1. Are NHS Orkneys services safe, effective and evidence based?

NHS Orkney has implemented all relevant SIGN and NICE guidelines to the services which are offered by the Board. Any incident that does take place within the Board is recorded on Datix which is the incident and risk management system. These incidents in turn are reviewed every week by the Clinical Governance team as well as the medical director and the Board’s improvement advisor where any themes or issues are highlighted and the level of investigation is agreed for each incident.

As part of the Hospital Standardised Mortality Ratio (HSMR), NHS Orkney reviews every in hospital death with a length of stay over 24 hours. This gives the Board assurance that the services provided are safe and that we are managing the patients effectively. Any issues raised by the HSMR review are escalated to the Medical and/or Nurse, Midwifery and AHP Directors and are also raised at the Safe and Effective Care meeting.

NHS Orkney holds a Safe and Effective Care meeting once a quarter in which any issues regarding services can be discussed and new guidelines and policies can be reviewed. In this meeting any learning that has originated from an adverse event is shared and is disseminated throughout the teams. This meeting feeds into the overall governance framework of the Board through reporting to the Clinical and Care Governance Committee.

The Board also submits data to the Scottish Patient Safety Programme and is currently focusing on falls prevention, medicines management, tissue viability and catheter urinary tract infections (CAUTI).

2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

NHS Orkney has a Patient Centred Care group that meets on a regular basis in which issues relating service delivery / patient experiences can be discussed. The Board also has a patient public representative group who meet quarterly to provide input into service redesign and guidance on communication and engagement activities with a particular focus on the New Hospital and Healthcare Facility which is currently being built.

The Board will also ask for patients to come and share their experiences both good and not so good at Board meetings using this to learn and reflect on how services could be improved if appropriate. Staff are also encouraged and invited to share their stories at Board meetings also.

As an Island NHS Board access to specialist and/or territory services are driven by on Island referrals. The Board is currently reviewing how some services are
delivered (quality measures) and are increasing the use of technology to enhance patient experience and reduce the need for off island travel.

3. **Do services treat people with dignity and respect?**

NHS Orkney aims to treat every patient with dignity and respect when they are using the services. This is engendered through our values and operating principles and embedded within our NHS Board Corporate Plan.

4. **Are staff and the public confident about the safety and quality of NHS services?**

The majority of staff and patients are confident about the safety and quality of the care given by NHS Orkney – this is evident through patient feedback and iMatter discussions within Teams. With the hospital being remote and rural it is not always possible to treat patients on island and we therefore need to stabilise and then transfer to another hospital on the mainland with the appropriate facilities. This can have an impact on some individuals’ perception of what constitutes safe and quality care.

In addition, NHS Orkney, like many other NHS Boards, is reliant upon locum doctors to provide services locally. This can sometimes be viewed negatively by members of the public however the Board is working hard to maintain a rotation of frequently used locums so that continuity of care is not compromised. New posts (Clinical Development Fellows) and imaginative contractual arrangements (2 week on/ 2 week off) has helped stabilise our workforce both in primary and secondary care.

5. **Do quality of care, effectiveness and efficiency drive decision making in the NHS?**

Absolutely. NHS Orkney has developed and adopted operating principles to guide decision making and these centre on the provision of safe, effective and person centred care and services.

6. **Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?**

NHS Orkney has robust systems to pick up on unacceptable quality of care. We have a Patient Experience Officer in post who deals with all the complaints that come from patients or their families/ carers. These complaints are shared with the relevant areas who can then review the processes that were carried out and identify where improvements can be made. Improvement and learning is a key feature in appraisal and revalidation discussions.

A multi disciplinary team review all in hospital deaths and will pick up on any unacceptable care to patients. If anything is picked up it is escalated to the medical or nurse, midwifery and AHP Directors and a Significant Adverse Event investigation is called and any improvements will be shared with the relevant teams as well reported to the Safe and Effective Care Group.
NHS Orkney uses Datix and this is now well established, staff are encouraged to use the system to record incidents especially when they believe there has been an unacceptable quality of care given to a patient.