Healthcare Improvement Scotland

Excellence in Care

Quality of Care Review Guidance: Evaluation

October 2025

NHS SCOTLAND

Published | October 2025

www.healthcareimprovementscotland.scot

Contents

Background

Quality of care (QoC) reviews are a care assurance process which can help to determine the extent to which people in receipt of healthcare have their needs and outcomes met through the provision of high quality, safe and effective person-centred care. As the national care assurance programme, Excellence in Care (EiC) has provided a structure to inform a consistent approach to QoC reviews at a local level, in order to drive continuous learning and improvement.

The QoC review guidance was launched in September 2024 and relaunched on the Right Decision Service (RDS) platform in April 2025. The guidance, tools and templates are available alongside several resources designed to help support implementation within local services.

The focus of the evaluation will be to identify how the guidance has been used in practice; where the guidance has been implemented across boards within Scotland (demonstrate spread or alignment to local care assurance processes); and barriers and enablers to the implementation of the QoC review guidance. Areas of success or learning identified during the evaluation will be used to further promote the implementation of the QoC review guidance through dedicated communications plan.

Methods

To address the above outcomes and associated evaluation questions, a mixed methods approach was developed using both the quantitative and qualitative data sources listed in the table below.

For the quantitative data sources, descriptive statistics were used where appropriate. Inferential statistics were not used due to the small sample sizes. For the qualitative data sources, thematic analysis was used.

Concept/Measure Name	**What/How to measure**	**Data Source**	**Frequency of Reporting**	**Chart Type**
Visits QoC review webpage/toolkit sections on RDS platform*	**Why measure?** Gather information on the number and location of users accessing the information. **What to measure:** • Count number of visitors • Location of visitors – by country	Google Analytics*	Monthly Monthly	Run Chart Bar chart

	• Count number of visitors to each section of the toolkit			
QoC review template downloads from RDS platform • Scope • Data gathering** • CAV template** • CAV tool • Final report	**Why measure?** Gather information on the number of users accessing the information and determine the templates that are used most frequently. **What to measure:** Count number of downloads **Analysis of elements chosen on the customised templates	Google Analytics*	Monthly	Run Chart
QoC review videos hosted on RDS platform • Why • How x4	**Why measure?** Gather information on the number of users accessing the videos, this will help us determine which templates need additional support **What to measure:** Count number of views	Google Analytics*	Monthly	Run Chart
QoC review example templates hosted on RDS platform • CAV child protection	**Why measure?** Gather information on the number of users accessing the information. This will help us understand which	Google Analytics*	Monthly	Run Chart

• CAV Community • CAV mental health • Data Gathering acute • Data Gathering mental health • Data Gathering secure environment • Scope template learning disabilities • Scope template maternity • Scope template mental health • Scope template health visiting	templates require additional support, or which areas/services are using the guidance. **What to measure:** Count number of views per individual example template. Count number of downloads per type of example template i.e. Scope, Data Gathering, CAV			
QoC Case Studies (view) hosted on RDS platform • CS1 – CAVs • CS2 – Assuring care in community settings • CS3 – Breaking it down • CS4 – A care assurance approach for everyone • CS5 – From development to implementation	**Why measure?** Gather information on the number of users accessing the information. We will see which topics are popular and useful to expand or promote. **What to measure:** Count number of views per case study	Google Analytics*	Monthly	Run Chart
Tester survey	**Why measure?** Gather information on whether teams who	MS Form with quants and qual questions	August-Sept 2025	Bar graphs, Line graphs, Pie charts as appropriate.

	initially tested the guidance are still using it **What to measure:** Quantitative and qualitative analysis of the survey questions			
Stakeholder survey	**Why measure?** Gather information on implementation in boards, what they like or dislike about the resource, challenges to implementation, enables, and any suggested changes **What to measure?** Quantitative and qualitative analysis of the survey questions	MS Form with quants and qual questions	August-Supt 2025	Bar graphs, Line graphs, Pie charts as appropriate
Case studies	**Why measure?** Explore with small sample of users: What was done? What went well? What could have gone better? **What to measure?** Qualitative analysis of the semi-structured interviews	Semi-structured interviews	Jan-Feb 2025	No chart
Engagement calls themes – see above for questions	**Why measure?** An understanding on the QoC reviews and/or CAVs	Engagement Call	Monthly	No chart

	being undertaken locally. Consider: • Reason • Speciality • Outcomes/learning • Local approach **What to measure:** Qualitative analysis from the engagement call log	Learning Log		
SG report themes –	**Why measure?** An understanding on the QoC reviews and/or CAVs being undertaken locally. Consider: • Reason • Speciality • Outcomes • Local approach **What to measure:** Qualitative analysis from the SG feedback reports	SG Report Feedback	Biannual	No chart

Quality of Care review guidance Right Decision Service analytics

One data source that was employed in this evaluation was the online usage analytics (e.g. how many times the resource pages were viewed or downloaded) of the resource. Whilst the QoC review guidance was launched on the Healthcare Improvement Scotland website in September 2024, usage analytics were limited and inconsistent and cannot be generated retrospectively. However, when the resource was launched on the RDS platform in April 2025, usage analytics (using Google Analytics functionality) were obtained from April 2025-September 2025, the end of the evaluation data collection period.

Overall use

In this data collection period, the QoC review guidance resource had 1,677 total active users. 'Active users' is a Google Analytics term which distinguishes from simple page views by identifying only those users who have stayed on the page for over 10 seconds or have had at least two page views. The number of active users who have utilised the resource over the course of the data collection period is presented below (Figure 1).

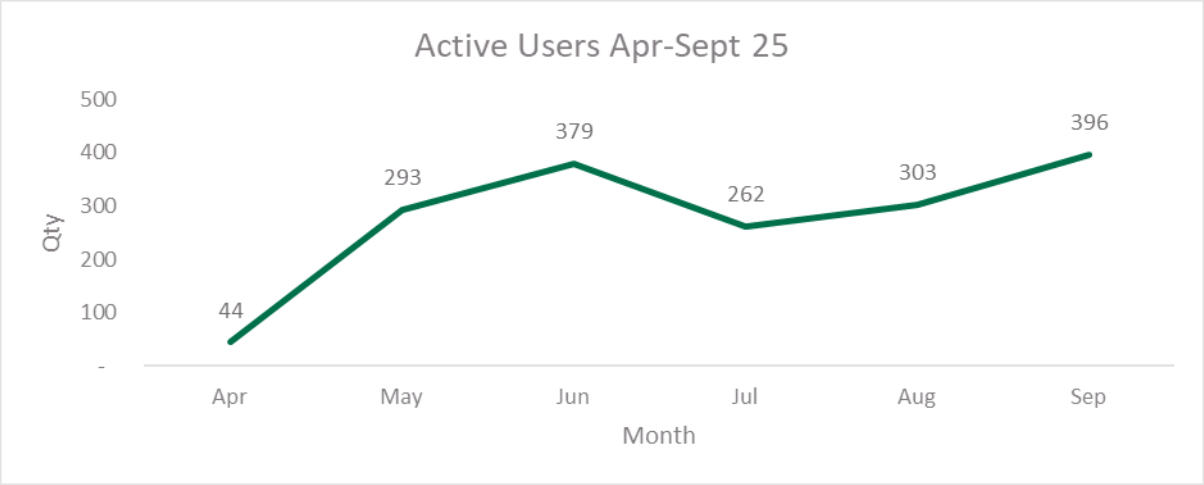

Figure 1. QoC review guidance: Active users Apr-Sept 25

Usage increases over the first three months since its launch, with 379 active users registered in June. This high number of users could be attributed to the NHS Scotland Conference presentation focusing on the resource, which took place in early June. This visibility at a national event could have served to direct people towards the resource. The increased users in September could be attributed to the 10-year anniversary of the EiC programme webinar that was hosted virtually with approximately 350 attendees, in which the resource was discussed, with shared learning presented from NHS Forth Valley and NHS Dumfries and Galloway, as well as links to the resource shared. The resource was also presented at the National AHP Workforce Group in September, which may also have contributed to the higher number of users that month.

The reach of the resource has not been limited to Scotland, with Google Analytics reporting active usage in 21 countries.[1] This is demonstrated in the heat map below (Figure 2), in which the size and colour of the circle correspond to the number of active users reported in that country.

[1] Google Analytics does not distinguish between active users in the four home countries when analysing country-wide statistics.

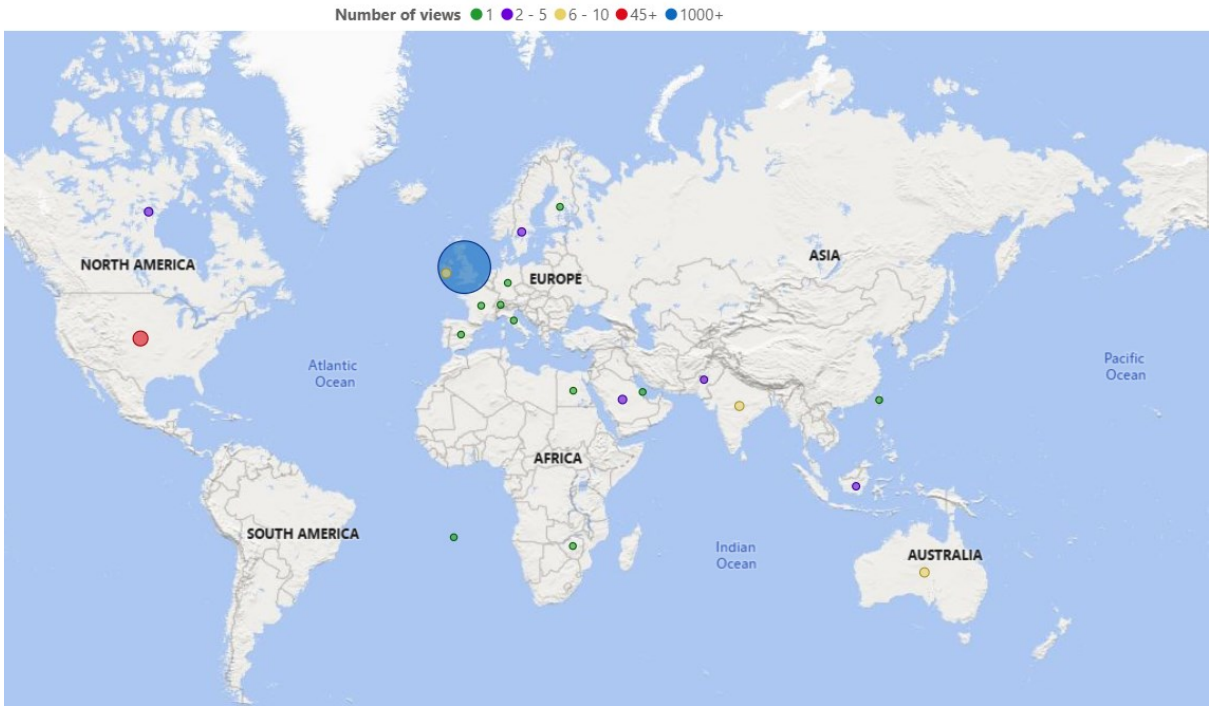

Figure 2. QoC review guidance: Geographical heat map of use

Unsurprisingly, the most use was observed in the United Kingdom (1128 views). This was then followed by the United States (46), Australia (8), Ireland (8), and India (7). Active usage was noted across the globe, including Europe, North America, Africa, Asia, and Oceania.

Guidance section views

Active usage can be further investigated by the individual sections of the guidance (Figure 3 below). The most widely used section was 'Why QoC reviews for care assurance are a priority', whereas the least commonly explored section was 'Guiding principles for undertaking QoC review'. However, all sections had over 182 active users or above, indicating that a large number of users are exploring the resource beyond the home page.

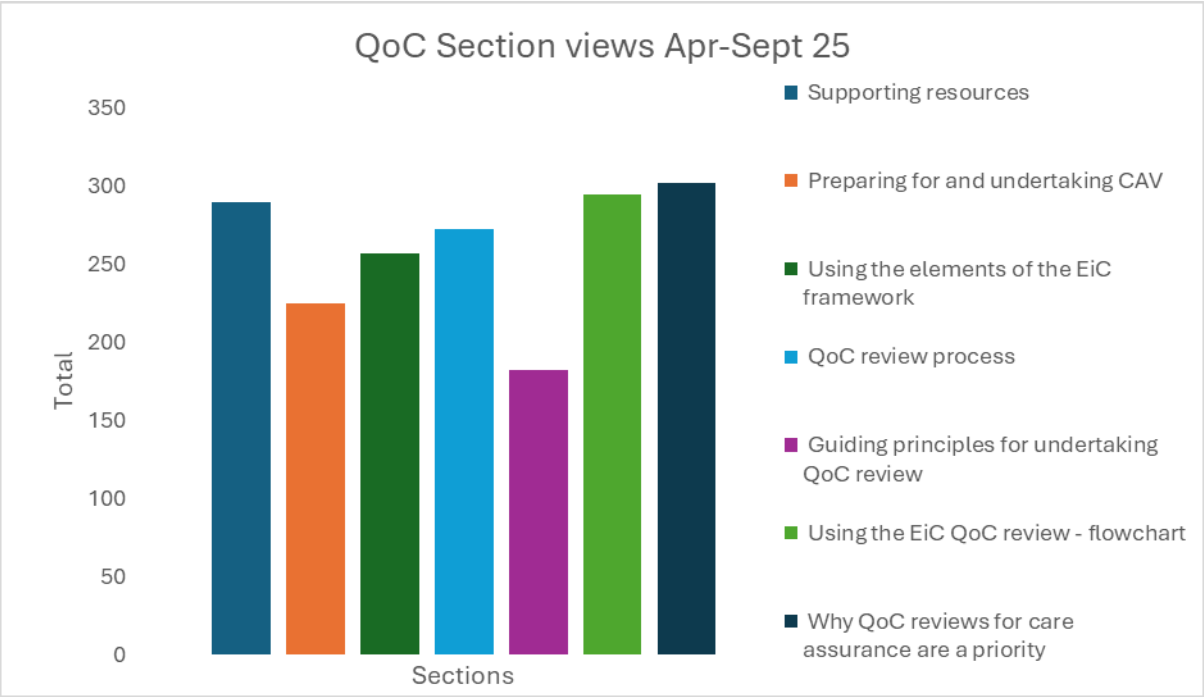

Figure 3. QoC review guidance: Section views Apr-Sept 25

Within the 'Supporting resources' section, there were also a number of completed templates from different clinical areas that users could explore and use as a guide when completing their own QoC or CAV. The view analytics for these templates are explored in the figure below (Figure 4). The most widely viewed example template was the 'Data Gathering Acute' (26 views). Complete example templates were also viewed for child protection, community, mental health, secure environments, and health visiting clinical areas. The resources for maternity and learning disability were not viewed, which indicates that there may be further work needed to implement this approach to care assurance in these settings.

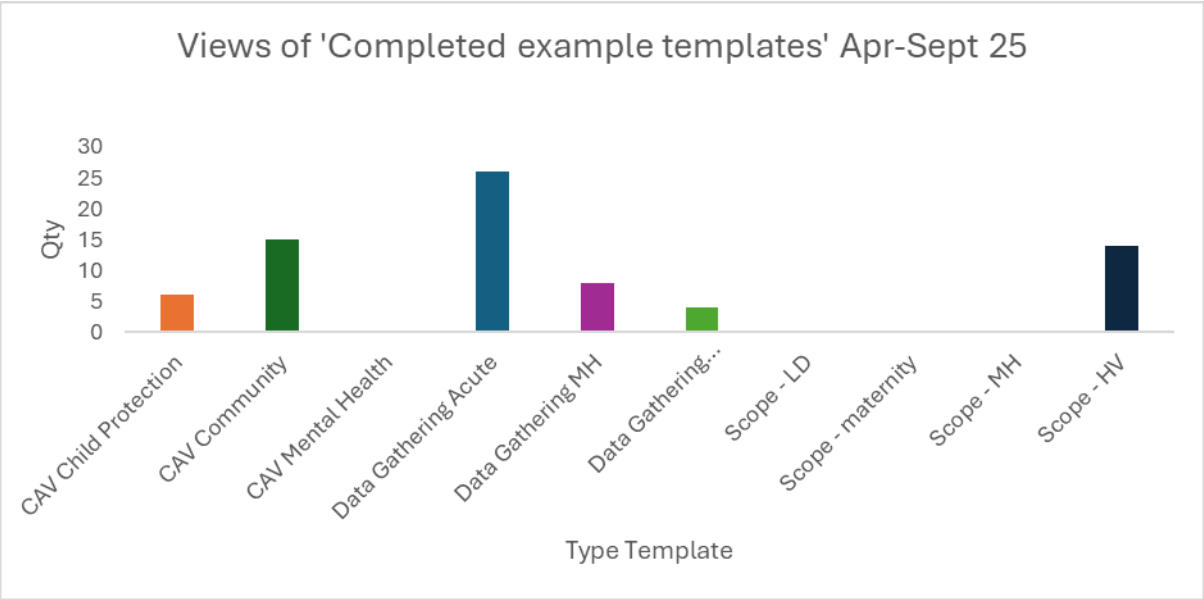

Figure 4. QoC review guidance: Views of 'Completed example templates' Apr-Sept 25

Videos and case studies

The guidance also contains a number of resources including videos on how to utilise this care assurance approach and case studies exploring examples of how other teams have implemented it (Figures 5 & 6 below).

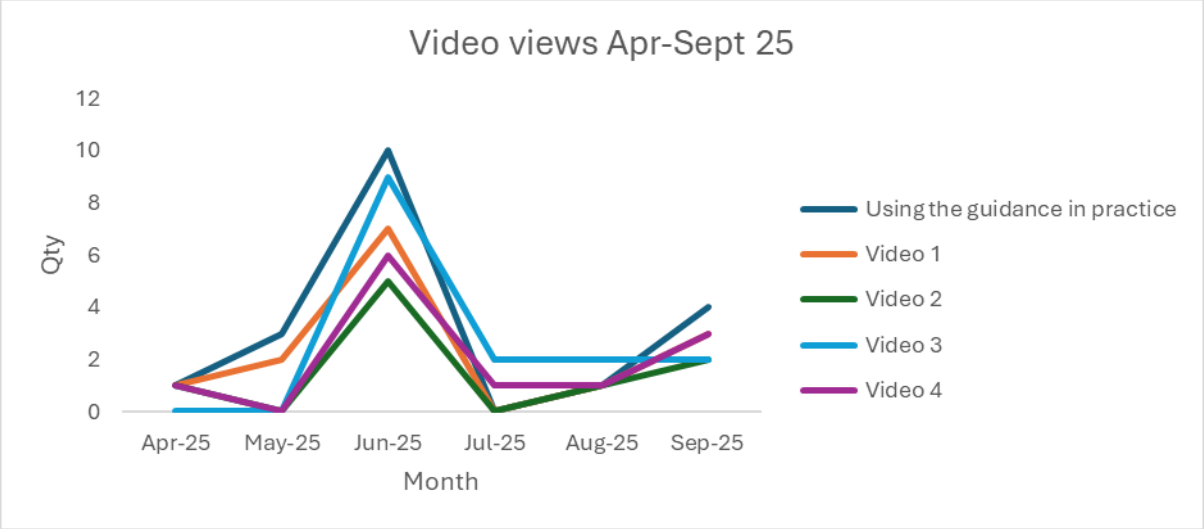

Figure 5. QoC review guidance: Video views Apr-Sept 25

The case studies were added to the platform in July 2025. The case studies were most viewed shortly after their launch with an uptick in September corresponding with the 10-year anniversary webinar.

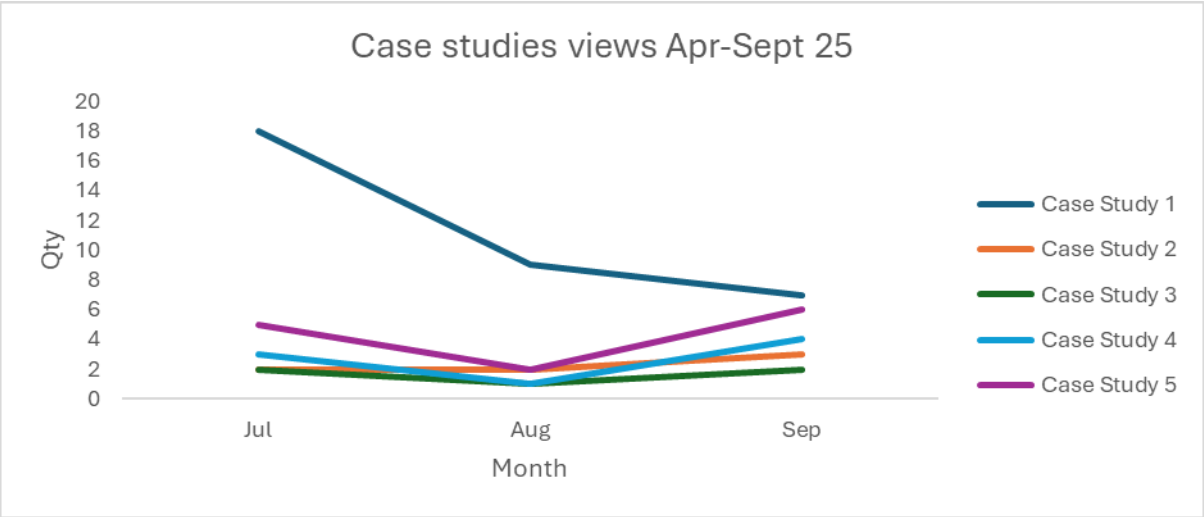

Figure 6. QoC review guidance: Case studies views Apr-Sept 2025

Tool and template downloads

In addition to the completed example templates highlighted above, users could also download supporting tools and blank templates to be used in their clinical areas. As the figure below (Figure 7) demonstrates, the 'CAV Tool' and 'Scope' tool were the most downloaded (230 and 200 times respectively). These tools are introductory to the QoC review guidance care assurance approach and a way to further explore what the process entails, which may explain why they are the most frequently downloaded. Whereas the 'CAV Template', 'Data Gathering', and 'Final Report' templates are more likely to be accessed and used by those who are actively undergoing a review, which could explain the fewer downloads in comparison to the other two tools.

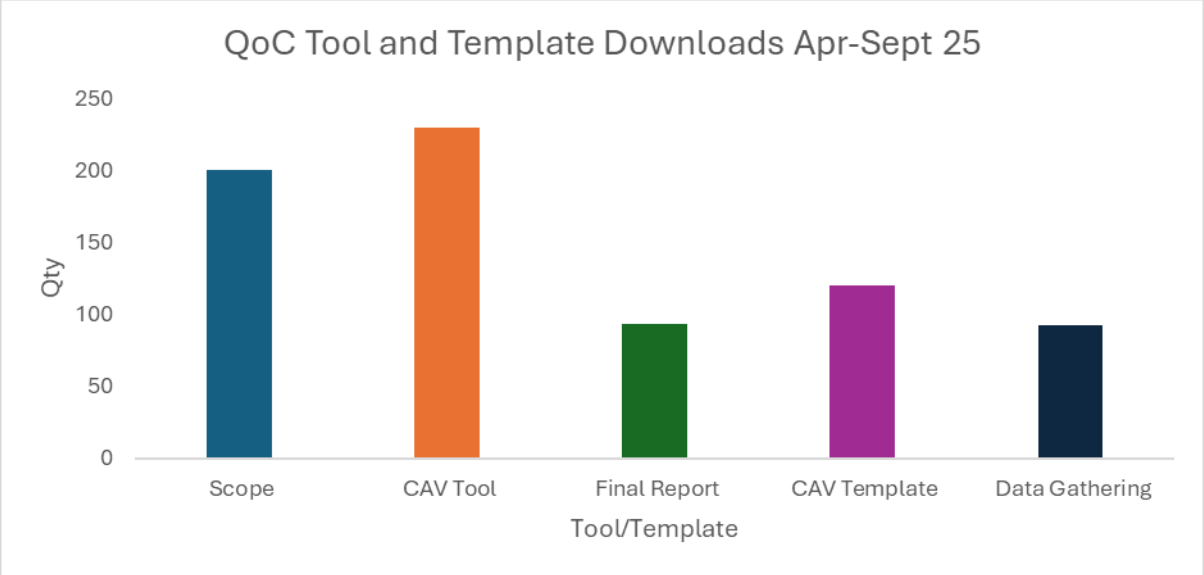

Figure 7. QoC review guidance: QoC tool and template downloads Apr-Sept 25

For those interested in using the 'CAV' and the 'Data Gathering' templates, they are able to create a customisable template, selecting the relevant elements of the EiC Framework for their care assurance needs at the time. The figure below (Figure 8) shows the overall number of

customisable templates downloaded from the RDS platform, evidencing that more users are downloading the CAV-related tool as opposed to the Data Gathering tool.

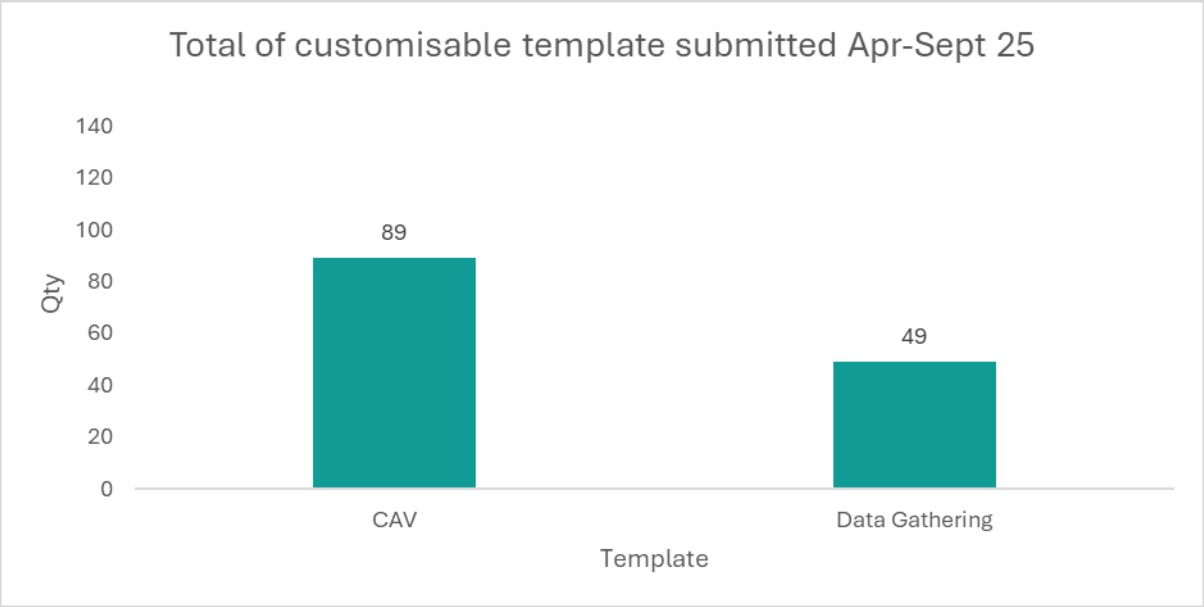

Figure 8. QoC review guidance: Total of customisable template submitted Apr-Sept 25

Of these customisable templates, data was gathered around what elements of the EiC Framework were requested. The EiC Framework elements that were requested for the customisable templates were similar regardless as to whether they were to be used in the CAV or Data Gathering tool. Therefore, in the figure below, the request data has been combined for these two tools (Figure 9).

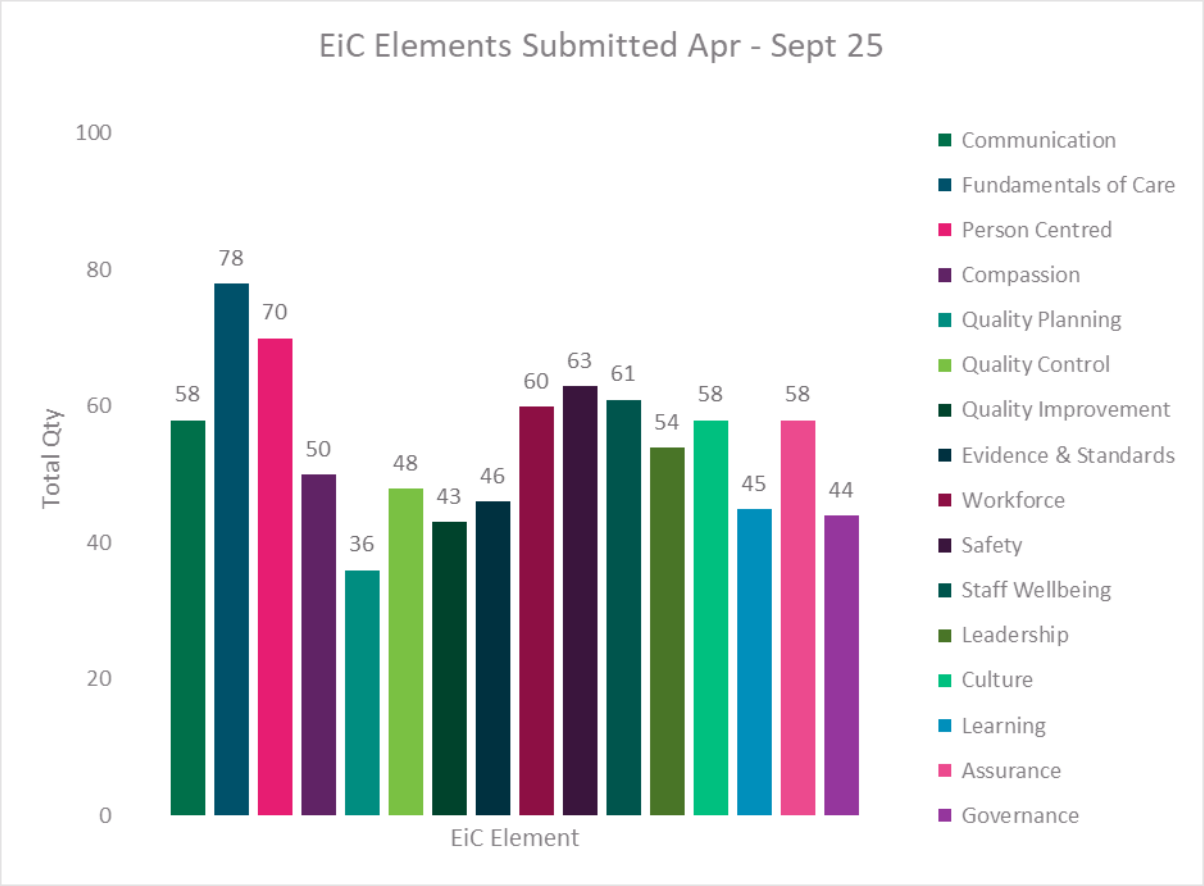

Figure 9. QoC review guidance: EiC elements submitted Apr-Sept 25

The three most requested Framework elements were: 'Fundamentals of Care', 'Person Centred', and 'Safety'. The three least requested elements were: 'Quality Planning', 'Quality Improvement', and 'Governance'. This is in line with recent findings from the EiC Framework review, which indicated that that stakeholders particularly valued person centredness, fundamentals of care, and leadership. This review also found that the elements associated with the Quality Management System (quality planning, control, and improvement) were less well understood by stakeholders. Ensuring clearer alignment with the QMS is currently underway as part of the redesign of the Framework.

Conclusion:

The usage analytics for the QoC review guidance on the Right Decision Service platform demonstrate a strong and steadily growing engagement with the resource, both within Scotland and internationally. Peaks in usage aligned with key promotional events, suggesting that targeted dissemination efforts are effective in driving uptake. The breadth of engagement across different sections of the guidance, as well as the use of supporting tools and templates, indicates that users are not only accessing but actively engaging with the resource further. This is supported by the survey data, case studies, and engagement call and Scottish Government report data that is explored below. However, the limited engagement with certain clinical area templates and Quality Management System elements highlights opportunities for further awareness-raising and support.

These insights will inform future iterations of the guidance and its implementation strategy, ensuring it continues to meet the evolving needs of health and care professionals.

Surveys

Testers:

This survey was sent out to those clinical areas who were involved in testing the guidance during the development phase from March to August 2024; in total, 37 teams tested the resource. This survey was sent out to the team leads and explored how the resource is being used (or not) currently. There were five responses to this survey. When asked about whether the QoC review guidance is still in use within their testing area, four respondents indicated positively.

The survey also provided a short answer question for participants to provide further reflections and feedback on its use in their local areas. Overall, the responses were extremely positive, with respondents emphasising and appreciating the collaboration between team members to undertake these reviews. One respondent did highlight the size of the guidance as potentially overwhelming, though their team has worked through the resource by breaking it down systematically using an action tracker.

One respondent provided detailed account of how the resource is being used in their area, describing a collaborative approach with Associate Directors and Lead Nurse for Patient Safety to design a care assurance programme using the QoC review guidance. Care Assurance Visits (CAVs) are currently routinely expected from all in-patient areas and thus far three full QoC reviews have been undertaken with subsequent development of improvement plans.

Whilst the response rate to this survey was poor (~14%), of those testing sites who did respond, the majority still use the QoC guidance and had overwhelmingly positive feedback about how it is being used and received by teams. However, limited conclusions about how the resource is being used more broadly amongst testers can be drawn given the small sample size.

Other stakeholders:

Beyond those who tested the QoC review guidance during its development, another survey was distributed by email to EiC Board Clinical Leads (BCLs), Healthcare Staffing Programme (HSP) Workforce Leads, the Scottish Acute Nursing Leaders (SANL) and members of the QoC Short Life Working Group (SLWG). EiC BCLs were also invited to share the survey link with staff in their board who may have utilised the resource as well, particularly their AHP colleagues.

In total, there were 23 responses received. There was a wide range of organisational representations with 14 boards having at least one respondent.

Of the 23 respondents, there was variety in the seniority of respondents with representation from Senior Charge Nurses (SCNs) up to Deputy Nurse Director level. Whilst most respondents were identifiable as having a nursing background, there was at least one respondent who identified as an AHP.

Participants were also asked to describe their involvement with the QoC review guidance (see figure below).[2] The range of respondents is encouraging, with only 11% indicating that they were directly involved in the guidance development as a member of the QoC SLWG. Forty-four percent of respondents identified as those in clinical roles as a 'nurse, midwife, or allied health professional', indicating that the awareness and use of the resource has spread since its conception.

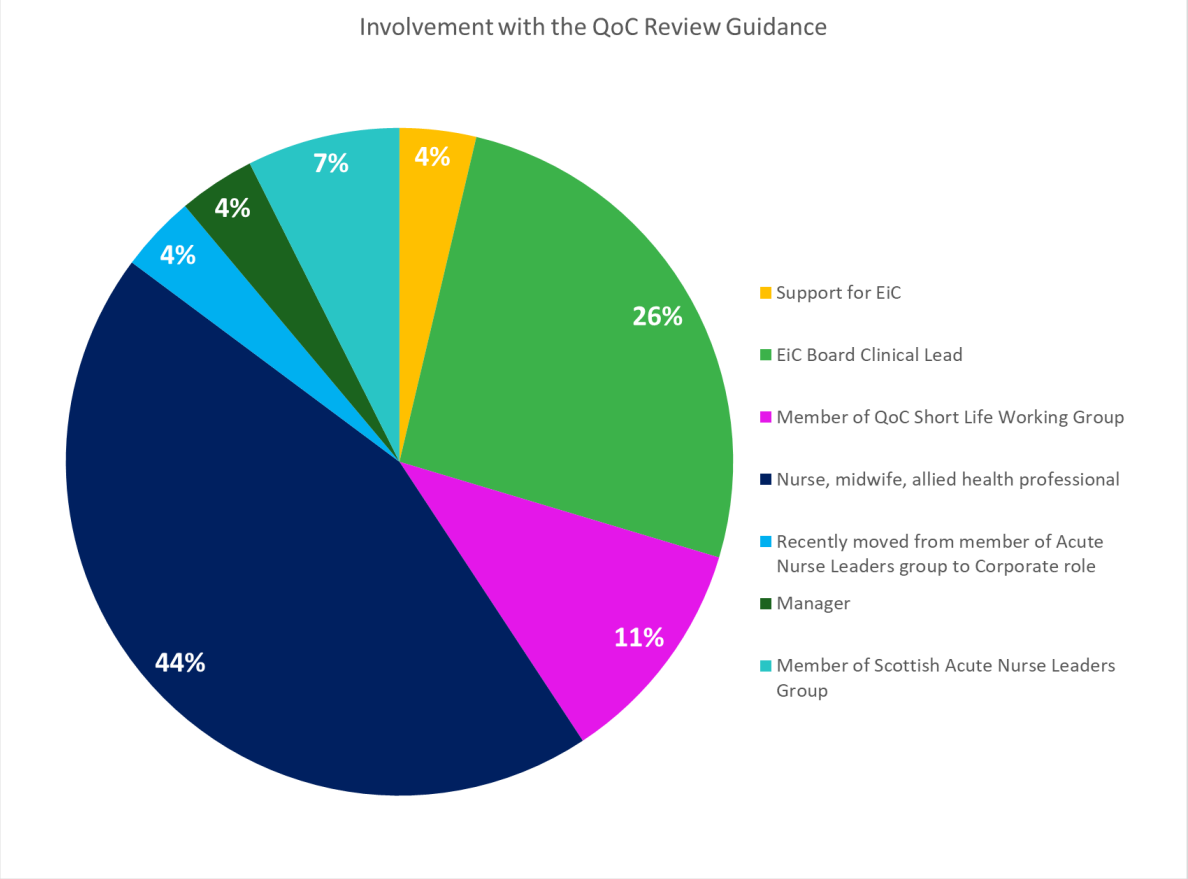

Figure 10. QoC review guidance stakeholder survey: Involvement with the QoC review guidance

Local implementation of QoC review guidance

This survey also explored how the QoC review guidance has been embedded in respondents' boards. Promisingly, all respondents indicated some level of use, indicating that it has been implemented in some areas (4), that there has been work to embed the resource into their governance and assurance structures (14), or that the QoC review guidance is being used as a primary method of assurance in their board (5).

The variation in implementation across the boards is echoed in the qualitative data gathered in this survey. Respondents described being at various stages in their efforts to embed this care assurance approach within their board or local care setting. A medium-sized board's participants

[2] Note that respondents could select multiple responses (e.g. identified as both a 'Manager' and a 'Nurse, midwife, allied health professional').

described notable integration of the QoC review guidance, specifically the CAV tools, across multiple clinical areas.

"[…] The QoC and CAV frameworks are an invaluable addition to our suite of assurance measures. We have almost fully embedded the EiC CAV framework across the whole system - now business as usual in acute, community hospitals, women and children's, mental health and LD inpatients (acute and community hospital), district and community nursing, and prisons. […]" (medium-sized board)

Other boards are partway through their implementation, with clinical areas such as acute and in-patient services prioritised. As highlighted by this respondent:

"We are seeking to use this review guidance as a primary method of assurance and have commenced with roll out within the Acute hospital before further spread to other areas, once fully embedded within Acute." (medium rural board)

However, that is not to say that other clinical areas, such as community or district nursing have not been included in boards' rollout of the care assurance approach. A participant from a medium-sized, rural board explained that they have undertaken three QoC reviews within their community and district nursing team, and this was use in community teams was similarly noted in another medium-sized board.

The survey identified one instance in which an AHP team has conducted a QoC review in a large urban board, however they are still in the process of exploring its use in that service. Although there is limited evidence of AHP-led QoC reviews from this survey, several participants highlighted the collaborative approach to their efforts.

"[…] This is a multidisciplinary effort, encouraging collaborative reflection and continuous improvement across all teams. The QoC Reviews are already supporting us in how we plan, assure, and discuss quality and improvement outcomes, and are helping embed a common language and shared understanding of quality across our services. […] (medium-sized board)

Boards are also adapting the QoC review guidance for their local setting and developing escalation models. This ability to customise is also highlighted as a positive feature of the guidance that will be discussed in further detail below. The respondents also indicated that there have been different strategies for implementation in terms of reactive versus proactive use. Although some boards have embedded the approach as a systematic methodology feeding into their clinical governance systems regularly, others are using the guidance in response to raised concerns. However, it is the aim of some respondents to move beyond a reactive model to a more proactive approach:

"We are increasingly using the review guidance across MH&LD Services - use at the moment has been primarily reactive. We are currently planning the use of the guidance in a proactive way to supplement and build on the existing care assurance activity underway in services. The guidance where used has been effective and well received due to its clarity and ease of use." (medium-sized board)

Some respondents indicated that their board is in the initial stages of implementation, with several reporting ongoing discussions with board leadership to explore how the resource can be utilised within their board. This is particularly evident amongst special boards, whose care contexts can look significantly different from a 'traditional', territorial board. As such, these conversations are to "make sure it reflects the unique nature of the services we provide" (special board).

However, for some, the limited implementation of the guidance is not due to the distinctiveness of their care delivery, but rather attributable to resource pressures and to existing assurance approaches. For example:

"I have worked with the SCM to look at it in relation to a specific area of the maternity services here in [island board]. However, this has stalled at the moment due to other pressures in the system. Not actively used as the Director of Nursing uses other assurances." (island board)

These barriers to implementation will be explored further below.

Improvement work as a result of QoC review guidance

Participants were also asked about any resulting improvement work that had been done in response to using the QoC review guidance. Over half indicated that it had been used to inform local improvement work. Yet approximately one third of respondents indicated that it had not been used in this way. However, the qualitative data indicated that in these instances, the integration of the guidance was still in the early stages within that board or clinical area.

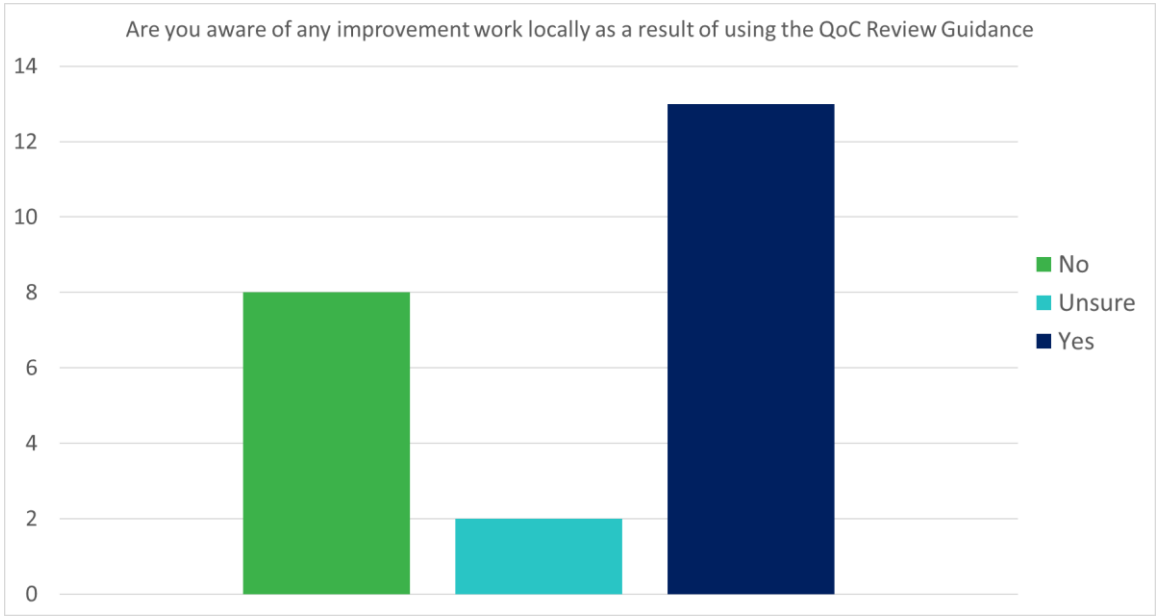

Figure 11. QoC review guidance stakeholder survey: Are you aware of any improvement work locally as a result of using the QoC review guidance?

This data also indicated a tremendous amount of improvement across the boards, with positive implications for patient safety, staff learning and development, patient experience and person-centred care, and multidisciplinary team working. These are listed in the table below.

Table 1. QoC review guidance stakeholder survey: improvement work resulting from use of QoC review guidance

Area of Improvement	Action	Proposed impact
Patient safety		
Pressure ulcer reduction	Bespoke training and education packages developed; review of dressing use and resources	Reduced risk of harm from pressure ulcers
Falls prevention	Targeted QI methodology, enhanced risk assessments, purposeful rounding, and environmental adjustments	Reduction in falls with harm
Medication safety	Improved documentation and handover processes; medicines management improvements	Safer transitions of care and reduced medication errors
Infection Prevention and Control (IPC)	Strengthened IPC measures based on audits and feedback	Lower infection risk and improved compliance
Review of safety and quality data	Development of Datix review groups	Identify trends in safety and quality data; develop plans to address areas of concern and identify good practice
Staff development and learning		
Leadership and assurance development	Workshops for SCNs; plans for Band 6/7 leadership programme	Stronger leadership capability and assurance at ward level
QI Training access	Focus on enabling staff to access QI training	Increased staff confidence and capability in improvement work
Local learning opportunities	Bespoke training on documentation, escalation protocols, and clinical pathways	Improved staff training and competence
Patient experience and person-centred care		

Communication and discharge	Better communication at discharge; consistent 'what matters to me' conversations	Enhanced patient satisfaction and involvement
Environmental improvements	Dementia-friendly signage, quite spaces	More supportive and inclusive care environments
Patient feedback integration	Patient experience surveys, feedback loops to teams and board	Responsive changes based on real patient voices
Multidisciplinary team working		
Collaborative reviews	Full 16-domain reviews in areas of concern, involving nursing, medical, and AHP staff	Shared accountability and coordinated improvement actions
Breaking down silos	MDT involvement in QoC reviews and governance discussion	Improved coordination in discharge planning and escalation of care
Reintroducing staff meetings	Reinstating regular staff meetings	Increased opportunity for staff to speak up and ensure all voices are heard

As the above table demonstrates, specific changes have been made as a result of implementing the QoC review guidance to improve care, focusing on areas such as patient safety, staff development, patient experience, and MDT collaboration.

Positive features of QoC review guidance

As the usage above suggests, the QoC review guidance has been broadly well received by local teams and in many instances has contributed to encouraging changes in the delivery of care. This warm reception was attributed to several positive features of the guidance. The clear structure and consistency of the guidance was frequently mentioned by participants.

"That is a consistent framework to follow - the website is a fantastic resource to guide teams on what is required/expected. It does not only enable consistent in a board however across the country. The focus on areas to celebrate and areas of improvement in providing feedback and the way the tool can be used for proactive review or planned." (medium-sized board)

This structure was perceived to help teams navigate complex situations and ensures a level of standardisation across services and boards.

Furthermore, participants valued the ability to tailor the guidance to specific contexts. Respondents commonly used phrases such as *"adaptable," "scope for professional judgement," "can be used in parts," "not prescriptive",* demonstrating that flexibility is considered a major strength of the resource. Participants appreciated that it balances consistency with freedom,

allowing teams to use the guidance as needed whilst still using a nationally promoted, structured approach to care assurance.

Participants also emphasized the ease of use, appreciating the availability of templates and the RDS platform on which the resource is located.

"I really like the RDS platform and the ability to request a template with only the elements that you are intending to focus on for that specific visit." (special board)

Respondents indicated that the resource was easy to find on the RDS platform and the functionality of the website makes it easy to navigate the guidance as needed.

Another positive feature of the guidance was the design and methodology to gather data. Respondents indicated that the guidance encourage drawing on multiple data sources and insights, generating *"comprehensive," "rich, meaningful information".* Moreover, several participants appreciated the opportunity to tell the story behind challenging areas not just report the data.

"Being able to have narrative behind issues, being able to tell the story, improvements/ actions." (medium-sized board)

Additionally, the guidance emphasises the importance of highlighted areas of good practice not just those in need of improvement. This was welcomed by participants, who valued the chance to identify "areas for celebration". Overall, respondents embraced the qualitative insights generated by this care assurance approach and the opportunity for meaningful reflection on the care provided in their local area.

Barriers to use of QoC review guidance

Whilst there is a broad appreciation for the QoC review guidance, participants highlighted a number of challenges that have slowed or halted progress to implementing the resource locally. The most frequently mentioned obstacle was staffs' limited time to engage in the reviews and competing priorities within the board.

"Identifying time for teams to undertake and participate" (medium, rural board)

"Time constraint" (medium-sized board)

This was exacerbated by the perception that the guidance and associated reporting require significant time and effort.

Beyond the demand on staff's time, limited resources (both financial and operational) was highlighted by participants as slowing the integration of this care assurance approach.

There were also several respondents who indicated that integration of the QoC review guidance was challenging due to previously used local assurance approaches. For example:

"Our initial barrier was due to the contrast in our previous local assurance template and the new template. Staff were use[d] to a tick box template with no area for narrative and very few open discussions." (medium-sized board)

For those who identified this barrier to use, they described undertaking work to align the QoC review guidance and their current assurance structures in response.

Individual participants also highlighted they had initial challenges with digital reporting and gaining staff buy-in. Whilst these challenges were not commonly reported, they bear consideration in how these problems can be addressed with further support. However, despite these barriers, several responses indicate barriers were initial and have been resolved through leadership support, structured timetables, communication and engagement strategies, and a RAG status implementation.

Enablers to use of QoC review guidance

As highlighted above, barriers to implementation can be overcome using various strategies. Leadership support was again frequently highlighted as a factor which facilitated the use of this approach was support from leadership teams.

"Nurse Director and senior management team engaged with QoC and value what they can add to practice. They have definitely helped to actively support this approach." (special board)

"The NMAHP Leadership Team within the Board have recognised the value and opportunities the guidance brings and have provided leadership in its use." (medium-sized board)

Furthermore, support from EiC BCLs was also highlighted as an important factor to embed the resource into local care assurance processes.

Additionally, shared learning was also perceived by respondents to broaden the potential strategies to draw from to implement the guidance. As a participant from a medium rural board described "hearing from how different NHS Boards are using this in action" was an enabling factor in their experience.

Staff buy-in was also highlighted as a factor which enabled use of the resource. A respondent from a medium rural board described "networking, conversations and visiting the teams to make it real" as part of the work they undertook to implement the QoC review guidance locally. Furthermore, addressing the aforementioned barrier of time constraints, a medium-sized board released time for the staff to undertake the work and protected time in their diaries to engage with care assurance.

Suggested changes to QoC review guidance

Whilst there were a number of factors that enabled integration of this care assurance approach into local systems, participants had further suggestions which could improve the QoC review guidance.

The usability of the guidance was highlighted as an area for improvement. Given the size of the resource, some participants suggested streamlining the guidance documents with less visual clutter. Furthermore, whilst the tool was perceived to bring some level of standardisation to care assurance in Scotland, it was felt that this could be improved further by clarifying the roles and responsibilities of those engaging in QoC reviews and CAVs. Another suggested that usability could be improved through greater digital functionality, with an interactive version of the tool kit in which clinicians could complete or edit the templates as needed. For example:

"If there was a way to be able to personalise the QoC template to reflect local services and when you log in to RDS you can select your own HB, that would be really helpful. […]" (special board)

The desire for further customisation was echoed in calls for additional resources that showcased a wider range of clinical settings. Participants requested more case studies and examples tailored to specific clinical settings, particularly those that are not in-patient. Users indicate that concrete, context-specific examples would guide in the application of this guidance more widely.

Whilst the above suggestions were explored by some participants, half of respondents proposed no changes to the resource. This indicates an overall high level of satisfaction with the QoC review guidance.

"Overall, the guidance is working well, and any suggested changes would be about enhancing usability and supporting sustainability, rather than addressing major gaps. Teams remain engaged and invested in the process, which is a strong indicator of its effectiveness." (medium-sized board)

So, although respondents explored suggestions to further improve the resource, participants largely felt that the guidance was a useful tool that promotes care assurance in their local area.

Conclusion:

In summary, the evaluation of the Quality of Care (QoC) review guidance reveals a broadly positive reception across a diverse range of clinical settings and health boards. Despite a modest response rate, the feedback demonstrates meaningful engagement with the resource, highlighting its adaptability, clarity, and potential to drive improvements in patient safety, staff development, and multidisciplinary collaboration. While barriers such as time constraints, resource limitations, and existing assurance structures have posed challenges, these have often been mitigated through leadership support, shared learning, and strategic implementation efforts. The suggestions for enhancing usability and contextual relevance underscore a commitment to continuous improvement but also affirm the guidance's value as a robust and flexible tool for care assurance. Overall, the QoC review guidance is seen not only as a mechanism for assurance but as a catalyst for reflective practice and quality improvement across Scotland's health services.

Case studies

A multiple case study design was used, where a small number of cases are used to conduct an in-depth inquiry, in order to account for the contextual factors that surround the phenomenon of interest. By using case studies in this evaluation, it is possible to deeply explore how five

organisations have used the national QoC and CAV guidance. This can provide a more detailed and fuller understanding of the value of this resource, and what enablers and barriers there are to its implementation in different contexts.

Case studies were recruited through existing EiC Clinical Lead networks, Nursing Directors, Midwifery Directors, and AHP Directors. For the purpose of this study, the inclusion criteria was limited to those who have conducted or taken part in a QoC review or CAV since the launch of the national resource in September 2024. This is a self-selected case study sample.

Case study 1: Jamie Doyle, Head of Nursing for Acute Services, NHS Fife

What was done?

NHS Fife has begun to embed this approach into their assurance governance, beginning with the CAV guidance. Care Assurance Visits were chosen initially as they were seen to be an easy transition from their existing care assurance, governance and documentation. This guidance was first used in acute service settings, eventually expanding into other areas such as theatres and outpatient settings.

Some care settings were initially hesitant to engage with the resources due to their perception the approach was only applicable in ward settings. In response, NHS Fife staff engaged with these teams further through a tabletop exercise in which staff could raise questions regarding the applicability of the approach and receive additional guidance as to how the resources could be used to assure care. These teams have since begun using the approach.

After initially using the CAV guidance, NHS Fife is planning to expand their use of the approach to include QoC reviews within hospital teams. Within these local teams, Clinical Nurse Managers have been tasked with leading a QoC review in the upcoming year, which will subsequently be reviewed by the Heads of Nursing and the Nursing Director to give final assurance sign off.

As part of this review the Clinical Nurse Managers must evaluate their existing data to identify priority sections of the review guidance and involve the multidisciplinary team as necessary. For example:

“we've encouraged everyone to take ownership of them and it's up to them to agree the review teams, but we want them to be diverse and appropriate.
So for instance, if a ward’s got high falls, we would recommend they get the nurse consultant for frailty in to help the physio or whatever. Or if there's pensioner's consultant or nutrition or tissue viability.
We've asked them to try and look at their themes as part of the data review before they do that”

Thus far, there has been buy-in from across the teams and disciplines promoting that “care assurance is not a nursing thing, [rather] that it is more everyone's business”. NHS Fife have engagement from AHPs, Nurse Consultants, specialist nurses, and medical teams.

What worked well?

The CAVs were well received by staff. Staff appreciated speaking to different members of leadership. Additionally, they welcomed that they had conversations about areas of their experience and care quality that had not been addressed in previous care assurance governance mechanisms.

"I think the staff really liked it because they were speaking to maybe people who they have never seen before.
And some of the questions, especially about their well-being and things which has never really been asked before, when we've done [previous care assurance visits]. It's all been very much the tick box where you go in and you're either clean or you're not, or the place is tidy or it's not."

Furthermore, in comparison to the previously used documents, the EiC resources encouraged more in-depth information gathering, with free text boxes encouraging more nuanced responses than previous binary 'yes/no' questions. These conversations also helped to build rapport with staff members and encourage open and honest communication that was distinct from an inspection.

"The big thing is they didn't feel it was an inspection. They felt it was more of kind of a visit and showcase."

Whilst the CAVs were recognised as distinct from inspections, the resource documentation and outputs were identified by staff to be useful when these inspections occurred. Staff could share their completed CAV report and demonstrate their knowledge of their local care context to the inspectors and highlight the ongoing efforts to improve weak areas.

"Also, they feel more empowered to when they say oh there's been an increase in falls, they've got the data there to say well actually your vacancy is this or that."

Staff's perceived value of the CAVs is further demonstrated by the enquiries from other teams about when they might expect to have a CAV with NHS Fife leadership. Moreover, after the CAVs that have occurred, staff from these teams have demonstrated initiative and developed improvement plans without prompting.

As a result of the CAVs, areas that were identified as needing improvement have been addressed. One example related to patient experiences, which involved a relatively simple change of bringing in additional televisions.

"There was only like 1 TV because the surgeons didn't want people to have the TV because they wanted them up out of bed but that was like an old fashioned method. So we quickly burst that, and we got the TV's up and going and we're still getting discharges and things like that."

Another improvement was made to address a ward that was identified as struggling with communication between staff and service users. They subsequently had coaching about compassionate communication and techniques to reduce staff stress when they get frustrated.

Gathering service user and relative's feedback was also perceived as a positive experience resulting from using the CAV resource. They were happy to engage with those conducting the visits and appreciated the opportunity to provide their views. Responses identified areas of good practice as well as highlighted areas of the service which could be improved.

What could have gone better?

The NHS Fife team recognised that given the demand on services, finding time to conduct CAVs and QoC reviews can be difficult. Nonetheless, it was acknowledged by staff that care assurance cannot be sidelined.

"It's really busy and it's all hands on deck. And I just got a phone call there to say we have to open up a discharge line and things like that.
We've got patients at endoscopy overnight and so it isn't an ideal situation, but the senior nurses will recognise there's never going to be the right time, and it is part of our role"

To manage the stretched resource, NHS Fife has instructed local teams to prioritise sections of the QoC review resource that they deem appropriate. Staff have positively responded to this guidance, especially given the perceived length of the documentation. However, teams have tended to complete more sections of the review than originally intended because of their interconnectedness.

"So at first people thought it was something extra to do so they weren't keen, but once they realised that was helping to really pull everything together and then plans what next… And I think when they first seen the booklet because there's so much, they thought they had to go through all of that. But then they realised that we just need to do what we think is appropriate.
And interestingly so some of them wanted to do 3 [sections], but by the end of it they've done six or seven because they knew that it all kind of dove tailed with each other."

Furthermore, given the size of the resource, the NHS Fife team felt that additional guidance was necessary to support staff to use the resource, particularly as the resource is quite large and can be "overwhelming". They also reported issues with the resource's PowerPoint formatting; staff were unable to print the documentation out or type directly into the resource which limited staff's engagement. To address this, formatting changes were made, and this resolved the issue.

Case study 2: Lead Nurse, Highland Council

What was done?

This case study explores how the approach has been used out with the NHS health boards, instead of hearing from staff who work for Highland Council. The Lead Nurse who was interviewed for this case study oversees community-based healthcare staff (e.g. health visitors, school nurses, children's home, primary mental health workers, etc.). New to her position, she had heard about the approach through the webinar and felt that the resources would provide a structure through which to assure nursing care quality.

The QoC review was conducted in a residential children's home and was prompted by an inspection report indicating that what had previously been a high performing care context now

had some indications that care quality had dropped. The review was led by an Associate Lead Nurse and involved members of the multi-disciplinary team, such as Nursing Mangers and Social Work Leads. Feedback was provided in real time to staff informally, and a more formal version of feedback will be written up as a report and shared more widely across the organisation.

What went well?

As the nursing leadership who conducted the QoC review were new to their roles, the resource was highly valued as a tool to assure care quality. The structure of the resource provided guidance and focus on what could have otherwise been an overwhelming process.

Additionally, because of the unique context in which the review took place (a residential home in which both health and social care are provided) this tool helped provide a language and structure which could be shared and understood across the multidisciplinary team.

"It was a really good way to articulate what we were doing in a nursing sense to people that don't understand nursing."

Moreover, given that the resource was developed to be used nationally across all healthcare settings, the multidisciplinary leadership team were confident that it could be used in their setting. Ultimately, whilst the resource was used in a defined setting in response to a concern about nursing quality, leadership felt it could be applied more widely to the nursing service across the organisation.

The respondent expressed an appreciation that the tool highlighted good areas of practice in addition to identifying areas for improvement. This was associated with putting staff at ease, who initially were felt to be anxious about the review.

"This staff group were very anxious and very worried about a number of things because of everything that's happened.
So being able to use the tool to help us look for the positives, for me was great, because you worry about staff well-being at this time."

As such, this review identified examples of positive person-centred care and a strong culture of teamwork.

"Well, the positives were definitely that the nursing staff really cared about the families. And the frontline care like that was actually really good. And there was, we could actually demonstrate that it was really good team working as well.
So then when there was a crisis, they would come together and cover staffing. And there's a real commitment to the care. So that shone through which was really good and I think that was really important feedback for the staff, given that the centre had been assessed as being weak, you know."

What could have gone better?

The context in which the QoC review was conducted by Highland Council staff was noted as a unique combination of health and social care in a residential setting. Though the resource was

appropriate for the residential setting of this case study, there was some concern that it may be difficult to use in a community setting in which care is spread out and not provided within a defined area (e.g. a ward or residential home). There were also some concerns as to how this could be scaled up, as conducting a QoC requires significant resource.

Furthermore, gathering service user feedback presented some difficulties given the populations' unique communication needs (e.g. learning disabilities). Whilst there are processes in place to include the 'child's voice' in their care plans, there is currently no mechanism to collect data on this, which makes care assurance more difficult. This finding was echoed in regard to violent incident reporting and complaints. However, this in itself identified an area for improvement.

"The guidance is asking for data, improvement data, but there isn't any mechanism to gather that data. But that tells us something in itself. […] we need to get a better system for that as a whole and this just taught us a lot about that.
That for me, I'm thinking about the whole service, not just this one.
So there's been a lot of learning for us on many levels doing this."

Additionally, the guidance was felt to be quite lengthy, however, staff appreciated the iterative nature of the tool and the ability to select sections to work through as appropriate.

Case study 3: Julie Campbell, Lead Nurse for Patient Safety and Care Assurance, NHS Borders

What was done?

Previous to using the EiC resource, NHS Borders had tried to remobilise their care assurance standards and had tested NHS Grampian's tool. However, they felt that these tools were repetitive and did not encourage engagement with the teams.

"I think as the EiC framework is a QMS it is more practical tool. Elements such as workforce or wellbeing could easily have been missed using other tools, on a regular basis. Previous tools were also repetitive on a monthly basis."

Without a preferred care assurance approach that they felt met their needs, NHS Borders was involved in testing the EiC resource. They have since used the CAV tool in a variety of care contexts including: the medical assessment unit, the emergency department, and maternity services. Thus far the tool has been used primarily in acute services, as these were the areas that they had initial concerns over regarding care quality. However, efforts have begun to embed this more widely within the Board's care assurance governance structures, for example community hospitals and inpatient mental health facilities.

Moving forward, Borders will use the resource to conduct partial CAVs monthly in acute wards. The CAV tool is broken down into its constituent elements to make it more manageable, allowing staff to identify which elements are most relevant to them at the time and thus what they might want to prioritise.

"Our Care Assurance Structure requires SCN and CNM to perform monthly CAV's, applying 2 elements from the framework each time, taking approximately 1.5 hours."

Clinical Nurse Managers and Senior Charge Nurses are expected to lead their areas CAVs. This collaboration is encouraged given SCNs' in-depth knowledge of their area and the CNMs' oversight of governance and their experience with QI. Additionally, whilst physiotherapists have been involved in the CAVs of acute services thus far, they recognise that the use of these resources has been very nursing led. There has not yet been a CAV or QoC specifically of an AHP service.

Though monthly CAVs will be led by senior team leaders, additional senior leadership will join the CAVs biannually. Ultimately, at the end of the year these CAVs are intended to then feed into an annual QoC review in each inpatient area.

In addition to the annual, planned QoC reviews, NHS Borders will conduct ad-hoc QoC reviews as needed in response to identified care quality concerns. For example, a QoC review was commissioned in one department following a CAV which identified limited assurance of an element. It involved setting up a designated day which included multi-professionals. Data was used from local Safety and Quality dashboards, and a learning improvement action plan was developed. Senior Charge Nurses can now use the CAV template to report back to their senior clinical management teams monthly whilst these plans are implemented.

What went well?

The resource was well received across the acute care context in the Borders.

"The QoC review guidance has been developed at a good time for NHS Borders. It is our preferred tool to use, and we are keen to design our care assurance standards around implementation of the tool."

After initial testing, the tool received support from the Associate Director for Acute Nursing, ultimately deciding to embed the tool into their governance structure. Local staff also perceived the new CAV structure to be positive. Although staff were initially a bit nervous regarding the CAVs, the identification of good practice in addition to areas that needed improvement resulted in staff being more comfortable with the process. Senior Charge Nurses also appreciated the practicality of the tool.

Moreover, the CAV tool was also identified as a positive resource to use in preparation for inspections so that teams can share their knowledge of their area and improvement plans.

"Implementation of the QoC review guidance locally provides assurance that we are prepared and consistent across all inpatient areas. It also provides SCN's autonomy to identify improvement initiatives following a CAV, SAER or complaint."

Gathering service user feedback went well, in part because this was already practiced in these areas. The feedback from service users was then escalated to the clinician providing care or the senior charge nurse.

What could have gone better?

One criticism levelled at the resource was that additional support was often necessary for staff to complete the CAVs, specifically to develop the final report. Whilst the templates were broadly viewed positively, it was suggested that additional guidance on writing up the full report and how to share the findings would be helpful.

"The QoC review guidance is easy to use. The final report was the only document that required additional information and thought on layout which was applicable to the QoC review, a partly completed table / template may have been useful to ensure that all elements were included."

Additionally, Lead Nurses who were unfamiliar with the EiC Framework required supplementary guidance; this was particularly relevant for the sections on quality improvement. As a result, Board leadership is currently looking into how they further develop staff's QI skills.

Furthermore, there is some concern over the amount of resource required to embed this resource into their care assurance standards, especially for the Lead Nurse for Patient Safety and Care Assurance.

"Locally we have had discussions relating to resource / capacity to support CAV's / QoC reviews. At the moment I have been facilitating these within the Acute setting, going forward consideration for wider facilitation is to be developed."

To address this issue of limited resource in the team, it was recognised that local leadership buy in is needed for the CAV tool to be used monthly as intended.

"Ideally, we hope that SCN's will continue to lead CAV's on a monthly basis, providing assurance to their governance groups. At the moment we are working to build this momentum and have senior buy in to support this."

Currently, it is unclear how invested local teams are in using this resource on a regular basis despite a positive reaction to the tool in general. If it is to be embedded in the Board's care assurance standards, additional consideration is needed regarding the resource of both the Lead Nurse for Patient Safety and Care Assurance and senior leadership teams.

Case study 4: Douglas High, Lead Nurse for Practice Development and Care Homes, NHS Forth Valley

What was done?

Within the Forth Valley case study, the Practice Development Unit supports the care assurance program. As part of this role, the PDU helps local teams to conduct CAVs by doing some pre-visit work and gathering relevant data sources. Historically, the tool they used for CAVs was very prescriptive and quantitative, with little room for context. As such, there was a desire for a new tool.

"We had been looking for some time at refreshing our approach to care assurance visits in line with our Forth Valley Quality Management system which is still in early stages itself - our Care Assurance Visit programme has to meet our needs because our old model was starting to feel like it was no longer giving us assurance of quality- parts of our system had moved on and progressed, but our CAV programme still felt like it sat in a pre-covid era, which we know due to the pace of change was a very different landscape.
From the perspective of our senior charge nurses, midwives and team leads, the Care Assurance visit had sometimes historically felt like something that provoked anxiety and felt a bit intrusive – the timing was right to change the culture around this and ensure that our CAV programme is embraced as a vital part of our learning system -psychological safety plays a key role in this"

The EiC 'Once for Scotland' care assurance approach was seen as an opportunity to refresh their care assurance governance and integrate it further into their quality management system.

As the previous iterations of CAVs templates used in Forth Valley were unique to each specialty, the PDU felt that additional guidance was necessary in transitioning to the EiC tool. The team set up a development day to scope out the new tool and discuss what would be relevant indicators of high-quality care in their care context that could be used to support completing the template.

The new CAV templates have been able to be integrated into their existing performance management system, which displays quality indicators, safety metrics, and workforce information. Each element of the framework is given a RAG rating within the system to quickly display the information, then staff can then see the full report PDF to explore further details.

Thus far, the board has primarily used the CAVs tool to great success, whilst the wider QoC tool is now being tested:

"The next step is for us to explore the wider Quality of Care review and determine how this fits into our system, what our flags, triggers and escalation points are for us to get there - it's an ongoing process. We're at the point just now where we're working on our QMS escalation and governance framework but it's not yet perfect. I think Quality of Care reviews will play a key role in this as it evolves."

What went well?

A key positive of the EiC CAV guidance was the dynamic interactions and meaningful conversations it encouraged with staff.

"The conversations have been in my experience really productive, and the feedback from our CAV support team has been positive. We would potentially never get the same depth of information if we hadn't asked the right questions - if we had stuck with our established, heavily quantitative CAV framework then we'd have nowhere near that richness of information and feedback from focussed conversations with staff. The psychological safety element of the CAV framework is absolutely integral to ensuring we have a valuable quality assurance programme, and not just something that ticks a box."

In addition to the rich discussions with staff facilitated by this approach, the CAVs have empowered staff to escalate concerns that are picked up on during the visit.

"There is an element of our CAV programme, which is about more than Quality Assurance, and about empowering Senior Charge Nurses, Midwives and Team Leads with another layer of intelligence, a fresh pair of eyes. In some cases, our SCNs have used CAV outcomes as a means of supportive data to escalate concerns or add weight to an ask for investment in improvements. CAV outcomes might help focus the local Clinical Educator's efforts in one area rather than another for example"

In this way, the findings from a CAV can be used as evidence to help bolster and justify suggested improvements to more senior staff.

Additionally, there has been a concerted effort to include AHPs in the process of integrating this approach to care assurance. Therefore, the fact that the resource was designed with a multi-disciplinary approach was received positively by the Forth Valley team.

"We wanted to take this opportunity of a refreshed programme to instil in our teams that Quality Assurance is for everyone, and therefore that our CAV framework isn't just a Nursing and Midwifery tool that we are applying to AHPs - this is an NMAHP tool, designed by NMAHPs to cover the breadth of our services.
Leadership and culture work at every level in Forth Valley have been focused on making sure that we have a dynamic, supportive and effective NMAHP family. The NMAHP approach to Quality Management, and therefore care assurance, is key in this – it's applicable to everyone. There's still lots of work to do but there is progress everywhere."

AHP Leads were included in the development day in which the PDU team discussed the new CAV approach. As a result of these discussions with the AHP leads, they identified that many of the AHP-led services do have similar care assurance processes, but these are not currently reported more widely or shared with senior leadership. The AHPs appeared to be "really keen" to introduce the EiC CAVs into their governance going forward.

Gathering patient and relative feedback as part of the CAV went well, particularly for those care settings where this has been established practice. However, for community settings, such as district nursing and health visiting, who have not traditionally gathered this information as part of their care assurance approach, additionally guidance around those conversations was required. With this support, the community teams have responded positively and have engaged meaningfully with this aspect of the tool.

What could have gone better?

Whilst the CAV tool has been broadly well received, the transition away from an overall score, quantifying their quality of care, has been difficult. Although this score did not allow for nuance and contextual narrative, it was an easily understood metric that could be shared widely with the team. Broadening the concept of care quality will be a longer-term process, that shifts focus to a more holistic view of care assurance. This transition appeared to be particularly difficult for those who infrequently conduct these visits, as the previous tool that was more of a checklist may be easier to use for those without much practice with this dynamic, conversational approach to CAVs.

"Some of those leads are only doing 4 visits a year, so they don't have like the momentum built up yet and they've still got… it's still a little bit sort of foutery and deliberate to work through it, I think.
They again quite liked having, if they're not it doing all the time, quite like having the 'Is there alcohol gel? Yes/No.' So it does take a bit more time."

Upon reflection, the participant suggested that a launch event or wider communication explaining the uptake of the new tool would have been helpful in addressing some of these issues.

Case study 5: Gillian McAuley, Nurse Director of Acute Service, NHS Lothian

What was done?

In this case study, this Nurse Director shared their experience in the development process of a 'Once for Scotland' care assurance approach and the QoC and CAV guidance. They described inconsistencies in care assurance approaches used across NHS Scotland, which resulted in a commission by the Scottish Executive Nurse Directors (SEND) for these resources. This effort was a collaboration between Scottish Acute Nurse Directors and the HIS EIC team, with membership including nurse directors, clinical representatives, and quality improvement staff.

They also shared their experiences in NHS Lothian, in which they have both commissioned a QoC review, as well as leading a QoC review. Commissioning the review was prompted by an external concern which was raised about one of the wards, thus they felt it was appropriate to conduct a QoC review in its entirety. This was also felt to be an opportunity to test out the review process in a real-world context and to familiarise the Lothian care assurance teams with the approach.

In another case, this nurse director was asked to lead a review of maternity services given concerns raised by internal and external individuals. This approach was considered especially useful in Lothian maternity services as a framework to review all aspects of care with a particular focus on essentials of safe care. This review consisted of a tabletop exercise with key stakeholders in the service. Through this review it was identified that there were "gaps in data collection, understanding systems, and processes of people" within this service. The review processes provided a framework for assessing the service in a triangulated way and advising on recommendations and actions.

What went well?

In terms of the development of the resources, it was highlighted that the HIS EiC team played a key role in the momentum of the project.

"There is no doubt that we wouldn't have been able to do the pace that we were doing without the HIS team being really strongly supportive of that. And I mean, even from the very practical elements of setting the agenda for the meetings, being clear about the actions that were to be delivered, the coordination of testing, The coordination of testing was a massive undertaking, and while the board teams did the testing, the outcomes and outputs of the testing , data extraction and using this to inform action, then reflecting this in the documents were all supported by HIS."

Furthermore, by utilising existing national frameworks (e.g. EiC, QAD) as the structure around which the tools and guidance were based, promoted alignment between the boards and HIS.

Additionally, the national endorsement of the approach was highlighted as a positive feature in this case study. When feeding back to the external organisation that raised the concern within a ward, the support from SEND and HIS was felt to contribute to the robustness and rigour of the process and assured those involved of the care quality and safety in that ward.

The templates were felt to be especially useful in the writing up of the report findings, providing a structure to what could otherwise have been an unwieldy task.

"Then writing that up in the format that was in the document really helped me stay focused. Stay focused to the scope that I was asked. And not go away off piste and come up with some sensible recommendations that, and then that was a bit of a feedback from the organization. Ultimately to feedback, to the scrutiny arm of HIS on that one. So again, allowing us to do that in a format that HIS would recognize because actually everybody was part of that, that process.

So therefore, again I think that demonstrated robustness and rigor around methodologies that we had used."

Moreover, the standardisation of these templates was also highlighted as a positive factor in reporting and sharing the outcomes of the review, particularly with national organisations such as HIS.

What could have gone better?

In the instance where the review was commissioned in response to an external concern, staff were initially dismayed by the review.

"The whole process for the ward team, I guess there was a wee bit of upset at the beginning because we've done something as an unannounced inspection and I always think that is a bit difficult for teams.
I do think it was the right thing to do. I think there was upset from the team that there had been concerns externally raised and why had the person that had raised them not come to them as a team?"

The spontaneous nature of the visit meant that staff felt blindsided by the review. This is in part due to the ward being considered 'exemplary', and thus staff were not expecting a review. However, the team conducting the review provided excellent explanation of the process and while this was not expected the review was done alongside the team with input and understanding of context.

For the QoC review of Lothian maternity services, the tabletop approach was felt to be insufficient for gathering the depth of knowledge required to assure care.

I didn't go into the service and do an actual physical review, but I did that much more as a tabletop exercise.

"On reflection, if I was to be asked to do the tabletop again, I think I would say that it's quite difficult to do it just entirely as a tabletop. […] I ended up having a couple of conversations with key people to gain depth of understanding. In this case and context, I would suggest that it couldn't actually solely be done as a tabletop. So that was of learning for me. […]

And I actually think if you're truly looking at the quality of care, I think you need, you need to use mixed methodologies that include a physical in person review."

Whilst the exercise did allow for data triangulation and initial conversations to explore concerns, it was not felt to be satisfactory. Ultimately further conversations were required. This may be particularly relevant learning for those conducting reviews in clinical areas that they are not as familiar with or embedded in. In such cases, visiting the service may be more necessary than in other cases.

Additionally, upon comparing the review that they commissioned versus the one that they led, this director felt that narrowing down the scope of the review where possible would be advantageous.

"I think I think it covers really broadly everything that you need to be looking at in terms of what are all the indicators I think knowing that you don't need to use it as broadly as that. If there's a very specific area of focus, but not to do that as a tabletop to go in and have a look at that in person, but not to feel overwhelmed by the fact that I need to do absolutely everything this is going to take ages and it's going to need a whole team. Actually. If there's one indicator that's not right, just use it for the one indicator."

Though the approach covers the breadth of care assurance, it is not always necessary to complete a full review as indicated by this case study.

Discussion

The extent to which this approach has been implemented into boards' governance structures varies across these case studies. Some have begun to embed the approach into these structures, by requiring each area to conduct a CAV of QoC review on a regular basis. Others have only used the approach in response to quality concerns thus far. Furthermore, some case studies have only used the CAV template whereas others have used the QoC review guidance and documentation. The rationale for this was due to several factors such as whether the care assurance was proactive or reactive, the scope needed, and the time scale for which the review or walkround was conducted.

The QoC reviews and CAV are being undertaken by staff across varying levels of the organisation depending on the needs of the area, staff experience with care assurance processes, and historic practices. Senior Charge Nurses, Clinical Nurse Managers, Associate lead Nurses, Nurse Directors, and Practice Development unit staff were all reported to have led these reviews and visits across

these five case studies. Whilst several participants emphasised that care assurance was not nursing specific, these care assurance approaches are still predominantly under the remit of the nursing profession. However, in these case studies, members of the multidisciplinary team were encouraged to be involved in these reviews and visits and in some instances lead reviews of their own services. Overall, other staffing groups were happy to engage in these processes, but ultimately it will likely take longer for cultural changes to occur -requiring resources such as time and leadership support- and to spread the resource wider across the scope of health and care professions.

For some contexts, these kinds of care assurance processes were completely unfamiliar, particularly in those areas that were not acute or run by the health board. In these cases, the structure and guidance were considered especially helpful. Other cases compared the EiC approach to previous methods of care assurance that they had used, finding that this method was less prescriptive and provided more room for professional judgement. Moreover, this approach was more expansive than other tools, involving elements that impact care quality and safety more indirectly and those that are harder to measure (e.g. workforce, culture).

These case studies demonstrated how the approach and tools can be used across a variety of healthcare settings, such as emergency departments and maternity units. Whilst one case study utilised the approach in a community residential setting, there were concerns that the resources may require more guidance to be used in many community settings as service users are dispersed and care is often delivered out with formal healthcare buildings. Additionally, it was expressed that many in community settings would be less familiar with care assurance processes and may require additional support to embed this approach into their governance. However, participants have described beginning to engage with community settings to use this approach with relative success.

In these case studies, several examples of actions taken in response to the QoC reviews or CAVs were identified. Simple changes, such as providing additional access to televisions, contributed to positive care experiences without impacting care outcomes. In the course of conducting these reviews and visits, it was recognised that the team or care context did not always have the necessary tools or resources to complete these assurance processes efficiently. For example, there were instances where quality and safety data was not readily available; in another case it was felt that local leaders did not have the desired understanding of the Quality Management System or the quality improvement skills to engage fully with the review or visit. These were important points of learning that can be applied more broadly across the care setting that will contribute to assuring care.

In addition to identifying areas for improvement, the approach was valued for its national recognition and executive support. The resources allowed for a common language around which to discuss and report care assurance, both within boards and out with organisations such as Healthcare Improvement Scotland or to those externally who had raised concerns regarding care quality. The support from national leadership also appeared to lend credence to the approach for

those who are less familiar with care assurance and was seen to be a rigorous process which had been tested widely.

The approach and tools were broadly well received by members of clinical staff. Whilst there was some initial hesitance described in several of the cases, staff seemed to be reassured that this was not an inspection. This was facilitated by the focus on open and honest conversations as well as the approach's inclusion of the positive feature of the care context. Furthermore, staff seemed to be engaged with the process and enjoyed speaking to leads and executives that they may have otherwise not spoken to previously. Staff could use this opportunity to express areas of concern directly to leadership and demonstrate the good practice of their team.

The case studies explored in this document did identify a few criticisms of the approach and associated tools, namely the length of the guidance. Some staff members felt that it could be overwhelming. However, one solution that was discussed in response to this was that QoC reviews and CAVs do not need to cover all elements within the Excellence in Care framework, rather elements most relevant to any review can be selected. Equally the review and visits can be divided up and completed over time, given the stretched resources of many care contexts.

It was also noted that for those individuals less familiar with the EiC Framework and principles of the Quality Management System, more guidance and support is often necessary. Additionally, a desire for more guidance on writing the final reports and dissemination was requested, though as the boards are implementing this approach differently, standardised templates for final reports may not be beneficial given the variance in governance structures.

Conclusion

Overall, these case studies emphasised that this care assurance approach is considered valuable, robust, and consistent. Those who commissioned, conducted, and supported these QoC reviews and CAVs described increased levels of confidence in their ability to assure care and an improved understanding of their system. With a collaborative approach to developing these resources and guidance, the Excellence in Care team has developed a successful, 'Once for Scotland' care assurance approach that can be used by the multidisciplinary team across a wide range of healthcare contexts.

Engagement calls and Scottish Government reports

This section of the report will combine the analysis from the engagement calls and Scottish Government reports. This approach allowed consideration for how boards have implemented the QoC review guidance over time. Each board is presented individually, with key themes identified from across the boards highlighted in the conclusion of this section.

Data was pulled from any engagement calls occurring between the launch of the resource (September 2024) to the end of the data collection period (September 2025). The number of engagement calls varied amongst boards, though it is recommended that each board has a minimum of four engagement calls per year, boards can also request additional calls with

members of the HIS National EiC Team. Data was pulled from the available reports authored by Scottish Government in response to the biannually submitted updates from each board. The two reporting periods for the Scottish Government data covered from July-September 2024 and October 2024 to March 2025.

The implementation of the HIS EiC QoC review guidance across Scotland's health boards reflects a diverse and evolving landscape. While some boards have embedded the framework into governance structures and routine assurance processes, others remain in early testing or scoping phases. Leadership engagement has emerged as a critical factor for sustained implementation, with boards that demonstrate strong executive involvement—such as through walkrounds or steering groups—showing greater progress and cultural buy-in.

Boards have adopted a variety of strategies to introduce the QoC and Clinical Assurance Visit (CAV) guidance. Phased rollouts are common, with initial testing in selected wards or services before broader application. Integration into existing governance structures has been successful in several boards, where the guidance is linked to Quality Management Systems and assurance boards. Others have adapted local tools to align with the national framework or used external peer reviews to support objectivity. Digital tools such as dashboards and scorecards are also being used to support data-driven reviews, and design methodologies like the double diamond approach have helped map assurance processes.

Despite these efforts, boards face several challenges. Leadership capacity and turnover have disrupted momentum in some areas, while system pressures and staffing constraints have delayed implementation. BCLs also have different roles within their boards and sit in varying departments, which may facilitate or inhibit implementing the HIS EiC QoC review guidance depending on their placement within local structures. Boards with well-established local tools have found integration complex, and services such as mental health and AHPs often require tailored approaches due to differing contexts. Data limitations and small team sizes have also hindered tracking and reporting, particularly in remote and island boards.

The QoC review guidance has been applied across a wide range of clinical services. Acute inpatient wards have been the most common starting point, followed by community nursing, mental health, maternity, paediatrics, learning disabilities, and prison healthcare. Some boards have extended the framework into social care settings, and special boards are exploring its applicability in their unique environments.

Allied Health Professional (AHP) involvement varies significantly across boards. In some areas, AHPs are actively participating in reviews and contributing to steering groups, while others have expressed interest but have not yet taken on leadership roles. The complexity of applying the framework across diverse AHP disciplines remains a challenge, and several boards have yet to engage AHPs meaningfully in the process.

Despite these challenges, boards have reported tangible improvements resulting from implementation. These include staffing adjustments based on review findings, improved

communication and care management, enhanced nutrition assessments through multidisciplinary collaboration, and reductions in falls and pressure ulcers. Patient feedback is increasingly being incorporated into assurance processes, often via Care Opinion or structured surveys. In some cases, service redesigns have led to more accessible, closer-to-home care, and staff engagement has improved through clearer understanding of the framework's purpose. Overall, the QoC review guidance is contributing to a positive cultural shift in care assurance, though continued leadership support, governance alignment, and cross-disciplinary collaboration will be essential to realise its full potential.

Discussion

The implementation of the Excellence in Care (EiC) Quality of Care (QoC) Review Guidance across Scotland's health boards has revealed a complex but promising landscape of care assurance development. The evaluation highlights a range of strategies, challenges, and outcomes that reflect both the diversity of Scotland's health and care settings and the adaptability of the QoC framework itself.

Strategies for Implementation

Boards have adopted varied approaches to implementing the QoC review guidance, often shaped by local governance structures, leadership capacity, and existing assurance mechanisms. A common strategy has been phased or staged rollouts, testing the guidance in selected areas before expanding its use. This incremental approach has allowed teams to build familiarity with the framework and tailor its use to specific contexts.

Several boards have successfully integrated the guidance into existing governance structures, linking it with Quality Management Systems and assurance boards. This alignment has helped embed the framework into routine practice and facilitated the development of improvement plans based on review findings. In other boards, leadership walkrounds have been used as a key mechanism for assurance and engagement, reinforcing the importance of executive visibility in driving cultural change.

Other boards have opted to adapt local tools to align with the national guidance, where existing frameworks were modified to reflect EiC principles. Other boards have conducted external peer reviews to ensure objectivity, a strategy particularly relevant for smaller boards. Digital tools such as CAIR dashboard and scorecards have supported data-driven reviews.

Challenges to Implementation

Despite these strategic efforts, boards have encountered several challenges that have impacted on the pace and consistency of implementation. Leadership capacity and turnover were frequently cited as barriers. System pressures and staffing constraints were also significant, where operational demands limited the time available for teams to engage with the guidance.

Boards with well-established local tools found integration complex, as existing frameworks were deeply embedded and required careful alignment with the national guidance. The applicability of

the framework across diverse services - especially in mental health and AHP-led contexts - was another challenge, with several boards highlighting the need for tailored indicators and approaches. Data and reporting limitations made it difficult to track usage and impact, while small team sizes in island boards posed logistical challenges to full implementation.

Clinical Areas of Use

The QoC review guidance has been applied across a wide range of clinical services, demonstrating its versatility. Acute inpatient wards were the most common starting point, leading early implementation efforts. Community nursing has also seen significant uptake. Mental health services have begun testing the framework in several boards, though integration remains uneven due to the need for tailored tools.

Maternity and paediatrics have been included in implementation plans in several boards, while learning disabilities services have engaged with the guidance in a couple of boards. Prison healthcare has been a focus in one medium-sized board, and social care settings have begun exploring the framework in a couple rural boards. Special boards are actively assessing the applicability of the guidance in their unique operational environments.

AHP Involvement

Allied Health Professional (AHP) involvement in QoC reviews varies significantly across boards. In some boards, AHPs have actively participated in reviews, contributing to multidisciplinary assessments and improvement planning. Others have noted AHP leadership in EiC steering groups, indicating a growing recognition of their role in care assurance.

However, many boards still rely on nursing-led reviews, with AHPs expressing interest but not yet assuming leadership roles. In others, AHP engagement with the QoC guidance has not yet begun, underscoring the need for targeted support and inclusion strategies.

Impact and Improvements

Despite the challenges, the implementation of the QoC review guidance has led to tangible improvements across multiple domains. Staffing adjustments in one board were made following review findings, while another board used thematic learning to address communication breakdowns and improve attentiveness. Multidisciplinary collaboration also led to enhanced nutrition assessments, and a couple boards reported reductions in falls through targeted interventions.

Patient experience has improved through better communication and discharge planning, dementia-friendly environmental changes, and the integration of patient feedback via surveys and platforms like Care Opinion. In one medium-sized board, service redesigns in diabetes care resulted in more accessible, closer-to-home services and reduced avoidable travel. Staff engagement has also increased, within a medium, rural board using surveys to inform improvement plans and an island board noted a positive cultural shift in understanding and acceptance of the framework.

The guidance has encouraged collaborative reviews, breaking down silos between disciplines and fostering shared accountability. In a medium-sized board, the inclusion of AHPs in development discussions has led to greater integration of their services into care assurance processes. The emphasis on celebrating good practice alongside identifying areas for improvement has helped build psychological safety and trust among staff, reinforcing the guidance's role as a tool for learning rather than inspection.

Themes and Reflections

Across all data sources, several key themes emerge. First, leadership engagement is consistently identified as a critical enabler. Boards with strong executive support—through walkrounds, steering groups, or direct involvement in reviews—have made more progress in embedding the guidance. Conversely, leadership turnover or limited capacity has hindered implementation.

Second, adaptability and clarity are major strengths of the guidance. Users appreciate its structured yet flexible format, which allows for tailoring to local contexts and priorities. The ability to select relevant elements and conduct partial reviews has helped teams manage workload and focus on areas of concern.

Third, staff engagement and culture are central to success. The guidance has helped shift perceptions of care assurance from inspection to learning, fostering psychological safety and encouraging open dialogue. However, in areas where there is not a pre-existing culture of walkrounds, such as AHP departments, additional work may be required to familiarise staff with this approach to care assurance and promote engagement. Staff have responded positively to the opportunity to showcase good practice and contribute to improvement planning.

Fourth, multidisciplinary involvement is growing but uneven. While AHPs are increasingly engaged in shared reviews and governance discussions, few boards have implemented AHP-led reviews. The complexity of applying the framework across diverse disciplines remains a challenge, and further support is needed to promote inclusive leadership.

Finally, digital infrastructure and usability are areas for development. While the RDS platform is well received, users have requested more interactive features, streamlined templates, and clearer guidance on reporting. Expanding case studies and examples from non-inpatient settings would also support broader applicability.

Conclusion and recommendations

This evaluation has demonstrated that the Quality of Care (QoC) Review Guidance is a well-received and increasingly utilised resource across Scotland's health and care services. While implementation varies by board and setting, the guidance has shown clear potential to support meaningful assurance, foster multidisciplinary collaboration, and drive improvements in patient safety, staff development, and care experience. The findings highlight both the strengths of the resource—its clarity, adaptability, and structure—and the challenges that remain, particularly around leadership capacity, usability, and integration into existing systems. Building on this

momentum, the following next steps outline key actions to support consistent, sustainable, and inclusive implementation of the QoC review guidance.

1. Enhance Usability and Accessibility of the Guidance

Improvements to the usability and accessibility of the guidance are essential. Whilst the transition onto the Right Decision Service (RDS) platform has been well received, users requested more interactive features and streamlined templates. It is recommended that editable and customisable templates be developed, alongside board-specific options to support local adaptation. Enhancing digital functionality will help teams engage more efficiently with the resource.

2. Promote Multidisciplinary and AHP-Led Engagement

Multidisciplinary engagement must be strengthened, particularly among Allied Health Professionals (AHPs). While AHPs are increasingly involved in shared reviews, few boards have implemented AHP-led assurance processes. Targeted support, including tailored guidance and case studies showcasing successful AHP-led reviews, should be developed to promote inclusive leadership and broaden the scope of implementation. The development of sector-specific case studies and examples is recommended.

3. Increase Visibility and Shared Learning

National visibility and shared learning should be maintained and expanded. Usage analytics demonstrated that engagement increased following national events and communications. Establishing a national learning network or community of practice would enable boards to share examples, challenges, and innovations, fostering a culture of continuous improvement.

Appendix 1

Acronym	Meaning
AHP	Allied Health Professional
BCL	Board Clinical Lead
CAV	Care Assurance Visit
CCAT	Continuous Care Assurance Tool
CHSC	Community Health and Social Care
EiC	Excellence in Care
HB	Health Board
HIS	Healthcare Improvement Scotland
HSP	Healthcare Staffing Programme
IPC	Infection Prevention and Control
LD	Learning Disabilities
MH	Mental Health
NHS	National Health Service
NMAHP	Nursing, Midwifery and Allied Health
PCAT	Person-Centred Assurance Tool
QAD	Quality Assurance Directorate
QI	Quality Improvement
QMS	Quality Management System
QoC	Quality of Care
RAG	Red-Amber-Green
RDS	Right Decision Service
SANL	Scottish Acute Nursing Leaders
SCM	Senior Clinical Manager
SCN	Senior Charge Nurse
SEND	Scottish Executive Nurse Directors
SLWG	Short Life Working Group

Published | October 2025

Need information in a different format? Contact our Equality, Inclusion and Human Rights Team to discuss your needs. Email his.equality@nhs.scot or call 0141 225 6999. We will consider your request and respond within 20 days.

Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.scot