NHS Shetland

Meeting:	**Shetland NHS Board**
Meeting date:	**19 September 2023**
Agenda reference:	**Board Paper 2023/24/30**
Title:	**Medical Director's Annual Report 2022/23**
Responsible Executive/Non-Executive:	**Kirsty Brightwell**
Report Author:	**Kirsty Brightwell, Medical Director**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Annual review of Medical Directorate work and adherence to statutory and strategic requirements. Appendices: Director of Medical Education and Organisational Duty of Candour annual reports.

2.2 Background

Professional governance of medical staff undertaken on behalf of the Board. Progress in establishing wider medical leadership and towards a sustainable medical workforce. Clinical Governance and Risk.

The Organisational Duty of Candour procedure is a legal duty setting out how organisations should tell those affected that an unintended or unexpected incident appears

to have caused harm or death. This includes the requirement to apologise and involve them meaningfully in a review of the events.

The Director of Medical Education report seeks to inform the Board of the activity to meet the GMC training standards and work with colleagues across NHS Shetland and within NHS Education for Scotland to ensure that we provide high quality, person-centred training.

2.3 Assessment

Professional governance procedures and delivery are described along with change in the emphasis of Appraisal.

Medical leadership progress towards a more disseminated approach.

Review of workforce and recruitment efforts.

Review of Clinical Governance and Risk activity

DoC Annual Report describes the process and our performance against this with 3 incidents triggering the Act.

High satisfaction scores for undergraduate and postgraduate training as well as attention to good Medical Education Governance through established processes.

2.3.1 Quality/ Patient Care

Appointment of Chief Nurse (Corporate) providing clinical leadership to Clinical Governance and Risk.

2.3.2 Workforce

Continuing recruitment work has maintained teams. Ongoing gaps in substantive posts filled with high quality bank staff.

2.3.3 Financial

N/A.

2.3.4 Risk Assessment/Management

Process for Risk Management overseen via the Clinical Governance team. Team remains small and redesign of posts will create more resilience.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

- AMD Acute
- Primary Care Manager
- Clinical Governance and Risk Manager and Lead
- Clinical Governance Committee

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1: NHS Shetland Director of Medical Education Annual Report 2022/2023
- Appendix 2: NHS Shetland Annual Duty of Candour Report 2022/2023

NHS Shetland: Medical Director's Annual Report 2022-2023

(including NHS Shetland Annual Director of Medical Education Report 2022/23)
AND Annual Duty of Candour Report 2022/23

Kirsty Brightwell June 2023

Preface

The prime role of the Medical Directorate is professional governance of the medical workforce. We continue to work towards a more sustainable Appraisal and Revalidation service alongside colleagues from Orkney and the Western Isles. This year has seen the development of a shared post to provide much needed support to the teams.

The changing health needs of the population, the post-pandemic increase in demand and well-recognised national shortage of medical workforce continue to create a moving target. We have had turnover in several posts notably in our rotational models of the Obstetrics and Gynaecology team as well as the Unst Medical Practice. Despite this, we have successfully recruited to both teams and are learning from this in our other teams. We have ongoing gaps but have maintained all services by managing to attract high-quality temporary staff providing good quality care across Shetland.

The teams in Acute and Community are actively looking at succession planning and working to create more sustainable solutions. However, there will be an ongoing need to maintain non-substantive staff in our services for the immediate future. Given our small teams, our services are vulnerable. Teams recognise the need to work together across professions, services, sectors and Boards to create sustainable solutions. This will create new demands on our enabling services as traditional ways of working are no longer compatible. All of this requires our workforce to be flexible and agile at a time when they feel close to overwhelm every day. We cannot underestimate how important it is for people to have space to reflect and make sense of the change as highlighted in the excellent work of the Clinical Governance Team.

Being a small workforce is both a risk and an opportunity as highlighted in the Annual Report of the Director of Medical Education (Appendix 1). This provides evidence of the high quality of education provided to the junior workforce and the commendable efforts of all our teams in maintaining this. As the medical workforce adapts to the changing needs of the population and workforce supply, medical education remains a strong compass for the organisation.

Professional Governance

1. Inter-Islands Appraisal Lead work

Background

The Medical Director is the Responsible Officer for NHS Shetland (the Designated Body). Doctors who work in multiple Boards should have the Board where they do the majority of their work as their Designated Body. They have a statutory duty to make recommendations for the revalidation of doctors to the GMC as set out in the Medical Profession (Responsible Officer) Regulations 2010 (as amended). This means that the RO must evaluate doctors' fitness to practise. This is achieved by having an Annual Appraisal system. Each doctor will have an Annual Appraisal with a qualified Appraiser. Every 5 years they must achieve the requirements of the GMC. The RO meets with the Appraisal lead to ensure that this has happened and submits a recommendation to the GMC.

Progress this year

The team remains small and vulnerable but with the support of NHS Orkney we continue to provide Appraisals for all doctors registered with NHS Shetland.

The outgoing Appraisal Lead (shared with NHS Grampian) continues to provide the Appraisal Lead function whilst we work with NHS Grampian on this role.

Data for 2022-2023

Measure	
Number of Appraisers associated with NHS Shetland	5
Number of doctors with NHS Shetland as Designated Body	74
Number of Appraisals completed	73
Number completed after April for previous year	0
Number of recommendations to GMC for Revalidation	7
Number of deferrals	0
Number on-hold	<5

Medical Leadership

Background

Medical Leadership is vital in delivering high-quality care. As NHS Shetland works towards its goals of sustainability and new models of care to deliver the new Clinical Strategy there is a growing need for leadership across our services.

Progress

The Board has had 2 Associate Medical Directors (Acute and Primary Care) providing 1 day a week each. The AMD for Acute is part of the Hospital Management Team and instrumental in recruitment and service model re-design. The Primary Care Associate Medical Director has been a highly valued member of the HSCP but resigned at the end of March 2023. Both AMDs have been integral to delivering professional and Clinical leadership alongside Clinical Governance and Managerial aspirations of improving patient outcomes and assurance to the Board.

It is a contractual requirement for each consultant and employed GP to have a job plan agreed with their employer on an annual basis as set out in their contract. This has been completed for 2022-2023.

Both the GP Sub-Committee and the Consultants' Group continue to meet regularly. They feed into the Area Medical Committee, a statutory committee of the Board, which reports to the Area Clinical Forum. It is an advisory/consultative committee to represent the views of the local medical profession. The committee is meeting regularly and reporting to the Area Clinical Forum.

Unfortunately, there is no representation at the IJB from the Medical Workforce and this is a gap.

The use of job plans as a tool for understanding capacity is now maturing and forming a foundation of service redesign.

Workforce: Primary Care

Table 1: Workforce Primary Care			
Practice	**Population**	**WTE GP Baseline**	**WTE GPs Employed**
Yell	982	1.41	0
Whalsay	1059	1.41	1.40
Brae	2547	1.60	1.2
Walls	700	0.8	0
Bixter	1200	1.04	0.5
Scalloway	3728	2.40	2.70
Lerwick	8559	6.67	5.17
Unst	628	1.41	1.40

Hillswick and Levenwick are independent contractors. Hillswick has 1 full-time GP and an associate GP (to cover leave and training), Levenwick has a baseline of 3 WTE GPs but has locum cover to support the 3 part-time GPs who are substantive.

The rotational team in Unst continues to work well with some turnover and has proven it is an attractive and more sustainable option. Yell continues to be staffed by locum GPs despite attempts at recruitment to a similar model. Bixter have 1 rotational GP who is providing some continuity. The Partnership are working with local communities on how to make these positions more attractive and sustainable whilst still delivering high quality care that meets the needs of the population.

Brae and Scalloway are benefitting from Advanced Nurse Practitioners which have been established for a long time in Lerwick Health Centre. Lerwick have been working with the nursing leads on new ways of working both within and outwith the practice in order to manage the increasing demand for appointments. An example of this is a new pathway for investigation of lung conditions utilising the skills of an ANP for the entire population of Shetland rather than just Lerwick Practice.

Rediscover the Joy continues to support many of our practices including the independent GP practices. Unfortunately further recruitment to the GP Joy Teams is frozen until the Government confirms the budget.

The Cluster Quality Lead post continues to provide leadership of improvement work in Primary Care and there is admin support provided by the Board. There is a GP Sub Committee of the Area Medical Committee that meets regularly. This year has seen1 year of funding secured from Macmillan for a Macmillan GP lead role. The postholder is networked with leads across Scotland and locally is working alongside the Oncology team, Health Information and the Cancer Tracking Lead to improve pathways for those with a possible diagnosis of cancer as well as palliative care for all patients.

Workforce: Acute and Specialist Care

Junior Doctors

Much as previous years, there have been a few unpredictable gaps emerging that have taken a lot of time and effort to plug by the AMD and HR team. NHS Education for Scotland are actively reviewing their processes for recruitment and assignment of junior doctors at various stages of training across Scotland. There is good communication between the Directors of Education, the Medical Directors and NES with junior doctor support forming part of the Scottish Association of Medical Directors regular workshops.

Table 2: Secondary Care (consultant grade unless otherwise specified)

Specialty	Established Posts	Substantive Post-holders	Gaps filled by bank
General Medicine	4 WTE (to include on-call ie 8EPAs)	1 WTE no on-call, 0.6 WTE no on-call 2/3rds of rotational post with on-call	4 regular bank doctors
General Surgery	4 WTE (to include on-call ie 8 EPAs) Specialty Doctor 1 WTE	3 WTE + proleptive post-holder every 4th weekend Specialty doctor 1 WTE	Exceptional circumstances
Aneasthetics	4 WTE (to include on-call ie 8 EPAs)	0.8 WTE	3 regular bank doctors and very occasional use of further bank
Obstetrics & Gynaecology	2.2 WTE (to include on-call ie 4 EPAs)	4 post-holders	Gaps this year due to resignation and ill-health
Paediatrics	0.6 WTE (0.1 for NHS Grampian)	0.6 WTE	Parental leave this year use of bank doctor.
CAMHs	Nil	Nil	SLAs with 2 visiting consultants
Microbiology	SLA with NHS Grampian	0.5 WTE	N/A

Workforce Public Health, Mental Health, Occupational Health and Public Health

The Public Health Consultant post remains vacant but there is a plan for redesign of the reporting structure within the Public Health department which will result in the post being advertised in the next financial year.

Community Mental Health Psychiatrists have been bank doctors working in rotation this year since the resignation for the substantive consultant last April. This provides a relatively stable workforce supplemented by the part-time Substance Misuse and Recovery Doctor.

Occupational Health have a part-time substantive doctor who has progressed through the Masters qualification in Occupational Health and is helping to build resilience in this small team to provide specialist services not just for the NHS and Local Authority workforce but to the wider population of Shetland. This is an area of growing need.

Table 3 sets out the current established roles and post-holder complements.

Table 3: Workforce Mental Health, Occupational Health and Public Health

Specialty	Established Posts	Substantive Post-holders	Gaps filled by bank
Public Health	1 WTE	Currently vacant	Post-holder is now DPH
Occupational Health	0.4 WTE hospital practitioner role	0.4 WTE	N/A
Psychiatry	2 WTE	0	2 bank doctors working on rotation
Substance Misuse and Recovery	0.6 WTE hospital practitioner role	0.6 WTE	N/A

Clinical Governance and Risk

The Clinical Governance team play a vital role in the organisation to help assure the Board that we provide high quality, safe and effective services but also to support clinicians to understand their role in this. The team should be commended for their hard work this year.

A new Clinical Governance lead was appointed bringing more capacity and new skills to the team. The improvement plan created following a review of the team and engagement exercise with the organisation continues. Given the amount of specialist knowledge individual members of the team hold there is a high risk of loss of service. The team are redesigning roles in order to improve resilience.

The Chief Nurse (Corporate) leads the team and is also the lead for Care Assurance, Excellence in Care and Patient Engagement.

The team continue to support individuals to report adverse events and encourage reviews to be based on learning and have been formalising routes of assurance for the various committees.

There has been a review of the clinical audits undertaken for the Board to identify gaps and work towards a more systematic approach to this work.

This year the Whistleblowing Standards work has come under the Clinical Governance team which will enable clearer reporting of performance against the standards. The Child Death Review process which feeds into the National Child Death Reviews is overseen by the Clinical Governance team as is the Significant Adverse Event review process. This year we have undertaken a review of the commissioning of investigations under these processes and have had an internal audit which has given no actions for improvement.

The team support the various Acute Clinical Governance Groups including regular reports for Medical Governance Group, Surgical Audit Committee, Anaesthetic Governance. They manage the process for the monthly open invitation Clinical Governance Afternoons and the monthly Patient Safety Walkarounds.

The Clinical Governance Committee is iterating its work and the Clinical Governance team support an annual workshop for the Committee to review how it effectively delivers assurance to the Board.

Risk Management

Background

The Board retains responsibility for the management of risk in its entirety. The Board delegates the development and detailed work associated with its implementation to the Risk Management Group (RMG) which reports to the Board.

The Chief Executive took over the role of Chair this year. Previously, the Medical Director had been the Chair but is now managerially responsible for the Risk Team. RMG has overall responsibility for the integration, co-ordination and standardisation of risk management throughout the Board. It provides assurance to the Board on the establishment and implementation of risk management processes and systems.

Progress

There are regular, quarterly meetings which provide scrutiny of the management of all Strategic Risks. RMG provides assurance to Audit Committee that Strategic Risks are being managed effectively.
The Director of Public Health has added the Strategic Risk 18 Risk of CBRN Contamination and Strategic Risk 19 Flu Pandemic.

Appendix 1: DME Annual Reports (Undergraduate and Postgraduate Parts 1 and 2)

Appendix 2: Organisational Duty of Candour Act Annual Report

Scotland Deanery

Director of Medical Education Report

NHS Board	Shetland			
Responsible Board Officer	Dr Kirsty Brightwell, Medical Director			
Director of Medical Education	Pauline Wilson			
Reporting Period	**From**	August 2022	**To**	June 2023

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Dawn Mann at Dawn.Mann@nhs.scot

Please complete and return to nes.medicalact@nhs.scot by 8th **August 2023**

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1: Undergraduate Medical Education: Quality Report

Key to survey results

Undergraduate Survey (UG)*

Key	
R	Score less than 0
A	Score 0 to less than 0.55
W	Score 0.55 to less than 1.55
G	Score more than or equal to 1.55
	No results available
▲	Better result than last year
▼	Worse result than last year
▬	Same result as last year

*This report utilises data from the Scottish Student Evaluation Survey. Results are only provided where there are at least three responses or there is available aggregated data. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. “Possible responses” is the number of students surveyed. Scores are calculated based on Universities’ scoring scales converted to Likert scale of between -2 and +2. Trend data: indicates an improvement in the flag from the previous year, a deterioration, and no change.

1.1 Site: Gilbert Bain Hospital, Specialty: General (internal) Medicine

Undergraduate Survey

School	Specialty	Class Year	Overall Satisfaction	Block Organisation	Treated with Respect	Teaching Delivery	Teaching Quality	Total Teaching	Learning Opportunities	Clinical Experience	Total Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total Support	IT Equipment	Access to Software	Total IT	Teaching Equipment	Teaching Accommodation	Total Facilities	Number of responses	Possible responses	Aggregated
Aberdeen	Medicine - General Medicine	5	W ▼	G	G		G	G	G		G	G		G	G	G	G	G	W ▼	G				5	7	

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

It is encouraging to see so many areas of the report on green.

The success with medical students this year has been down to enthusiastic and consistent teaching from all members of staff. NHS Shetland remote and rural placement offers bountiful educational opportunities for final year medical students. Each rotation is offered our self-created Prep For FY1 program - Delivered by junior doctors for our future junior doctors. Further teaching in simulation training, high quality weekly Shetland delivered teaching and practice clinical exams. Emphasis is placed on making the students feel part of the team. They each have their FY1 shadowing week as part of the placement.

Efforts have been made this year to ensure medical students are included in activities with other junior doctors appreciating few may find the placement isolated. Informal feedback received has been excellent

Areas of good practice:

1. Medical Education Administrator meets with all students at the start of the block and carries out induction to both the hospital and Shetland - * see note below.
2. Each student has an assigned block lead.
3. Each student has a Clinical Development Fellow mentor.
4. Students are integrated into the teams and encourage to get to know the whole ward team including the domestic and clerical staff as well as the nurses, AHPs and doctors.
5. Time is taken to discuss the students' educational needs for the block and teaching is tailored to this.

6. The Clinical Development Fellows have developed a teaching programme for the 8-week block and cover
    - Suturing practice
    - Preparation for FY1
    - Simulation training
    - Practical training
    - Lecture based session lead by a different team member every week.
7. Student are encouraged to take part in weekend work and be part of Hospital at Night Team (HAN)
8. Students are included in social ward activities – such as pizza nights.

Area for development (white flag)
In terms of access to software – there is a new junior doctor and medical student room about to open in the clinical skills area where they will have better access to computers and quite place to study – the clinical education space was taken over during covid as a clean green space and the clinical education team are in the process of moving back in.

It is disappointing that not all students took the time to feedback despite being encouraged to do this. We do highlight to students that we listen to feedback and make changes based on what they say.

1.2 Site: Gilbert Bain Hospital, Specialty: General Surgery

Undergraduate Survey

School	Specialty	Class Year	Overall Satisfaction	Block Organisation	Treated with Respect	Teaching Delivery	Teaching Quality	Total Teaching	Learning Opportunities	Clinical Experience	Total Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total Support	IT Equipment	Access to Software	Total IT	Teaching Equipment	Teaching Accommodation	Total Facilities	Number of responses	Possible responses	Aggregated
Aberdeen	Surgery - General Surgery	5	G —	G —	W ▼		W ▼	W ▼	G —		G —	W ▼		W ▼	G —	G —	G —	G —	G ▲	G —				4	7	

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

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8. Students are included in social ward activities – such as pizza nights

Area for development (white flags)

1. In September 2023, NES team are coming to Shetland to deliver a two-day programme for all educator – Leadership in the learning environment and identification of struggling trainee.
2. The teaching delivered to surgical students is very similar to the medial team – this discrepancy will be discussed at the next Medical Governance Group to see if we can account for the difference.
3. The feedback was that the students found it hard to get their long case undertaken. This has been understood by the teaching team and work on this area has begun to see if we can make this easier for the students and the team.

It is disappointing that not all students took the time to feedback despite being encouraged to do this. We do highlight to students that we listen to feedback and make changes based on what they say.

Wendy Cooper, Medical Education Administrator was runner up, NES awards for Support Staff category.

Wendy Cooper has been the Clinical Education Administrator at the Gilbert Bain Hospital, for the past three 3 years. In her role:

- Wendy is the first person that new medical students and junior doctors meet on their arrival at the hospital. Her friendly manner is very welcoming for those with apprehensions about a position in the remote location of the Shetland Islands - she quickly makes them feel at home and an integral part of the close-knit hospital community.
- Wendy is central to our work experience project for those applying for medical school. She coordinates essential administration. She keeps track of their attendance at key preparatory events, and she books them into our comprehensive work experience matrix and makes sure they and their mentors know all the arrangements for each session, so that they are safe and learning effectively. Much more than this she acts as a friendly contact point for them, takes a keen interest in their progress and celebrates their successes.
- She is meticulous in coordinating the logistics of hospital teaching and is integral to keeping everyone up to date on scheduled sessions. She is always on hand to assist presenters as they provide teaching, some for the first time, with simple encouragement.

If there is anything Wendy can do to help, she does it. Whether that is sitting to chat in a stressful situation, providing home bakes to enjoy after teaching or fetching some shopping for someone who is unwell, she will go out of her way to help. Wendy never fails to provide support to her peers, students, visitors, and everyone else around her, with her warmth and kindness.

"Wendy is a delight to work with and I cannot think of anyone more deserving of this award. She goes above and beyond for the students, junior doctors and her colleagues. I'm quite certain that Wendy's day to day work surpasses what was stated on her Original job description".
Dr Jillian Scott, CDF

2 Sign-off

Form completed by	Role	Signature	Date
Pauline Wilson	DME	Pauline Wilson	10/07/2023

Scotland Deanery

Director of Medical Education Report

NHS Board	Shetland			
Responsible Board Officer	Dr Kirsty Brightwell			
Director of Medical Education	Dr Pauline Wilson			
Reporting Period	**From**	3 August 2022	**To**	1 August 2023

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Alex McCulloch at alex.mcculloch@nhs.scot.

Please complete and return to alex.mcculloch@nhs.scot by **5pm Wednesday 14 June 2023.**

1. Educational Governance

1.1 Does the full Health Board itself receive a regular report to support its governance responsibilities around the quality of postgraduate and undergraduate medical education and training? • **How often does it receive a report around educational governance?** • **What is covered in these reports?** • **Is there a board member with responsibility for MET?**
• **How often does it receive a report around educational governance?** The DME report is included as part of the Medical Directors annual report to the Health Board • **What is covered in these reports?** DME part one and part two report – included with MD annual report The minutes and action tracker from the Medical Education Governance group goes to the Operational Governance Group, which then reports to Clinical care and Professional Governance Committee (CCPGC). The CCPGC reports to the Integrated Joint Board and NHS Shetland Board. • **Is there a board member with responsibility for MET?** The chair of the Operational Governance Group has responsibility for providing the Board with assurances regarding governance as a whole and this includes Medical Education and Training.

1.2 Is there a Health Board committee with responsibility for the governance around the quality of postgraduate and undergraduate medical education and training?

- **What is it called?**
- **How often does it meet?**
- **What data and information is considered by this committee?**

- **What is it called?** Medical Educational Governance Group (MEGG)

- **How often does it meet?** Monthly

- **What data and information is considered by this committee?** MEGG considers operational, educational and strategic issues

  Operational issues:
  - Vacant posts and rota gaps
  - Planning for gaps in staffing
  - Role of Trainers issues
  - Rota's
  - Induction
  - Monitoring of hours
  - ACT funding
  - Equality, diversity, and inclusivity is a standing item on the agenda
  - Feedback from junior doctors forum via junior doctor representative

  Educational issues:
  - Ensuring rota matches the curriculum requirements for each grade of trainee
  - Discussion on ACT funding to match with medical student teaching and training
  - Monthly teaching programme
  - Educational opportunities that would benefit the wider Multi-disciplinary Team

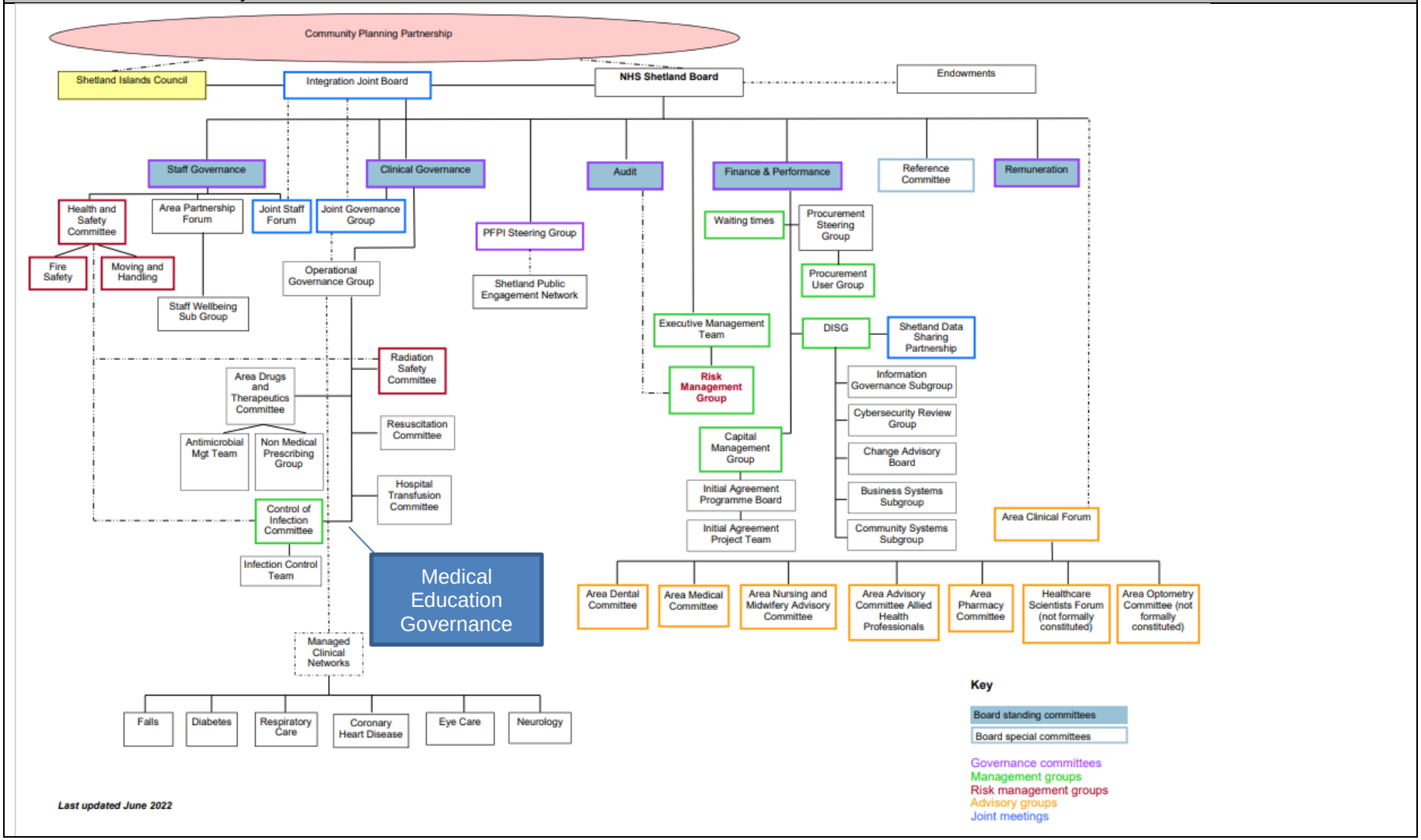
  Strategic:
  - Medical staffing and how to maximize trainee experience in the Shetland service
  - Work with University of Aberdeen about accommodating increasing numbers of medical students

The MEGG co-ordinates the both the operational and educational nature of hosting medial students and junior doctors. It allows for a system wide approach with tangible solutions to problems that could either affect service provision or training.

The membership of the group includes representation from:

- The wider MDT team involved in teaching and training – e.g. nursing
- Trainers – both secondary and primary care
- Staff development team
- Undergraduate block leads
- Executive management Team – Director of Acute Services and Medical Director
- Finance
- Accommodation team – by invite
- Human Resources Department
- Trainees

1.3 Is there a governance committee structure that links the delivery of education and training in LEPs to either the Health Board or the Health Board's educational governance committee? If there is, can you describe the elements of that and how information flows to the Board/Board committee? (You may wish to share an organogram if there is one that described the committee structure.)



1.4 Describe the quality control activities in relation to MET that have been undertaken by your HB in this training year?

- Medical Education Governance Group (MEGG) meets once a month
- Trainee representatives sit on the Medical Education Governance Group
- Trainees have regular contact with the Medical Director of Education
- RAG data is discussed at MEGG and at a consultant group. The Medical Director and Chief Executive attend the consultant's group so are sighted on any areas of good or challenged practice.
- Feedback from training is collected and informs changes to training content

1.4 Are there forums within your HB whereby senior officers (CEO, MD) or site-based senior clinical management have regular, scheduled meetings with trainee doctors to discuss their training and receive feedback? Please provide full details.

- The Medical Director if possible, meets with the junior doctors at induction
- Director of Medical Education meets with all new trainees at induction and informally throughout the block
- Acute Services Director and Medical Director are members of the Medical Education Governance Group as is the Associate Medical Director for Primary Care so they are aware of feedback from the trainee representatives concerning operation and educational issues affecting trainee doctors.
- There is a junior doctor's forum and the junior doctor representative is a member of MEGG.

1.5 How are learners made aware of who is responsible for what within education for your organisation.

- An induction handbook is sent out to all trainees prior to starting in Shetland with deals of personnel
- Director of Medical Education meets with all trainees at induction and the educational organisational structure is discussed with them
- NHS Shetland links into the North Deanery induction where they meet the Director of Medical Education for NHS Grampian and the Postgraduate Dean.
- International Medical Graduates are linked into the Grampian mentoring support structures
- Each trainee has a named joint Educational and Clinical Supervisor – due to the small nature of the orgainsation the trainees work on a day to day basis with their supervisors.

1.6 If your review of quality management data highlights a number of new red flags in a particular department how do you address that?

- NHS Shetland is a small rural hospital site. This allows for early identification of issues and feedback to the departments
- All RAG data and other trainee feedback data is discussed at the MEGG so we can adopt a Multi-disciplinary approach to solving any issues raised
- Areas of concern or good practice is also discussed at the consultant's group
- The DME feedbacks directly to the department about any concerns raised or red flags and works with the department to address the underlying issues that has resulted in issues developing. After working with the department to address the concerns the DME keeps in contact with the department and trainees to ensure that the issues have been resolved or there is evidence of improvement.

1.7 What are the mechanisms in place for trainees to receive feedback from DATIX?

- There are departmental (medical and surgical) governance groups – at these meetings datix and learning are discussed. The juniors are invited to the governance meetings.
- Datix system facilitates feedback but consultant lead for the case will usually be involved in review of any Datix involving a trainee.
- Once a month there is a hospital wide governance meeting where any datix or wider team learning is discussed
- Medical department has a weekly Morbidity and Mortality meeting – cases discussed with the wider medical and nursing team – records of theses case reviews then are forward to clinical governance department

1.8 At each site, how many trainee doctors have been involved in an SAE?

Site	Unit/Specialty	Number of SAE	Was the Deanery notified and involved in the follow up?
Gilbert Bain Hospital		**none**	
Lerwick Health Centre		**none**	

1.9 At each site, how many trainee doctors have required 'reasonable adjustments' to their training in relation to a declared disability?

None

1.10 How do you ensure educators are appropriately trained and that their training is kept up to date?

- New supervisors attend FDA approved training
- Educators are encouraged to attend regional and national education conferences such as NES Medical Education Conference
- Educators are invited to the Medical Education Governance Group
- Through Job Planning
- Educators are encouraged to attend forums arranged by Training Programme Directors (TPD) e.g. IMT supervisor links into NHS Grampian TPD Internal Medical Trainee update sessions
- GP TPD links in with GPStR Educational Supervisors and is arranging up-date sessions for the hospital based clinical supervisors
- Educator Training is reviewed as part of the appraisal process – Role of trainer

NHS Shetland have been in contact with the Role of the Trainer NES team and in September they coming to Shetland to deliver:

Day one - Leadership in the Learning Environment (LitLE) Course 09.30 to 14.30
The Leadership in the Learning Environment Course is a one-day face-to-face course for Recognised/Approved medical trainers who have at least a year's experience in that role. The course picks up on some of key themes from the Trainer Workshop by highlighting the relationship between workplace culture, the quality of patient care provided and the delivery of effective training.

Day two - Performance Support Course 09.00 – 16.00
The Performance Support Course aims to increase the confidence of trainers in recognising and managing trainees requiring additional support. The course considers the multi-factorial influences on individual performance and conduct, the different roles of those directly involved in managing poor performance or allegations of misconduct and the management planning process

1.11 Describe the mechanisms in place to ensure all educators have appropriate time in their job plans to meet their educational requirements?

- The Director of Medical Education has 2 session allocated for the role
- Educators have allocation of 1 hour per week per trainee
- Each consultant is encouraged to keep an up to date job plan
- Education component of job plan is reviewed at appraisal

Any new educational activities are discussed at MEGG and allocation of time for teaching and training is discussed.

NHS Shetland is due to host increasing numbers of medical students in 2023 – in order to accommodate the increase there is now an ACT funded GP lead (on session per week alongside 10 hours per week admin support for the role).

A bid has just been submitted to ACT for 0.5 session Obstetrics and Gynecology teaching time as well as 0.5 paediatric consultant teaching time in order to host medical students in a child and family health block as part of new GP teaching modules.

1.12 What educational resources and funding can educator's access?

- Each consultant has a study leave budget
- Educational supervisors are encouraged to attend NHS Grampian Medical Education symposium
- Educational and clinical supervisors are encouraged to attend NES Medical Education programme
- Study leave support is available for potential educators to attend FDA approved Education Supervisor training

There is an ACT fund that staff can access to attend educational training/conferences related to medical student placements

It is worth noting that the provision of high-quality digital access to training/educational resources has improved since 2020 and this has been of benefit to remote and rural sites. This has resulted in easy of attending educational meetings and has cut the need to travel (which come out of the study leave budget). The only issue with attending digital teaching and training events is safeguarding time and not being pulled back into work related activities. The continuation of high-quality online training will benefit remote and rural boards.

1.13 Is support available to educators when they are dealing with concerns? Please provide full details.

There are robust mechanisms in place for Educators dealing with concerns:

- The Medical Education Governance Group (MEGG) is the ideal forum to raise general concerns with regards to the teaching and training environment.
- As the MEGG sits embedded in NHS Shetland's governance structure there are internal mechanism for escalation of concerns
- The DME sits on various external groups and is part of the DME network – this provides mechanisms to be sighted on developments or challenges that could face Local Education Provider and local educators
- Educational supervisors are part of a larger specialty network e.g. ES for internal medicine meets regularly with the TPD and other ES for IMT in Grampian – this is helpful for raising concerns for a particular curricular programme
- Regular contact with the TPD for Rural Tract GP programme – this gives an opportunity to discuss challenges and educator concerns
- The DME is a member of the Tutelage Group, University of Aberdeen – at each meeting a verbal or written report is provided on the educational environment in NHS Shetland

Course to be delivered by NES in September - **Performance Support Course**
The Performance Support Course aims to increase the confidence of trainers in recognising and managing trainees requiring additional support. The course considers the multi-factorial influences on individual performance and conduct, the different roles of those directly involved in managing poor performance or allegations of misconduct and the management planning process

1.14 How do you ensure there are sufficient opportunities for learners to undertake educational CPD?

- Medical Education Administrator publishes a weekly teaching timetable that outlines programme specific teaching as well as local teaching opportunities
- Trainees are encouraged to attend bleep free programme specific teaching
- There are opportunities to attend local teaching sessions e.g. surgical skills, scenario-based simulation teaching as well as lecture-based teaching
- In 2021, the rural general hospitals have set up a monthly "Grand Round". This provides an opportunity to network and discuss cases. Trainees are encouraged to attend and present.
- Monthly RCP Edinburgh evening medical update teaching
- ILS and local ALS courses
- Trainees attend programme specific Boot Camps – rural and surgical
- Prior to blocks in Shetland foundation doctors are given the opportunity to attend Rural Boot Camp
- Monthly journal club
- Trainees attend locally run Intermediate Paediatric Life support training – half day session per block

Pre- pandemic - in remote and rural areas the access and the quality of link to remote teaching used to be poor as the hosting sites often did not have the expertise to teach remotely and the platforms used such as VC links often did not work. Educators often did not have the expertise to keep remote learners engaged with the teaching sessions

Benefits of technology enhance learning for remote and rural sites:

- The use of TEAMs for linking into programme specific teaching is better than the VC link that required a bridge connection
- The interactive nature of TEAMs teaching with the use the chat function is helpful
- Host sites are better educated on the needs of remote learners

1.15 How do you ensure there is a balance between providing services and accessing educational and training opportunities?

The Medical Education Governance Group has the responsibility to ensure that there is a good balance between service provision and education and training opportunities:

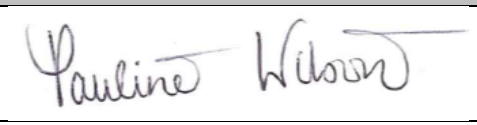
- The agenda at MEGG is split into operational, education and strategic discussions
- Thought is given to rota design in that rotas are individualised to reflect the programme specific educational requirements of the trainee:
    - Surgical trainees have built in rota opportunity to attend theatre

- IMTs have clinics built into their rota
- GPStR's GP Practice placements
- Foundation doctors are provided with taster days/sessions

- Junior doctor representation on the MEGG
- Junior doctor forum
- Care is taken to fill any unfilled post as we understand the knock - on effect this can have on the educational opportunities for trainees
- Regular monitoring of the rota is undertaken to ensure that it is working time compliant

All LAS and CDF doctors have an appraisal

2 Sign-off

Form completed by	Role	Signature	Date
Pauline Wilson	DME		08/06/2023

Scotland Deanery

Director of Medical Education Report

NHS Board	NHS Shetland			
Responsible Board Officer	Dr Kirsty Brightwell			
Director of Medical Education	Dr Pauline Wilson			
Reporting Period	**From**	3 August 2022	**To**	2 August 2023

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Alex McCulloch at alex.mcculloch@nhs.scot or 07908770914.

Please complete and return to alex.mcculloch@nhs.scot by **5.00 pm on the 8th of September 2023.**

1. Year in review: 2022-23

1.1 Please outline the main training achievements in your board in the last training year:

We have had another successful year with training in the Gilbert Bain Hospital. This is on a background of a number of challenges that faced us:

1. No FY1 for 8 months in medical unit (December 22 to August 23)
2. A late withdrawal from IMT3 - 6 months post starting in August 2023
3. Late notification that surgical CT1 in August was only 0.67 WTE – with no conversation about this beforehand in how it may impact on a rural board with two LTFT GP trainees.
4. Two LTFT GP trainees (0.67 and 0.8 WTE)
5. IMT GP trainee start in August who did not have skill set to undertake nightshifts – this put additional pressure on stretch system

In order to make the training experience good for the remainder of the trainees and ensure curriculum specific and working time compliant rotas NHS Shetland had to do a late recruitment round to fill gaps left by unfilled training posts and LTFT (0.93WTE unfunded gap).

Despite these challenges we are heartened to see that this did not impact on the trainees and that the training experienced was good; with some posts in the top 2 %. This is down to the dedication of the Medical Education Governance Group (MEGG) who work hard to ensure that teaching and training experience is reviewed alongside strategic decisions on staffing. The MEGG membership is made up of decision makers including Executive Board members – this allows for fast and efficient decision making.

Our Rural Tract GP training scheme continues to be a success with high quality trainees who are invested in staying in Shetland. In 22/23 we have developed a new hospital based placement – Women and Child Health. This has been well received by the trainees as well as the trainers. There have been challenges in identifying new GP trainers to replace those who are retiring - the MEGG is sighted on this and efforts are being made to recruit GP trainers to ensure that the GP Rural tract scheme continues – we have a number of GPs working in Shetland who have gone through this training scheme so we understand the importance of this continuing.

Our Medical Education Administrator was runner up in the May 2023 NES awards for support staff – Ms Cooper goes above and beyond welcoming new starts to Shetland:

- Welcome pack sent prior to arrival
- Useful contacts leaflet sent prior to arrival
- Well-coordinated induction day for all new starts

- Pastoral care
- Organisation of local teaching programme

1.2 Please highlight any sites where you have identified good practice	
Site	**Details about good practice**
Gilbert Bain Hospital Child and Women's health (Rural Tract GP)	Psychiatry block used to be part of the rural tract training programme but due to staffing changes we were unable to run this. In order to safe guard the Rural Tract GP training programme a new block was developed in collaboration with GP Training Programme Director. This has been well received by the trainee, trainers and departments.
Core Surgical Training	This new training post continues to be a success – with the rotas designed to ensure that the trainee and trainer have protected theatre and clinic time.
Internal Medical Training	Each trainee is able to attend protected clinics – we get good feedback from the trainees about this as it seems they struggle in other places to achieve this. We run MRCP teaching session for IMTs.
Medical Education Governance Group	This is a well-attended group with representation from: • Director of Medical Education - Chair • Trainers • Human Resources • Executive Management • Medical administration • Finance • Staff Development • Trainee rep • Nursing • General Practice

	The group focus on: 1. Workforce issues 2. Training 3. Strategic issues – future staffing models As decision makers are present it is an efficient group where immediate actions can be taken.
Working with Foundation Training director in the North	When we found that we had no FY1 on medical ward from December to August, Dr Joy Miller was very accommodating in agreeing to let a FY2 stay in Shetland for 4 extra months (trainee completed surgical and medical placements in Shetland). This is an excellent example of collaborative working where the whole system was reviewed and trainees placed where the need was greatest (trainee also offered to undertake medical placement in Shetland).

1.2 Please outline the main issues that your board has faced in the last training year:

See section 1.1 for context.

1. Late withdrawals such as the IMT 3 who had decided to undertake palliative care training.

2. Late notice of LTFT training – with no conversation about this and how it might impact on fragile R&R rotas. It would be good to have better dialogue and wider system understanding when these decisions are being made.

3. Rural areas continued to have to board fund around 50% of non-training grade junior doctor posts in order to ensure training is good for all and rotas work. The additional strains due to the 5 points mentioned in 1.1 above did put additional costs into the system as no back fill money is available – we would welcome a high level conversation about this.

1.4 Please outline any new issues that your board is likely to face in the coming training year(s)

There is an increasing difficulty in staffing R&R areas with full time substantive post holders. There are increasing numbers of hybrid senior post holders who do some time in R&R settings. This has created an issue of having enough local trainers. In September 2023 NHS Shetland is to hold a two day training event hosted by NHS Education for Scotland (NES) Role of the Trainer staff with an aim attract new trainers and support existing trainers.

A conversation has begun with NES about how we can provide Educational Supervision support differently in order to safe guard R&R training status.

1.5 Please identify any sites that should be considered for a visit	
Site	**Reason why a visit may be necessary**
Foundation Training expansion	In 2023, due to increased number of Foundation doctors NHS Shetland is to host a FY1 in surgical department. We have been in conversation with the Training programme Director and invited them to Shetland to review foundation training and see if we can continue to host an FY1 in surgical team.
Gilbert Bain Hospital	The team works hard to protect the Local Education Provider (LEP) status of the Gilbert Bain Hospital with many invested in making this happen successfully year after year. We would welcome an informal visit to review training and showcase the training opportunities on offer. It would provide an opportunity for a conversation on the challenges of R&R teaching and training and would be good way to work with NES on future proofing high quality education in R&R sites.

2 Postgraduate Medical Education: Quality Report

Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

No Aggregated data is available this year

- The information used to create the STS Triage lists is from Scotland only. The NTS triage lists are based on UK data.
- If criteria is met from any of the following lists (bottom 2%), they will be noted on the triage list; NTS All Trainee list, NTS Level of trainee list, STS All Trainee List, STS Level of trainee List and NTS Trainer Survey Data List. The criteria used for the triage list are: Number of red flags, significant change in scores, significantly low scores for Specialty, excess triple red flags, aggregated low scores for Specialty and number of aggregated red flags (if applicable).
- If criteria is met from any of the following lists, they will be noted on the High Performers list (top 2%); NTS All Trainee list, NTS Level of trainee list, STS All Trainee list, STS Level of trainee list and NTS Trainer survey data list. The Criterion for the High Performers list are: Triple green flags, significant change in scores, number of green flags, persistent high score, high scores for specialty

- A site can be on both the High Performers and Triage lists because of different scores for the different criterion being in the top or bottom 2%. Two departments with similar results can have different outcomes because of the 2% threshold, as they may be just either side of the threshold meaning one is on the main part of the DME report.
- Please note the number of trainees may not always tally due to the inclusion of programme trainees within the data. For example, Dermatology trainees in a post may actually be part of the Medicine Programme.

2.1 Departments in the bottom 2% for that Specialty

None

2.2 Departments in the top 2% for that Specialty

2.2.1 Site: Gilbert Bain Hospital - Z102H, General (internal) medicine

Identified by: STS Level High Performers list (persistent high scores) and STS All Trainee High Performers list (persistent high scores)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainee																			<3

Scottish Training Survey

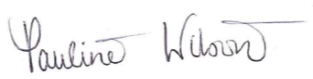
Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
All Trainees	W—		G	W	W—	W—	W—	W	W—	W	W	G	7
Foundation	W—		G	W	W—	W—	W—	W	W—	W	W	G	5
GPST													2
GPST	L—				W	W	W—		P—				(5 aggregated)

GMC Trainer Survey

Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
General (internal) medicine										100%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?
Good practice: 1. Trainee forum with trainee representation in Medical Education Governance Group 2. Curriculum specific rotas, which are working time compliant 3. Protected teaching times 4. Pastoral care provision for trainees 5. True team work – where junior doctors feel part of the wider NHS Shetland team 6. Pizza evenings and outdoor team events – boat trips and hikes 7. Encouragement of trainees to present at regional meetings 8. MRCP teaching and preparation

3 Sign-off

Form completed by	Role	Signature	Date
Pauline Wilson	Consultant Physician/ Director of Medical Education/ Associate Medical Director (Acute)		20/07/2023

Appendix 1. NTS Data for departments not on Triage/High Performers lists

Site	Programme Group	Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
Gilbert Bain Hospital - Z102H	Cardiology	All Trainee																			<3
Gilbert Bain Hospital - Z102H	General surgery	All Trainee																			<3
Gilbert Bain Hospital - Z102H	GP Prog - Obstetrics and Gynaecology	GPST																			<3
Gilbert Bain Hospital - Z102H	Internal Medicine Training Stage One	IMT																			<3
Gilbert Bain Hospital - Z102H	Medicine F2	F2																			<3
Gilbert Bain Hospital - Z102H	Obstetrics and gynaecology	All Trainee																			<3
Gilbert Bain Hospital - Z102H	Surgery F2	F2																			<3
Lerwick Health Centre - 39091	General Practice	All Trainee																			<3

Appendix 2. NTS Trainer Data for departments not on Triage/High Performers lists

Site	Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
Gilbert Bain Hospital - Z102H	Emergency medicine										50%
Gilbert Bain Hospital - Z102H	General surgery										33%

Appendix 3. STS Data for departments not on Triage/High Performers lists

Site	Specialty	Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
Gilbert Bain Hospital	General Surgery	All Trainees	W—		W	W	W—	G—	W—	W	W—	W	W	G	6
Gilbert Bain Hospital	General Surgery	Core													2
Gilbert Bain Hospital	General Surgery	Core	W—				W	W	W—		W—				(6 aggregated)
Gilbert Bain Hospital	General Surgery	Foundation	W		W	G	W	G	W	W	W	W	W	L	3
Gilbert Bain Hospital	General Surgery	GPST													1

Site	Specialty	Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
Gilbert Bain Hospital	General Surgery	GPST	W				W	W	W		W				(3 aggregated)
Gilbert Bain Hospital	Geriatric Medicine	All Trainees													2
Gilbert Bain Hospital	Geriatric Medicine	All Trainees													(2 aggregated)
Gilbert Bain Hospital	Geriatric Medicine	IMT													2
Gilbert Bain Hospital	Geriatric Medicine	IMT													(2 aggregated)
Gilbert Bain Hospital	Obstetrics and Gynaecology	All Trainees													1
Gilbert Bain Hospital	Obstetrics and Gynaecology	All Trainees													(1 aggregated)
Gilbert Bain Hospital	Obstetrics and Gynaecology	GPST													1
Gilbert Bain Hospital	Obstetrics and Gynaecology	GPST													(1 aggregated)
Gilbert Bain Hospital	Paediatrics	All Trainees													1
Gilbert Bain Hospital	Paediatrics	All Trainees													(1 aggregated)
Gilbert Bain Hospital	Paediatrics	GPST													1
Gilbert Bain Hospital	Paediatrics	GPST													(1 aggregated)
Lerwick Health Centre	General Practice	All Trainees													1
Lerwick Health Centre	General Practice	All Trainees	W—				W	W	W—		W—				(6 aggregated)
Lerwick Health Centre	General Practice	GPST													1
Lerwick Health Centre	General Practice	GPST	W—				W	W	W—		W—				(6 aggregated)

NHS Shetland Annual Duty of Candour Report 2022/2023

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the Duty of Candour is implemented in our services. This short report describes how NHS Shetland has operated the Duty of Candour during the time between 1 April 2022 and 31 March 2023.

1. About NHS Shetland

NHS Shetland is responsible for healthcare for a population of around 23,000. Local Hospital Services are provided from the Gilbert Bain Hospital. In addition, visiting consultants from NHS Grampian provide out-patient clinics as well as in-patient and day-case surgery to complement the service provided by our locally-based Consultants in General Medicine, General Surgery, Anaesthetics, Paediatrics and Psychiatry. Community Health, Health Improvement and Social Care services are delivered from a network of locations, including health centres, resource centres, care centres, community centres and in people's own homes.

Shetland's Health and Care Vision:
Our Vision is that by 2025 everyone is supported in their community to live longer, healthier lives and we will have reduced health inequalities.

2. How many incidents happened to which the Duty of Candour applies?

Between 1 April 2022 and 31 March 2023, there have been 4 incidents where the Duty of Candour applied. A total of 106 adverse events/complaints have been considered for the Duty of Candour process with 102 of them not requiring the Duty of Candour process to be followed and four were considered to be Duty of Candour.

These events include a wider range of outcomes than those defined in the Duty of Candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2022 and 31 March 2023)**
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A person's treatment increased	2
The structure of a person's body changed	1
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
TOTAL	**4**

To what extent did NHS Shetland carry out the Duty of Candour procedure?

The following table sets out a summary of the 4 cases subject to Duty of Candour requirements over the last year. This includes timescales for the process and learning / changes in practice as a result of the individual events:

Datix ID	Incident Date	Date Reported	DoC Triggered	Apology Issued/ Patient Involved	Theme	Learning / Actions
8351	08/9/21	17/11/21	11/05/22	17/05/2022 Meeting held 09/06/2022	Management of Patient - an increase in their treatment	Changes to Protocol for clinical management, address communication issues
8569	06/03/22	22/3/22	05/4/22	27/4/22 No active involvement wanted	Inappropriate treatment, permanent disability either physical or psychological	Communication issues and HR process
8741	24/06/22	06/07/22	13/09/22	13/09/22 Meeting held 28/9/22	Delay in action from lab results. Increase in their treatment	Improvement to processes
8763	19/07/22	19/07/22	24/11/22	01/12/22 Meeting Held 06/03/23	Failure to follow up Changes to the structure of their body	New processes for waiting list reviews

The full Duty of Candour Annual Report for 2022/2023 is attached as Appendix 1.

3. Information about our policies and procedures

What processes are in place to identify and report unexpected or unintended incidents that may require activation of the Duty of Candour procedure?

Every adverse event is reported through our local reporting system as set out in our Learning from Adverse Events through Reporting and Review Policy and Procedures.

These are based on the Health Improvement Scotland (HIS) national adverse event management framework. We continued to report monthly to HIS in line with the timescales set out for the national notification system.

The Medical Director, Chief Nurse (Corporate) and clinical governance and risk team undertake a weekly review of the incidents to identify any with a potential for the application of the Duty of Candour process. Consideration for applying the process is then assessed using the Duty of Candour checklist to aid decision making.

We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify Organisational Duty of Candour incidents.

What criteria do you use to assess whether the Duty of Candour procedure should be activated?

Through our adverse event management process and complaints we can identify incidents that trigger the Duty of Candour procedure. We use the Scottish Government organisational Duty of Candour guidance for implementation of the procedure. The Duty of Candour process map which includes a link to the guidance, the Duty of Candour outcomes (definitions), the apology factsheet and our Duty of Candour trigger checklist are all available on the Duty of Candour intranet page. There is also a section of useful tools and resources for staff.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity (using the NHS Scotland risk assessment matrix) of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review, and local management teams develop improvement plans to meet these recommendations. The learning summary template we use from HIS has been added onto the Datix Reporting System to enable the learning to be shared more easily both within the Board and externally.

The monthly guidance and learning bulletin has been revised in the last 12 months in order to better clarify the status of various guidance within NHS Scotland, and to enable us to provide more targeted advice to specific disciplines or areas of service. The bulletin provides a mechanism by which evidence based information and

learning from national sources, such as Scottish Public Services Ombudsman (SPSO), Adverse Events Network, national guidance e.g. SIGN, NICE and local learning from adverse events and other sources such as complaints and quality improvement is brought together into one central location, accessible to all staff via a web page on the Board's Intranet site.

During 2022/2023 to increase organisational learning from adverse events we have used the monthly Corporate Newsletter to highlight key messages /learning which have arisen as a result of reported adverse events.

What support is available to staff who are involved in unintended or unexpected incidents resulting or could result in harm or death?

All staff receive training on adverse event management and implementation of the Duty of Candour Act as part of their induction. This was extended to locums with an e-learning module on clinical governance and risk management which is also being completed by the wider staff groups. Awareness sessions and 1-1 sessions have been delivered to staff and teams. The Duty of Candour e-learning module for staff to complete is a module in our e-learning system, TURAS. We do not routinely monitor the figures as it is a national module. Any member of staff who is involved in the Duty of Candour process is fully supported and the Clinical Governance and Risk Team highlight the requirements to them. We have noticed an increase in awareness from senior managers regarding the Duty of Candour process.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational health and resources are available on our intranet. We have also got in place a Trauma Risk Management (TRiM) team who provide a TRiM risk assessment for any staff who have been involved in a potentially traumatic incident at work.

They also follow up with individuals who have experienced a traumatic event, identifying and suggesting further psychological support as necessary.

Over the last year we have also explored the feasibility of introducing Schwartz Rounds which are a supportive environment in which staff from all professional

backgrounds can explore social and emotional aspects of care. Unfortunately due to the other pressures in the workforce this has not been able to be progressed. However, a programme of ‘spaces for listening’ has been introduced, led by the Medical Director, and this has enabled staff to come together, better understand each other as individuals and the pressures each are facing, offering support to each other where needed. The effectiveness of this is currently being evaluated.

What support is available to relevant persons who are affected by unintended or unexpected incidents resulting or could result in harm or death?

Staff are open and transparent with patients and family when things go wrong. A lead clinician is identified to provide support to the family and can refer to the relevant services accordingly. The Medical Director is the Executive Lead and acts as the main point of contact for an incident where Duty of Candour is being considered. At the end of the process, the Medical Director provides written confirmation of the outcome of the process to the relevant persons.

What changes, learning and/or improvements to services and patient outcomes can you identify as a result of activating the Duty of Candour procedure and the required reviews that have taken place?

An overview of the learning and improvement to services is set out in Section 2 of the report.

What improvements/ changes, if any, have been made to the approach to considering and implementing the Duty of Candour process itself, as a result of activating the procedure?

No changes have been made in the last 12 months to how we implement the Duty of Candour process. We have, however, built a comprehensive Duty of Candour section into our Adverse Events reporting form which enables key information to be recorded in relation to the event and the Duty of Candour process, thus supporting accurate documentation of the process followed, as well as providing monitoring data.

4. Covid-19 Pandemic

Setting the context

What processes were put in place to manage the impact of Covid-19 when activating the Duty of Candour procedure?

The processes we have described above continued to remain in place throughout the pandemic.

Did the timeframe in which it took to review cases increase due to the ongoing pressures of dealing with Covid-19? If so, by how much?

The timeframe was not impacted by Covid-19.

How many or what percentage of the times when the Duty of Candour procedure was activated this year have been directly attributable to Covid-19?

There were no Duty of Candour events when the procedure was activated over this last year which have been directly attributable to Covid-19.

Practical Actions Taken

How has involving the relevant person been impacted by Covid-19? For example, involving relevant persons in review meetings and continuing communication.

The involvement of the relevant persons has not been impacted by Covid-19.

In light of the Covid-19 pandemic, what adjustments have you made to continue to involve relevant persons as required by the Duty of Candour procedure?

There have not been any adjustments made as we have continued with the processes as outlined above.

The Duty of Candour procedure provisions reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. In light of this and the Covid-19 pandemic, how did you ensure a person centred approach was maintained when the decision was made to activate the Duty of Candour procedure?

Throughout the Covid-19 pandemic we continued with the processes as outlined above in progressing Duty of Candour cases. The only changes to the process

related to offering people a choice of communication methods eg by letter, email, video or face to face adhering to the Infection, Prevention and Control guidance in place at the time. We have continued to offer communication via this range of methods, adopting the method which suits the individual/family best thus ensuring that we are as person centred as possible in our approach to Duty of Candour issues.

Learning for the future

Responding to the Covid-19 pandemic will have meant changes to NHS Shetland's policies and processes, including activating the Duty of Candour procedure for unintended or unexpected incidents resulting or could result in harm or death.

Duty of Candour Procedure

- **What changes, if any, to the way you consider and implement the Duty of Candour procedure will you continue with as the Covid-19 pandemic continues?**

We will continue to offer people a choice of meeting format as detailed above.

- **What difficulties have you encountered when reviewing unintended or unexpected incidents due to Covid-19? What learning can be taken away from these particular difficulties?**

We have not had any incidents due to Covid-19.

Provision of Healthcare Services

- **Has there been specific learning from activating the Duty of Candour procedure to unintended or unexpected incidents which have resulted in or could have resulted in harm and death which are directly linked to the Covid-19 response? If so, what has this learning been?**

There were no Duty of Candour events relating to Covid-19 so this is not applicable.

What other learning have you been able to identify as a result of applying the Duty of Candour procedure?

We have no other learning for sharing identified at this time.

5. Additional information

Please provide any further information you think might be important or relevant. For example, ways in which discussion, decision-making and reviews linked with the Duty of Candour procedure have supported continuous improvements in delivering safe, effective and person-centred care?

We also continue to have a very thorough, team-centred approach to clinical pathway changes which also helps reduce risk in change.

This is the fifth year of the Duty of Candour requirements being in operation and we continue to learn and refine our existing adverse event management processes to support implementation of the Duty of Candour outcomes.
There is a national review of the Duty of Candour guidance currently taking place, the Chief Nurse (Corporate) and Clinical Governance and Risk Team are participating in this review. Any changes required as a result of the outcome of the review will be implemented in local practice as appropriate.

As required, we will submit this report to Scottish Ministers and published it on the NHS Board website.

If you would like more information, please contact our Clinical Governance and Risk Team in NHS Shetland.