help NHS Boards better understand patients' views.

Work has been taken forward between NHS 24, the Scottish Emergency Dental Service and NHS Boards to develop **dental key performance indicators** which will monitor the patient journey in Out of Hours. As all dental practices are not linked electronically some specific measures may take longer to implement locally.

6. Continue to give priority to anticipatory care.

Changing demographics to an aging population with multiple long-term conditions and complex needs underpins the need for a planned and systematic approach to influence and provide strategic direction in the primary prevention of ill health and reduce health inequalities. Sharing best practice and influencing what happens in primary care by encouraging participation, involvement and challenge of all key players including professional organisations is crucial to make a positive impact in reducing unscheduled hospital activity, enabling people to better manage their own health and keep them well in their own home for as long as possible. National level activities supporting this concept of anticipatory care include:

Change Fund for older people's services is a partnership resource for health, social care and the third and independent sectors, which is expected to act as a catalyst for more radical, innovative redesign of older people's care and support. The aim of the fund is to

improve outcomes for older people and their carers through greater integrated planning, commissioning and delivery of adult health and social care and in partnership with third and independent sectors. It aims to put an end to the “cost-shunting” between the NHS and local authorities that too often ends up with older people being delayed in hospital longer than they should or being admitted to hospital due to social support at home being too difficult and bureaucratic to access quickly. The Change Fund is facilitating a shift in the locus of care from hospital and long-term residential care to primary and community settings, and shifting the focus of care upstream towards anticipatory care and preventative spend.

The Fund is influencing decisions taken with respect to the totality of Partnership spend on older people’s care and support. Following the 2012 Spending review, £80m Change Fund for older people’s services has been made available for Partnerships in 2012/13, with £80m committed for 2013/14 and £70m for 2014/15.

From April 2012, NHSScotland has mainstreamed the **Keep Well programme** of targeted health checks. The programme offers a systematic cardiovascular disease risk assessment and management programme for people aged between 40 and 64 who are at greatest risk of preventable ill health because of their life circumstances. The programme was developed as part of plans to tackle health inequalities and aims to shift primary care practice and culture towards anticipatory care. Patient experience of the Keep Well health programme is being captured as part of the ongoing work on performance indicators which will be a mix of quantitative and qualitative measures.

During 2011 NHS 24 rolled out its **Life Begins at 40** service inviting all adults in Scotland over the age of 40 to complete a health check over the telephone or online. Users who complete a self-assessment questionnaire are given health information tailored to their needs and signposted to other sources of information on local and national services. The online and telephone check-ups are part of a £15m package of services devised to help people over 40 with their health.

DALLAS (Delivering Assisted Lifestyles At Scale) initiative will examine the use of new technologies to support people in their own homes and find out which innovative products, systems and services work best. The three-year programme is part of a UK-wide scheme run by the UK’s innovation agency, The Technology Strategy Board.

The Technology Strategy Board will invest up to £18m over four years to establish three to five DALLAS sites across the UK, with £5m of this for a site in Scotland. The Scottish Government, Scottish Enterprise, Highlands and Islands Enterprise are investing a further £5m in the Scottish Assisted Living Programme. Within Scotland, DALLAS is phase one of the wider Scottish Assisted Living Programme, which aims to deliver effective technologies to support care for people with disabilities and or health conditions in their own homes.

Five areas of Scotland are to take part in the programme that will focus on finding innovative solutions that could improve the lives 10,000 or more older adults with long-term conditions. The work will be led by NHS 24’s Scottish Centre for Telehealth and Telecare (SCTT) and will examine how new technologies can help improve the quality of life of, and support independent living for, older people and people living with long-term health and care issues.

The key objective behind the initiative is to take the next step towards integrating new healthcare and wellbeing technology and services across the public sector, the private sector and the third sector, including by charities and social enterprises. The next steps will be to work closely with the partnerships in the identified areas to scope out the specifications required for the programme which gets underway in 2012 and will run until 2015.

Childsmile adopts a multi-agency approach to improving children's oral health through dental practice, community, and education settings and has a holistic approach to healthy living and health improving life skills. The **Childsmile Core Programme** provides every child with a dental pack containing a toothbrush, tube of 1000ppm fluoride toothpaste and an information leaflet on at least six occasions by the age of 5 as well as a free-flow feeder cup by the age of 1. The **Childsmile Practice Programme** promotes oral health from birth, with families supported in the community via a network of Childsmile Oral Health Support Workers (OHSW) who work closely with Public Health Nursing Teams and encourage toothbrushing, healthy diet and registration with a dentist. Since October 2011, Childsmile is included in the statement of dental remuneration within which those General Dental Practitioners providing NHS items of treatment and the salaried dentists work, so oral health promotion and clinical preventative care can be delivered by all local dental practices. **Childsmile Nursery & School Programmes** provides daily, supervised toothbrushing for all children attending nursery schools and additional clinical preventative programmes such as fluoride varnish for children attending nurseries and schools in our most deprived areas.

7. Help the professions with their workforce planning.

It will be important for NHS Boards and primary care services to modernise and further develop their models of delivery by reconfiguring the existing workforce and introducing a new mix of skills and competencies to meet the challenges faced by the changing population demographics, service delivery imperatives, future workforce profiles and the subsequent change in the needs of patients. National activities in this area include:

The **Modernising Nursing in the Community** (MNiC) Programme Board was set up to support NHS Boards in their workforce planning and development by developing and testing a framework which will assist NHS Boards to carry out this work in a Scotland-wide co-ordinated approach, while enabling local solutions. The online interactive toolkit resource that was launched in January 2012 assists NHS Boards in service redesign and workforce planning/configuration. The site consists of three platforms:

- Children, Young People and Families
- Work and Wellbeing
- Adults and Older People

Each platform illustrates the 12 elements of the framework and will support the delivery of safe, effective and person-centred care in the community. From April 2012 the programme will transition to the **Delivering Modernised Community Nursing Action Plan** which will support Boards in a number of areas including the sustainability of the website and the future direction of education provision.

The **Allied Health Professional (AHP) National Delivery Plan** will help Boards to plan future AHP services and determine priorities including where AHPs can contribute to best effect in achieving national and local targets. The AHP workforce has an essential role to play in implementing the *Reshaping Care for Older People* strategy; they effectively help to keep people well and independent at home, and prevent hospital admissions. In particular, The Change Fund Plans submitted for 2011/12 were reviewed with respect to AHP contribution. Analysis showed that most Partnerships plan to use the rehabilitation and reablement skills of AHPs to help reshape services for older people. AHPs can also support GPs to achieve the new Quality and Outcomes Framework (QOF) indicators by providing alternative pathways for some hospital outpatient referrals and providing services to prevent hospital admissions. To maximise their contribution, the AHP workforce may need to redesign how and where services are delivered, including a shift from acute to community focus, integration across health and social care, better links with GPs and more preventative/anticipatory work.

NES Delivering Quality in Primary Care Co-ordinating Group has been formed to help share information on educational support for primary care. Much of the NES primary care activity is part of a general educational approach to improving quality which often cuts across the specific areas of work in the Action Plan. Examples of how NES is supporting the primary care workforce include **Practice-based Small Group Learning** – an approach to continuing professional development originally developed for general practitioners in Canada. It is now a core NES activity and well established in primary care. It has been shown to reduce professional isolation, plays an important part in developing Communities of Practice and more recently in fostering Faculty Development. Groups were initially established for GPs, then Practice Nurses, and now also for doctors from across primary and secondary care. The aim of the primary and secondary care mixed groups was to enable joint working on educational topics with the wider aim of encouraging productive dialogue between primary and secondary care.

NHSScotland and the NHS Institute for Innovation and Improvement, in partnership with general practices designed and tested a new innovative programme, The **Productive General Practice**, which is now being used in practices across Scotland. It's a practical, flexible programme designed to help practices reduce waste and streamline services for the benefit of partners, staff and their patients. It takes proven approaches used in other areas of healthcare and the worlds of engineering and design and adapts them to the primary care environment.

The programme enables general practices to dramatically improve internal efficiencies whilst increasing support for clinicians, enhancing quality of care, increasing safety and working to better meet the needs of the local population. As well as releasing time there are other gains for practice staff, such as the development of improvement and change management capability.

Productive General Practice is aligned with the Primary Care Patient Safety Programme in Scotland and the RCGP P3 patient involvement work. It can be used by practices in improving pathways, access and working with partners in primary and secondary care.

8. Take steps to ensure more effective partnership between the different primary care professionals.

The establishment and effective operation of the DQPC steering group itself has provided a powerful context for more collaborative working and joint endeavour to address shared problems. The impact continues to be felt both nationally and at the local level, with for example the establishment of similar groupings in some Board areas.

The RCGP and NES have begun a collaborative project on developing and implementing a **leadership programme** for primary care practitioners. This is being carefully designed to ensure that all primary care professions can benefit in their own right and from collaborative learning. This leadership capacity within primary care will be essential in the context of the commitment to ensure that there is clear and effective clinical leadership in and of the new bodies to be created in the context of the integration of health and social care.

There have been a number of specific collaborative endeavours including an innovative joint venture between Community Pharmacy Scotland and Optometry Scotland to ensure each profession can draw more effectively on the skills of the other for the benefit of patients.

The framework, *Breaking Down the Barriers*, produced jointly by the Royal Pharmaceutical Society and the RCGP has provided opportunities for discussion on closer collaboration between general practice and community pharmacy, both in terms of practical linkages and, going forward, in respect of the ongoing review of pharmaceutical services and the GMS contract. The Productive General Practice Programme also provides excellent materials and opportunities to enhance partnership working at local level.

May 2010 saw the beginning of the roll out of the **Chronic Medication Service** (CMS). CMS provides personalised pharmaceutical care by a pharmacist to people with long-term conditions. It is underpinned by a systematic approach to pharmaceutical care of people with long-term conditions. CMS formalises the role of community pharmacists in supporting people with long-term conditions by making better use of their skills and expertise to improve an individual's understanding of their medicines and to help to maximise the clinical outcomes from their therapy. It promotes the ethos of therapeutic partnerships between patients, pharmacists in the community, hospital pharmacists and GPs so that patients receive optimum benefit from the care and medicines they receive.

Importantly, the CMS involves **collaborative working between patients, community pharmacists and general practitioners**, subject to patient consent. It is based on three stages, registration, pharmaceutical care planning under a generic framework and shared care allowing an eligible person's GP to produce a serial prescription for 24 or 48 weeks which can be dispensed at appropriate time intervals determined by that person's GP.

Patients are registered for the service electronically and the patient's GP practice is notified via the electronic registration. In relation to serial prescriptions eCMS will be capable of delivering electronic feedback on both items dispensed and clinical activities thereby facilitating regular feedback and communication between the participating GP and the community pharmacist.

Over **60 GP practices** and **137 community pharmacies** are currently participating in the early adopter phase of CMS roll out. These early adopters are being used to ensure the supporting IT infrastructure is tested, using one uncomplicated medical condition, prior to national roll out. The roll out process will be informed by lessons learned during the early adopter phase.

By mid May 2012, 157,000 patients had been registered for CMS across all community pharmacies in Scotland. Over 138,000 Pharmacy Care Records (PCRs) had been created for individual patients and over 14,000 care issues recorded.

The introduction of CMS is central to the longer-term vision of sustainable, high quality NHS pharmaceutical care in Scotland and is consistent with the principles of the 20:20 Vision. Indeed, Scottish Ministers are committed to ... *further enhance the role of pharmacists, building on the introduction of the Chronic Medication Service, and encourage even closer joint working between GPs, pharmacists and other community services.*

Over the past 18 months the Scottish Government has been working with Community Pharmacy Scotland so that remuneration arrangements are better shaped towards the delivery of CMS and its contribution to person-centred, safe and clinically effective care. Work will continue in this area and to identify opportunities for pharmacy contract funding arrangements to best deliver these ambitions.

In October 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced a **Review of NHS Pharmaceutical Care of Patients in the Community**. The review is well underway. Central to the review is how NHS pharmaceutical care can best contribute to care that is person-centred, safe and clinically effective to every patient every time.

The review is taking evidence from a wide range of stakeholders to enhance the role which pharmacists play in contributing to the healthcare of patients in the NHS, and encourage closer working with GPs and other community-based services and the associated challenges.

The outputs from the review will form the basis of the biggest work programme on NHS pharmaceutical care since *The Right Medicine*. A report setting out the review's conclusions and recommendations is expected in Autumn 2012 and will provide a significant contribution to delivering the Quality Strategy and the 20:20 Vision for achieving sustainable, high quality healthcare in Scotland.

There has been particular focus on the need to achieve **effective partnership between primary and secondary care**, the new quality and productivity indicators of the GP contract have provided a mechanism (and resource) or improved and productive dialogue throughout the country. There is evidence of the face-to-face dialogue between clinicians leading both to service change and improvement and to enhanced partnership working more generally.

9. Continue to attach priority to, and implement, cost-effective solutions to improve communications within primary care and between primary and secondary care.

The national **eyecare integration project** aims to have 95% of referrals from optometrists/ OMPs to hospital eye services made electronically by April 2014 and provide for electronic submission of payment claims from optometrists/OMPs to Practitioner Services Division (PSD). The first tranche of funding to support the project was issued to Boards in October 2011 (£0.75m), with second tranche anticipated in Summer 2012. Planning is underway within Boards, supported by the eHealth Leads forum, and the Eyecare Integration Steering Group. Proposals are in place to raise public awareness of optometrists/OMPs as the first port of call for patients with eye problems are in the early stages of development. The project will bring benefits by:

- A reduction in time from referral to treatment;
- The allocation of the patient to the correct clinic at first hospital visit;
- A reduction in unscheduled attendances; and
- Identification of patients suitable for community care.

The potential of a common national aggregated approach for **primary care datasets** for supporting local clinical care, local and national quality and safety improvement, clinical governance, NHS planning and supporting research and development is one which has been agreed and discussed in many forums. Two short-life working groups have been convened to look, in discussion with the profession, at **data extraction** requirements from GP IT clinical systems and the **common set of data** that could potentially be made available as practice profiles.

These groups will report and provide recommendations on:

- Governance and support structures which can support the extraction and use of patient data whilst adhering to a common set of information governance and confidentiality principles;
- Common data sets and quality requirements;
- Objective benchmarking, both between practices and over time, on particular parameters so as to identify variation and areas for improvement, in whatever part of the system they need to occur;
- Objective benchmarking between and within Board areas so as to identify any geographical variation;
- The collection of national data sets to inform national policy and practice; and
- Ensuring that Information Services Division (ISD), NHS Board IT and other colleagues prioritise to ensure that there are effective processes for collecting and using robust, reliable data.

The **HEAT performance targets** are intended to set out the accelerated improvements that will be delivered specifically by NHSScotland in support of the quality outcomes and quality indicators. It is therefore essential to have a shared agreement on these key areas for HEAT target setting, and an understanding of how these targets will contribute to the Quality Outcomes. As a result, work is underway to develop proposals for new HEAT targets in 2012/13 one of which seeks to improve the timeliness and accuracy of communication at the interface between primary and secondary care to support the delivery of safe and effective care. The purpose of the communication is to highlight the key information to clinicians, improve patient safety and reduce readmission.

The **Key Information Summary** (KIS) is a summary of medical history and patient wishes which will replace paper-based faxing of patient information between GP practices and Out of Hours. It is intended to be a replacement for the “special notes” sent to Out of Hours and for anticipatory care forms for patients with long-term conditions.

The KIS builds on patient information already contained within the patient’s Emergency Care Summary (ECS) and will be pre-populated from the GP system as much as possible. In addition to the basic medication, demographic and adverse reaction information on ECS, the KIS will hold the following information:

- Medical History
- Diagnoses
- Patient Wishes
- Special Alert Messages
- Future Care Plans
- Resuscitation Status
- Emergency Contacts and Next of Kin Details
- Legal Information such as Power of Attorney
- Preferred Place of Care

The benefits of the KIS include:

- Reduction of errors in the transcription of data from paper-based records, as all patient data will be automatically downloaded from GP Practices to the ECS;
- Reduction of the risk that inappropriate care is given by displaying patient information on one easy to access user interface;
- The KIS is patient-centred: the patient and/or the patient’s carer will be directly involved in the creation of the KIS;
- The KIS information will be available quickly for Out of Hours and Emergency users; and
- The KIS will contain up-to-date patient information, which will save time for clinicians, as they will not have to phone GP Practices to obtain critical information.

A GP will create a KIS for the patient if required. It will be the responsibility of the GP to explain to the patient how the KIS works, how it will be updated, and who will have access to it. If the patient is happy for their information to be shared with other NHS staff and gives consent, the GP can then set up the KIS for the patient. Patient information leaflets and posters about KIS are available for practices.

KIS will be rolled out to all Health Boards in Scotland during 2012/13 in line with the eHealth Strategy. All patients, where appropriate to do so, will be offered a KIS by 2014.

10. Ensure primary care practitioners contribute to a clearer understanding between patients and practitioners on what it will mean to be a fully mutual NHS in the decade ahead.

The Quality Strategy's person-centred ambition will be achieved through the delivery of a healthcare experience that recognises and responds flexibly to each person as a unique individual, builds trust and empathy, and engages them in decisions that affect their healthcare and wellbeing. Actions to achieve improvements in person-centredness are system wide and will be led and delivered locally, by staff in partnership with patients and the public. These actions will be focused on:

- Enabling our systems to deliver person-centred care, through clear leadership and values of how we care;
- Improving services based on patient experiences and outcomes;
- Improving staff experience; and
- Improving communication and effective collaboration between patients and staff.

In support of this a number of national activities are underway or have already been delivered these include:

The Patient Rights (Scotland) Act 2011 which gained Royal Assent on 31 March 2011. The Act aims to improve patients' experiences of using health services and to support people to become more involved in their health and healthcare. It will help the Scottish Government's aspiration for an NHS which respects the rights of both patients and staff. The Act also provides for the publication of a **Charter of Patient Rights and Responsibilities**. This will summarise the rights and responsibilities people have when accessing NHS healthcare in Scotland. The intention is that it will be published by 1 October 2012.

The **national patient experience surveys** form the backbone of the information that is used to evidence progress for the national patient experience quality outcome indicator. **The Better Together Programme** has now led delivery of two national surveys focusing on primary care including GP services as well as three national inpatient surveys. In general, most GP practices report that patients experience good or excellent care. However, there is variation in the quality of healthcare experience between Boards and across practices that needs addressed. The most recent survey relevant to primary care published results in late May 2012. It is hoped that Boards will support their GPs to engage with the data and use it

to inform improvement activities at practice and Board level. The results this year, for the first time, include questions relating to other community healthcare services including Out of Hours. It will also include questions on the outcomes reported by patients as a consequence of accessing these and other services.

Most communities have a network of hubs which connect people and offer useful support, such as libraries, churches, schools, voluntary groups and community associations. However, they may be unconnected and poorly understood. **The Links Project** was a six-month project, to allow 10 GP teams, time and support to explore the nature of connections between primary care and communities. During the course of the project, teams gathered data and met to explore aspects of linking with communities which influence signposting to non-medical resources.

Key observations included:

- A significant number of people were willing to accept a recommendation from a GP to attend a community resource and were still attending four to six weeks later;
- The importance of personalised, relationship-based approaches, online up-to-date local information and experiential learning;
- To support community connections is essential; and
- Staff were interested in using local resources if they had opportunity to become familiar with them.

Adopting an organised approach to linking resources may have significant mutual benefits for citizens, primary care teams and providers of support. An emerging vision for improving links in communities is personalised, relationship-based supported by robust technology.

The Links Project is now being further developed in a partnership between RCGP and Long Term Conditions Alliance Scotland (LTCAS) with the aim of producing evidence that the detailed approaches and recommendations that have emerged are operationally sustainable for GP practices and community health partnerships.

The Links project drew in part on volunteers from the **Deep End** general practices, a grouping of those practices serving Scotland's 100 most deprived communities. This initiative has, for the first time, given a voice to practitioners working day by day to address the multiple health and other issues encountered in Scotland's areas of blanket deprivation. Together with the RCGP's *Time to Care* publication it has given renewed focus to the pressing issue of health inequalities.

About 40% of the Scottish population live with a long-term health condition. An important part of helping people to live well with their condition is enabling them to manage their own health. To be confident and successful self-managers, people require support and advice. self-management support is usually provided close to home, sometimes by people who have been through similar experiences. The **ALISS** (Access to Local Information to Support self-management) project aims to make information about self-management support more findable. A key part of the ALISS project has been the development of the ALISS Engine which will link up current data and new contributions to make a richer set of information about

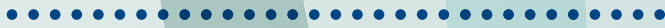
local self-management support, openly available to all. The Engine manages an online index of links. It is the one place that information about self management resources can be brought together. At the moment this information lives inside separate databases around Scotland. To find them we have to know where they are held in order to search for them. Once the Engine holds links to them, they will be in a single, open, searchable national collection of data. ALISS is working with those who already develop directory services to explore ways in which it can incorporate their data. Tools are being developed which will allow a wide of individuals to contribute ideas and suggestions. In this way ALISS can learn from and share the experiences of those who live with long-term conditions.

11. Ensure that NHS performance management and accountability structures reflect the central importance of primary care.

Recognising the key role of primary care has been a crucial element of the DQPC Action Plan. Combining the progress that NHS Boards are making in implementing the plan along with NHS Boards' **annual review process**, have provided the first steps in integration between performance management of primary care and the rest of the health system. Furthermore, there is a need to achieve agreement between the Scottish Government Health Directorates and NHS Boards on strategic issues which will enable primary care in general and the independent contractors in particular, to play a full part in delivering the ambitions of the Quality Strategy. **The Primary Care Strategic Forum** has been created to provide an environment for structured engagement between the Scottish Government Health Directorates and NHS Boards on strategic primary care issues, encouraging joint working and identifying areas for further development. The forum will encourage integration by taking decisions on how primary care should be incorporated into whole system solutions in NHS Boards, partner organisations, SGHD and more widely. In order to maximise primary care's contribution to delivering the aims of the Quality Strategy the forum will ensure that Chief Executives and others are aware of the opportunities offered and challenges faced as well as ensure the most effective primary care input into other parts of the National Quality Strategy Delivery Group infrastructure.

Steps have been taken to ensure that, in exercising its performance management function in respect of Boards, the Scottish Government gives appropriate prominence to primary care issues. This includes closer working between the relevant Scottish Government divisions and joint work in developing a fit-for-purpose national data set.

5. Conclusion



This report can, by its nature, reflect only a small proportion of the excellent work which is going on day by day in primary care. There are many examples across NHSScotland where Boards have taken the national priorities set out in the DQPC action plan and developed local solutions to meet the needs of their patients. Much of this work is at the forefront of innovation and best practice.

It can also only articulate a small proportion of the many challenges we face in delivering sustainable high quality care. We believe, however, that having to make choices and set priorities is a positive virtue. If, by working closely together and with determination and focus, we are able to tackle successfully the key issues flagged up in this report, then we shall have gone a long way to delivering – sustainably – the quality ambitions to which we are all committed and which will make a material difference to the people of Scotland.



Annex A

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The Steering Group met on eight occasions and considered each of the areas in the DQPC Action Plan. It focused less on taking action in its own right and more on ensuring that others with primary responsibility were driving forward the key activities to further the vision for primary care.

Progress in each of the action areas as at the time of this report is summarised in section 4.

Membership of the steering group:

Sir Lewis Ritchie (Chair)

Robert Kinloch, British Dental Association

Elsbeth Weir, Community Pharmacy Scotland

Peter Carson, Optometry Scotland

Dr John Gillies, Royal College of General Practitioners

Dr Alan McDevitt, Scottish General Practitioners' Committee, British Medical Association

Clare Mayo, Royal College of Nursing

Dr Frances Elliot, Healthcare Improvement Scotland

Dr Andy Russell, NHS Tayside

Prof Fiona MacKenzie, NHS Forth Valley

Karen Murray, West Glasgow Community Health Partnership

Dr James Ferguson, Scottish Centre for Telehealth and Telecare

Dr Martin Wilson, NHS Highland

Marion McLeod, Scottish Practice Managers' Network

Charles Waddell, Patient Representative

Dr Anne Hendry, Scottish Government

Dr Gregor Smith, NHS Lanarkshire

Duncan Miller, NHS Lothian

Rose Marie Parr, NHS Education Scotland (NES)

Evelyn McPhail, Directors of Pharmacy

Secretariat:

Frank Strang, Scottish Government

John Alvin, Scottish Government

Jessica McPherson, Scottish Government

Lee Doyle, NHS Lothian



Annex B

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Delivering Quality in Primary Care: National Actions

1. Work with the independent contractors on proposals for ensuring that all the contracts are better able to support the delivery of quality care.
2. Improve access for patients.
3. Develop and implement the Scottish Patient Safety Programme in Primary Care.
4. Ensure we have in place an up-to-date, agreed suite of care pathways.
5. Develop, as part of the quality measurement framework, national quality indicators for the delivery of primary medical services Out of Hours.
6. Continue to give priority to anticipatory care.
7. Help the professions with their workforce planning.
8. Take steps to ensure more effective partnership between the different primary care professionals.
9. Continue to attach priority to, and implement cost-effective solutions to, improve communications within primary care and between primary and secondary care.
10. Ensure primary care practitioners contribute to a clearer understanding between patients and practitioners on what it will mean to be a fully mutual NHS in the decade ahead.
11. Ensure that NHS performance management and accountability structures reflect the central importance of Prima.



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