Board Paper 2020/21/34

Shetland NHS Board

Meeting:	Shetland NHS Board		
Paper Title:	Quality Report – Update on Progress		
Date:	6 October 2020		
Author:	Kathleen Carolan	**Job Title:**	Director of Nursing & Acute Services
Executive Lead:	Kathleen Carolan	**Job Title:**	Director of Nursing & Acute Services

Decision / Action required by meeting:

The Board is asked to note the progress made to date with the delivery of the action plan and other associated work which focuses on effectiveness, patient safety and service standards/care quality.

High Level Summary:

The report includes:

- A summary of the work undertaken to date in response to the 'quality ambitions' described in the Strategy;
- Our performance against a range of quality indicators (locally determined, national collaborative and national patient safety measures)
- When available, feedback gathered from patients and carers – along with improvement plans

Key Issues for attention of meeting:

Noting the good performance as shown in the report

Corporate Priorities and Strategic Aims:

The quality standards and clinical/care governance arrangements are most closely aligned to our corporate objectives to improve and protect the health of the people of Shetland and to provide high quality, effective and safe services.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*

Service Users, Patients and Communities:	The focus of the quality scorecard is on evidencing safe practice and providing assurance to service users, patients and communities that services are safe and effective
Human Resources and Organisational Development:	The focus of this report is on evidencing effective training and role development to deliver care, professionalism and behaviours which support person centred care
Equality, Diversity and Human Rights:	EQIA is not required.
Partnership Working	Quality standards and assessment of impact applies in all NHS settings.
Legal:	

Finance:	Quality standards and the delivery of them is part of the standard budgeting process and are funded via our general financial allocation.	
Assets and Property:	Nil	
Environmental:	A Strategic Environmental Impact Assessment is not required or has been completed.	
Risk Management:	The quality agenda focuses on reducing risks associated with the delivery of health and care services. The adverse event policy also applies to HAI related events.	
Policy and Delegated Authority:	Delegated authority for the governance arrangements that underpin quality and safety measures sit with the Clinical, Care and Professional Governance Committee (and the associated governance structure)	
Previously considered by:	Data in this report is also shared with the Joint Governance Group which will meet in November 2020	

"Exempt / private" item	*Public document*

PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION
PROGRESS ON THE DEVELOPMENT OF A PATIENT EXPERIENCE FRAMEWORK

The Board supported a formal proposal to develop an approach (or framework) that would enable us to bring together the various systems that are in place to gather patient experiences and feedback so that we can demonstrate clearly how feedback is being used to improve patient care.

Progress continues and since October 2020 the following actions have been taken:

- There continues to be regular interactions via social media and with the local media during the pandemic to make sure that people in our wider community and patients know how to access our services and know how services have changed in order to meet new requirements as a result of COVID 19. This has included films, radio interviews, podcasts, articles in local news media and live streaming information sessions on social media, facilitated by the Chief Executive. Our most recent collaboration was working in partnership with Shetland Library Services, who produced a children's information film about attending Child Health.

- The Unicef Baby Friendly standards form part of an accreditation programme, so that services can demonstrate how well they are enabled to support families with feeding and help parents to build a close and loving relationship with their baby. In September 2020, 20 parents provided feedback in respect of how they have been supported by our Health Visiting team to establish feeding and bonding with their baby. The feedback provided by parents demonstrates that the Health Visitors in Shetland are providing high quality, person centred advice and support. This audit outcome is very significant, because Health Visitors have adapted ways of working during the pandemic and continued to sustain very high quality support and this has been recognised by parents who have accessed the service. The full results of the audit are shown in Appendix A.

- Health Improvement Scotland (Community Engagement) local team and the Clinical Governance Unit are working together to undertake a thematic analysis of all of the patient feedback we have received since 2018. This work will form part of the data gathering exercise we are undertaking as part of the approach to refresh our clinical strategy. A project has commenced to undertake a review of the clinical strategy and the methodology includes bringing together a very broad set of perspectives. Patients, community leaders, members of the public and third sector organisations will be invited to participate in every stage of the strategy development between now and March 2021. Some of the early engagement includes invitations to participate in semi structured interviews to help design the initial workshop. There will be live social media interactive sessions to promote awareness of the work commencing at the end of September 2020.

DELIVERING QUALITY CARE AND SUPPORTING STAFF DURING THE PANDEMIC

Excellence in Care Celebration Event

We have hosted an Excellence in Care Celebration event every year since the programme was launched in 2018. This year we have widened the focus to include improvement and redesign work that has specifically contributed to patient care and/or staff wellbeing during the pandemic. This adds a fifth category to the existing themes of: education, person centred care, prevention and innovation. The event this year will be hosted digitally and will take place on 16/10. All staff are being encouraged to participate by either offering an expression of interest in presenting an improvement idea, or attending the event to support colleagues and learn/share improvement ideas.

POGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION FOR INFORMATION AND NOTING

Our focus over the last nine months has been to ensure that we maintain safe and effective care in all settings during the initial phase of the pandemic and through into more recent months where we have remobilised services.

The Joint Governance Group (JGG) is currently reviewing how clinical and care governance structures could best operate, in line with our experience of a more agile clinical and care governance approach during the pandemic and also taking into account the learning from the national review of clinical and care structures. At the meeting in September 2020, the JGG considered local recommendations to develop the clinical and care structures to enhance our governance arrangements. The next step will be to discuss the recommendations at professional groups e.g. Area Clinical Forum and seminars with members of the Board and the IJB.

In the interim, whilst the Clinical, Care and Professional Governance Committee (CCPGC) is stood down we are continuing to provide assurance and Appendix D sets out a summary of the mechanisms for assurance that have been put in place.

Some care assurance improvement work has been paused during the pandemic, as shown in Appendix A which sets out the quality dashboard. However, service improvement work, including the Excellence in Care programme have now resumed. Throughout the pandemic we have maintained key care assurance work such as strategies to reduce patient falls whilst in hospital, tissue viability and safeguarding children and adults. We have also been encouraging teams to undertake debriefs following adverse events to share learning and opportunities for improvement. In July and August 2020, approximately 10% of all adverse events also included a learning debrief as part of the process. A summary of debriefs undertaken and the opportunities for change are shown in Appendix C. Work is also underway to review risk registers i.e. corporate, departmental and pandemic related to ensure that we have robust systems in place to identify and mitigate risks across the organisation.

In terms of remobilisation, plans continue to be implemented in order to re-establish or increase service provision across the organisation – whilst at the same time, considering how best to manage a potential further COVID outbreak. Outbreak management planning discussions will be facilitated at the clinical pathways meeting during October 2020, so that any additional winter planning requirements can be identified.

As part of winter planning arrangements, we are currently undertaking a number of tests of change to increase the use of remote consultations for urgent care, offer patients specific appointments (Same Day Emergency Care) instead of ad hoc attendances at A&E and developing more capacity for primary care clinics out of hours. We will evaluate the impact of the change to our urgent care pathways at the end of October 2020 to make a decision on whether to retain through the winter months or redesign further. These plans are essential in being able to provide effective urgent and emergency care to all patients and also ensuring that we have enough capacity across the system to continue to provide planned care such as Health Centre appointments, Outpatient clinics and hospital procedures/diagnostics.

Considerable work has been undertaken by NHS Shetland and the Health and Social Care Partnership to provide enhanced support in community settings during the pandemic. This includes input from multi-disciplinary teams to provide care assurance in Care Home settings and more recently, environmental audits in Health Centres to enhance infection control measures and ensure that requirements for physical distancing are implemented.

There was also notable collaborative work undertaken to provide the ‘Caring for Shetland’ plan and the legacy of this is also seen in the next phase of the Anchor Project and Community Led Support, where some of the service hubs will be developed further to provide access to people who require support. Workshops commenced in September 2020 to develop a plan for embedding the learning from the Anchor project in mainstream models of care and service provision.

Appendix A Unicef UK Baby Friendly Initiative: Summary of assessment findings
Re-assessment: Building on good practice- health visiting/public health nursing service

Please note that these results are preliminary only and will be confirmed in the full report.

Name of health visiting service:	**NHS Shetland Community**	**Number of staff interviewed:**	**9 +2**
Assessment dates:	**21 & 22 September 2020**	**Number of mothers interviewed:** Breastfeeding Formula feeding	**20** **15** **5**
		Number of facilities completed observation forms:	**7**

Standard	Theme	Criteria	Standard required	Result
1	Antenatal information *(If antenatal services are provided)*	Staff who were able to give effective information about feeding / explain the importance of close relationships	80%	100%
				100%
		Mothers who confirmed that they had the opportunity for a discussion about feeding their baby / they had the opportunity for a discussion about the importance of developing a relationship with their unborn baby and that the conversation met their needs	80%	Not assessed
				Not assessed
2	Recognising effective feeding	Staff who were able to describe how they would recognise effective feeding	80%	100%
		Mothers confirmed that they were aware of how to recognise effective feeding	80%	100%
	Positioning and attachment	Staff who were able to demonstrate/describe how they would support a mother with positioning and attachment	80%	100%
	Hand expression	Staff who were able to demonstrate/describe how they would support a mother with hand expression	80%	87%

	Responsive feeding	Staff who were able to describe baby led feeding and how to recognise feeding cues / who were able to describe responsive feeding	80%	100%
				100%
		Mothers confirmed that they understood baby led feeding and how to recognise feeding cues / they understood responsive feeding	80%	100%
				87%
	Support with breastfeeding	Mothers confirmed that breastfeeding was assessed at the new birth visit	80%	100%
		Mothers confirmed that they were aware of support available and how to access this	80%	93%
	Clinic visits	Mothers confirmed that the information was helpful and they felt able to ask questions	Yes	Yes
	Groups/peer support	Mothers confirmed that the service/s met their needs	Yes	Yes
	Barriers to continued breastfeeding	Mothers confirmed that they had the opportunity to discuss issues affecting ongoing breastfeeding, and that the discussion was helpful	80%	100%
3	Maximising breastmilk	Staff who understood how to support mothers to maximise breastmilk	80%	100%
		Mothers confirmed that they had been supported to maximise breastmilk given	80%	100%
	Starting solids	Staff who understood about why waiting until around six months of age is important	80%	100%
		Mothers confirmed that they had received information about starting solid foods	80%	79%
		Staff who were able to discuss the International Code of Marketing of Breastmilk Substitutes	80%	100%
	Formula feeding mothers	Staff who demonstrated understanding of how to support formula feeding mothers with making up feeds / understanding of responsive bottle feeding	80%	100%
				100%
		Mothers confirmed that they had been supported with learning about making up feeds / responsive bottle feeding	80%	100%
				86%

4	Support with relationships	Staff who understood the importance of close and loving relationships and how to support this	80%	100%
		Mothers confirmed that they had received information about the importance of close and loving relationships	80%	90%
	Safer sleep	They had received information about how to keep their babies safe when they are asleep/had received written information	N/A	100% 95%
	Communication	Staff who demonstrate that they could communicate in a mother centred way	Yes	Yes 100% Partial No
	General	Mothers' overall satisfaction with the Service	Very happy with care 95% Fairly happy or neutral 5% Unhappy with care overall	

Supporting information			**Achieving Sustainability standards**		
Observations within the facilities	No advertising	No advertising	Leadership	Meets standards	Manager training required
Staff who have been orientated to the policy	80%	100%	Audit and evaluation	Meets standards	Meets standards
Staff who have completed the training programme	80%	100%	Collaborative working	Meets standards	Meets standards
Policies and guidelines	Meets standards	Meets standards	Mothers reported that staff were kind and considerate		All 100% Mostly Sometimes Not at all
Written and other information	Meets standards	Meets standards			
Mechanisms	Meets standards	Meets standards	Excellent outcome to this remote reassessment.		
The written curriculum meets the standards	Meets standards	Meets standards			

Appendix B Quality Report - Board

Generated on: 24 September 2020

Health Improvement

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HI-01 Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter)	Only measured quarterly			64.3%	63.5%	63.7%		58%	Exceeding national target of 50% and local target of 58%. National data for 2018-19 shows us at 59.7% - the 2nd best performing Board in Scotland and well above the national average (43.5%).
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	1			49	80	1		63	The number of ABI screenings undertaken is high, but patients asked do not tend to meet the threshold for a full ABI. This could be interpreted as positive in that it means people are not drinking at hazardous or harmful levels, or it may mean that the screenings are being targeted at the wrong people. The ABI Delivery Improvement plan was disrupted due to COVID-19; a revised timescale for delivery of training modules is under development. ABIs has been paused due to the pandemic; however, Directors are going to be asked to take responsibility for ensuring that their staff deliver ABIs appropriately and record them. Priority groups for delivery of ABIs are Maternity, A&E, Pre-operative assessment, and primary care

Patient Experience Outcome Measures

	Months			Quarters			Icon	Target	
Code & Description	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-01 % who say they had a positive care experience overall (aggregated)	Survey suspended - COVID-19	100%	94.1%	100%	100%				
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	Survey suspended - COVID-19	100%	93.75%	100%	100%				
NA-HC-14 What matters to you - % of people who say we took account of the things that were important to them whilst they were in hospital (aggregated)	Survey suspended - COVID-19	100%	100%	100%	100%				
NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated)	Survey suspended - COVID-19	100%	87.5%	92.31%	100%				
NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated)	Survey suspended - COVID-19	100%	95.59%	96.61%	100%				
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	Survey suspended - COVID-19	95%	93.33%	92.86%	100%				
NA-HC-26 % of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them (aggregated)	Survey suspended - COVID-19	95%	94.12%	92.31%	100%				

Patient Safety Programme - Maternity & Children Workstream

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-CF-07 Days between stillbirths	1,036	1,067	1,098	854	945	1,036		300	
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21	
NA-CF-15 Rate of stillbirths (per 1,000 births)	0	0	0	0	0	0		4	
NA-CF-16 % of women satisfied with the care they received									Currently reviewing the questionnaire and collation process.

Service & Quality Improvement Programmes - Measurement & Performance

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
MD-HC-05 SEPSIS Six - actions performed < 1 hour (Sepsis is a complication of an infection when the body's immune defences attacks the body's own organs and tissues)									Ward 3 will be undertaking the Sepsis audit as part of their ongoing Clinical Governance work. There will be a review of the anaesthetic team's job plans to help identify an individual to conduct the audit on behalf of the surgical ward.
NA-HC-08 Days between Cardiac Arrests	13	44		468	559	13		300	See Appendix 1 of the previous Board Quality Report (August 2020)
NA-HC-09 All Falls rate (per 1000 occupied bed days)	7.54	7.46		6.28	2.83	7.54		7	
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	0	1.49		0	1.42	0		0.5	

	Months			Quarters			Icon	Target	
Code & Description	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	16	21	51	0	36	16	🛑	300	See Appendix 1 below
NA-HC-54 Pressure Ulcer Rate (grades 2-4)	1.51	1.49		2.09	0	1.49	✅	0	
NA-HC-59 % of patients discharged from acute care without any of the combined specified harms	98.6	98.9		99.5	96	98.6	✅	95	
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered				90	100			75	Data has been collected for June, July and August – awaiting validation by clinician
NA-HC-75 % of total observations calculated accurately on the NEWS 2 charts – Ward 1	Audit suspended - COVID-19	92.89%	94.26%				✅	95%	
NA-HC-76 % of NEWS 2 observation charts fully compliant (Accuracy) – Ward 1	Audit suspended - COVID-19	45%	55%				🛑	75%	See Appendix 1 below
NA-HC-77 % of total observations calculated accurately on the NEWS 2 charts – Ward 3	Audit suspended - COVID-19	94.85%	89.85%				✅	95%	
NA-HC-78 % of NEWS 2 observation charts fully compliant (Accuracy) – Ward 3	Audit suspended - COVID-19	55%	30%				🛑	75%	See Appendix 1 below
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Only measured quarterly								The format of the Patient Safety Conversations was reviewed and agreed by the Joint Governance Group. The new approach was to be tested in a few departments, the first being in Ward 3 on 17th March. Unfortunately, this had to be cancelled due the COVID-19 lockdown. The Medical Director plans to recommence as soon as it is safe to do so.
NA-IC-23 Percentage of cases where an infection is identified post Caesarean section	Only measured quarterly			0%	0%				Note: Surgical Site Infection surveillance was paused this quarter to enable additional support for the COVID-19 response.

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-IC-24 Percentage of cases developing an infection post hip fracture	Only measured quarterly			0%	0%				Note: Surgical Site Infection surveillance was paused this quarter to enable additional support for the COVID-19 response.
NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation	Only measured quarterly			0%	0%				Note: Surgical Site Infection surveillance was paused this quarter to enable additional support for the COVID-19 response.
NA-IC-30 Surgical Site Infection Surveillance (Caesarean section, hip fracture & large bowel procedures)	Only measured quarterly			0%	0%				Note: Surgical Site Infection surveillance was paused this quarter to enable additional support for the COVID-19 response.

Treatment

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2020	July 2020	August 2020	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q1 2020/21	Q1 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
CH-MH-03 All people newly diagnosed with dementia will be offered a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan	100%			100%	100%	100%		100%	This is not currently being measured as a target at national level. We *offer* the link worker to everyone newly diagnosed and therefore we meet the target (understandably, not everyone wants to take up the offer). See CH-MH-04 for details of our balancing measure.
CH-MH-04 People with diagnosed dementia who take up the offer of post diagnostic support (ie have an active Post Diagnosis Support status)	Only measured quarterly			43%	38.6%				Note: this is a local measure showing the number of people with an active PDS Status as a percentage of those diagnosed with dementia who take up the offer of post diagnostic support. 51 of 132 cases. This measure was revised for year 2019-20.
MD-HC-01 Quarterly Hospital Standardised Mortality Ratios (HSMR)	Only measured quarterly			1.12	1.19				Latest available provisional national data. Prone to small number variation. Rate remains consistently well within expected levels. Next data due Nov 20.

APPENDIX 1

During July 2020 and August 2020, 1 patient was admitted to Hospital and developed a pressure ulcer.

PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
Jul-20	1	Avoidable	Not Optimal	No	The patient already had a pressure ulcer on admission to the ward but it progressed during the patients inpatient stay. The patient had a pressure reliving pad at home, however this was only realised when ward nursing staff spoke to community nursing. This piece of equipment was then put in place. Documentation did not explain why a SSKIN[1] bundle was not been completed on admission and throughout the patients stay in hospital. Investigation into why the documentation was not complete is ongoing.

[1] SSKIN bundle is an ongoing assessment process which includes a review of: surfaces (e.g. pressure relieving devices); skin inspection; keep moving (e.g. mobility); incontinence and nutrition

NEWS 2 - EARLY WARNING SCORES OBSERVATION CHARTS			
Date	**No. of charts reviewed**	**Most common issues identified**	**Steps being taken to address practice issues**
August 2020	40 (20 per ward)	**Ward 1** • Date not being recorded • Score added wrongly • Frequency of observations not been carried out in the time specified **Ward 3** • Frequency not within the time specified • Accuracy - not counting score correctly • Omissions from observations chart	**Ward1** Spot checks and offering additional training **Ward 3** Nurse in charge will do regular chart checks and provide additional training where needed. A display board has been created in ward 3 MDT room to discuss at every handover. White boards are being used to record when all patient observations are due and this is updated regularly.

Appendix C - Adverse Event Data July and August 2020

Month	Number of Adverse Events	Number of Category 1	Number of Debriefs Completed	Thematic Learning
July 20	56	0	8	• **Communication** - improved handovers with community nursing staff and ward staff, ensuring all relevant care information is passed over x2 • **Record Keeping/Documentation** - need to ensure tasks are highlighted in daily sheet and there are clearer instructions on the sheets • Thorough and additional checks of patient details when patient has a different calling name • **Patient safety** - ensure patients are identified who are at risk of falls at the soonest opportunity • **Risk management** - reporting Near Misses in Datix, this allows us to get the learning's and apply controls earlier • No knew learning identified x2
August 20	55	0	3	• No knew learning identified x3
Total	**111**	**0**	**11**	**-**

Appendix D Clinical and Care Governance Structure NHS Shetland October 2020

Situation

With the advent of COVID the current Clinical and Care Governance structure was stood down. NHS Shetland moved to a more agile system of governance. There is a recognition that the previous structure did not provide an optimum level of assurance to the parent bodies and as such we are taking the opportunity to redesign the structure using the learning that we have gained.

The current modified processes of clinical governance continues to provide assurance.

Background

In March 2020, the Clinical and Care Professional Governance Committee was stood down as were several of the groups and committees feeding into the structure. Decisions were made by Gold Command to stand down collection of some data that was deemed either not possible due to capacity or not necessary by Government in the context of a pandemic where service delivery took precedence.

A structure of bronze (operational), silver (tactical) and gold (strategic) command was established. Professional bodies also modified the processes of assurance of professionals. It is also recognised that the risk management structure should be reviewed so that where appropriate services manage their risks and they are understood across the whole system.

Assessment

During the past 6 months, Directors have retained accountability for professionals and the services they delivered. We have continued to produce a score card around those metrics collected on acute services. We continue to support clinicians to regularly, openly and jointly debrief where there have been adverse outcomes or near misses. Many groups/committees have continued to meet eg Surgical Audit Group, Hospital Transfusion Committee, the Medical Education Governance Group and APF.

The Maternity Governance, Medical Governance Group and Monthly Governance Meetings are planned to restart shortly.

New ways of working for clinical and care governance introduced:

- Weekly Waiting Times Meeting to review delays or potential delays as well as operational issues. Weekly Care Home Assurance Group bringing together service managers and directors to review performance, quality and safety in care homes.
- Fortnightly Clinical Pathways Meeting with clinicians and managers to trouble shoot, review, discuss and approve new pathways of care.
- The Clinical Governance Team has weekly meetings with the Medical Director to monitor and flag the reporting of adverse events and duty of candour.

- The Joint Governance Group has continued to provide a vehicle to oversee service performance.

Recommendations

The Board note that there are robust processes in place to provide assurance whilst the structure of Clinical and Care Governance is reviewed and remobilised.

NHS Shetland Feedback Monitoring Report 2020_21 Q1

Since April 2017 all NHS Boards in Scotland have been required to further monitor patient feedback and to report performance against a suite of high level indicators determined by the Scottish Public Services Ombudsman (SPSO). This report outlines NHS Shetland's performance against these indicators for the period April to June 2020_21 (Q1).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2020 is provided (this allows an overview of types of complaints in year and also for any open complaints at the point of reporting to be completed at a subsequent iteration of the report). All Stage 2 complaint learning from 2019/20 was included in the Feedback and Complaints Annual Report presented to the Board in August 2020.

A summary of cases taken to the Scottish Public Services Ombudsman from April 2019 onwards is included at the end of this report, allowing oversight of the number and progress of these and also the compliance with any learning outcomes that are recommended following SPSO investigation.

Summary

- Corporate Services recorded 12 pieces of feedback in Quarter 1 of 2020_21 (1 April 2020 – 30 June 2020):

	01.04.20 – 30.06.20		01.01.20 – 31.03.20 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	2	17	2	8
Concerns	3	25	13	54
Complaints	7	58	9	38
Totals:	**12**		**24**	

- The seven complaints received related to the following areas:

	01.04.20 – 30.06.20		01.01.20 – 31.03.20 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	2	28.5	2	22.2
Directorate of Community Health and Social Care	3	42.9	7	77.8
Acute and community	1	14.3	-	-
Corporate	-	-	-	-
Other	1	14.3	-	-
Withdrawn	-	-	-	-
Totals:	**7**		**9**	

Key highlights

- We received official notification of one further case referred to the SPSO during the reporting period which they are considering for further investigation. We closed one SPSO set of recommendations in August 2020.
- ISD no longer collates complaint performance data on a quarterly basis. As NHS Bodies already publish annual reports covering complaints, we are asked instead to include complaints information covering nine Key Performance Indicators (KPIs).

  A standardised reporting template regarding the key performance indicators has been agreed with complaints officers and the Scottish Government.
- Quarterly complaint data received for Family Health Service providers has not been included in this report. Compliance with returns remains low and for those areas that do submit the numbers are negligible. This will continue to be picked up through professional leads.
- Complainant experience in relation to the complaints service provided for Stage 1 and Stage 2 complaints will be included on an annual basis given the low numbers involved.

Complaints Performance

Definitions:
Stage One – complaints closed at Stage One Frontline Resolution;
Stage Two (direct) – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);
Stage Two Escalated – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

1 Complaints closed *(responded to)* at Stage One and Stage Two as a percentage of all complaints closed.

Description	01.04.20 – 30.06.20	01.01.20 – 31.03.20 (previous quarter)
Number of complaints closed at Stage One as % of all complaints	71.4% (5 of 7)	55.5% (5 of 9)
Number of complaints closed at Stage Two as % of all complaints	28.6% (2 of 7)	44.5% (4 of 9)
Number of complaints closed at Stage Two after escalation as % of all complaints	0% (0 of 7)	0% (0 of 9)

2 The number of complaints upheld/partially upheld/not upheld at each stage as a percentage of complaints closed *(responded to)* in full at each stage.

Upheld

Description	01.04.20 – 30.06.20	01.01.20 – 31.03.20 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	20% (1 of 5)	40% (2 of 5)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	50% (1 of 2)	0% (0 of 4)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

Partially Upheld

Description	01.04.20 – 30.06.20	01.01.20 – 31.03.20 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	20% (1 of 5)	60% (3 of 5)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	50% (1 of 2)	75% (3 of 4)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

Not Upheld

Description	01.04.20 – 30.06.20	01.01.20 – 31.03.20 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	60% (3 of 5)	0% (0 of 5)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	0% (0 of 2)	25% (1 of 4)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

3 The average time in working days for a full response to complaints at each stage			
Description	**01.04.20 – 30.06.20**	**01.01.20 – 31.03.20 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	5.6	3.2	5 wkg days
Average time in working days to respond to complaints at Stage Two	19	78.5*	20 wkg days
Average time in working days to respond to complaints after escalation	-	-	20 wkg days

*Response times for Stage 2 complaints from Quarter 4 were significantly impacted upon by the Covid-19 Pandemic.

4 The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days			
Description	**01.04.20 – 30.06.20**	**01.01.20 – 31.03.20 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	40% (2 of 5)	100% (5 of 5)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	100% (2 of 2)	25% (1 of 4)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	-	-	80%

5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description	**01.04.20 – 30.06.20**	**01.01.20 – 31.03.20 (previous quarter)**
% of complaints at Stage One where extension was authorised	60%	0%
% of complaints at Stage Two where extension was authorised	0%	75% (3 of 4)
% of escalated complaints where extension was authorised	-	-

Learning from complaints

For Quarter 1 there are no particular complaint trends to highlight although restrictions resulting from the Covid-19 Pandemic have contributed to concerns being raised.

Staff Awareness and Training

Staff are provided with key information on feedback and complaint handling at each induction session. Staff attending mandatory refresher training are given an update sheet on feedback and complaints. The Feedback and Complaints Officer is continuing to speak with departments to try and empower more people to feel confident to handle a Stage 1 complaint or signpost effectively to the appropriate support. Reminders have been put in staff briefings.

A management bundle on feedback and complaints has been developed for delivery by the Feedback and Complaints Officer through 2020.

Staff are also able to access excellent e-learning resources regarding feedback and complaint handling, including investigation skills, through TURAS Learn.

Stage 2 complaints received 1 April 2020 to 30 June 2020

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Actions
1	Complainant felt there could have been an earlier diagnosis of cancer	Consultant/GP	Yes		Partly upheld	• No evidence to suggest outcome would have been different with an earlier diagnosis. Decision making at each stage found to be understandable in the circumstances. • Review of systems to ensure a safe process for the review and communication of results
2	Availability of results and potential harm in delay	Medical Records/A&E	Yes		Upheld	• Longer term looking at an electronic ordering system. Until then a daily histology report from Aberdeen has been put in place to avoid issues with postal delays.

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2019 to 28 September 2020

Date notified with SPSO	Our complaint ref	SPSO ref	Area of complaint	Date of SPSO outcome	SPSO outcome	SPSO recommendations	Action update	Board/SPSO status
2019/20								
21.10.19	2018_19_24	201902265	Unreasonable attempt to continue procedure and should have been stopped sooner	09.06.20	Upheld	1. letter of apology for the failings identified by 10.08.20 2. Evidence that this matter has been fed back to relevant medical staff in a supportive manner that encourages learning by 09.10.20 3. Evidence that the junior doctor included this case in their appraisal by 10.08.20	File submitted 07.11.19 Letter of apology sent to family Evidence sent to SPSO for all three actions 10.08.20	Considered closed by SPSO
09.01.20	2019_20_16	201908764	GP attitude during consultation	09.01.20	Will not take forward	None		Closed
12.08.20	2018_19_18	201907983	Complication following surgical procedure		Under review		Additional information submitted for consideration	Open

Key:
Grey – no investigation undertaken nor recommendations requested by SPSO
Green – completed response and actions
Amber – completed response but further action to be taken at the point of update
No colour – open case