

NHS Shetland

Local Report ~ August 2007

**Clinical Governance & Risk Management:
Achieving safe, effective, patient-focused
care and services**

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Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services

Every person using health services should expect these to be safe and effective. The NHS Quality Improvement Scotland (NHS QIS) clinical governance and risk management standards came into effect from November 2005. They have been developed to support NHSScotland to establish systems and processes, ensuring that care and services are safe and effective. This report presents the findings from the peer review of performance against the standards.

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Contents

1	Setting the scene	5
1.1	How the standards were developed	6
1.2	How the review process works	6
1.3	Reports	8
2	Summary of findings	10
2.1	Overview of local service provision	10
2.2	Summary of findings against the standards	11
3	Detailed findings against the standards	13
	Appendix 1 – Glossary of abbreviations	27
	Appendix 2 – Details of review visit	28
	Appendix 3 – Timetable of review visits	29

1 Setting the scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

About this report

The 'National standards for clinical governance and risk management: achieving safe, effective, patient-focused care and services' were published in October 2005. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of **NHS Shetland**. This review visit took place on **10 May 2007**, and details of the visit, including membership of the review team, can be found in Appendix 2.

1.1 How the standards were developed

In September 2003, a clinical governance and risk management standards project group was established and chaired by Dr John Browning, Medical Director, NHS Lanarkshire. The project group had a broad membership, drawn from a range of backgrounds, reflecting all dimensions of healthcare governance and representatives from interest groups.

The remit of the project group was to set standards for clinical governance and risk management, which integrated the healthcare risk management standards developed for NHSScotland by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and the generic standards (Clinical Standards Board for Scotland, 2002). These standards have, therefore, been designed to focus on clinical governance and risk management from the perspective of patient outcomes.

When developing the clinical governance and risk management standards, four focus groups were commissioned to ascertain public views on the standards. These groups were designed to capture a variety of perspectives from different geographical locations in Scotland.

1.2 How the review process works

The review process has three key parts: local self-assessment, pre-visit analysis and external peer review. The review process is described in more detail below (see also the flow chart on page 9).

Self-assessment by NHS Boards

On receiving the standards, each NHS Board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg policies and reports) required to allow a proper assessment of performance against the standards to be made.

Pre-visit analysis

On receipt of the self-assessment, NHS QIS performance analysts review the self-assessment and evidence, and produce a pre-visit analysis report which is given to the NHS Board for comment. Following discussion between the NHS Board and the performance analysts, this report is agreed and sent to the external peer review team, together with the self-assessment and evidence.

External peer review

An external peer review team visits and speaks with local stakeholders (eg staff) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

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

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise, pre-visit analysis and the on-site visit.

The visit concludes with the team providing feedback on its findings to the NHS Board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

Performance assessment statements

A quality improvement tool is used by each review team to assess performance against the standards. The quality improvement tool enables the review team to assess how an NHS Board is achieving each standard through development, implementation, monitoring and reviewing. These four key stages represent the continuous improvement cycle through which each NHS Board can ensure that all patients in hospitals receive safe, effective, patient-focused care and services.

The most appropriate performance assessment statement is agreed by the review team to describe an NHS Board's current position against each core area. This allows an overall performance assessment statement to be arrived at for each of the standards, which indicates the NHS Board's level of achievement for each standard.

The agreed standard level statements will be added together and this assessment of performance will feed into the Scottish Executive Health Department (SEHD) Performance Delivery Unit in June 2007, and will be used to determine the NHS Board's targets for the following year.

Links with other organisations

Clinical governance and risk management is part of a shared agenda. During this review process we have focused on working more effectively in partnership with the organisations who monitor other aspects of healthcare governance to inform the assessment process.

We have lead responsibility for assessing the performance of all NHS Boards against the clinical governance and risk management standards. By working together we share information and scheduling, ensuring organisations are not subject to unnecessary multiple reviews.

The organisations we are working with are Audit Scotland, Chief Scientist Office, NHS Education Scotland, NHS National Services Scotland, Scottish Executive Health Department, and Scottish Health Council.

1.3 Reports

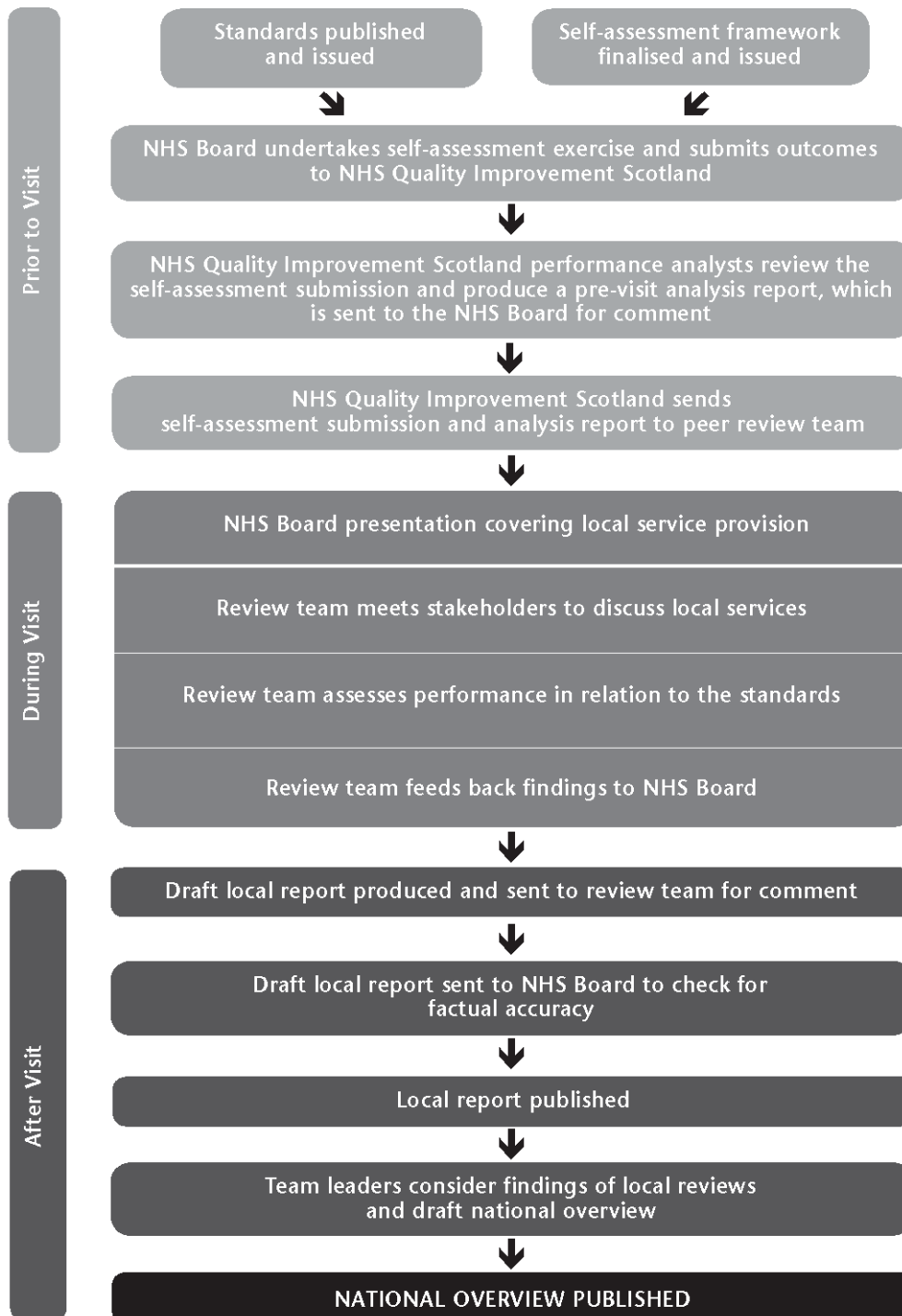
After each review visit, NHS QIS staff, with input as appropriate draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS Board to check for factual accuracy. The local report will then be published and made available on the NHS QIS website.

Once the clinical governance and risk management national review cycle is completed, the team leaders will meet to examine review findings and make recommendations. The team leaders then oversee the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

Please note – all reports published are available in print format and on the NHS QIS website.

The review process



2 Summary of findings

2.1 Overview of local service provision

Shetland is an island group situated north of mainland Scotland and has a population of around 22,000. Many of the population live in the town of Lerwick, although a significant proportion live in rural areas. The proportion of older people in the population is below the national average, as are levels of illness and deprivation.

Local NHS system and services

Shetland NHS Board has the same functions as mainland NHS Boards. It is responsible for improving the health of the local population and for the delivery of the healthcare required. The NHS Board provides strategic leadership and has overall responsibility for the efficient, effective and accountable performance of the NHS in Shetland.

There is one community health partnership (CHP). A CHP covers a geographical area and is a way of organising non-acute care where an NHS board maximises its ability to support integration across health services and between these and other agencies such as social services.

The NHS Board is also accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

Further information about the local NHS system can be accessed via the website of NHS Shetland (www.shb.scot.nhs.uk).

2.2 Summary of findings against the standards

A summary of the findings from the review is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

Standard 1 – Safe and effective care and services

Overall position statement:

The NHS Board is implementing its policies, strategies, systems and processes to control risk, continually monitor care and services and work in partnership with staff, patients and members of the public.

NHS Shetland is embracing a risk management culture at operational level, and staff are risk aware. Due to the size of the organisation, a number of informal practices are in place. The review team noted that NHS Shetland may benefit from formalising such processes and procedures.

Effective emergency plans are in place across NHS Shetland and learning from exercises is incorporated into revised plans. However, business continuity plans are at different stages of development across the organisation and a consistent approach is required.

NHS Shetland has evidenced clinical effectiveness and quality improvement work at an operational level. However, more formalised information gathering is required to provide board assurance.

Standard 2 – The health, wellbeing and care experience

Overall position statement:

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

NHS Shetland demonstrated an innovative approach to access, referral, treatment and discharge. The organisation works jointly with local organisations and other NHS Boards to enable a collaborative approach to patient care.

The equality and diversity taskforce is leading the Fair for All work in NHS Shetland. The review team recognised the amount of equality and diversity work being undertaken at an operational level, however agreed that this work needs to be more widely disseminated to all levels of staff.

NHS Shetland has an internal and external communications strategy in place which was updated in May 2006. The organisation uses a wide range of methods to communicate with staff and the public, and feedback from the local partnership forum and team brief is used to monitor and appraise the effectiveness and impact of the communications strategy.

Standard 3 – Assurance and accountability

Overall position statement:

The NHS Board is implementing its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides.

NHS Shetland has a clinical governance and quality improvement framework in place, as well as a clinical governance strategy which has been signed off by the Board and has generated an action plan.

There are a number of policies and procedures in place within NHS Shetland to support fitness to practice. The review team noted the organisation's individualised approach to staff training needs.

The organisation uses a variety of methods to communicate with the public, and the review team was pleased to note the way in which NHS Shetland uses the local media for this purpose.

NHS Shetland envisages that a recent management re-structure will enhance performance management arrangements within the organisation. The review team agreed that the focus on corporate objectives at a senior level required to be disseminated to operational staff.

NHS Shetland reported that the review visit has acted as a catalyst for the organisation with regard to information governance. The organisation has drafted a number of policies and procedures, and the review team noted that the development of an information governance framework would be of benefit to NHS Shetland.

3 Detailed findings against the standards

Standard Statement 1: Safe and effective care and services

Care and services are safe, effective, and evidence-based.

Overall position statement

The NHS Board is implementing its policies, strategies, systems and processes to control risk, continually monitor care and services, and work in partnership with staff, patients and members of the public.

Core area: 1(a) Risk management

Position statement: The NHS Board is implementing its risk management policy, strategy, systems and processes across the organisation.

Development

NHS Shetland is embracing the risk management culture at operational level within the organisation. The risk and incident co-ordinator is the main contact for operational issues; the post holder works with heads of department to ensure that risk assessments and departmental-level risk are managed and reported. Stakeholders are involved at strategic level in risk framework development and delivery through the community health partnership (CHP) management team, senior management team and standing committees of the Board. NHS Shetland also has a local community risk register in place which describes relevant corporate risks from all local agencies.

At the time of the visit, departments in NHS Shetland were at different stages of developing local risk registers. The Board envisages that the strategic risk management work plan will assist in rolling out risk registers to all departments. The review team noted that, due to the size of the organisation, staff are able to deliver a personalised, rapid response to identified risks. Staff are committed and risk aware, however, although informal processes are in place, there is a lack of co-ordinated information. The development of a formal approach to risk management reporting structures would benefit all staff, in particular those new to the organisation.

Implementation

NHS Shetland identifies corporate objectives at Board level. Risks to these objectives are identified by the senior management team and reported back to the Board. Risk management strategic objectives are identified in the risk management strategy and key risks relating to non-clinical areas are detailed in the Board's audit action plan. The corporate action plan and audit action plan link the strategic risk management objectives to the wider organisational objectives and priorities. Corporate risks are incorporated into the overall risk register. Each risk is assigned to a director, who is responsible for identifying controls and actions, and updating these where necessary.

NHS Shetland uses an in-house database to collect incident forms and produce results. Separate databases are used for incident recording and the corporate risk register.

A joint audit committee, clinical governance committee and clinical governance co-ordinating group workshop agreed the establishment of a controls assurance group (CAG) for NHS Shetland. The CAG identifies, reviews and takes actions on corporate risks; formalises the senior management team's oversight of risk management including reporting arrangements; and is formally linked into the service redesign committee and reports formally to the clinical governance committee. The Board also receives quarterly reports from the CAG and receives annual updates in respect of corporate risk management. The Board reported that non-executive directors are not cited on the risk management control process or on the system of risk reporting, however, they do receive a quarterly monitoring report which includes examples. Reports from the clinical governance co-ordinating group and the CAG provide assurance to the Board and non-executive directors.

Regular risk appraisal takes place through the senior management team every 6 months. As risk ratings change, risks are updated along with control measures, treatments and actions. The risk management strategy sets out the methodology and framework for prioritising risk management actions based on the risk assessment rating. Risk profiling is the main approach used to prioritise risks, agree profile level and develop an action plan. The risk management framework is reviewed through the clinical governance co-ordinating group when new national guidance is issued. The appraisal process is monitored through the clinical governance co-ordinating group and overseen by the clinical governance committee and the audit committee, as appropriate.

NHS Shetland prepares summary incident reports quarterly and these are submitted to the clinical governance co-ordinating group, clinical governance committee, and made available to all clinical managers and heads of department. There is a specific distribution list for dissemination which includes a wide range of stakeholders.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to risk management was being monitored throughout the Board area.

Reviewing

As NHS Shetland has not demonstrated that it is monitoring its approach to risk management, there is not yet a process in place to undertake a review.

Core area: 1(b) Emergency and continuity planning

Position statement: The NHS Board is developing emergency and continuity planning systems.

Development

NHS Shetland has effective emergency plans in place, however, business continuity plans are at varying stages of development across the organisation. The Shetland major emergency forum is responsible for the development of local emergency planning policy and procedures. The strategic co-ordinating group oversees risk assessment and multi-agency controls. The emergency planning officer is a joint appointment between the local authority and health, and supports the public health department which takes the lead for emergency planning issues in NHS Shetland.

NHS Shetland has an emergency planning exercise programme in place with exercises being held annually, including NHS Shetland exercises as well as other multi-agency emergency planning tests and exercises. All exercises have formal debriefs, and the learning and action points are reported to the local emergency planning forum as well as being used to revise local plans. There is a website link to the emergency planning procedure on the local authority website, via the NHS Shetland intranet, where the plans are publicly available.

The Board reported that staff are aware of how to respond to incidents, however, there was no documented organisation-wide business continuity plan. A template has been developed with prompts to aid departments in developing business continuity plans, however, a consistent approach is not evident and all departments are not aware of it. GPs and some departments have business continuity plans, however, this is not consistent across the organisation.

Implementation

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to emergency and continuity planning was being implemented throughout the Board area. However, the review team agreed that the organisation had responded well to live events which enabled the Board to test local emergency plans.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to emergency and continuity planning was being monitored throughout the Board area.

Reviewing

At the time of the visit, the Board was unable to demonstrate reviewing of its emergency and continuity planning arrangements across the organisation.

Core area: 1(c) Clinical effectiveness and quality improvement

Position statement: The NHS Board is implementing co-ordinated programmes for clinical effectiveness and quality improvement across the organisation.

Development

NHS Shetland is undertaking considerable clinical effectiveness and quality improvement work at an operational level. The senior management team identifies priorities for the audit work plan through the local delivery plan and health improvement plan. The responsible officer takes the lead for ensuring that audit activity takes place through management teams, clinical teams and strategic groups. The process of audit topic identification is led by senior healthcare staff and topics are offered for inclusion in the plan. The clinical governance committee and clinical governance support team staff monitor progress with each project. Other audit/quality improvement topics are identified through regional and national planning groups and clinical/public health networks. The audit plan for the organisation is updated every 2–3 months with audit progress and outcomes, and is presented to the clinical governance co-ordinating group and the clinical governance committee in quarterly updates.

Implementation

NHS Shetland has a number of service improvement programmes in place which act as a mechanism for sharing knowledge and learning, for example: planned care collaborative; unscheduled care collaborative; clinical/care networks with multi-agency membership. Specific measures are set within the quality improvement programmes which reflect local and national (or regional) indicators and outcomes. Regional planning groups are also in place to support the development of regional services, to ensure there is an integrated approach to planning, and to provide a mechanism for reviewing regional performance. A number of indicators are used to monitor improvement in patient care and outcomes, for example: health improvement, efficiency, access and treatment (HEAT) targets; national performance indicators; quality improvement programmes supporting Delivering for Health; national standards; and local targets.

NHS Shetland has a number of targets in place to drive continuous improvement in the health of the population, including national targets, through the local delivery plan. Routine surveillance of epidemiology and public health is published through the public health annual report. A range of indicators are monitored through specific service arrangements, for example clinical networks, strategic groups and health improvement programmes.

All national standards and guideline sets are sent to the clinical governance support team for dispatching and dissemination. There is a process in place through the clinical governance co-ordinating group for agreeing where standards and guidelines need to be sent. There is a record in the clinical governance co-ordinating group minutes of who has taken responsibility for progress against the implementation of the guidelines.

NHS Shetland uses a variety of processes and mechanisms to seek information and feedback from patients and the public on the effectiveness and quality of the care and services provided. These include a comments and suggestions scheme, patient focus and public involvement (PFPI) group, lay membership of service planning groups, and NHS Shetland 100, a register of members of the general public who can be consulted on different issues.

The review team recognised the strong-evidenced clinical effectiveness and quality improvement work being carried out at operational level, however, noted that there were issues regarding communication between the operational staff and the Board. The review team noted that the clinical effectiveness and quality improvement information being gathered by NHS Shetland was not as comprehensive as it could be to assure the Board and identify trends. The review team agreed information gathering should be planned, systematic and comprehensive to provide Board reports assurance.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to clinical effectiveness and quality improvement was being monitored throughout the Board area.

Reviewing

As NHS Shetland has not demonstrated that it is monitoring its approach to clinical effectiveness and quality improvement, there is not yet a process in place to undertake a review.

Standard Statement 2: The health, wellbeing and care experience

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

Overall position statement

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

Core area: 2(a) Access, referral, treatment and discharge

Position statement: The NHS Board is monitoring implementation of its policy and partnership approach to access, referral, treatment and discharge across the organisation.

Development

NHS Shetland has demonstrated an innovative approach to access, referral, treatment and discharge arrangements throughout the organisation. The PFPI steering group oversees the range of methods of awareness raising and patient information in use within NHS Shetland. These include publicity about the Board's strategic groups and planning processes, practice support groups, NHS 100, the internet, use of the local media for advertising features and press releases, and hospital information leaflets. The review team noted that a challenge to the organisation will be to develop a strategic overview of the multiple arrangements in place for access, referral, treatment and discharge. This would then provide a comprehensive picture to identify areas to progress.

Implementation

NHS Shetland has a range of strategic planning groups which have user and carer membership and involvement. Different forums are used for specific service strategies and developments, for example focus groups within the development of the older people's strategy. The Board received feedback from these groups as part of the older people's strategy. NHS Shetland is a member of the Shetland transport partnership and the community planning board, and works closely with the local authority on the joint development and planning of services through the extended local partnership agreement.

Carers' needs and requirements have been identified and assessed in NHS Shetland within needs assessment work to inform strategy development and planning, for example the assessment of carers' needs within the single shared assessment. The Board has developed carers' and young carers' strategies and a national carers day took place. In addition, there is a carers database and system in place to identify carers within the Board area.

Patient information is developed through a variety of condition specific groups and patient awareness-raising days focusing on specific conditions have taken place in NHS Shetland. New patient information is developed with patients and tested with the PFPI steering group. A range of patient information is developed within departments as a result of good practice guidelines and feedback from patients.

NHS Shetland reported that individual patients are actively involved in making decisions about their own care. An independent advocacy service is in place and the organisation has a policy on informed consent. At the time of the visit, the consent policy was being updated and will then go to the PFPI steering group and through the Board's clinical governance process.

The review team was interested to hear about nurse-led services on small islands which have no GPs. All such islands have a direct link with local practices on larger islands and some access to video links.

Monitoring

NHS Shetland has developed joint admission and discharge protocols with the local authority through a multi-agency admissions and discharge group. A local single shared assessment process is also in place which has been developed with the local authority and other service providers. The joint performance information and assessment framework (JPIAF) monitors progress with joint future targets and outcomes with the local authority. A recent review of the single shared assessment resulted in a revision of the procedures and a revised training programme which is being implemented. Some referral guidelines are in place with NHS Grampian, and other guidelines have been developed through regional groups. Waiting times are monitored routinely at Board and senior management team level, and intensive monitoring of all urgent referrals and the referral process takes place. The Board receives reports specific to areas of work, for example Joint Future. The Board also receives a high-level finance and performance monitoring report at each meeting and a quarterly overall performance monitoring report which is aligned to HEAT targets.

NHS Shetland has a discharge policy which was prepared by a multi-agency group, and, at the time of the visit, was being revised by the admissions and discharges group within the joint future group structure. A joint appointment with the local authority for a joint future manager has been made and this person oversees the work of the admissions and discharges group. A discharge exceptions feedback tool is used by the organisation and any issues that arise within the discharge process are raised through the admissions and discharges group. The review team was pleased to note the discharge liaison nurse posts, in particular the post in Grampian, where the post holder ensures that all arrangements are in place for patients returning to Shetland, following time in hospital in NHS Grampian. The discharge liaison nurse carried out a formal evaluation of the service provided which was presented to clinical and management staff in NHS Shetland. The review team was also pleased to note the electronic GP referral methods which enable referral monitoring.

Reviewing

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to access, referral, treatment and discharge is being reviewed through the Board area.

Core area: 2(b) Equality and diversity

Position statement: The NHS Board is implementing its equality and diversity policy in accordance with legislation, national guidance and best practice across the organisation.

Development

NHS Shetland is undertaking equality and diversity work at an operational level. The review team recognised that a task group has been progressing work on individual strands for a number of years. The Board and relevant committees do not accept policies and procedures unless they have an attached impact assessment. The Board reported that from 2007, the diversity taskforce will annually check random sample policies to ensure consistency and accuracy. The review team noted the strong links between equality and diversity and the partnership forum and the reporting back through staff governance. However, the review team agreed that a common understanding with regards to equality and diversity needs to be developed between the board and operational staff.

Implementation

NHS Shetland uses health needs assessments and national best practice information, for example diabetes and heart disease in certain black minority and ethnic groups, to identify the needs of specific groups or individuals in the population. A needs assessment was undertaken as part of the development of the disability strategy, which included contributions from people with disabilities. The disabilities steering group also has the disability equality scheme as a standing item for discussion on its agenda at meetings.

The equality and diversity taskforce was established approximately 2 years ago and has links with the PFPI steering group through joint membership of key individuals. The taskforce considers all strands of Fair for All with staff allocated to specific strands. An action plan has been developed and reported on for each strand. The review team noted the amount of equality and diversity work being undertaken at an operational level, however, the Board recognised there was a challenge for the taskforce in ensuring the wider dissemination to all staff.

Equality and diversity is included in induction session, and mandatory training is also in place. All managers also carry out online training. Staff are contacted 3 months after attending training to establish how they have incorporated the training into their work. Due to the small population, statistical monitoring is a challenge and data must be collected in a sensitive manner to ensure that individuals cannot be identified.

The review team was pleased to note the personal commitment, as opposed to organisational requirement, from staff to progress the equality and diversity agenda, although a challenge will be for all staff to take ownership of this.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to equality and diversity was being monitored throughout the Board area.

Reviewing

At the time of the review visit, the Board was unable to demonstrate reviewing of its equality and diversity arrangements across the organisation.

Core area: 2(c) Communication

Position statement: The NHS Board is monitoring its policies, strategies and procedures for improving the way that staff communicate with each other, patients and the public across the organisation.

Development

NHS Shetland has developed and implemented procedures for communicating with staff, patients and the public. The communications strategy, for internal and external communications, was updated in May 2006. The strategy was developed with the PFPI steering group, in consultation with the local partnership forum, and the staff governance committee before being approved by the board.

Implementation

NHS Shetland uses the local partnership forum, its intranet site, a team brief system and small working groups as a means of communicating with staff.

The NHS Shetland communications strategy was consulted on with NHS 100. NHS 100 was established by advertising in the local paper and on the local radio for people in the community with whom the Board could develop a relationship and who had an interest in healthcare. Members of NHS 100 are asked to join specific groups, for example one member has joined the redesign committee, and are sent consultation documents to comment on. The senior management team attend NHS 100 meetings to answer any questions members of the group may have.

Monitoring

NHS Shetland uses feedback from the local partnership forum and team brief to monitor and appraise the effectiveness and impact of the communications strategy. The results of staff and patient surveys also inform practice and procedures. A specific staff inclusion survey feeds into staff governance work, and the staff governance action plans for 2007–2008 include reference to actions from feedback on the staff team brief system.

Reviewing

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to communication is being reviewed throughout the Board area.

Standard Statement 3: Assurance and accountability

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

Overall position statement

The NHS Board is implementing its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides.

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

Position statement: The NHS Board is implementing its policy and strategy to co-ordinate clinical governance and quality assurance arrangements across the organisation.

Development

NHS Shetland has a framework in place for clinical governance and quality assurance. The clinical governance strategy and associated action plan has been signed off by the Board. The review team was pleased to note that the clinical governance and quality improvement framework was in place. However, a challenge to the Board will be to operationalise the clinical governance strategy to develop a clinical governance and quality improvement agenda with measurable outcomes.

The framework for clinical governance was developed and refined through the clinical governance committee and delivered through the clinical governance co-ordinating group, advisory groups and management teams. The framework is set out in specific strategies, for example the clinical governance, risk management, and PFPI strategies, which include a formal scheme of delegation. There are a number of specific committees and operational groups that have delegated authority from the Board and the clinical governance committee for overseeing the clinical governance and quality assurance framework. For example, the clinical governance co-ordinating group has an operational role to oversee the implementation of clinical effectiveness.

Implementation

Community planning conferences are held annually in NHS Shetland to discuss key local issues and develop plans in line with specific corporate objectives and local delivery plans. In addition, strategic and advisory groups have been established to develop key services including those arranged around clinical networks and joint planning. Feedback on the effectiveness of consultation and planning methodology is provided through the service redesign committee and also directly to the Board.

NHS Shetland has a service redesign committee which is a standing committee of the Board with delegated responsibility for ensuring that service improvement activity is monitored throughout the organisation. Progress and performance against the service redesign programme is reported quarterly to the service redesign committee. Performance monitoring reports against all HEAT and Delivering for Health targets are presented to the Board every quarter. The clinical governance co-ordinating group and clinical governance committee monitor the organisation-wide audit and survey programme, which includes summary details of audit project

activity. The audit and survey programme is widely circulated and made available to all staff and the public through the internet.

NHS Shetland uses a variety of methods to monitor quality and performance across services. These include patient and service user feedback, performance reports, local performance measures which are set and reviewed through the corporate action plan, needs assessments undertaken by health improvement/public health teams.

The commissioning team, led by the director of clinical services and director of finance, ensures that specific aspects of the service level agreement (SLA) with NHS Grampian are consistent and cost effective. The SLA for the provision of joint health and social care services is monitored through the joint futures management team. The CHP management team oversees the Quality and Outcomes Framework (QOF) review process and monitors performance against locally agreed measures.

Since January 2007, following new national guidance, the NHS Shetland local research ethics committee has been disbanded. The process for ethical review now sits with the North of Scotland research ethics committee. The clinical governance co-ordinator continues to co-ordinate local support and guidance for local research projects.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to clinical governance and quality improvement was being monitored comprehensively and systematically to offer the Board assurance of the effectiveness of systems and processes.

Reviewing

As NHS Shetland had not demonstrated that it is monitoring its approach to clinical governance and quality improvement, there is not yet a process in place to undertake a review.

Core area: 3(b) Fitness to practice

Position statement: The NHS Board is implementing its policies and procedures across the organisation that will ensure its workforce is fit to practice.

Development

NHS Shetland has a range of organisation-wide fitness to practice policies that are being implemented across the Board area. Qualification, registration and accreditation checks are made during the recruitment process, at selection and interview, in addition to confirming registration with the relevant bodies. The responsibility for renewing and updating registration/accreditation is held with staff, and line managers have a responsibility to check this has been done. With the implementation of the Scottish Workforce Information Standard System (SWISS), these records will be held centrally. The review team noted that a challenge to the organisation will be to formalise a Board-wide process to allow a common understanding and agreement in this area.

Implementation

Staff governance issues in NHS Shetland are reported through incident reporting mechanisms and the quarterly clinical governance summary to the clinical governance committee. When specific issues regarding human resources and service delivery arise, these are reported to the clinical governance co-ordinating group, management teams and the clinical governance committee. The staff governance groups (for example, workforce planning, equality and diversity) report to the Board and performance monitoring reports include targets on staff governance issues such as absence rates.

The NHS Shetland clinical supervision policy was developed and approved by the area nursing and midwifery advisory committee and is in use throughout NHS Shetland. Clinical supervision for junior doctors is set out in the new foundation programme - part of the Modernising Medical Careers (MMC) framework. Junior doctors have weekly protected educational and clinical supervision sessions. The review team noted the effective programme to develop the skill sets of medical staff and the individualised support and training packages which are provided. The focus to recognise individual needs and to tailor training needs was recognised as a strength of the organisation. The review team was pleased to note the GP and midwifery rotations that are in place to ensure that staff's skill mix is kept up to date.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to fitness to practice was being monitored throughout the Board area.

Reviewing

At the time of the review visit, the Board was unable to demonstrate reviewing of its fitness to practice arrangements across the organisation.

Core area: 3(c) External communication

Position statement: The NHS Board is monitoring the implementation of its external communication strategy across the organisation.

Development

NHS Shetland has developed and implemented its communications strategy across the organisation and, at the time of the visit, was monitoring the effectiveness of its implementation. The communications strategy, which includes internal and external communication, was developed in 2003. The strategy was updated and approved by the Board in May 2006. The updated strategy was developed through the PFPI steering group and consulted upon through the local partnership forum and staff governance committee.

Implementation

NHS Shetland undertakes a number of practices and activities to engage with, liaise with and inform key local, regional and national stakeholders on service developments, issues and achievements. These include engagement with the Scottish Executive Health Department (SEHD) comprising attendance at national meetings, involvement in the North of Scotland Planning Group, working with the community planning partners, attending meetings of community councils, working with the

PFPI steering group which oversees the PFPI activity of the Board, and using the NHS Shetland internet. The review team was pleased to note the way in which NHS Shetland uses the local site to communicate with the public, for example publishing the annual report as an insert in the Shetland Times newspaper.

Monitoring

NHS Shetland monitors and appraises the communications strategy through a variety of feedback mechanisms including: a comments scheme open to patients, the public and staff; groups such as the PFPI steering group and community planning board; and public consultations.

Reviewing

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to external communication was being reviewed throughout the Board area. An external review of communications was last conducted in 2002.

Core area: 3(d) Performance management

Position statement: The NHS Board is implementing its performance management arrangements across the organisation.

Development

NHS Shetland is progressing the implementation of its performance management agenda. Performance management arrangements are discussed at senior management team and Board meetings. The senior management team have implemented a management re-structure that is envisaged will enhance performance management by combining all elements of performance management within the service improvement directorate.

Implementation

The Board of NHS Shetland has eight high-level corporate objectives. Below these are the local delivery plan and then a corporate action plan which links to the corporate objectives. The Board sees an overview of performance through the corporate action plan updates as well as specific performance management reports. The corporate action plan also links to specific, measurable, achievable, realistic and timely (SMART) objectives for individual managers. A member of the senior management team is responsible for each action arising from the accountability review. This is incorporated into the corporate action plan and reported to the Board every quarter. NHS Shetland has a variety of performance management arrangements in place, for example the quarterly monitoring reports, Delivering for Health reports, and corporate action plan set out key objectives including national targets and reports against performance. Specific actions are added to individual senior management team member's objectives. The review team noted the focus on corporate objectives at a senior level, and agreed that this information required to be disseminated to operational staff.

NHS Shetland reported that key performance indicators (KPIs) have been set for the delivery of the clinical governance framework and the risk management strategy and that they reflect wider performance monitoring targets set locally and determined at a national level. Performance data linked to access targets are actively monitored through the senior management team – risk management arrangements and action

plans in respect of access performance/wider performance management targets are noted by clinical governance committee.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to performance management was being systematically monitored throughout the Board area. The review team were informed that the new structure within NHS Shetland and the establishment of the CAG will allow systematic and comprehensive monitoring in the near future.

Reviewing

As NHS Shetland has not demonstrated that it is monitoring its approach to performance management, there is not yet a process in place to undertake a review.

Core area: 3(e) Information governance

Position statement: The NHS Board is developing a framework for information governance that includes systems, policies and procedures.

Development

NHS Shetland has used the review visit as a catalyst to develop its information governance agenda. A draft information governance policy has been developed by the information support group which is the lead committee responsible for overseeing the implementation and operation of information governance.

The clinical governance committee has an overseeing role for all clinical governance policy and has responsibility for approving some elements of the wider information governance strategy. The operational responsibilities for delivering the information function and information governance are discharged directly by the relevant senior managers, and reported through the senior management team (in future this will be through the CAG).

NHS Shetland has a number of safeguards in operation to guarantee the confidentiality and security of patient information. A number of policy documents are in place, for example an IT security policy and an IT user policy. A multi-agency information sharing policy is also in development to be used across the community planning board agencies.

Leaflets describing how patient information is used are available in hospital departments throughout the organisation. Specific leaflets have been developed by GP practices describing how personal information is used, stored and protected. A draft medical records policy is in place which describes the process of accessing personal information. It is envisaged that this policy will be discussed by the Board in June 2007. The medical records policy also contains details of the procedure for disclosure of information without consent of the patient. Patients can access their personal and medical information through a 'request for information' leaflet. Once completed, this leaflet is forwarded to the consultant responsible for that episode of care to consider if access is appropriate.

Caldicott principles training is in place for staff to support safe use and access to information. The IT security and IT user policies have guidance on accessing information and information systems.

The review team agreed that NHS Shetland has drawn together a number of draft policies and procedures as a result of completing the self-assessment, and the review visit has acted as a catalyst to progressing the information governance agenda. However, the review team noted the reliance on individuals and also that the organisation may benefit from a more structured approach to information governance which would be supported by the development of an information governance framework.

Implementation

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to information governance was being implemented throughout the Board area.

Monitoring

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NHS Shetland's approach to information governance was being monitored throughout the Board area.

Reviewing

At the time of the review visit, the Board was unable to demonstrate reviewing of its information governance arrangements across the organisation.

Appendix 1 – Glossary of abbreviations

CAG	controls assurance group
CHP	community health partnership
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme
HEAT	health improvement, efficiency, access and treatment
JPIAF	joint performance information and assessment framework
KPI	key performance indicator
MMC	Modernising Medical Careers
NHS QIS	NHS Quality Improvement Scotland
PFPI	patient focus and public involvement
QOF	Quality and Outcomes Framework
SEHD	Scottish Executive Health Department
SLA	service level agreement
SMART	specific, measurable, achievable, realistic and timely
SWISS	Scottish Workforce Information Standard System

Appendix 2 – Details of review visit

The review visit to NHS Shetland was conducted on 10 May 2007.

Review team members

Dr Elizabeth Robertson (Team Leader)

Associate Medical Director, NHS Grampian

Mrs Margo Biggs

Public Partner, Forth Valley

Mr Andy Crawford

Clinical Governance Manager, NHS Greater Glasgow and Clyde

Sister Susan Dillet

Director of Nursing, St Andrew's Hospice

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Risk Management Facilitator, The State Hospital

Mr William May

Public Partner, Greater Glasgow

Mr Colin Sloey

Director of North CHP, NHS Lanarkshire

Ms Kim Kingan (Observer)

Information Governance Co-ordinator, NHS National Services Scotland

NHS Quality Improvement Scotland Staff

Mrs Anne Hanley

Team Manager

Ms Joanne McDonald

Project Officer

During the visit, members of the review team met with Board-level, strategic and operational staff.

Appendix 3 – Timetable of review visits

Organisation reviewed	Visit date(s)
Golden Jubilee National Hospital	8 November 2006
NHS 24	17 August 2006
NHS Ayrshire & Arran	13 February 2007
NHS Borders	24 May 2006
NHS Dumfries & Galloway	8 June 2006
NHS Education for Scotland	5 December 2006
NHS Fife	1 March 2007
NHS Forth Valley	1 February 2007
NHS Grampian	6 July 2006
NHS Greater Glasgow and Clyde	27 September 2006
NHS Health Scotland	26 April 2007
NHS Highland	29 March 2007
NHS Lanarkshire	7 September 2006
NHS Lothian	17 October 2006
NHS National Services Scotland	20 December 2006
NHS Orkney	23 November 2006
NHS Shetland	10 May 2007
NHS Tayside	14 March 2007
NHS Western Isles	12 April 2007
Scottish Ambulance Service	15 June 2006
The State Hospitals Board for Scotland	18 January 2007

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