National Overview ~ November 2008

Asthma Services for Children and Young People (incorporating Clinical Governance and Risk Management)
NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.
National Overview ~ November 2008

Asthma Services for Children and Young People (incorporating Clinical Governance and Risk Management)
Introduction and acknowledgements

NHS QIS’ vision is of an NHS that achieves excellence in the care of every patient every time. It leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions:

• providing advice and guidance on effective clinical practice, including setting standards
• driving and supporting implementation of improvements in quality, and
• assessing the performance of the NHS, reporting and publishing the findings.

In addition, NHS QIS also has central responsibility for patient safety and clinical governance across NHSScotland.

Within this remit it develops and runs a national system of quality assurance of clinical services. For each service, NHS QIS establishes a project group to:

• develop and consult on the standards and self-assessment framework
• oversee the process of external peer review, and
• report findings to the NHS QIS Board.

The asthma services for children and young people project group was established in June 2005 under the chairmanship of Dr John Haughney, General Practitioner and Research Fellow, NHS Lanarkshire/University of Aberdeen.

The Clinical Standards for Asthma Services for Children and Young People1 were developed by this group and published in March 2007 following extensive consultation. Copies of the standards are available on request from NHS QIS or on the website (www.nhshealthquality.org).

Peer review visits to territorial NHS Boards in Scotland were conducted between November 2007 and May 2008 to assess performance against the standards. A local report2 on each NHS Board visit, including a detailed assessment of their performance against each standard, has also been published and is available on the website or on request from NHS QIS. In addition, Asthma UK was commissioned to undertake a review of patient experience from the perspective of children and young people and this work is published alongside this report.
NHS QIS gratefully acknowledges the work of the asthma services for children and young people project team leaders for their contribution to this project and the publication of this report. In addition, the contribution made by every member of the peer review teams was crucial to the success of the visit programme.

To those NHSScotland staff who contributed to the peer review visits, NHS QIS wishes to record its thanks; in particular, the liaison co-ordinators, local review facilitators and lead clinicians in NHS Boards who were responsible for preparing staff locally for peer review visits and for the compilation of comprehensive self-assessment material prior to visits.

This report, based on the NHS QIS local report for each NHS Board area, presents a national overview of asthma services for children and young people within NHSScotland, reporting on the performance across Scotland against the standards and including relevant examples of practice which is taking place at local level.
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Executive summary

Introduction

We published clinical standards for asthma services for children and young people in March 2007; the first time we have published a set of standards specifically for children and young people. Asthma is common – over 1 in 8 children suffer from the condition and it is the most frequent cause of emergency hospital admission in childhood, with rates particularly high in children under the age of five. Asthma does not just affect a child’s health; it can also result in tiredness, poor performance and absence from school as well as psychological problems such as anxiety and stress. Although there is no cure for asthma, symptoms can be controlled and with the right treatment and care, most children with asthma enjoy a healthy and active life.

The standards focus on the infrastructure that needs to be in place to provide the best possible clinical care and seek to maintain a balance between good clinical care and good systems and processes. To review performance in this context we took a new approach to performance assessment against the standards and this summary provides an overview of the method we used as well as our findings.

Our approach (what we set out to assess)

Strategy into practice

Our challenge was to test the link between an NHS Board’s clinical governance and risk management (CGRM) framework and their direct patient care: essentially to explore whether outcomes for patients are improved where services are well planned, managed and monitored, and delivered by trained, confident staff.

We use the term CGRM to describe the framework through which all the components of quality, including patient and public involvement, are brought together on the agenda of every NHS organisation. An NHS Board’s clinical governance framework oversees quality improvement and seeks to recognise the value of systems and teams in healthcare, as well as each healthcare professional’s personal contribution. We published national CGRM standards in October 2005 which are used as a measure of continual quality improvement in NHS Boards through the Scottish Government Health Directorates (SGHD) health, efficiency, access and treatment (HEAT) targets.
Executive summary

Making the link

We believe there is a positive relationship between process and outcome, and that this is measurable. To test this, we need to know:

• Whether the systems and processes described as being in place at Board level have worked their way into frontline clinical services?
• How does risk management work in a busy clinical setting?
• Who plans the service and do they involve the public?
• Who monitors the performance of the service and do they involve the public?
• How do clinical staff report up to the Board and how does the Board respond?

To test this relationship we took a set of standards developed by a multidisciplinary group and wrapped them within the CGRM standards, combining the second CGRM standard with the clinical standards for asthma services for children and young people. The review, therefore, covered three standards:

1 - Safe and effective care and services
2 - The health, wellbeing and care experience
3 - Assurance and accountability

Patient focus

We also worked in close partnership with Asthma UK Scotland to make sure we reflected the experiences of those using these services. The overwhelming message was that children and young people wanted to be involved as equal partners at every stage in their care.

Hypotheses

To successfully test the link between effective CGRM and frontline clinical services we made three initial hypotheses:

• data to monitor services are available. The data set we needed was simple and included basic information such as the number of children with a diagnosis; their age; and their use of inhaled steroids
• clinical teams are familiar with their NHS Board’s risk management arrangements and with basic risk assessment methodology, and
• links between primary and acute care are in place and are straightforward, supporting referral and specialist assessment and treatment where necessary.
Our findings

In this summary we set out our key findings and conclusions against standards reviewed. Detailed information against each criterion is provided in Chapter 2 of this report.

Standard 1 – Safe and effective care and services

All NHS Boards have strategies and policies in place for identifying, assessing and recording risks, and frontline staff were able to describe how these had been put in place for children’s services, including asthma. We also found good evidence that strategy and policy have been implemented at practice level. However, clinical staff would benefit from more direct support from specialist risk management staff in collecting and using monitoring information to improve practice.

At a strategic level, NHS Boards struggled to plan for loss of services such as IT or diagnostic facilities and this was reflected at operational level in services for children and young people. Most NHS Boards were at an early stage in setting up straightforward business recovery plans, which is important in a service such as asthma care as there is a high dependency on shared computerised records. However, all NHS Boards were aware of the need to work on this and much work is under way at local and national level to address this.

Key message

NHS Boards need to support clinical teams in collecting and using risk management monitoring information to improve the quality of care they deliver.

Standard 2 – The health, wellbeing and care experience (NHS QIS clinical standards for asthma services for children and young people)

We highlighted two key areas in reviewing performance against these standards:

Making sure every child and young person gets the right care every time: To make sure children get the right care at the right time, much work has gone into making clinical services accessible. Every NHS Board provides information on asthma in a variety of ways: face to face, with specialist nurses playing a particularly important role in this; through leaflets; and on websites. In particular, much of the information is individually tailored to meet the needs of children and young people. The staff we met were highly professional and knowledgeable and aware of key guidelines such as the Scottish Intercollegiate Guidelines Network (SIGN) and British Thoracic Society (BRS): British Guideline on the Management of Asthma which describes evidence-based asthma care. We were impressed by the way in which individuals and teams provided a high standard of clinical care.
Executive summary

It was more difficult to piece together a picture of the consistency of care and the way in which NHS Boards identified and implemented improvements in care. For example, no NHS Board could tell us how many children have a diagnosis of asthma; how they are treated; and how clinical care is improving, despite some NHS Boards carrying out local audit in preparation for these reviews.

At the crux of this lies the lack of a clear focus for co-ordination and improvement. The asthma services for children and young people standards state that every NHS Board should have a Board-level multidisciplinary group to oversee asthma services with particular responsibility for reviewing core data on a regular basis, using the findings to improve services. Almost half of NHS Boards have set up such a group although they are all at an early stage, still agreeing membership, priorities and communication plans. One NHS Board has had such a group for a number of years and can demonstrate that this co-ordinated approach has been key to improving asthma services across the organisation.

Without this focus, NHS Boards have been unable to develop protocols/guidelines that cover diagnosis, treatment and care that meet every element of the criteria covered in the standards, although many have effective elements of these to build on. Further, no NHS Board was able to implement a consistent approach to asthma care across the whole organisation. Although there were pockets of good practice – most NHS Boards have a well-developed system within acute care – extending this across primary and community care remains a challenge.

Key message

NHS Boards need to co-ordinate planning and management of asthma services. NHS Boards can achieve co-ordinated services by streamlining and harnessing work already under way within the context of the broader agenda of services for children and young people.

Measurement and monitoring: Service planning, performance monitoring and quality improvement all depend on measurement. The standards ask for a simple data set and there is evidence that this information can improve clinical care: the number of children with a diagnosis of asthma, the number of emergency admissions and unscheduled care contacts, and the use of inhaled steroids. We found that NHS Boards cannot routinely provide data on asthma care to monitor and improve care and services. While there are up-to-date electronic records for children and young people with a diagnosis of asthma at individual GP level, these data are not collated and cannot be
used routinely for service improvement. Further, while GP systems collect certain data in the recommended core data set, other data items need to be gathered from different systems and there is no straightforward system that provides regular reports on activity and outcome.

Children and young people with a diagnosis of asthma at high risk of deterioration provide a stark example of this. There are a variety of localised systems but these are stand alone and cannot communicate with each other. NHS Boards do not have a register of children and young people at risk of acute deterioration and cannot easily and routinely plan and monitor their care.

**Key message**
Routine collection of data that is used to improve care is a priority for the SGHD, NHS Boards, patients and the public.

**Standard 3 – Assurance and accountability**
All NHS Boards have a clinical governance strategy in place and most have a clinical effectiveness programme. However, without data or measurement of the service provided and the outcome of this, it is difficult to hold NHS Boards to account for the quality of care they provide.

**Key message**
NHS Boards cannot easily demonstrate accountability for high quality standards of care without routine monitoring and reporting systems.
Conclusions

Combining the outcome of the previous CGRM reviews we were able to show a correlation between NHS Board strategies and the provision of care at the front line: we also confirmed the importance of supporting the translation of strategy into practice.

Our initial hypotheses were not borne out. In particular, the lack of data meant that NHS Boards were unable to demonstrate what they achieve and how they achieve this. While there is no doubt that expert and highly professional clinical services are in place, this could not be evidenced. We did find that clinical teams routinely risk assess their practice and that the links between primary and acute care are well established if not well documented.

As our findings were mirrored across all NHS Boards we make two core recommendations:

Co-ordinating care

NHS Boards oversee asthma services for children and young people, either through the establishment of a multidisciplinary group that reports into the clinical governance committee, or through alternative arrangements linked to the Long Term Conditions Collaborative. NHS Boards should be imaginative about who is included in making this happen – it is essential to involve local authorities (schools and leisure services) as well as the Scottish Ambulance Service and NHS 24.

Improving care

NHS National Services Scotland to work with NHS Boards and other key organisations including the Royal College of General Practitioners (RCGP) Scotland and the Scottish General Practitioners Council (SGPC) to develop information systems that support the collection and sharing of key data to improve asthma care and services, in particular on children and young people at risk of acute deterioration.

While the first recommendation may be fairly easy to implement at face value, the benefits will not truly be felt until co-ordinated arrangements are bedded in and this will take time. In the short term, NHS Boards are encouraged to develop action plans that prioritise the developments needed to improve their services and to use their local report to inform this.
The second recommendation is not unique to asthma care and extends to long-term conditions generally. In preparing this report we have spent much time discussing data availability with NHS National Services Scotland and others, and while much of the data needed for improvement are available from a variety of sources, the challenges lie in pulling these together in a co-ordinated way and in using the information to improve care. We believe there is a unique opportunity to address this issue working closely with the Long Term Conditions Collaborative and through the eHealth strategy to achieve this.

**Our learning**

This is the first time we have used this approach and we have learned from our experience and from the feedback provided by NHS Boards. While it has demonstrated the challenges inherent in providing safe and effective care to every patient, every time, it is also clear that NHS Boards can achieve this by co-ordinating, building on and supporting the work of expert professionals, and making the most of existing teams and systems, as well as individual contributions.

Our key learning points are:

• promote a clear understanding of the role of protocols in supporting clinical judgement, and

• standards should be flexible enough to allow NHS Boards to assess themselves in a way that meets their local circumstances and can be supported by local data collection and monitoring systems.

We are committed to supporting improvements in clinical care and to target implementation and we will use the experience of this round of reviews to inform our future approach.

Specifically, to make sure NHS Boards continue to improve asthma services for children and young people we will review services against our two key recommendations. We will work with partner organisations to support implementation of our recommendations and report on progress in 2011–2012.
Chapter 1

Setting the scene
1 Setting the scene

1.1 Introduction to asthma

In the UK, asthma is the most common long-term respiratory condition in childhood. There is evidence that the prevalence of childhood asthma has increased over the past two decades. Respiratory disease was reported to be the most frequent cause for children to consult a GP, with diagnosed asthma accounting for 15% of consultations for respiratory disease and 5% of all consultations.

Diagnosis of asthma in children

Diagnosis in young children can be difficult. The diagnosis of asthma is based on the presence of key features in the child's history and careful consideration of alternative diagnoses.

Repeated reassessment of the child and their response to treatment is important in confirming the diagnosis of asthma.

Management of asthma in children and young people

The management of a child's asthma takes place mainly in the community. Children and young people with asthma and their parents/carers/families require the support and co-operation of both healthcare professionals, such as the GP, practice nurse, hospital specialist, pharmacist, physiotherapist and school nurse, and non-healthcare professionals, including nursery staff, school teachers and other care workers. Communication between all these individuals is essential in order to provide optimum care for a child or young person with asthma.

1.2 Introduction to asthma services for children and young people

In August 2003, NHS QIS established a children's health services steering group. The remit of this group was to consider the work of NHS QIS and other organisations, and to scope the area of children's health services generally. In addition, the group was to produce recommendations as to how NHS QIS could best support services which would improve the quality of care for children, young people and their families.

This work was completed in the context of the strategic direction set by the then Scottish Executive Health Department. In light of this, the group made recommendations on work that could be carried out during the development of the strategic framework. One of those recommendations was the development of standards for the management of long-term conditions in childhood. Asthma requires a co-ordinated approach across primary, secondary and specialist healthcare, and was selected as the exemplar condition.
1.3 Background to the clinical standards for asthma services for children and young people

In June 2005, a project group first met to develop asthma services for children and young people standards. The group identified seven critical areas, which became the standards. The standards were widely consulted upon during the consultation period and during this time NHS QIS commissioned Asthma UK Scotland and Children in Scotland to hold separate consultations with children and young people with asthma and their parents/carers. Your Asthma Services Tell Us What You Think: Report of Consultation with Children, Young People and Parents was produced in May 2006.

1.4 Background to the national standards for clinical governance and risk management

Standards for generic clinical governance were first published in January 2001. Two rounds of review visits against these standards were completed, resulting in the publication of national overviews and local reports in April 2002 and May 2003.

In September 2003, a project group first met to develop the CGRM national standards. The remit of the group was to set standards, which integrated the healthcare risk management standards developed for NHSScotland by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and the Clinical Standards Board for Scotland (CSBS) generic standards. Following consultation, the standards were published in October 2005.

1.5 Reviewing asthma services for children and young people and clinical governance and risk management together

This review cycle assessed the level of performance of each NHS Board against the asthma services for children and young people standards and also relevant sections of the CGRM standards at an operational level. Therefore, the focus of the local reports and this report is on what NHS Boards are doing at a service level to implement the clinical standards for asthma services for children and young people and how they ensure that the necessary infrastructure, strategies, policies and procedures are in place to support delivery of these services.
1.6 The NHS Quality Improvement Scotland approach to assessment

NHS QIS uses a methodology which draws upon other quality assurance models to enable it, in partnership with healthcare professionals and members of the public, to develop standards for clinical services and to assess performance across NHSScotland against these standards.

The methodology for this review process has three key parts: self-assessment, pre-visit analysis and external peer review. Further information and definitions of the terms used in the standards and in the assessment of performance are contained in Appendix 3.

Performance assessment statements were used as the assessment scale for this review process.

**Performance assessment statements**

A quality improvement tool is used by each review team to assess performance against the standards. The quality improvement tool enables the performance analysts and review team to assess how an NHS Board is achieving each standard through:

- development
- implementation
- monitoring, and
- reviewing.

These four key stages represent the continuous improvement cycle through which each NHS Board can ensure that all patients receive safe and effective care. The performance analysts and the review team work through each of the four key stages to arrive at an overall position statement, which indicates the NHS Board's level of achievement for each standard. The quality improvement tool also enables the review team to provide structured feedback on the NHS Board's delivery of the standards, and to inform local action plans for continuous improvement.

The overall position statements for each standard can be found in Appendix 1.
1.7 Frequently asked questions

Questions children and their parents/carers may wish to ask

Q What is asthma?

A Asthma is a condition that affects the airways – the small tubes that carry air in and out of the lungs. When a person with asthma comes into contact with an asthma trigger, the muscle around the walls of the airways tightens so that the airway becomes narrower. The lining of the airways becomes inflamed and starts to swell. Often sticky mucus or phlegm is produced. All these reactions cause the airways to become narrower and irritated – leading to the symptoms of asthma.

The common symptoms of asthma are:

• coughing
• wheezing or a whistling noise in the chest
• getting short of breath, and
• a tight feeling in the chest.

Q What causes asthma?

A Asthma can start at any age. It is difficult to know what causes asthma, what is known is that:

• asthma can be inherited
• many aspects of modern lifestyles – such as changes in housing and diet and a more hygienic environment – may have contributed to the rise in asthma
• smoking during pregnancy increases the chance of a child developing asthma
• irritants in the workplace may lead to a person developing asthma
• second-hand smoke may make asthma symptoms worse, and
• environmental pollution can make asthma symptoms worse, but it has not been proven to cause asthma.

Q What are the things that can set off (or trigger) asthma symptoms?

A A trigger is anything that irritates the airways and causes the symptoms of asthma to appear. Everyone’s asthma is different and you will probably have several triggers. Common triggers include colds or flu, tobacco smoke, exercise and allergies to things like pollen, furry or feathery animals or house-dust mites.
Q How is asthma treated?

A There are some excellent treatments available to help you to control your asthma. The most effective way of taking most asthma treatments is to inhale the medicine so it gets straight into your lungs. There are a variety of inhalers available and it is important that you use a device that you are comfortable with and can use properly. Your doctor or nurse will advise you on the most appropriate device and should demonstrate how to use it correctly.

There are two main types of asthma medicine:

- **Reliever inhalers** are usually blue and you take them to relieve symptoms. They work quickly by relaxing the muscles surrounding the narrowed airways. They are essential in treating asthma attacks. If you need to use your reliever inhaler 2–3 times every week, you should go back to your doctor or nurse and have your symptoms reviewed so that they can be kept under control.

- **Preventers** usually come in brown, red or orange inhalers. They work by controlling the swelling and inflammation in the airways, stopping them from being so sensitive and reducing the risk of severe attacks. Their effect builds up over a period of time so they need to be taken every day, usually morning and evening, even when you are feeling well. Most preventers contain a steroid medicine. It is important to understand that it is not the same as anabolic steroids used by athletes to improve their performance.

There are other types of medicine that can be added to your reliever and preventer inhaler if needed, such as preventer tablets and long-acting relievers. For information about new medicines that may be more effective for you, speak to your doctor or nurse.

Q How might asthma affect my lifestyle?

A Some people may have to change parts of their lifestyle because of worsening asthma symptoms. It can be difficult to identify exactly what triggers your asthma. Sometimes the link is obvious, for example when your symptoms start within minutes of coming into contact with a cat or pollen. Some people have a delayed reaction. By avoiding the triggers that make your asthma symptoms worse, and by taking your asthma medicines correctly, you can reduce unnecessary symptoms and continue to enjoy your usual lifestyle.
Q How do I know if my symptoms are getting worse?
A If your symptoms are getting worse you may recognise some or all of the following:
• needing more and more reliever treatment
• waking at night with coughing, wheezing, shortness of breath or a tight chest
• having to take time off school/college/work because of your asthma, and
• feeling that you cannot keep up with your normal level of activity or exercise.

Q What should I do during an attack?
A You should:
• take two puffs of your reliever (blue) inhaler
• sit up and loosen tight clothing
• if no immediate improvement during an attack, continue to take one puff of reliever inhaler every minute for five minutes or until symptoms improve, and
• if your symptoms do not improve in five minutes (or if you are in doubt) call (or get someone else to call) 999 or a doctor urgently, especially if:
  – you are too breathless or exhausted to talk
  – your lips are blue.

Q Is there a risk that my asthma will get worse with age?
A Yes, that risk cannot be disregarded. Poorly treated asthma gets worse with age, and the lungs of people with untreated asthma function less well than those of non-asthmatic individuals. Modern asthma treatments have not been available for long enough for us to be certain whether or not lung function will still deteriorate more rapidly in patients with treated asthma as they grow older. However, most asthma doctors think that regular, preventative asthma treatment can prevent your asthma from getting worse and help to preserve your lung function.
Q Can I outgrow my asthma?

A Whether you can outgrow your asthma depends on how old you were when it started and how severe it was at the time. Around half the children with mild asthma will have no symptoms by the time they reach their mid-teens. Asthma does, however, often recur in adulthood. Children with more severe asthma are less likely to be free of symptoms when they get older.

Asthma that develops in adulthood can be associated with long-term exposure to specific triggers, such as chemicals or pollution, and can sometimes be greatly improved if the triggers are avoided. Most asthma can be well controlled with appropriate medication, but as an adult you are unlikely to outgrow it completely.

1.8 Useful contacts

1 Asthma UK Scotland
4 Queen Street
EDINBURGH
EH2 1JE

Phone: 0131 226 2544
Website: www.asthma.org.uk/scotland

2 British Lung Foundation Scotland
Suite 110-111
Baltic Chambers
50 Wellington Street
GLASGOW
G2 6HJ

Phone: 0141 248 0050
Website: www.lunguk.org/
Chapter 2

National performance against the standards
This section presents the findings across Scotland in terms of performance against individual standards. A number of examples of innovative local solutions and areas of good practice are featured at the end of each standard section. These examples are not exhaustive – every review team noted examples of good practice during visits and these were often in place in more than one NHS Board. Key recommendations are also listed.

Giving the public and the service the chance to review many aspects of the way in which care is provided has been fundamental to the approach taken and is a starting point for many activities including:

- identifying good practice
- disseminating good practice
- stimulating multidisciplinary working
- involving those who use the service; and, perhaps most importantly
- reviving the appetite to ensure that both the provision of patient care is balanced by the monitoring of that care against key performance standards, and that the quality of care is continually improved.

Fourteen NHS Boards were reviewed to assess performance against the standards. This national overview summarises the 14 local reports. NHS 24 and the Scottish Ambulance Service were not involved in this review cycle. However, they have provided details of the service they deliver to children and young people with asthma and this information can be found in Appendix 5.
2.1 Detailed findings against the standards

Standard 1: Safe and effective care and services

Standard statement 1
Care and services are safe, effective, and evidence based.

Essential criteria
Core area: 1(a) Risk management

1a.1 There are processes and procedures in place for risk management.

All NHS Boards have strategies and policies for risk management in place, however, the extent to which these have been integrated and embedded into the daily functions of the services provided to children and young people was variable.

All NHS Boards have procedures for identifying, assessing and recording risks. Routes for risk escalation were well defined in the majority of NHS Boards with staff able to describe how they would identify, assess, record and escalate risks. However, in some NHS Boards, operational staff would benefit from additional support from specialist risk management staff. All NHS Boards have made considerable efforts to encourage staff to report risks, incidents and near misses, and ensure that staff learn from incidents. Some NHS Boards have specific risk registers which cover services provided for children and young people.

The majority of NHS Boards have electronic systems in place for recording incidents, with DATIX risk management software being the most commonly adopted system. Some NHS Boards are still using paper-based recording systems, although the output from these systems is being transferred to electronic databases for reporting and monitoring purposes.

Core area: 1(b) Emergency planning

1b.1 There are local systems in place for emergency planning.

In all NHS Boards, there are some local systems in place to respond to major emergencies, which have the potential to impact on the delivery of their services to children and young people.
Most NHS Boards have engaged with other local agencies and partners in the development and multi-agency testing of their emergency plans. Some NHS Boards have appointed an emergency planning officer or manager to drive forward their emergency planning arrangements. The extent to which emergency planning training is provided across the NHS Boards is variable and is mainly provided at staff induction.

**Core area: 1(c) Continuity planning**

1c.1 There are local systems in place for continuity planning.

Most NHS Boards are still in the early stages of developing local continuity planning systems across the services they deliver to children and young people. However, all NHS Boards recognise the importance of having business continuity plans in place and work on developing and implementing these plans is ongoing. Some NHS Boards have specific business continuity plans in place for children’s services. All NHS Boards, which have developed business continuity plans, have tested their plans, and learning from these tests has been disseminated to staff. Some NHS Boards have appointed a business continuity lead or manager to drive forward their business continuity planning. As with emergency planning, the extent to which business continuity training is provided across the NHS Boards is variable and is mainly provided at staff induction.

**Key recommendations**

**NHS Boards to:**

- ensure adequate support and advice to operational staff on reporting, recording, assessing and mitigating risks for children’s services across the NHS Board area, including primary care.
- continue to develop and test formal business continuity plans and ensure operational staff know their role in the implementation of the plans.
It’s happening locally

NHS Dumfries & Galloway
As a component of the risk management systems being implemented by NHS Dumfries & Galloway, significant event analysis meetings are held to discuss adverse incidents. The parents of children who have been involved in an adverse incident are invited to attend the meetings to provide an opportunity for them and NHS Board staff to communicate openly in the best interest of patient safety.

NHS Shetland
NHS Shetland has developed a template for business continuity planning which has been distributed across the NHS Board area. This has been designed so that it can be adapted to suit the individual needs of each service. This is in the process of being rolled out across secondary care.
2 National performance against the standards

Standard 2: The health, wellbeing and care experience

Standard statement 2
Care and services are provided in partnership with patients, carers and the public, treating them with dignity and respect at all times, and taking into account individual needs, preferences and choices.

Essential criteria
Core area: 2(a) Access to asthma services

2a.1 Information on services provided by the NHS Board is available to patients, carers and the public.

2a.2 Care and services are provided that reflect the needs of those using them and there is a system in place to ensure accessibility, that gives consideration to such factors as individual needs, waiting times, response times, geographic location and availability.

The majority of NHS Boards are able to provide some evidence that they offer information about local asthma services and how to access these services, to patients, carers and the public. All NHS Boards provide information about the care and treatment of asthma and most make it available in a variety of different formats. The most popular way to communicate information to the public is through leaflets and via each NHS Board’s website.

Some NHS Boards offer outreach clinics and evening clinics so that children and young people can access appointments in places and times that would better suit them. Others have developed specially-designed teenage clinics. In some NHS Boards, there are systems in place to allow patients direct access to the paediatric ward in an acute or emergency situation.

Most NHS Boards use Asthma UK literature both within primary and secondary care. In addition, some have produced their own information leaflets and booklets for children, young people and their parents. Translation, interpretation and sign language services are also available when required.
Core area: 2(b) Organisation of asthma care (i)

2b.1 There is an established multidisciplinary group at NHS Board level to oversee asthma services for children and young people, which meets at least annually and includes representatives from primary, secondary, emergency, tertiary care (where appropriate), and children and young people or their representatives.

2b.2 The group is responsible for ensuring there is a protocol in place covering diagnosis, treatment and care, reporting arrangements and accountability, which is disseminated across the NHS Board.

2b.3 Minimum agenda items for the group to discuss on an annual basis include:

- the number of children and young people with a recorded diagnosis of asthma
- mortality rates of children and young people due to asthma
- the number of children and young people in the health board area who are admitted to intensive care unit (ICU), high dependency unit (HDU) or paediatric intensive care unit (PICU) due to asthma
- the number of children and young people who have more than one emergency hospital admission due to asthma
- the number of children and young people who have three or more attendances at a department of emergency medicine or out-of-hours services due to asthma
- the number of children and young people who have more than three unscheduled healthcare contacts with a GP due to asthma
- the number of children and young people who are prescribed inhaled steroids at doses higher than those recommended in the product licence, and
- a needs assessment of asthma training and education.

2b.4 The group publishes minutes of meeting(s), which include the minimum agenda items.

2b.5 Systems are in place to provide assurance of the quality of asthma services provided by the NHS Board and those provided jointly with other agencies.

2b.6 There are policies, developed in partnership with other agencies that guide, monitor and improve the way that staff communicate and engage with each other and with patients, carers and the public.
Almost half of the NHS Boards have set up a multidisciplinary asthma group to oversee asthma services for children and young people. Most of the groups are in the early stages of development in agreeing membership, remit and key priorities, however, one group has been established for a number of years and has made considerable progress in improving asthma services for children and young people locally. Some groups have already agreed how minutes of their meetings will be published and distributed, although most groups are still discussing this.

All NHS Boards have still to develop a protocol covering diagnosis, treatment and care, reporting arrangements and accountability which is disseminated across the whole NHS Board area. Although some NHS Boards have implemented extensive and well-researched documentation for the care of children and young people with asthma, this is mainly within a secondary care setting and the documentation does not cover all criteria as required by the standards.

Core area: 2(c) Organisation of asthma care (ii)

2c.1 There are up-to-date electronic records of all children and young people with a diagnosis of asthma.

2c.2 There is a system in place to collate the total number of children and young people with a recorded diagnosis of asthma.

Up-to-date electronic records of children and young people with a diagnosis of asthma exist within primary care at an individual GP practice level. However, these data are not gathered centrally to enable NHS Boards to use the information to improve the quality of treatment and care. Therefore, there are no NHS Board-wide electronic systems in place to record core information about the care of all children and young people with a diagnosis of asthma for use in direct patient care and service audit. Neither are there systems in place to collate the total number of children and young people with a recorded diagnosis of asthma.

Although asthma data are currently collected via the Quality and Outcomes Framework (QOF), they are limited in content and unable to capture core information about the care and treatment of the patient as required by the standards. QOF asthma data collection starts at children aged eight years and above and so a significant number of children with a diagnosis of asthma will not be included in QOF statistics.
There are small pockets of good practice within some NHS Boards where asthma data are collected via various electronic systems, such as the Scottish Programme for Improving Clinical Effectiveness in Primary Care (SPICE). Within secondary care, some NHS Boards use locally-developed databases to record information about the care and treatment of children and young people they see. However, these are not NHS Board-wide systems and data cannot be collected and used except on a local basis.

**Core area: 2(d) Healthcare professional training and education**

2d.1 The NHS Board has undertaken a needs assessment of training and education for all healthcare professionals involved in paediatric asthma care and implemented appropriate training and education programmes.

Within all NHS Boards, a variety of training and education opportunities exists for staff involved in paediatric asthma care. Many NHS Boards have developed their own training materials and workshops, and have been implementing and evaluating these sessions for a number of years. However, all NHS Boards have still to undertake an NHS Board-wide needs assessment of training and education for all healthcare professionals involved in paediatric asthma care. Therefore, all NHS Boards have still to develop paediatric asthma training and education programmes based on a needs assessment.

Some NHS Boards have carried out a needs assessment of staff involved in caring for children with asthma, however, not all healthcare professional groups have been included. Therefore, subsequent training and education programmes may not have been adapted for, and offered to, certain professional groups within the organisation.

**Core area: 2(e) Schools**

2e.1 There is an agreed joint policy in place between the NHS Board and local authorities, which guides, monitors and improves the management of asthma within the primary and secondary school setting.

2e.2* All children and young people with asthma within the primary and secondary school setting have an individual healthcare plan, as appropriate to their needs.

* (This criterion is desirable.)
Most NHS Boards are in the process of developing an agreed joint policy with local authorities, which guides, monitors and improves the management of asthma within the primary and secondary school setting. Two NHS Boards have implemented such a policy and much work has been done with local authority education departments to facilitate this. Many NHS Boards reported that the multidisciplinary asthma group would be taking this forward once better established.

The administration of medicines in schools policy is in place across all NHS Boards, however, there is no specific section in this document which guides monitors and improves the management of asthma at school.

Not all children and young people with asthma within the primary and secondary school setting have an individual healthcare plan, as appropriate to their needs. Most NHS Boards reported that only children and young people with severe or complex asthma would have an individualised healthcare plan. No NHS Board is able to provide numbers of children with healthcare plans and in some cases healthcare plans are developed by the schools and parents without input from a healthcare professional.

Core area: 2(f) Linking care

2f.1 There is an agreed written protocol in place for shared care, referral and discharge between primary care and specialist services, which is jointly reviewed at least annually.

2f.2 When a child is transferred to secondary care adult respiratory services their paediatric asthma consultant provides a written handover summary to a named secondary care adult respiratory consultant, the patient’s GP and the patient.

None of the NHS Boards has an agreed written local protocol in place for shared care, referral and discharge between primary care and specialist services. Most NHS Boards anticipate that this would be developed by the multidisciplinary asthma group, however, timescales for this are unclear.

All NHS Boards reported that there are very few occasions when a child is transferred to secondary care adult respiratory services. When this does happen, most NHS Boards manage this on a case-by-case basis. Some NHS Boards are able to evidence that when this type of transfer occurs, a written summary of the patient’s condition and management to date is sent to the adult respiratory consultant, GP and patient/carer.
### Core area: 2(g) High risk asthma groups

| 2g.1 | There is a system in place to identify and manage children and young people with asthma who have more than one emergency hospital admission within a year. |
| 2g.2 | There is a system in place to identify children and young people with asthma in the NHS Board area who are admitted to HDU, ICU or PICU within a year. |
| 2g.3 | There is a system in place to identify and manage children and young people with asthma who have had three or more attendances at a department of emergency medicine or out-of-hours services within a year. |
| 2g.4 | There is a system in place to identify and manage children and young people with asthma who have had three or more unscheduled healthcare contacts with a GP within a year. |
| 2g.5 | There is a system in place to identify and manage children and young people prescribed inhaled steroids at doses higher than those recommended in the product licence. |

Various different systems exist across primary and secondary care that gather information about children and young people who may be at risk of poorly controlled or acute severe asthma. However, most are stand-alone and unable to communicate with each other. Some emergency department systems are able to flag and record repeat admissions and some NHS Boards hold local databases of high risk asthma patients. However, these systems do not identify and manage all children as stated by the standards and systems are not NHS Board-wide. A register of children and young people at risk of acute deterioration does not exist within primary care.

In particular, all NHS Boards have not been able to develop a system to identify and manage children and young people prescribed inhaled steroids at doses higher than those recommended in the product licence. However, a small number of NHS Boards have begun to develop protocols. Most NHS Boards believe that, should a child or young person be prescribed high dose steroids, then he or she would be known within the secondary care setting and by the paediatrician or nurse running the clinic. However, no NHS Board could provide evidence to demonstrate this.
Core area: 2(h) Clinical review

2h.1 There is a protocol in place, which specifies that all children and young people with a diagnosis of asthma are offered the following at annual clinical review:

- assessment using a structured assessment tool
- review of any emergency or unscheduled asthma care
- discussion of asthma symptoms, triggers and treatments, peak flow, if appropriate, and particular action to be taken in case of an emergency (for example, asthma action plan)
- review of treatment/medication
- consideration of steroid dosage
- an accurate height measurement
- assessment of ability to use medication device/inhaler technique
- assessment of the patient’s and parents/families/carers (where appropriate) understanding of asthma and its treatment
- consideration of immunisation, and
- health education on smoking, diet and exercise.

All NHS Boards have still to develop a protocol, which specifies that all children and young people with a diagnosis of asthma are offered all the points listed in the criterion at annual clinical review. Most NHS Boards stated that a clinical review protocol will be part of the multidisciplinary asthma group’s future work programme.

Currently, a review is offered to all patients with asthma, aged eight and above, every 15 months as part of QOF. However, all points listed in the criterion are not necessarily reviewed and if they are, not always recorded. As it is only a requirement for GP practices to conduct a review for patients aged eight and above, a significant number of children with a diagnosis of asthma may not have an annual review. Most NHS Boards reported that children and young people seen in secondary care will be offered a detailed clinical review at least annually.
Core area: 2(i) Emergency care

2i.1 There is an agreed protocol in place, based on national guidelines, for children and young people with an acute asthma emergency, which specifies:

- acute asthma management
- asthma education to be provided
- treatment following discharge, and
- communication with the patient’s GP or asthma nurse regarding follow-up care, which should be arranged as soon as possible.

2i.2 The acute asthma emergency protocol is in use for individual patient management in all healthcare settings where emergency care for children and young people is provided.

Many NHS Boards have developed local emergency care protocols or integrated care pathways based on the SIGN/BTS management of asthma guideline for use in secondary care and in particular, for the emergency department. Some GP practices have also developed specific emergency care protocols for local use. However, not all protocols include a requirement to cover asthma education, treatment following discharge and communication with the patient’s GP or asthma nurse. In addition, these protocols have not been implemented on an NHS Board-wide basis.

Although none of the NHS Boards have one single emergency care protocol in place across all possible sites where an asthma emergency may occur, some are able to describe and evidence a system in place for the distribution of SIGN guidelines, and subsequent updates to these guidelines, to all relevant healthcare professionals.
Core area: 2(j) Equality and diversity

2j.1 All new and existing asthma services for children and young people are reviewed, developed, or improved, to ensure that every person has equal access to services and that equality and diversity impact assessments are carried out where necessary.

2j.2 Systems are in place to identify, assess and respond to the needs of groups and individuals within the population, who have particular needs or preferences for children and young people’s asthma services.

Most NHS Boards are in the early stages of developing equality and diversity systems across the services they deliver to children and young people. Many have rolled out the impact assessment toolkit and are beginning to offer training to staff on how to carry out equality and diversity impact assessments. Some NHS Boards have equality schemes in place covering some of the Fair for All strands.

A small number of NHS Boards are at the implementation stage of the continuous improvement cycle. Some NHS Boards have carried out an equality and diversity impact assessment on children’s services. In relation to services delivered to children and young people, groups who had particular needs or preferences included minority groups, travelling families and looked after children.

Key recommendations

NHS Boards to:

• ensure there are a variety of mediums to inform members of the public on how they can access asthma services for children and young people.

• establish a multidisciplinary group or expand the membership of existing groups to cover all the points as described in the standards, as a matter of urgency.

• agree and implement across the NHS Board, a protocol covering diagnosis, treatment and care, reporting arrangements and accountability.

• undertake an NHS Board-wide needs assessment of training and education for all healthcare professionals involved in paediatric asthma care and, following this, develop a training and education programme.
• agree and implement a joint policy between the NHS Board and local authorities, which guides, monitors and improves the management of asthma within the primary and secondary school setting.

• agree and implement a protocol for shared care, referral and discharge between primary care and specialist services, which is jointly reviewed at least annually.

• ensure that there are agreed NHS Board-wide systems in place to identify and manage the needs of children and young people who may be at risk of poorly controlled or acute severe asthma, as detailed in the standards. In particular, ensure there is a system in place to identify and manage children and young people prescribed inhaled steroids at doses higher than those recommended in the product licence.

• agree and implement, across the NHS Board, a protocol which specifies that all children and young people with a diagnosis of asthma are offered all items as listed in the standards at annual clinical review.

• agree and implement a local protocol, for use in all healthcare settings where emergency care for children and young people is provided, based on national guidelines, for children and young people with an acute asthma emergency, which covers all the points raised in the standards.

**NHS National Services Scotland to:**

• assist NHS Boards in allowing electronic records to be shared across the NHS Board area, in particular between primary and secondary care.

• work with GPs to make use of data already being collected in relation to the standards and how this data is shared with NHS Boards.
It’s happening locally

NHS Greater Glasgow and Clyde
An interactive computer programme has been developed locally by NHS Greater Glasgow and Clyde and is designed to educate children and families who have had to attend hospital with a child suffering from acute asthma on how to manage and recognise the condition. The programme is called ‘Attacking Asthma’ and is available in emergency departments and also on specific wards. This was developed through a research study and a pilot was conducted with families to ensure its appropriateness.

NHS Lanarkshire
Within NHS Lanarkshire, plans are being developed to set up a patient focus group to include the views of children and families on local asthma services delivered to children and young people. It is hoped that Asthma UK will facilitate this group and then feedback into the NHS Board-wide multidisciplinary asthma group. This will allow patients, parents and the wider public to influence service design.

NHS Tayside
NHS Tayside has been working in collaboration with the Angus local authority to improve the management of asthma in schools within the Angus Community Health Partnership (CHP). A training needs analysis was conducted in order to identify the gaps in the service and this resulted in a series of half-day training sessions which took place on in-service days within the school setting. This was delivered to school staff by asthma-trained practice nurses/pharmacists and the primary care development manager. Almost 500 school staff have participated in the training to date.
Standard 3: Assurance and accountability

Standard statement 3
NHSScotland is assured and the public are confident about the safety and quality of NHS services.

Essential criteria
Core area: 3(a) Clinical governance and quality assurance

3a.1 There are processes and procedures in place to ensure the clinical programmes and ‘research’ projects undertaken are assessed and approved.

* ‘Research’, in this context, refers to all audit, clinical effectiveness projects and practice development activity.

The majority of NHS Boards have systems in place to ensure clinical programmes and ‘research’ projects undertaken for the services delivered to children and young people are assessed and approved. Most NHS Boards have a clinical governance strategy in place.

Most NHS Boards have a programme of clinical effectiveness activity and a clinical effectiveness group in place, to provide direction and guidance for their clinical effectiveness activities. Although NHS Boards have no specific programmes for children’s services, clinical effectiveness activity for children and young people is included in overall plans and programmes. In a few NHS Boards, clinical governance and clinical effectiveness activity is supported by sector-based CGRM staff to support the work of units and departments.

The majority of NHS Boards have systems in place to engage with children and young people and their carers, to promote recruitment into ‘research’ studies. These include recruiting directly at clinics or appointments, advertising in hospital and GP practice waiting areas, and through patient surveys. However, the extent to which this involvement is achieved is variable across NHS Boards.
2 National performance against the standards

Core area: 3(b) Fitness to practise

3b.1 There are systems in place to ensure staff are fit to practise.

All NHS Boards have policies and procedures in place to ensure that staff working across the services they provide to children and young people have the required qualifications, valid registration, skills and experience necessary to fulfil their role. However, not all NHS Boards have a policy in place to ensure that staff registration status is kept up to date following appointment, although all NHS Boards are able to discuss how registration is checked in individual departments. In some NHS Boards, it is the responsibility of line managers to check the registration status of current employees. Most NHS Boards have policies on clinical supervision in place, however, some are in draft format.

Core area: 3(c) Performance management

3c.1 There are arrangements in place for performance management.

Most NHS Boards are at the early stages of developing performance management systems across the services they deliver to children and young people. Some NHS Boards have developed specific key performance indicators for the services delivered to children and young people, a number of them through the integrated children's services planning process. In addition, some multidisciplinary groups have plans to develop specific key performance indicators for children's asthma.

Core area: 3(d) Information governance

3d.1 There are procedures in place to manage patient information.

All NHS Boards have a range of policies, procedures and leaflets to ensure that a patient's personal information is stored in a secure environment, disposed of appropriately and that patients are aware of their rights to determine how their information is shared and protected. However, some policies, procedures and leaflets are in draft format. NHS Boards are able to provide evidence to demonstrate how they assist patients in accessing their personal and medical information on request and, in particular, any challenging situations which may arise from any conflicting wishes of children and their parents/carers. Some NHS Boards have formed an information governance steering group or similar group to drive forward the information governance agenda.
Key recommendations

NHS Boards to:
• ensure the development of performance management systems for services delivered to children and young people.
• finalise and implement information governance strategies.

It’s happening locally

NHS Highland

Since December 2007, NHS Highland has been operating an information governance training programme. The training is delivered by staff from NHS Highland and is designed to provide support and advice to any member of staff who requires clarification around information governance arrangements. More in-depth training may be available to interested staff once the current training programme is complete.
Chapter 3

Appendices
Appendix 1: NHS Board performance against the standards

Asthma services for children and young people (incorporating CGRM) performance for NHS Boards

### Standard 1: Safe and effective care and services

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**Overall Position Statements**

1. The NHS Board is **developing** its systems to control and manage risk for the services it delivers to children and young people.
2. The NHS Board is **implementing** its systems to control and manage risk for the services it delivers to children and young people.
3. The NHS Board is **evaluating** the effectiveness of its systems to control and manage risk for the services it delivers to children and young people.
4. The NHS Board is continuously **reviewing** and improving its systems to control and manage risk for the services it delivers to children and young people.

### Standard 2: The health, wellbeing and care experience

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**Overall Position Statements**

1. The NHS Board is **developing** its systems to provide asthma care and services for children and young people that take into account individual needs, preferences and choices.
2. The NHS Board is **implementing** its systems to provide asthma care and services for children and young people that take into account individual needs, preferences and choices.
3. The NHS Board is **evaluating** the effectiveness of its systems to provide asthma care and services for children and young people that take into account individual needs, preferences and choices.
4. The NHS Board is continuously **reviewing** and improving its systems to provide asthma care and services for children and young people that take into account individual needs, preferences and choices.
Standard 3: Assurance and accountability

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Standard 3 Overall Position Statements

1. The NHS Board is **developing** its systems to promote public confidence about the safety and quality of the services it delivers to children and young people.

2. The NHS Board is **implementing** its systems to promote public confidence about the safety and quality of the services it delivers to children and young people.

3. The NHS Board is **evaluating** the effectiveness of its systems to promote public confidence about the safety and quality of the services it delivers to children and young people.

4. The NHS Board is **continuously reviewing** and improving its systems to promote public confidence about the safety and quality of the services it delivers to children and young people.
Appendix 2: References


Appendix 3: The review process

Prior to Visit
- NHS QIS publishes standards
- NHS QIS finalises and issues self-assessment document and guidance
- NHS Board completes self-assessment and submits with evidence to NHS QIS
- NHS QIS performance analysts review the self-assessment submission and produce a pre-visit analysis report, which is sent to the NHS Board for comment
- NHS QIS sends self-assessment submission and analysis report to peer review team

During Visit
- NHS Board presentation to review team covering local service provision
- Review team meets stakeholders to discuss local services
- Review team assesses performance in relation to the standards based on the submission and visit findings
- Review team feeds back findings to NHS Board
- NHS QIS produces draft local report and sends to review team for comment
- NHS QIS sends draft local report to NHS Board to check for factual accuracy
- NHS QIS publishes local report

After Visit
- Team leaders consider findings of all local reviews and draft national overview
- NHS QIS publishes national overview
Appendix 3: The review process

Standards
All standards set by NHS QIS comprise a standard statement and related criteria.

Standard statement
Describes the agreed performance for the specific area, determined by those who are involved in the delivery/receipt of the service.

Criteria
State exactly what must be done for the standard to be reached.

Some criteria are essential as it is expected that they will be met wherever a service is provided. Others are desirable in that they will promote continuous quality improvement as they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve.

Self-assessment
Each set of standards has an accompanying self-assessment framework. This framework gives guidance about the type of evidence required to demonstrate performance against the standards. It is completed and submitted to NHS QIS prior to a peer review visit, together with extensive additional documentation. The evidence obtained from this self-assessment exercise comprises the main source of written evidence considered by each peer review team.

Pre-visit analysis
For some topics including this one, on receipt of the completed self-assessment, NHS QIS performance analysts review the self-assessment and supporting evidence and produce a pre-visit analysis report which highlights any gaps/points for clarification. This gives the NHS Board the opportunity to respond with further information prior to the visit. This report is then returned to NHS QIS and distributed to the peer review team.

Peer review
Peer review is the process by which a multidisciplinary review team, including members of the public, carries out a visit to validate the quantitative data submitted through the self-assessment. This is done by means of gathering qualitative information through discussions with staff.

The composition of each team varies, and members have no connection with the NHS Board they are reviewing. Both of these factors facilitate
the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than makes comparisons between one NHS Board and another.

In order to determine the position on the assessment scale of a particular standard, each review team requires to identify evidence on a variety of levels. For example, to demonstrate that there is an organisational policy in place for a particular function, evidence is sought during the peer review process as follows:

- copy of the policy and description of how it was developed (submitted as part of the self-assessment)
- confirmation of awareness and content of the policy through staff interviews
- evidence of a process in place for the regular monitoring of the policy, and
- evidence of a process in place for the policy to be regularly reviewed and updated.

During each asthma services for children and young people review visit, the review team is guided by a team leader to ensure a multidisciplinary consensual assessment is reached. At the conclusion of the review, the review team provides feedback to the NHS Board giving a broad overview of its assessment, which is based on the written self-assessment, and on evidence obtained during the review visit.

To enhance the consistency of the process, an NHS QIS manager and project officer accompany each visit.

The schedule for the asthma services for children and young people external peer review visit included:

- initial communications with key personnel responsible for the service under review
- dialogue with clinicians, audit staff and managers based on the written evidence
- scrutiny of documentation
- interviews with members of the Board and staff members
- regular team briefings throughout the day to assess progress and to compile the local report, and
- feedback to the NHS Board representatives on conclusion of the visit.
Appendix 3: The review process

Reports

A local written report is drafted following each visit by NHS QIS. The draft report is then circulated to the review team for comment, and to the NHS Board concerned to allow a check for factual accuracy. Once the NHS Board has agreed that the report is factually accurate, the final report is published and available on the NHS QIS website.

On conclusion of the peer review programme, the team leaders discussed the findings and examined trends in order to draw conclusions and make recommendations to NHS QIS.

The responsibility of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet agreed standards, but not to review individual cases or the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered. Where such variation exists between services (for example between services within an NHS Board), this will be stated.
Appendix 4: NHS Boards reviewed

1 NHS Ayrshire & Arran
2 NHS Borders
3 NHS Dumfries & Galloway
4 NHS Fife
5 NHS Forth Valley
6 NHS Grampian
7 NHS Greater Glasgow and Clyde
8 NHS Highland
9 NHS Lanarkshire
10 NHS Lothian
11 NHS Orkney
12 NHS Shetland
13 NHS Tayside
14 NHS Western Isles
NHS 24 and the Scottish Ambulance Service were not involved in this review cycle. However, as Special Health Boards that encounter/treat children and young people with asthma, they completed a short questionnaire providing details of the service they provide. The information below is a short summary of the information provided by both Special Health Boards.

**NHS 24**

NHS 24 provides a confidential 24-hour telephone health advice and information service which is available across Scotland. There are four regional NHS 24 contact centres in Clydebank, Cardonald, South Queensferry and Aberdeen. In addition to these, there are currently five smaller local centres which have been established in partnership with NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Highland, NHS Lanarkshire and NHS Tayside.

All calls are initially answered by call handlers in one of the four regional contact centres. These calls can either be dealt solely by the call handlers or routed through the national telephone network to an appropriate adviser. These advisers may be in regional or local centres or part of partner services such as Breathing Space for mental health calls or the Scottish Emergency Dental Service. Staff in all centres have access to the same information systems, training and processes as their colleagues in the regional contact centres.

NHS 24’s main role is to support out-of-hours services across Scotland and provide telephone triage and advice to callers both in and out-of-hours. All calls are initially answered by a call handler and directed onwards using guidance known as a routing tool. If this tool indicates that the call handlers should not deal with the call themselves, then patients are put through to one of a range of healthcare professionals, such as a nurse adviser, pharmacist or dental nurse. These professionals will recommend either self-care approaches; that the patient sees a doctor or another health professional or, in some cases, they will order an ambulance for assistance. NHS 24 staff do not treat patients directly and are not in a position to prescribe medication. They will advise on ‘over the counter’ medication use and on currently prescribed therapies.

Nurse advisers in the call centres have access to decision support software called algorithms to support initial assessment of patient symptoms if required. These algorithms are reviewed internally against national guidelines, and are reviewed with multidisciplinary internal and external stakeholders on an annual basis.
NHS 24 has an electronic system in place to record clinical information when a patient uses the service. The patient relationship management (PRM) system, allows NHS 24 to connect to the unscheduled care hub in all NHS Boards, the national community health index (CHI) and the national emergency care summary databases, and to special patient notes from the local out-of-hours service which have been uploaded by the patient’s GP. Clinical information is recorded in free text fields on the PRM. However, as NHS 24 is a telephone triage system, nurse advisers are unable to attach a diagnostic label to the outcome of calls, and instead record symptoms. Therefore, no accurate data were available to indicate how many children and young people with a definite diagnosis of asthma were dealt with in the 12 months prior to May 2008. However, NHS 24 can report on the numbers of children who present with symptoms of respiratory illness.

All healthcare professionals within NHS 24 undertake mandatory training in treating children with breathing difficulties. NHS 24 has developed a training session entitled ‘recognition of the sick child’, which contains specific information relating to breathing difficulties in children. A module on asthma is also available to staff. Staff are provided with training at induction, and during clinical supervision and continuing professional development sessions. Reports on eLearning modules are distributed to senior managers, and are used to review and improve the training and education programmes. These programmes are also reviewed as a result of evidence-based change, for example changes to SIGN guidelines and also in response to staff, patient, and partner feedback.

NHS 24 reported that it has currently no involvement in multidisciplinary groups responsible for overseeing asthma services for children and young people in the NHS Boards.

Scottish Ambulance Service

The Scottish Ambulance Service (SAS) provides a nationwide ambulance service by delivering accident and emergency services, together with non-emergency and other associated services. There are five divisions within the SAS and services are provided from a total of 152 locations. Ambulance stations and home-based operating points make up the mixture of these locations. Each division is headed by a general manager and managed by a divisional management team. There is also a national risk and resilience department within the service that manages all aspects of the Civil Contingencies Act 2004, which includes emergency preparedness, business continuity and risk management. The department also manages three full-time special operation response
teams based in Glasgow, Edinburgh and Aberdeen and five on-call teams based in Dundee, Inverness, Stirling, Dumfries and Glasgow. These teams are specially trained to respond to chemical, biological, radiological and nuclear related incidents and other major incidents. There is also an air ambulance service which operates from four bases, two in Glasgow and one in Inverness and Aberdeen.

The SAS reported that it has currently no involvement in multidisciplinary groups responsible for overseeing asthma services for children and young people in the NHS Boards. However, the SAS is currently working with the charity, Asthma Support in Rural Scotland to improve response to acute asthma incidents and has set up the grid reference identification project (GRIP) in the Grampian area to assist people who have a diagnosis of asthma or other high risk conditions.

The project enables emergency service operators to rapidly acquire all of the data they need on a caller in order to get an ambulance to them as quickly as possible. Any patients deemed at risk are given a reference number (for example, GRIP 135) which they quote when connected with an operator. By searching for this number, the operator gets instant access to the patient’s address, contact details and condition.

The SAS has a protocol in place covering the treatment of children and young people with asthma based upon the joint royal colleges ambulance service liaison committee clinical guidelines. Compliance with this is monitored using the SAS clinical database, and a new electronic reporting system has been rolled out throughout the SAS. At present, patients presenting with breathlessness are recorded electronically, however, patients with a diagnosis of asthma are recorded on paper records, so no data were available to indicate how many children and young people with asthma symptoms were dealt with in the previous 12 months prior to May 2008.

A care pathway for asthma that allows patients to be assessed, treated and, if appropriate, managed at home, has been developed by the SAS. The education and training delivered to support staff applying this pathway is embedded in core and mandatory training programmes. Additional training programmes are in place for asthma and training is mandatory for all operational staff. These programmes are subject to review by internal service committees and external accreditation and registration bodies. Reports on activity are submitted to the director of human resources and clinical development.
### Appendix 6: Glossary

<table>
<thead>
<tr>
<th><strong>accountability</strong></th>
<th>Answerability. Responsibility to someone for an activity or service performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>acute</strong></td>
<td>Describes a disease or infection of rapid onset, severe symptoms and brief duration.</td>
</tr>
<tr>
<td><strong>acute asthma</strong></td>
<td>A sudden asthma attack which is potentially life-threatening.</td>
</tr>
<tr>
<td><strong>acute care</strong></td>
<td>Where a patient is treated for an acute (immediate and severe) episode of illness, or for injuries related to an accident or other trauma, or care during recovery from surgery. Acute care is usually given in a hospital by specialised personnel using complex and sophisticated technical equipment and materials. Acute care is often necessary for only a short period of time.</td>
</tr>
<tr>
<td><strong>adverse event</strong></td>
<td>An event, situation, incident or omission which causes physical or psychological harm.</td>
</tr>
<tr>
<td><strong>advocacy</strong></td>
<td>Where an individual acts independently on behalf of, and in the interests of a patient/service user who may feel unable to represent themselves in their contacts with staff. Throughout this document advocates have been included under the term ‘carer’.</td>
</tr>
<tr>
<td><strong>assessment</strong></td>
<td>The process of measuring patients’ needs or the quality of an activity, service or organisation.</td>
</tr>
<tr>
<td><strong>assurance</strong></td>
<td>A process which provides feedback on the efficiency, effectiveness, integrity and quality of an organisation’s operations.</td>
</tr>
<tr>
<td><strong>asthma</strong></td>
<td>A long-term lung disease caused by inflammation of the airway.</td>
</tr>
<tr>
<td><strong>asthma action plan</strong></td>
<td>A plan agreed with the individual patient and held by them, which sets out how they can manage their asthma and what to do if it becomes more severe, or acute.</td>
</tr>
<tr>
<td><strong>asthma nurse</strong></td>
<td>A nurse whose specialised area is treating asthma. Sometimes employed in a doctor’s surgery and may run specialist asthma clinics.</td>
</tr>
<tr>
<td><strong>audit</strong></td>
<td>The measuring and evaluation of performance against agreed standards with a view to improving practice and care delivery.</td>
</tr>
<tr>
<td><strong>carer</strong></td>
<td>A person who looks after relatives, partners or friends in need of help because of age, physical or learning disabilities or illness on a voluntary basis. Within this document the term has been employed broadly to also include a patient’s family and, where applicable, appointed advocates.</td>
</tr>
<tr>
<td><strong>CHP</strong></td>
<td>See community health partnership.</td>
</tr>
</tbody>
</table>
### Civil Contingencies Act (2004)

The Civil Contingencies Act (2004) is an important part of the UK government’s and Scottish Government’s strategy to enhance emergency preparedness and improve resilience across the UK. The Act was developed following a major review of emergency planning by the UK government, in partnership with the Scottish Executive, in 2000–2001, and came into force in November 2004. The Act places a range of statutory obligations and duties upon NHS Boards, including the requirement for Boards to produce emergency and continuity plans.

### civil contingency planning

The process of planning for civil emergencies, such as natural disasters, terrorist incidents, security threats and attacks by foreign powers. Through the Civil Contingencies Act (2004) civil contingency planning is now a vital part of the everyday business of government and other public sector organisations. See also emergency planning and continuity planning.

### clinical effectiveness

The extent to which specific clinical interventions do what they are intended to do, ie maintain and improve health, securing the greatest possible health gain from the available resources.

### clinical governance

The system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services, and safeguarding high standards of care and services.

### clinical governance committee

NHS Boards are required to work within a framework through which they are accountable for both continuously improving the quality of their services, and safeguarding high standards of care. Clinical governance committees have a duty to oversee delivery in these areas.

### clinical guidelines

Systematically developed statements, which help in deciding how to treat particular conditions.

### Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)

The insurance scheme through which NHSScotland collectively protects itself from both clinical and non-clinical risk. The scheme was introduced on 1 April 2000 with membership mandatory for all NHS organisations. Following extensive liaison with Willis Ltd, the clinical risks work was integrated with the CGRM standards produced by NHS QIS in 2005, and NHS QIS assumed future responsibility for this area of the scheme. The non-clinical risk side of CNORIS remains the responsibility of Willis Ltd.

Website address: www.cnoris.com

### clinical risk

Risk arising directly from the provision and delivery of healthcare. This includes clinical errors and negligence, healthcare associated infection and failure to obtain consent.

### clinical service

A service provided by healthcare professionals.
<table>
<thead>
<tr>
<th><strong>clinical supervision</strong></th>
<th>The process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CNORIS</strong></td>
<td>See Clinical Negligence and Other Risks Indemnity Scheme.</td>
</tr>
<tr>
<td><strong>community health partnership (CHP)</strong></td>
<td>A way of organising non-acute care where NHS Boards maximise their ability to support integration across health and between health and other agencies such as social services. A CHP covers a geographical area and the number within an NHS Board depends on the distribution and size of the population. Website address: <a href="http://www.show.scot.nhs.uk/sehd/chp/index.htm">www.show.scot.nhs.uk/sehd/chp/index.htm</a></td>
</tr>
<tr>
<td><strong>continuity planning</strong></td>
<td>Arrangements to maintain provision of care and services in case of a sudden and severe event which affects the capability of the organisation to operate in the usual way.</td>
</tr>
<tr>
<td><strong>control options</strong></td>
<td>Methods of minimising and mitigating identified risks.</td>
</tr>
<tr>
<td><strong>corporate governance</strong></td>
<td>The system by which an organisation directs and controls its functions and relates to its stakeholders.</td>
</tr>
<tr>
<td><strong>criterion/criteria</strong></td>
<td>A rule giving the detailed and practical information on how to achieve a standard.</td>
</tr>
<tr>
<td><strong>desirable criterion/criteria</strong></td>
<td>Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive.</td>
</tr>
<tr>
<td><strong>diagnosis</strong></td>
<td>The identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and possible causes for the symptoms.</td>
</tr>
<tr>
<td><strong>discharge</strong></td>
<td>The formal end of an episode of care. Types of discharge include inpatient discharge, day-case discharge, day-patient discharge, outpatient discharge and discharge from the care of allied health professionals.</td>
</tr>
<tr>
<td><strong>diversity</strong></td>
<td>Recognising and valuing that society is composed of people with different characteristics, cultures, beliefs, values, talents, abilities and needs.</td>
</tr>
<tr>
<td><strong>emergency</strong></td>
<td>An event, situation or incident which requires the implementation of special arrangements by one or more of the emergency services, the NHS, or local authority.</td>
</tr>
<tr>
<td><strong>emergency planning</strong></td>
<td>The process of ensuring NHSScotland is able to meet essential healthcare needs effectively when normal services become overloaded, restricted or non-operational for any reason. NHS Boards have a statutory duty under the Civil Contingencies Act (2004) to prepare emergency plans and be able to respond to the potential needs arising from major emergencies occurring within their area of responsibility.</td>
</tr>
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</table>
## Appendix 6: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>equal access</strong></td>
<td>Access to the same quality of treatment and services regardless of age, sex, ethnicity, faith, disability, sexual orientation, social origin, geography, financial status or any other personal characteristic.</td>
</tr>
<tr>
<td><strong>equal opportunities</strong></td>
<td>The prevention, elimination or regulation of discrimination between people because of their age, gender, sexual orientation, disability, race, faith/spirituality, socio-economic status, geographic location or any other personal characteristic including beliefs and opinions.</td>
</tr>
<tr>
<td><strong>equality</strong></td>
<td>The principle of ensuring everyone can participate, regardless of their age, sex, ethnicity, faith, disability, sexual orientation, social origin, geography, financial status or any other personal characteristic, and has the same opportunity to fulfil their potential.</td>
</tr>
<tr>
<td><strong>equality and diversity</strong></td>
<td>The promotion of equal opportunities across NHSScotland. The initiative seeks to ensure NHSScotland recognises and responds sensitively to the individual needs, background and circumstances of people’s lives. As part of this initiative the Scottish Government has produced an Equality &amp; Diversity Impact Assessment Toolkit, to enable NHS organisations to improve how they design, develop and deliver their policies, functions and services. Website address: <a href="http://www.scotland.gov.uk/library5/health/eqdiat-00.asp">http://www.scotland.gov.uk/library5/health/eqdiat-00.asp</a></td>
</tr>
<tr>
<td><strong>essential criterion/criteria</strong></td>
<td>Should be met wherever a service is provided. See criterion/criteria.</td>
</tr>
<tr>
<td><strong>evaluation</strong></td>
<td>The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.</td>
</tr>
<tr>
<td><strong>evidence-based</strong></td>
<td>Using the process of systematically retrieving, appraising, and applying relevant research findings.</td>
</tr>
<tr>
<td><strong>Fair for All</strong></td>
<td>Published in 2002, Fair for All is the Scottish Government’s policy for ensuring NHSScotland is able to meet the challenge of achieving fairness for all who work within it, and for whom it provides care and services. It aims to develop a ‘culturally competent’ NHSScotland and on its foundations a range of equality and diversity initiatives has been developed.</td>
</tr>
<tr>
<td><strong>General Practice Administration System for Scotland (GPASS)</strong></td>
<td>The national primary care system for Scotland and one of Britain’s leading general practice computer systems. Website address: <a href="http://www.gpass.scot.nhs.uk">www.gpass.scot.nhs.uk</a></td>
</tr>
<tr>
<td><strong>generic standards</strong></td>
<td>Standards that apply to most, if not all, clinical services.</td>
</tr>
<tr>
<td><strong>governance</strong></td>
<td>The system by which an organisation directs and controls its functions and relates to its stakeholders. There are several strands including healthcare, clinical and corporate governance.</td>
</tr>
<tr>
<td><strong>GPASS</strong></td>
<td>See General Practice Administration System for Scotland.</td>
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<tr>
<td><strong>grid reference identification project (GRIP)</strong></td>
<td>Providing the grid references of asthma patients and others (for example, patients with diabetes, epilepsy and cardiac conditions, as well as patients whose other medical conditions render them vulnerable) considered to be at risk in rural areas, to enable ambulance crews responding to an emergency call to locate them much more quickly.</td>
</tr>
<tr>
<td><strong>guidelines (non-clinical)</strong></td>
<td>A document which presents operational good practice in a way that can guide day-to-day activities within an organisation.</td>
</tr>
<tr>
<td><strong>health &amp; safety (H&amp;S)</strong></td>
<td>The legislative and regulatory framework designed to safeguard the health and safety of employees and all others who may be affected by work activities.</td>
</tr>
<tr>
<td><strong>healthcare governance</strong></td>
<td>The overall framework through which NHS organisations are accountable for continuously improving clinical, corporate, staff and financial performance.</td>
</tr>
<tr>
<td><strong>healthcare plan</strong></td>
<td>A document drawn up by healthcare professionals which details the action required to promote the optimal physical, emotional and psychological health and development of the child or young person.</td>
</tr>
<tr>
<td><strong>healthcare professional</strong></td>
<td>A person qualified in a health discipline.</td>
</tr>
<tr>
<td><strong>immunisation</strong></td>
<td>An artificial way of creating protection against certain infections, by using relatively harmless antigens that come from, or are similar to the micro-organisms that cause the diseases.</td>
</tr>
<tr>
<td><strong>impact assessment</strong></td>
<td>Considering the difference of effect that a policy, decision or action have in practice.</td>
</tr>
<tr>
<td><strong>implementation</strong></td>
<td>Carrying out and completing a task, action or project.</td>
</tr>
<tr>
<td><strong>individual healthcare plan</strong></td>
<td>A healthcare plan tailored to the needs of a child or young person, whilst in a school setting, which has been agreed between the school health services, the child or young person and their parents/carers.</td>
</tr>
<tr>
<td><strong>inhaler</strong></td>
<td>A portable device for administering medicine through drawing it in by breathing.</td>
</tr>
<tr>
<td><strong>intervention</strong></td>
<td>Healthcare action intended to benefit the patient.</td>
</tr>
<tr>
<td><strong>Knowledge and Skills Framework (KSF)</strong></td>
<td>Defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff.</td>
</tr>
<tr>
<td><strong>legislation</strong></td>
<td>Law passed by a parliament, often referred to as an act of parliament.</td>
</tr>
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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>monitoring</td>
<td>The systematic process of collecting information on the performance of clinical or non-clinical activities, actions or systems. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.</td>
</tr>
<tr>
<td>multidisciplinary</td>
<td>An approach combining the knowledge, skills and expertise of a range of organisations and professionals.</td>
</tr>
<tr>
<td>national guidelines</td>
<td>Guidelines defined at national level. See guidelines (non-clinical) and clinical guidelines.</td>
</tr>
<tr>
<td>near miss</td>
<td>An unwanted event, situation, incident or omission - however, no physical or psychological harm resulted.</td>
</tr>
<tr>
<td>NHS Board</td>
<td>There are 22 NHS Boards of two types: 14 are territorial Boards responsible for healthcare in their areas and eight Special Health Boards or agencies which offer supporting services nationally. See NHS Board (territorial) and Special Health Board.</td>
</tr>
<tr>
<td>NHS Board (territorial)</td>
<td>There are 14 territorial Boards, the mainland being covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three. They are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each NHS Board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. NHS Boards work together in regional planning arrangements for some services. See community health partnership and single system working. Website address - board directory: <a href="http://www.show.scot.nhs.uk/organisations/orgindex.htm">www.show.scot.nhs.uk/organisations/orgindex.htm</a></td>
</tr>
<tr>
<td>NHS Quality Improvement Scotland (NHS QIS)</td>
<td>A Special Health Board established in 2003, leading the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland. It performs three key functions: providing advice and guidance on effective clinical practice, including setting standards; driving and supporting implementation of improvements in quality; and assessing the performance of the NHS, reporting and publishing the findings. In addition, NHS QIS also has central responsibility for patient safety and clinical governance across NHSScotland. Website address: <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a></td>
</tr>
<tr>
<td>other agencies</td>
<td>Other public bodies, organisations and stakeholders, such as local authority social work departments, local authority housing departments and the emergency services, with which NHS Boards must liaise and work in partnership in order to deliver joint services.</td>
</tr>
<tr>
<td>outcome</td>
<td>The end result of a system, process or care, treatment and/or rehabilitation.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>paediatric</td>
<td>Relating to the care and medical treatment of children and young people.</td>
</tr>
<tr>
<td>paediatric specialist services</td>
<td>Within healthcare services there are staff trained to meet the special requirements of children.</td>
</tr>
<tr>
<td>patient</td>
<td>A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary.</td>
</tr>
<tr>
<td>patient focus and public involvement (PFPI)</td>
<td>The Scottish Government’s framework for involving patients and the public in the design, development and delivery of patient-focused NHS services.</td>
</tr>
<tr>
<td>patient relationship management (PRM) system</td>
<td>A software package which assists in gathering patient information, including name, address, date of birth, location, telephone number, GP details, presentation and duration of symptoms.</td>
</tr>
<tr>
<td>peak expiratory flow rate (PEFR)</td>
<td>The maximum rate that air is expired from the lungs when blowing into a peak flow meter or a spirometer. The rate is given in the form of litres per minute.</td>
</tr>
<tr>
<td>peer review</td>
<td>Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS QIS approach, all members of a review team are equal.</td>
</tr>
<tr>
<td>personal development plan (PDP)</td>
<td>A structured and supported process undertaken by an individual to reflect upon their own learning, performance and/or achievement and to plan for their personal, educational and career development.</td>
</tr>
<tr>
<td>PFPI</td>
<td>See patient focus and public involvement.</td>
</tr>
<tr>
<td>plan</td>
<td>An operational tool which details a series of steps to be carried out or goals to be accomplished. A plan allows activity to be managed in the quest to achieve objectives.</td>
</tr>
<tr>
<td>policy</td>
<td>An operational statement of intent in a given situation.</td>
</tr>
<tr>
<td>preventer</td>
<td>Medication taken regularly which stops symptoms developing.</td>
</tr>
<tr>
<td>primary care</td>
<td>The usual first point of contact between a patient and the NHS. This is the care given to patients outside hospitals and is typically, though not always, delivered through general practices. Primary care services are the most often used of all services provided by the NHS. Primary care covers a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.</td>
</tr>
<tr>
<td>PRM</td>
<td>See patient relationship management system.</td>
</tr>
<tr>
<td>procedure</td>
<td>The steps taken to fulfil a policy.</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>protocol</strong></td>
<td>Operational instructions which regulate and direct activity. Protocols may be national, or agreed locally to take into account local requirements.</td>
</tr>
<tr>
<td><strong>Quality and Outcomes Framework (QOF)</strong></td>
<td>A voluntary incentive programme designed to deliver financial rewards for high-quality care, and part of the arrangements for the new General Medical Services contract. The QOF sets out a range of national standards based on the best available research evidence, divided into four domains: clinical standards linked to the care of patients suffering from chronic diseases; organisational standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management; additional services, covering cervical screening, child health surveillance, maternity services and contraceptive services; and patient experience, based on patient surveys and length of consultations. A set of indicators has been developed for each domain to describe different aspects of performance. Practices are free to choose the domains which they want to focus on and the quality standards to which they aspire.</td>
</tr>
<tr>
<td><strong>quality assurance (QA)</strong></td>
<td>The process of improving performance and preventing problems through planned and systematic activities, including documentation, training, audit and assessment.</td>
</tr>
<tr>
<td><strong>rationale</strong></td>
<td>Scientific/objective reason for taking specific action.</td>
</tr>
<tr>
<td><strong>record</strong></td>
<td>Any instrument which contains information, personal or non-personal, in any medium, which has been created, gathered, or retained as a result of any aspect of the work of NHS organisations.</td>
</tr>
<tr>
<td><strong>referral</strong></td>
<td>The process by which a patient is transferred from one professional to another, usually for specialist advice and/or treatment.</td>
</tr>
<tr>
<td><strong>referral pathway</strong></td>
<td>How a patient is assessed by a healthcare professional and the steps which follow if they are identified as needing specialised examination and/or treatment. A referral pathway should be set out in a formal document.</td>
</tr>
<tr>
<td><strong>regional planning</strong></td>
<td>A systematic approach to fulfil the statutory duty of effective co-operation amongst NHS Boards to plan and deliver services for population groups which span more than one NHS Board area.</td>
</tr>
<tr>
<td><strong>review</strong></td>
<td>Examine or assess (something) formally with the possibility or intention of bringing about change if necessary. See peer review.</td>
</tr>
<tr>
<td><strong>risk</strong></td>
<td>The likelihood, high or low, that somebody or something will be harmed by an unwanted event or incident, multiplied by the severity of the potential harm. Risks are measured in terms of their likelihood and consequences.</td>
</tr>
<tr>
<td><strong>risk assessment</strong></td>
<td>The systematic process of identifying risks and evaluating their potential likelihood and consequences.</td>
</tr>
<tr>
<td><strong>risk management</strong></td>
<td>The systematic identification, evaluation and treatment of risk, a continuous process with the aim of reducing risk to organisations and individuals alike. The ‘culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.’ (Australian/New Zealand Risk Management Standard 4360:2004).</td>
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<tr>
<td><strong>Royal College of Paediatrics and Child Health (RCPCH)</strong></td>
<td>The professional and advisory body overseeing the education and qualifications of paediatricians. Website address: <a href="http://www.rcpch.ac.uk">www.rcpch.ac.uk</a></td>
</tr>
<tr>
<td><strong>scheme of delegation/escalation</strong></td>
<td>An agreed document setting out the way in which issues and responsibilities should be assigned to junior staff or passed to a higher level.</td>
</tr>
<tr>
<td><strong>scoping exercise</strong></td>
<td>Before a project can be given a full go-ahead, its purpose and targets need to be agreed. This also means looking in an organised way at the range and depth of work to be undertaken, planning, assessment of risks, and the resources and expertise required.</td>
</tr>
<tr>
<td><strong>Scottish Government Health Directorates (SGHD)</strong></td>
<td>Government department responsible both for the central management of NHSScotland and for the development and implementation of health and community care policy across Scotland.</td>
</tr>
<tr>
<td><strong>Scottish Intercollegiate Guidelines Network (SIGN)</strong></td>
<td>To help improve the quality of healthcare SIGN develops national clinical guidelines aimed at reducing variations in clinical practice and in outcomes for patients. Founded in 1993 by the Academy of Royal Colleges and Faculties in Scotland, SIGN became part of NHS QIS on 1 January 2005. The evidence base for many of the clinical standards developed by NHS QIS has been drawn from SIGN guidelines. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA. Website address: <a href="http://www.sign.ac.uk">www.sign.ac.uk</a></td>
</tr>
<tr>
<td><strong>Scottish Programme for Improving Clinical Effectiveness in Primary Care (SPICE)</strong></td>
<td>An initiative for anonymised patient data collection developed by the Royal College of General Practitioners (Scotland) in 1999. SPICE is now hosted by the Healthcare Information Group of NHS National Services Scotland and supported by NHS QIS.</td>
</tr>
<tr>
<td><strong>secondary care</strong></td>
<td>Hospital-based (acute) health services which are provided on an inpatient or outpatient basis. See also acute care.</td>
</tr>
<tr>
<td><strong>secondary care adult respiratory services</strong></td>
<td>Hospital-based adult specialist respiratory services for patients with asthma, which are provided on an inpatient or outpatient basis.</td>
</tr>
<tr>
<td><strong>self-assessment</strong></td>
<td>Assessment of performance against standards by the individual/clinical team/NHS operating division/NHS Board providing the service to which the standards relate. See assessment.</td>
</tr>
<tr>
<td><strong>SGHD</strong></td>
<td>See Scottish Government Health Directorates.</td>
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</tbody>
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**Appendix 6: Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>shared care</td>
<td>Care of a service user shared between primary and secondary care services.</td>
</tr>
<tr>
<td>SIGN</td>
<td>See Scottish Intercollegiate Guidelines Network.</td>
</tr>
<tr>
<td>single system working</td>
<td>A way of working to improve service organisation and delivery throughout NHSScotland. The white paper Partnership for Care (2003) outlined proposals for removing barriers in local NHS systems. Health Department Letter HDL 2003(11) dealt further with the duties placed on NHS Boards to improve integration, decentralisation, service redesign and patient focus. See NHS Board.</td>
</tr>
<tr>
<td>Special Health Board</td>
<td>Special Health Boards provide national clinical and non-clinical care and services to NHSScotland.</td>
</tr>
<tr>
<td></td>
<td>Website address: <a href="http://www.show.scot.nhs.uk/organisations/special_hbs.html">www.show.scot.nhs.uk/organisations/special_hbs.html</a></td>
</tr>
<tr>
<td>SPICE</td>
<td>See Scottish Programme for Improving Clinical Effectiveness in Primary Care.</td>
</tr>
<tr>
<td>stakeholders</td>
<td>People and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity.</td>
</tr>
<tr>
<td>standard statement</td>
<td>An agreed statement of required performance with NHS QIS standards.</td>
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<tr>
<td>statement on internal control</td>
<td>Internal control is the process employed by an organisation to ensure that its established objectives are met. It involves identifying and evaluating risks to an organisation and stating how these will be managed and mitigated. A NHS organisation is required to produce an annual statement on internal control, alongside its annual accounts, summarising the process employed and the results of all evaluations of its abilities to meet its objectives and discharge its functions.</td>
</tr>
<tr>
<td>statutory obligations</td>
<td>A requirement, duty or function stipulated by an act of parliament.</td>
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<tr>
<td>steroid</td>
<td>Medication that reduces swelling and inflammation, available in pill, cream and inhaled forms.</td>
</tr>
<tr>
<td>strategy</td>
<td>A high-level document setting out the framework and vision for achieving objectives. A strategy will often incorporate a plan, outlining the actions, initiatives and milestones required to deliver the strategy.</td>
</tr>
<tr>
<td>system</td>
<td>A set of interdependent elements interacting to achieve a common aim(s). These elements may be both human and non-human (equipment, technology etc).</td>
</tr>
<tr>
<td>systematic</td>
<td>Methodical, according to plan and not casually or at random.</td>
</tr>
<tr>
<td>tertiary care</td>
<td>Specialised care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has the personnel and facilities for special investigation and treatment.</td>
</tr>
<tr>
<td><strong>transition</strong></td>
<td>Moving or preparing to move from one service to another, for example paediatric to adult services.</td>
</tr>
<tr>
<td><strong>treatment plan</strong></td>
<td>Protocol of action, which specifies what should be done, when it should have been done and towards what aim.</td>
</tr>
<tr>
<td><strong>waiting time</strong></td>
<td>The length of time a patient is required to wait before receiving care, treatment, rehabilitation or another service.</td>
</tr>
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