Agenda Item:
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Meeting:	Shetland NHS Board
Date:	17 August 2021
Report Title:	Medical Director Annual Report 2020 (including Duty of Candour Annual Report 20/21)
Reference Number:	Board Paper 2021/22/28
Author / Job Title:	Kirsty Brightwell, Medical Director

Decisions / Action required:

The Board is asked to note the contents of this annual report.

High Level Summary:

This report highlights:

1. Medical leadership cadre within NHS Shetland Board.
2. The workforce challenges across Primary care within the Board including an update on GP training.
3. General Practitioner with Special Interests (GPWSI's)
4. The Acute services medical workforce in NHS Shetland and the challenges therein.
5. Evolution of Quality Assurance of healthcare
6. Improvements to processes within Risk Management across NHS Shetland including the planned new Risk Management Strategy.
7. The NHS Shetland Duty of Candour (DoC) Annual Report
8. Education and Training
9. Appraisal and Revalidation
10. Project Management Office 1 year trial
11. Clinical Strategy
12. Covid19 Pandemic impact

Corporate Priorities and Strategic Aims:

To create the right conditions for front-line staff to deliver safe and effective service, ensuring high quality care is provided by skilled workforce that is appropriate for remote & rural settings in Shetland.

Key Issues:
Noting • Changes in medical workforce • Challenges in recruitment and retention • Ongoing work to improve quality assurance and risk management process • Commitment of the workforce through the Pandemic

Implications : *Identify any issues or aspects of the report that have implications under the following headings*	
Service Users, Patients and Communities:	*Maintaining high quality and safe care across the specialties for Shetland communities*
Human Resources and Organisational Development:	*Enhancing individual and organisation resilience particularly during the response phase of the Covid-19 response phase.*
Equality, Diversity and Human Rights:	*N/A*
Partnership Working	*Developing capabilities within the teams to work in collaboration & across organisational boundaries*
Legal:	*Ensure compliance with NHS Shetland statutory obligation.*
Finance:	*This report outlines a reduction in locum cost and outlines future potential savings due to changes in workforce modelling*
Assets and Property:	*NA*
Environmental:	*NA*
Risk Management:	*The report highlights changes to the risk management process during the management of the Covid-19 pandemic response phase.*

Policy and Delegated Authority:	*NA*	
Previously considered by:		

"Exempt / private" item	

The main report is to be attached together with a list of the appendices and references to any background documents or material e.g. include web links.

Appendix A – NHS Shetland Annual Duty of Candour report

Medical Director's Annual Report 2020-2021

(including NHS Shetland Annual Duty of Candour Report 2020/21 AND Annual Director of Medical Education Report 2020/21)

Foreword

Since the Medical Director's Annual Report in 2020, Dr Kirsty Brightwell was appointed as substantive Medical Director and joined the Board on 6th July 2020. Therefore this Medical Director's Report will cover the period from 6 July 2020 till April 2021.

Medical Leadership

There has been further development of the Medical Directorate during this reporting period with the appointment of a Substantive Associate Medical Director (AMD) in the acute sector in Dr Pauline Wilson.

Dr Dylan Murphy intimated his intention to resign from the Associate Medical Director (AMD) Primary Care post after several years in post and we thank him for his contributions. Dylan has been instrumental in establishing the GP Cluster Group and establishing the AMD post as pivotal for integrated working establishing supportive relationships between management and clinicians as well as clinician to clinician. There is a plan to appoint an interim AMD.

Dr Pauline Wilson has been formally appointed as Director of Medical Education (DME) and has been well engaged in a Regional and National basis to ensure that the training needs of NHS Shetland are represented appropriately. She has also been working with NHS Education for Scotland (NES) as Associate Postgraduate Dean on the Credentialing of the Remote and Rural Practitioner as commissioned by the General Medical Council (GMC).

Workforce - Primary Care

There have been resignations in Unst, Yell and Bixter practices. Brae Practice has had long term vacancies but since January been stabilized by the appointment of a long term locum and the commitment of the Primary Care Pharmacist in undertaking a review and some improvement work in long term conditions management to get people through reviews that had been postponed due to COVID.

The Re-discover the Joy of General Practice project has remained a successful mode of supporting GPs to safely work in remote and rural areas like Shetland without the barrier of committing to a substantive post and by providing additional support and training. The project involves NHS Shetland, Orkney, Western Isles and Highland with support from the Scottish Rural Medicine Collaborative (SRMC). These are high quality GPs who are looking to be more than locums and see themselves as part of the substantive workforce in a practice albeit for short periods of time.

Unst practice has gone to recruitment based on the success of the Rediscover the Joy project in supporting GPs to work in a rotational model with 4 GPs working blocks of 3 weeks. This is providing continuity of high quality care in Whalsay already and this will be replicated in Unst. Bixter practice was advertised but currently there have been no applicants.

Lerwick Health Centre is the largest practice, as well as being a GP training practice and site for new models of care such as First Contact Physiotherapist, Advanced Nursing Practitioners and closer working with Mental Health colleagues. Levenwick Practice is also a GP training practice but has recently had to suspend its training due to staff illness.

Lerwick Practice supported 4 trainees in the past year but has had a GP resignation and is struggling for clinical space for their clinicians. There is a recognition that following the cessation of routine long term conditions management, there is a backlog of work in Primary Care in order to meet the needs of those with chronic disease. The newly appointed PMO will support the Primary Care team to realise the intentions behind the Primary Care Improvement Plans as well as the aspirations set out in the Clinical Strategy.

L Health Centre (LHC) have also supported a GP returner (a GP who has been out of NHS practice for more than 2 years) who is on course to join the substantive workforce.

GPs employed to work in the outer isles have formed a supportive team who meet weekly to discuss clinical cases and clinical improvements in an effort to reduce professional isolation and improve retention as well as clinical governance.

The GP Cluster and GP Sub-Committee have started to meet regularly providing the potential to work collaboratively to improve services.

General Practitioner with Special Interests (GPWSI's)
The GPwSI in Paediatrics has now resigned. The GPwSI in Rheumatology is unable to support that work. The GPwSI in Dermatology has left the island and the GPwSI in Occupational Health remains on secondment to Occupational Health leaving a gap in Primary Care.

The current Interim Chief Officer continues to work as a dentist with special interest in Oral Maxillo-Facial Surgery (OMFS) and has acted as a link between the Grampian OMFS team and the patient base in Shetland. This has resulted in local clinics running in conjunction with the Grampian Team especially for review of suspected cancer cases negating travel to the mainland for patients. There has also been a monthly theatre list to help with the flow for oral surgery patients.

Workforce - Secondary Care
Consultants - NHS Shetland Consultant medical staffing establishment is set as follows:
Consultant Physician - 4.0 Whole Time Equivalent (WTE);
Consultant Anesthetist - 4.0 WTE;
Consultant General Surgeon - 3.0 WTE (plus 0.75WTE additional locum support for periods of leave);
Consultant Psychiatrist- 2.0 WTE
Consultant Paediatrician (Community) – 0.6 WTE
Locum Consultant Microbiologist – 0.5 WTE
Consultant Public Health – 1 WTE

Middle Grade doctors - NHS Shetland has one permanent full time surgical middle grade doctor. Middle grade doctors support the work of the consultants and work closely with junior doctors to ensure safe delivery of care. They contribute to service improvement, clinical audit and undertake in-service training aligned to the needs of the service. This individual is also the Lead Clinician for the Regional Trauma Network.

Medical Director's Annual Report 2020-2021
(including NHS Shetland Annual Duty of Candour Report 2020/21 AND Annual Director of Medical Education Report 2020/21)

Junior Doctors
These are doctors in training (employed by NHS Education for Scotland) as well as Locum Appointments for Service (LAS) posts who are directly employed by the organisation. NHS Shetland Board currently has an establishment of posts ranging from FY1 to GPSTs. They provide cover to the hospital wards and A&E.
To maintain a safe and compliant Junior Doctor rota, NHS Shetland also recruits to LAS posts which are not recognised for training; NHS Shetland operates a compliant junior doctor rota.
NHS Shetland has developed Clinical Development Fellow (CDF) posts in conjunction with the University of Aberdeen. These posts are non-training and have a 12 hour per week allocation to a developmental project. Post holders are given an honorary clinical lectureship with the University.
NHS Shetland Board currently has two CDF posts.
During the Covid-19 pandemic recovery phase, the complement of junior doctors has remained at 16 to sustain patent pathways during potential surge periods in activity, as well as to provide workforce resilience. During recovery, review of junior doctor posts via the Medical Education Governance Group (MEGG) has concluded that the complement of junior doctors moving forward will decrease with the assumption of an Advanced Nurse Practitioner into the junior doctor rota. This was been put on hold whilst the Board remained in emergency measures.

Recent changes in medical workforce
During this reporting period, there has been a continued reliance on locums to provide safe and quality care within NHS Shetland. Whilst it is acknowledged that there are associated cost implications using such a model, the individuals engaged by the Board have been long term engagements which have ensured that services provided have remain safe, especially during the pandemic period.

General Medicine
There has been a successful appointment of a Consultant in Elderly Medicine who has increased the diversity of skills and knowledge in the team. They are liaising with community teams to support people to safely stay at home or in homely settings.

The rotational model is being tested in the area of General Medicine with the appointment of another Emergency Medicine Consultant to join the one appointed last year. This has allowed development of the Same Day Emergency Clinic and a Direct Access service for stroke and transient ischaemic attacks.

An anaesthetic 6 month fellowship commenced in August 2020 for a 6 month period. It evaluated positively and opens the possibility for further appointments and opportunities for junior doctors to experience working in Shetland which is one of the ways of attracting a future workforce.

Quality Assurance
NHS Shetland has a Clinical Care and Professional Governance framework in place which provides assurance to both to the Integration Joint Board (IJB), the Council and the Health Board. The assurances provided reflect that governance processes for health and care are in place and that services provided are within the standards agreed within the Governance frameworks and Directions issued by the IJB. The Medical Director is one of the professional lead officers responsible for ensuring that lines of professional accountability are explicit, that staff are

supported to practice safely and professionally, and that there are systems to provide clinical and professional assurance to the Health Board, IJB, Council and Scottish Government.

The Clinical Care and Professional Governance Committee (CCPGC) is a statutory committee which provides assurance that appropriate Clinical Governance mechanisms are in place and effective throughout the organisation. The Medical Director is the executive lead for CCPGC. The Joint Governance Group (JGG) is a group of operational professional and service leads who oversee and support the implementation of Clinical and Care Professional Governance. It is at this meeting that the Director of Medical Education provides feedback from the Medical Education Governance Group and JGG are sighted of the Minutes of this group. Work has been done within the Joint Governance Group to ensure that the assurance provided is across both Health and Care specialties, and that the assurance provided reflects the professional and operational work being undertaken across this spectrum.

COVID measures have meant that the CCPCG was stood down and review of the governance framework has shown that the structure needs review and preliminary work has been progressing to create a more streamlined and obvious thread for clinical governance of NHS and Shetland Island Council (SIC) services whilst remaining cognisant of the IJB strategic role.

Review of the JGG terms of reference as well as agenda items has been to try and support a more holistic approach to health and care assurance. The group provides an important role in understanding the roles and responsibilities in the integrated working as well as the opportunity to have a deeper dive into the governance of joint services.

The Sudden Death Group reviews all drug related and suicide deaths. There has been an expectation that all sudden deaths involving alcohol be included and that this should expand to include all deaths where alcohol was a factor. Simultaneously a National review of child deaths has delivered an ask of the Boards to lead on child death reviews to systematically collect learning and contribute to a national drive at reducing preventable child deaths. The Sudden Death Groups TOR are to be reviewed to encompass this work.

There is a recognition post-COVID that people have changed the way that they work including governance processes. The Clinical Governance team have worked hard to support clinicians to maintain standards whilst flexing to work differently. They have created a regular bulletin to keep clinicians up to date and share local learning to encourage teams to review regularly and create a framework of support to embed clinical governance more firmly.

Risk

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 Medical Director is the Chair of this Group. It 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

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The Risk Management Group has not met this year due to the need to concentrate resources on the Pandemic response and await the outcome of the promised Scottish Government's Agile Governance paper. Executive Management Team (EMT) has reviewed all corporate risks. Many have been closed with some new COVID-related risks added. Following review several risks have been closed or delegated to directorate/departmental level.

Work has continued on addressing the recommendations from the internal audit report with a number completed and the rest nearing completion. A Risk Management Strategy will shortly be provided to the Board with recommendations for management of risk in NHS Shetland to better understand the context of service delivery and further improve patient and staff experience.

Duty of Candour (DoC)

The Medical Director is the organisational lead for the DoC which came into effect from 1st April 2018 and has responsibility for making the decision to activate the DoC procedure within NHS Shetland.

Between 1 April 2020 and 31 March 2021, there have been no incidents where duty of candour was applied. The Medical Director undertakes 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 trigger checklist to aid decision making.

From April 2020 until the end of March 2021, a total of 35 adverse events/complaints have been considered for the duty of candour process. 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.

The Medical Director Annual Duty of Candour report is attached Annex A.

Education & Training

NHS Shetland continues to facilitate both undergraduate and postgraduate training. Undergraduate students mainly come from Aberdeen Medical School with smaller cohorts from St Andrews University and few elective students from medical schools all over the world. Trainee feedback during this academic year has again been consistently high and the Director of Medical Education (Dr Pauline Wilson) has been instrumental in liaising with external agencies to ensure good governance of all training pathways

In last year's ACT (Additional Cost of Teaching) bid, more money was allocated for undergraduate medical administration. NHS Shetland also committed funding for postgraduate administration hours. In January 2020, NHS Shetland successfully recruited a Medical Education Administrator. This is a very important role and the post holder is responsible for the main bulk of support functions for trainee doctors including induction, facilitation of local teaching programmes, rota management and oversight of alignment to working time directives.

During this year, NHS Shetland's newly established onsite Education Centre within the Gilbert Bain Hospital has continued to be re-purposed for "clean green elective surgical patients", therefore the Clinical Education Team have adapted and set up a dedicated teaching room off site.

NHS Shetland has continued to support the Rural Boot Camp for foundation doctors. There is a focus on non-technical skills as well as technical skills across multiple systems and specialties. There are simulated sessions demonstrating the management of acute scenarios, including myocardial infarction and trauma. The synopsis of attendees is that the course is a good preparative enabler to working in a remote and rural environment.

The DME report is included within the Medical Director report as Annex B.

Appraisal & Revalidation
All doctors are required by the GMC to undertake an annual appraisal, leading to revalidation of the doctors' license to practice every 5 years.

Appraisals recommenced on 1 October 2020. Four doctors with a prescribed connection to NHS Shetland Board were identified by the GMC for revalidation up till 31 March 2021 and all have been recommended for Revalidation.

The Medical Director has been working closely with the Appraisal Lead to establish processes for Appraisal and Revalidation locally. There are around 60 doctors with a prescribed connection to NHS Shetland with 4 doctors due for revalidation by 1 April 2021. There has been a relaxing of the rules on Appraisers approved by NHS England working in Scotland and this has seen an increase in the number of Appraisers working in Shetland to 6 doctors. There is work progressing with the NHS Orkney Appraisal team to create collaborative working to increase the pool of appraisers creating more triangulation and choice.

The Medical Director is working with the team to support opportunities to support the quality of the appraisal process through CPD opportunities for the Appraisers and more peer support.

Project Management Office
EMT approved the appointment of a PMO function as a 1 year trial. The purpose was to consider what is required in the short to medium term in order to meet the needs of the Shetland population. The PMO was appointed within the Planning function of Public Health but the Medical Director was appointed as the Executive lead. Recruitment was successful and the Program Manager, Project Support Officer and Admin support started work in January 2021. The PSO post became vacant rather quickly when this individual got a job with SIC.

The PMO have worked with a great number of individual staff and teams to understand the experience of the organisation and what is required and the type of projects required to realise the change needed to make NHS Shetland sustainable.
The PMO has now started to work specifically with Primary Care and Mental Health and will shortly undertake further scoping work around Digital and Workforce to clarify what is required. Part of the evaluation of the work is to understand what capacity should continue beyond the year.

Clinical Strategy
During 2020/21 the Medical and Nursing Directors have led on the production of a Clinical Strategy in order to communicate how NHS Shetland needs to work for the next 10 years. Working with the

Digital Health Innovation Hub from Strathclyde University and Glasgow School of Art, there were various forms of engagement. A public questionnaire was developed and distributed via Facebook, local shops and press; there were individual semi-structured interviews with key staff; there was a series of workshops with public representatives, third sector, community groups, staff and invited guests and a series of clinical groups did further deep dives into services. The report will be finalised shortly and will provide an insight into how we should be working in order to deliver effective health care in the future.

Covid -19 Pandemic

The pandemic continued to restrict services in the last year but also created opportunities for teams to work together more routinely. As the lockdown eased, the possibility of undertaking elective procedures in the Gilbert Bain Hospital had to be balanced with the need to maintain the ability to flex where patients required more intensive respiratory therapy. At the same time new ways of working with red, amber and green pathways continued to demand reconfiguration of teams and wards. It is to the credit of the clinicians, admin support, estates and IT that the hospital remained fit for purpose during the pandemic.

The workforce continued to have to flex where there was a concern about spread within a ward team as well as the demands of the vaccination program. The teams continued to meet regularly at the fortnightly Clinical Pathways meeting which has fed so well into the Clinical Strategy report.

I would like to acknowledge the hard work and efforts of those working within the health, care and support teams during these unprecedented times. In synopsis, their contribution has been awe-inspiring and it has been a privilege to have worked with the individual teams during the pandemic.

Kirsty Brightwell
Medical Director, NHS Shetland
June 2021

Medical Director's Annual Report 2020-2021
(including NHS Shetland Annual Duty of Candour Report 2020/21 AND Annual Director of Medical Education Report 2020/21)

APPENDIX 1

NHS Shetland Annual Duty of Candour Report 2020/2021

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 2020 and 31 March 2021.

1. About NHS Shetland

NHS Shetland is responsible for health care for a population of around 23,000. Local Hospital and Community 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 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 2020 and 31 March 2021, there have not been any incidents where the duty of candour applied. A total of 35 adverse events/complaints have been considered for the duty of candour process with 35 of them not requiring the duty of candour process to be followed and one was 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 2020 and 31 March 2021)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
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	**0**

As there were no incidents where the duty of candour applied and there were none outstanding from 2019/20, the procedure did not need to be followed.

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 Procedure. These are based on the Health Improvement Scotland (HIS) national adverse event management framework. Our procedure was reviewed and updated in line with the 3 year review date with minor changes made. During 2020/21 we embedded the monthly reporting to HIS in line with the timescales set out for the new national notification system.

The Medical Director undertakes 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 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 was developed and includes a link to the guidance, the duty of candour outcomes (definitions), the apology factsheet and our duty of candour trigger checklist. There is also the duty of candour intranet page which includes these documents and 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. A review and update of the Lessons Learnt template has been undertaken to enable the learning outcomes from a range of sources to be captured more easily.

The Medical Director undertook a review of a sample of lessons learnt from adverse events. The relevant managers were contacted and asked to report on progress of any improvements, if the learning could be shared and any comments on the adverse event process etc. The responses received were collated and lessons learned and preventative actions shared within the departments and services affected.

A monthly learning bulletin has been produced and shared bringing information into one location via a web page including learning from national sources: SPSO, adverse events network which includes from other Boards; national guidance e.g. SIGN, NICE and local learning from adverse events and other sources such as complaints, quality improvement.

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 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. We also delivered a session for managers on investigations skills as part of the management bundles. The duty of candour e-learning module for staff to complete is a mandatory module in our e-learning system and we report the numbers completing the module in our adverse event quarterly report. 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.

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 would refer to the relevant services accordingly. The Medical Director is the Executive Lead and provides a written confirmation 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?
There have not been any changes made as there have not been any duty of candour events. We have continued to review and update how we include the consideration of duty of candour criteria on the Datix Reporting System.

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?
We have continued to review and update how we include the consideration of duty of candour criteria on the Datix Reporting System.

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 during the pandemic. Although the work was done differently during the early part of the pandemic the function continued. The volume of adverse events fell due to the reduction of patient numbers again at the beginning of the pandemic. This then increased and returned to the normal processes.

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 as there were no duty of candour events.

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 so this is not applicable.

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.
There were no duty of candour events so this is not applicable.

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 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?
There were no duty of candour events so this is not applicable.

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 offer people a choice of meeting format which will now include near me.

- **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 had incidents where family members have felt due to the visiting restrictions they have been less involved in each stage. We have noticed an increase in complaints and adverse events about communication during in-patient stays and the discharge process. These however have not triggered the duty of candour. There is an action plan in place based on the learning.

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 so this is not applicable.

What other learning have you been able to identify as a result of applying the duty of candour procedure?
There were no duty of candour events so this is not applicable.

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?

COVID-19 has meant that we have had a lower through-put of patients and therefore this may have made the duty of candour less likely.

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

This is the third year of the duty of candour 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.

As required, we have submitted this report to Scottish Ministers and we have also placed our website.

If you would like more information about, please contact our Corporate Services Team in NHS Shetland.

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**	5 August 2020	**To**	3 August 2021

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Jill Murray at jill.murray@nhs.scot or 07769 367613.

Please complete and return to jill.murray@nhs.scot by **5pm Monday 7 June 2021.**

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?**
  The minutes and action tracker from the Medical Education Governance group go to the Joint 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. The DME report is included in the annual report to NHS Shetland's Board.

- **Is there a board member with responsibility for MET?**
  The chair of the Clinical and Professional Governance Committee 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

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

- **What data and information is considered by this committee?** MEGG considers operational and educational issues
  Operational issues:
  - Vacant posts and rota gaps
  - Planning for gaps in staffing
  - Rota's
  - Induction
  - Monitoring of hours

- ACT funding
- Equality, diversity, and inclusivity is a standing item on the agenda

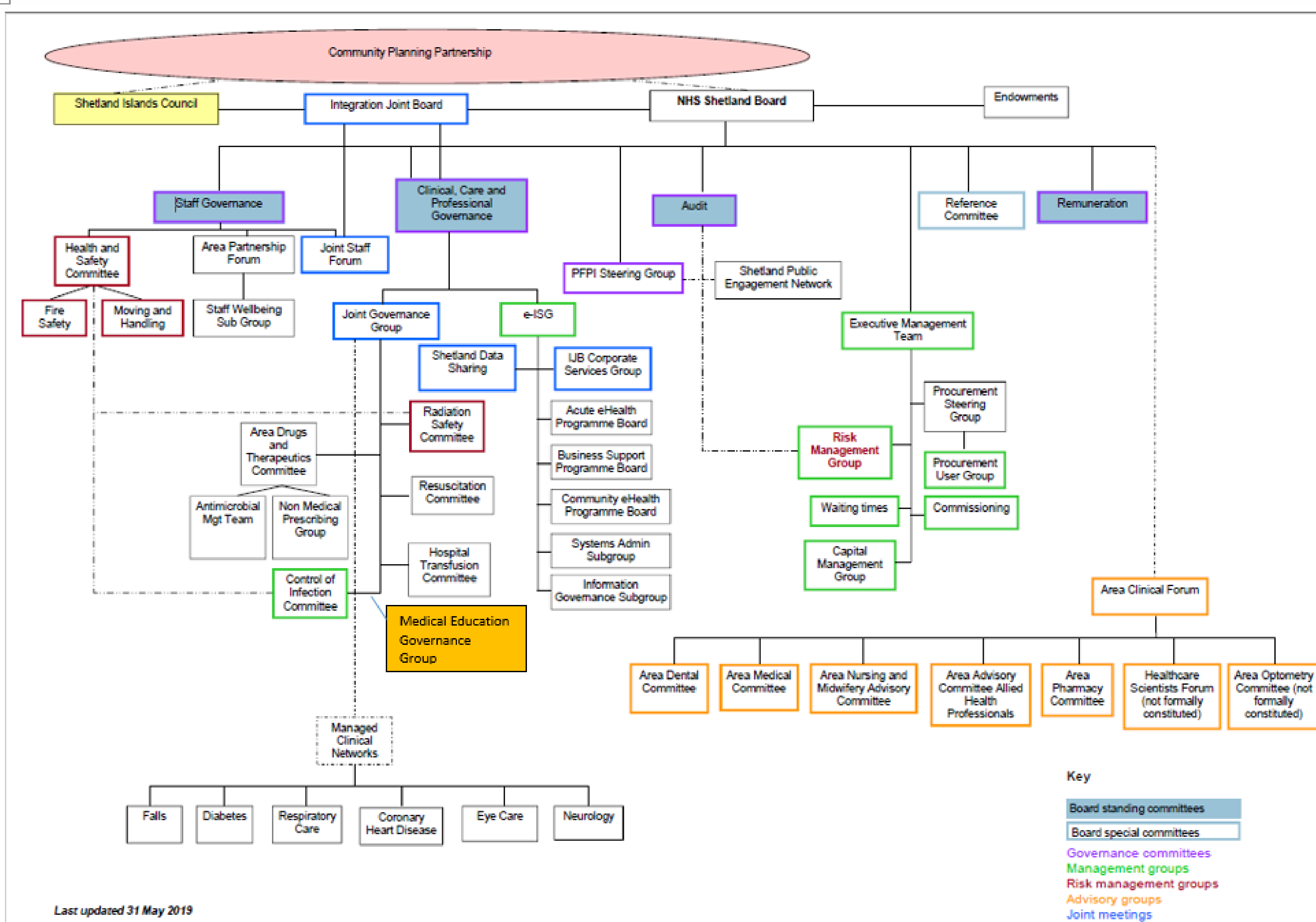
Educational issues:

- 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

The fact that this group ties together 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 other members of the MDT team involved in teaching and training. There are also representation from the Executive management Team and Human Resources Department. There is trainee representation to the MEGG.

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 – it has continued to meet during the pandemic via TEAMs
- Trainee representative's 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.

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

- A 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.
- 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 the issue raised
- Areas of concern or good practice is also discussed at the consultant's group
- The DME feedback 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?

This is an area that NHS Shetland is working on in terms of a quality improvement. The new Associate Medical Director (Acute) has started working with the Clinical Governance department to ensure that there are robust mechanisms in place to ensure learning form datix/incidents. There is also work being undertaken to ensure that patterns are identified better through the datix and governance reporting systems.

Mechanisms include:

- Datix and incidents are discussed at ward governance meetings and recorded on ward action trackers
- Individual feedback that is required to trainees takes place – e.g. a TEAMs meeting was set up with a trainee who has left Shetland to discuss a learning point linked to their prescribing practices that was identified via datix and only came to light after they had moved on to the next block
- Learning summaries are sent out to the consultants and trainees by the Associate Medical Director (Acute)

Work in progress:

- Re-establishing monthly clinical governance meetings where incidents are discussed by the wider teams. These meetings have not taken place during covid and work is underway to recommence these meetings either by TEAMs platform or by in-person attendance by August 2021.
- NHS Shetland has employed a board funded CDF post from August 2021 – 4 hours per week of CDF time is going to be dedicated to working with the Clinical Governance Department to:
  - Re-design learning summaries
  - Link datix patterns to learning and teaching programme
  - Ensure robust processes for evidence of ongoing learning and improvement

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?
N/A	**N/A**	**N/A**	**N/A**

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
- 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

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

1.12 What educational resources and funding can educators access?

- Each consultant has a study leave budget
- GP TPD has visited Shetland in the past to help develop and support GP training
- There are plans for the GP rural tract TPD to provide TEAMs bases teaching for the GP clinical supervisors
- 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

It is worth noting that the provision of high-quality digital access to training/educational resources over the past year 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 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

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 Edin evening medical update teaching
- ILS and local ALS courses
- Trainees attend programme specific boot camps
- Prior to blocks in Shetland foundation doctors are given the opportunity to attend Rural Boot Camp
- Monthly journal club
- In 2021, we have established regular teaching and training updates form the GMCs education department
- Trainees attend locally run Intermediate Paediatric Life support training – half day session per block

In 2020/21 there have been challenges to the delivery of teaching and training however the education team has adapted teaching methods in order to ensure the continuation of educational opportunities for the whole Multi-disciplinary team. There has been much more use of technology enhanced learning. TEAMs has become the platform for the delivery of a number of teaching sessions both formal programme specific and local teaching.

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 the MEGG is split into operational and education discussions
- Thought is given to rota design in that rotas are individualized to reflect the programme specific educational requirements of the trainee - ST1 has opportunity to attend theatre, IMTs have clinics built into their rota and GPStR's GP Practice placements
- There is junior doctor representation on the MEGG
- Care is taken to fill any unfilled post as we understand the knock-on effect this can have on the educational opportunities for trainees
- We encourage taster day- for example the foundation doctors can spend a day with another team e.g. if a Foundation doctor thinks they may wish to undertake a career in General Practice we can arrange a day for them to spend time with a GP
- Regular monitoring of the rota is undertaken to ensure that it is working time compliant

2 Sign-off

Form completed by	Role	Signature	Date
Dr Pauline Wilson	DME	Pauline Wilson	07/06/2021