A Quality Assurance Framework for Knowledge Services
Supporting NHSScotland

Supported by NHS Education for Scotland and NHS Quality Improvement Scotland

Leadership
A1. Analysis and Planning

Innovation
A2. Implementation

Enabling Staff
A3.1 Monitoring

Resources
B.

User Support
C.

Degree, Post Graduate, Masters

Entry Level

S/NVQ H/NC/D

Knowledge Services

A3.2 Measurable impact on health service

E. Measurable impact on health service

Fellowship
Certification
Chartership
Foreword

We welcome the launch of this Quality Assurance Framework for Knowledge Services supporting NHSScotland. It is a practical working tool developed through three years of continuous collaboration across knowledge services in NHS Boards and partner agencies. The process has been jointly facilitated by NHS Education and NHS Quality Improvement Scotland as two Special NHS Boards with a shared commitment to embedding knowledge management as an integral part of healthcare practice.

This Framework underlines the fundamental importance of knowledge services in underpinning delivery of patient care, improving health and developing organisations and services across the healthcare system. As part of the evidence provided for the NHS QIS Clinical Governance and Risk Management Standards, it highlights the accountability of NHS Boards for the quality and impact of knowledge services provided to their staff and patients.

We commend this framework to managers and users of the wide diversity of knowledge services supporting healthcare in different organisations and sectors. It is designed to help these services in planning strategically and working together to build the infrastructure of knowledge resources, processes, skills and values that will improve health and the patient experience through best practice based on knowledge and evidence.

David Steele
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Contents

1. **Purpose** ................................................. 2

2. **Scope** .................................................. 3

3. **Development Process** ................................. 4

4. **Choice of Model** ....................................... 5

5. **Integration with Healthcare Governance and Risk Management Standards** .......................... 6

6. **Accreditation award and maintenance** .......... 7

7. **Evaluation process** ................................... 8

8. **Governance and Support** ............................ 10

9. **The Framework** ....................................... 11
   - Standard A. Strategy for Knowledge Services
   - Standard B. Resources
   - Standard C. User Support
   - Standard D. Partnership
   - Standard E. Enabling Staff

10. **Guidance Notes** ..................................... 21

11. **References** ........................................... 30

12. **Working Group membership and services participating in the pilot** ......................... 31

**Appendices** .............................................
   - Appendix 1: Preliminary Self-Assessment and Action Plan .............................................. 33
   - Appendix 2: Final Self Assessment Report and Evidence Portfolio - Guidance on Production and Formatting .......................... 34
1. Purpose

Knowledge Services play a vital role in integrating knowledge with working and learning throughout NHSScotland, ensuring that knowledge is embedded in the core activities of: caring for patients; improving health and addressing health inequalities; developing services and organisations; and enhancing personal and professional learning. NHS Education’s strategic framework for Knowledge Management *From Knowing to Doing: transforming knowledge into practice in NHSScotland* set out a commitment to produce a Quality Assurance Framework (QAF) to support continuous improvement of Knowledge Services for NHSScotland.

This Framework:

- **Supports the vision and values** expressed in *From Knowing to Doing* - a commitment to continuous and equitable knowledge support for all stakeholders, sectors, disciplines and organisations involved throughout all stages of the patient journey

- **Aims to be “achievable but stretching”,** reflecting the practical reality of the current state of service provision and the differential state of development of knowledge services across the system. It also incorporates mechanisms for regular review to ensure that the Framework remains relevant and up to date

- **Provides a practical tool** that will empower services to plan strategically and make practical improvements to the quality of their services. It should not be regarded merely as an assessment system

- **Focuses on measurable improvement** of outcomes rather than processes

- **Links quality assurance for NHSScotland Knowledge Services to the NHS QIS review process for clinical governance and risk management**
2. Scope

“Knowledge Services” in the context of this document covers the range of activities, resources, tools, skills, values and attitudes which support the knowledge management cycle illustrated below.

Knowledge services support: the analysis of knowledge needs; the identification of appropriate knowledge sources - both explicit (published) and tacit (personal); retrieval and capture of knowledge; evaluation and synthesis to create new knowledge; sharing and communication of knowledge; and application of knowledge to practice.

The Quality Assurance Framework is sufficiently generic to apply to the full range of knowledge services which support the work of NHSScotland - including:

- Physical, electronic and hybrid service models - including local physical libraries, online library services and Managed Knowledge Networks
- Services which manage data, information and knowledge in contexts other than the established “library” environment - e.g. Training and Organisational Development; Information Services; Health Intelligence, Patient Information, etc.
- Standalone service units and network structures operating at local, regional and national levels
- Specialist as well as generic services
- Services managed by Higher Education, Voluntary Sector, Local Authority and other sectors as well as the NHS
- Services with patients, carers and the public as the primary audience as well as those focused primarily on the needs of healthcare staff

The Framework emphasises the importance of partnership working, reflecting the overall transition to a more integrated and continuous model of care within wider health service development. Services are encouraged to apply the Framework on a collaborative or networked basis, reflecting the fact that strengths need to be drawn from multiple sources in order to support the full spectrum of user and organisational need.
3. Development Process

Development of this Framework began in August 2004, at a Study Day and brainstorming session open to all NHS Librarians. This was followed by discussion at the Librarian Communicators’ Group and at regional Librarian Network meetings during September 2004-January 2005.

The draft Framework was developed during February 2005-September 2005 by a working group of NHSScotland Librarians representing the North, West, South-East and Special NHS Board Librarian Networks. Facilitation and guidance were provided by the Programme Director for Knowledge Management within NHS Education for Scotland, and by a Senior Project Manager from NHS Quality Improvement Scotland.

Consultation on the draft Framework extended from January 2006 to April 2006, and included:

- Directors of Clinical Governance
- Other healthcare governance leads
- e-Health and IM&T leads within NHS Boards
- Heads of Training and Organisational Development
- Senior Managers with responsibility for Library Services
- NHS Librarians
- Managed Knowledge Networks
- Clinical and non-Clinical Directors
- Community Health Partnership leads

The draft Framework was piloted by five NHS Library and Knowledge Services from May 2006 to May 2007, and revised in the light of the pilot experience.
4. Choice of Model

Development of the Framework involved exploration of a wide variety of Quality Assurance models and processes, including those applied to NHS services, library services, and public sector services more broadly. The working group adopted the EFQM Excellence Model\(^2\) (produced by the European Foundation for Quality Management) as a comprehensive, widely recognised, and externally validated model to underpin the Framework. The EFQM balance of “enablers” and “outcomes” was particularly welcomed by the working group, as it ensured that delivery of outcomes in terms of improved patient care and health services remained the consistent focus throughout the development process.

Figure 2 shows how the Quality Assurance Framework for NHSScotland Knowledge Services maps to the EFQM model.
5. Integration with Healthcare Governance and Risk Management Standards

The Quality Assurance Framework for NHSScotland Knowledge Services is closely linked with Healthcare Governance standards. This is reflected in:

- Mapping of the QAF to the NHS QIS Standards for Clinical Governance and Risk Management\(^3\) and to the Staff Governance Standards\(^4\)
- Incorporating the reports on the accreditation process for NHSScotland Knowledge Services as part of the evidence gathered for the NHS QIS review of the Clinical Governance and Risk Management Standards

Aligning the QAF to Healthcare Governance and making it part of overall NHS Board accountability for service delivery underlines the central importance of Knowledge Services in delivering the essential objectives of health service delivery.

\[\text{NHS Boards are fully accountable for the quality of the Knowledge Services they provide. This is an integral part of NHS Board responsibility for Clinical Governance and Staff Governance.}\]
6. Accreditation award and maintenance

As outlined in the main body of this document, the Quality Assurance Framework comprises five Standards. Each standard has a number of criteria, and each criterion is associated with a set of possible accreditation levels, ranging from 1-3.

The overall accreditation status awarded to a service is calculated as follows:

- **Service with accreditation at Level 1** fulfils all Level 1 criteria. This is the minimal level of accreditation, judged to be achievable by all services
- **Service with accreditation at Level 2** fulfils all Level 1 criteria and all Level 2 criteria
- **Service with accreditation at Level 3** fulfils all Level 1, 2 and 3 criteria

While the Framework is designed to be as generic as possible in nature, it is recognised that some degree of flexibility is necessary to accommodate the wide diversity of Knowledge Services across NHS Scotland. Services will have the option to make a case explaining why individual criteria do not apply in their specific circumstances.

Accreditation will be awarded for a period of three years. Services will be able to resubmit for a higher accreditation level at any point during those three years. At the end of the three year period a resubmission is required to maintain or improve the original accreditation level.

Accredited services will submit to the QAF Coordinating Group a short annual report for the first two years of the three year accreditation period, carrying out another brief self-assessment, outlining progress on the development areas identified in the original report, and highlighting any issues affecting service quality.
7. Evaluation process

A combination of self-assessment and external evaluation is applied.

The report on the Quality Assurance Framework forms part of the evidence submitted to NHS Quality Improvement Scotland as part of the review of NHS Boards’ fulfilment of the NHS QIS Clinical Governance and Risk Management standards. The next round of NHS QIS reviews is scheduled for April 2009-March 2010. The pilot has demonstrated that a minimum of 12 months is required for services to complete the QAF process, so it is suggested that Knowledge Services start work on their submissions during early 2008.

**Stage 1: Self-assessment and action planning**
Each service or network of services seeking accreditation should:

- Carry out an initial self-assessment against the Framework
- Define the accreditation level target it will aim to achieve
- Define the gaps between the self-assessment and the target accreditation level
- Produce an action plan which the service will follow in order to achieve the specified accreditation level

The gap analysis and action plan should be submitted to the QAF Coordinating Group for review and comment. This provides the opportunity to identify at an early stage any issues which might affect attainment of the target accreditation level.

Appendix 1 provides a template for the self-assessment process.
Stage 2: External evaluation
On completion of the QAF process, the service submits its final self-assessment and evidence portfolio to the QAF Coordinating Group. It is important that this submission is scheduled for at least two months in advance of the time at which NHS QIS gathers the evidence for the review of the Clinical Governance and Risk Assessment standards for the Board concerned. Appendix 2 provides guidance on the submission format and process.

The Coordinating Group will appoint an External Evaluation Panel with the following representation:
- NHS Education for Scotland (except where NES services are under review)
- Manager of a “peer” knowledge service with comparable aims and scope
- Clinical Governance representative
- e-Health and/or Training and Organisational Development representative

The Panel will:
- Review the self-assessment report
- Organise an on-site visit to meet the service staff and user representatives for purposes of clarification. A minimum of two Panel members will normally take part in the site visit. The Panel will define the aims and format of the visit and the representatives it wishes to meet
- Following the visit, agree the accreditation level to be awarded to the service, and key recommendations for development

NES Knowledge Services will produce the Evaluation Report, which will be approved by the Evaluation Panel before issuing to the service concerned. While NES Knowledge Services will normally write the report, all members of the External Evaluation Panel are jointly responsible for its content.

Stage 3: Review and inclusion in the NHS QIS Clinical Governance and Risk Assessment process
The service receiving the Evaluation Report will have three weeks to feed back on any points of clarification or errors of fact. It may also convene a meeting with members of the Evaluation Panel to discuss the findings and development recommendations.

Following any revisions resulting from the service feedback, NES Knowledge Services will send the Evaluation Report to NHS QIS for inclusion in the evidence considered by the Review Team for the Clinical Governance and Risk Management Standards.
8. Governance and Support

The organisational structure supporting implementation of the QAF is as follows:

1. A Quality Assurance Framework Coordinating Group, with representation from:
   - NES Knowledge Services which will convene the group
   - NHS Quality Improvement Scotland
   - Knowledge Services that participated in the pilot process
   - Clinical Governance Leads
   - Organisational Development and Training
   - e-Health

This will operate principally as a virtual group with two face to face meetings per year from April 2008. One member of the group plus a NES Knowledge Services representative will be nominated to feed back on the self-assessment report and action plan produced at Stage 1 by each Knowledge Service.

The Coordinating Group will also nominate the Evaluation Panel members for each external assessment process. It will receive a copy of the report on each review and will monitor and advise on the overall implementation process.

This Group will be the locus of control for any changes that may be proposed to the implementation process for the Quality Assurance Framework or the Framework documentation. It will serve as the final authority on any appeals made against the accreditation level awarded to services, and will serve as the primary channel for communication with NHS Quality Improvement Scotland about links with the Clinical Governance and Risk Management Standards.

2. Quality Assurance Framework Peer Support Network

This network will comprise representatives from the Knowledge Services that participated in the pilot process, and those undertaking the process from April 2008 onwards. It will be chaired by a representative from a service that has successfully completed the QAF process, and will serve as source of mutual support, consultation and advice. Much of the communication of this group will take place virtually. A Shared Space will be established to share documents, including successful submissions, and to support online dialogue. NES Knowledge Services will fund up to three half-day meetings per year of this Network.

As a growing number of services undertake the QAF evaluation process, the Coordinating Group and Peer Support Network may recommend additions and modifications to the QAF Guidance to support future submissions.

3. NHS QIS Review of the Quality Assurance Framework

With the support of the Coordinating Group, NES Knowledge Services will produce in mid-2010 a report on the first year of full implementation of the QAF, linked with the 2009-2010 review of the Clinical Governance and Risk Management Standards. This will form the basis for review with NHS QIS of the scope for updating the Framework to take into account the changing nature of health service needs and the improved baseline for Knowledge Services.
9. The Framework

Figure 3 summarises the Framework in diagrammatic form.

The focal point of the Framework is the evaluation of impact of Knowledge Services on patient care and health service delivery. This evaluation of impact forms the final criterion within Standard A. As a whole, Standard A reflects the strategic development which reflects the strategic development cycle of planning, implementation and evaluation of impact of knowledge services. The outcomes-based planning in Standard A forms the foundation for standards B to E, focused respectively on management of resources, user support, partnerships and staff.

The dependency of all elements of the Framework on the strategic development process is reflected by the fact that in many instances accreditation level 1 as applied to a criterion describes a service at the planning stage of development; level 2 indicates that the service has progressed to the implementation stage; and level 3 indicates that the service has now reached the point of monitoring and evaluation, feeding into the next planning cycle.
## Standard A. Strategy

The strategy for service development reflects the needs of the NHS organisation(s) served; contributes to national NHS objectives, including the national strategy for NHSScotland Knowledge Services; is founded on the principles of equity and inclusivity; and focuses on outcomes in the form of improvements in health services.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Evidence and Accreditation Level</th>
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<tbody>
<tr>
<td><strong>A1. Analysis and Planning</strong></td>
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</tr>
<tr>
<td><strong>A1.1 Mission</strong></td>
<td>Level 1: Mission statement is under development.</td>
</tr>
<tr>
<td>The service has a clear mission statement which demonstrates a commitment to the principle of equity of access, reflects the needs of the NHS organisation(s) served, and is aligned with national NHS objectives, including the national strategy for NHSScotland Knowledge Services.</td>
<td>Level 2: Mission statement is in place and approved by line management or other organisational route.</td>
</tr>
<tr>
<td><strong>A1.2 Objectives</strong></td>
<td>Level 1: Objectives are under development.</td>
</tr>
<tr>
<td>The service has clearly defined objectives linked to organisational objectives</td>
<td>Level 2: Objectives are in place and approved at organisational level.</td>
</tr>
<tr>
<td><strong>A1.3 Needs analysis</strong></td>
<td>Level 1: Consultation mechanisms are in place on “reactive” model - e.g. usage statistics gathered through routine service processes.</td>
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<tr>
<td>Strategy is based on consultation with the full range of stakeholders.</td>
<td>Level 3: Strategically planned proactive consultation is in place, e.g. interviews, focus groups, etc.</td>
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<tr>
<td><strong>A1.4 Documented strategy</strong></td>
<td>Level 1: Evidence that planning processes for production of strategy are in place.</td>
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<tr>
<td>A documented strategy is in place.</td>
<td>Level 2: Strategy document is available in outline form.</td>
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<td>Level 3: Full strategic document is available and has obtained organisational approval.</td>
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## A2. Implementation

### A2.1 Implementation plan

An implementation plan with measurable deliverables and timescales is in place to fulfil the strategic objectives.

**Mapping to NHS QIS Clinical Governance and Risk Management Standards:**
3d2 Performance management arrangements are aligned to clinical governance systems and are underpinned by explicit organisational objectives, targets, and indicators, which ensure prioritisation of decision-making.

<table>
<thead>
<tr>
<th>Evidence and Accreditation Level</th>
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<tbody>
<tr>
<td><strong>Level 2:</strong> Plan in place with clearly defined deliverables, timescales, and allocation of responsibilities to team members. Plan submitted for organisational approval.</td>
</tr>
<tr>
<td><strong>Level 3:</strong> Plan in place with clearly defined deliverables, timescales, and allocation of responsibilities to team members. Organisational approval gained.</td>
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## A3. Monitoring and impact

### A3.1 Review and evolution

The strategy and associated implementation plan are continuously reviewed and evaluated, and evolve to reflect changing needs.

**Mapping to NHS QIS Clinical Governance and Risk Management Standards:**
1c4: A system is in place to review, prioritise, implement and monitor national and local standards, guidance and policy.

3a2: Systems are in place to ensure that patients, carers, public and staff are informed, consulted and able to provide feedback when the NHS Board is planning, monitoring and improving services.

3d 1 and 3d2: Performance management arrangements aligned to local, regional and national planning; aligned to clinical governance systems and underpinned by explicit organisational objectives, targets and indicators.

**Evidence and Accreditation Level**

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<thead>
<tr>
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<tr>
<td><strong>Level 2:</strong> Evidence that service has considered approach to evaluation and monitoring; draft process in place.</td>
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<td><strong>Level 3:</strong> Evidence of a programme of ongoing monitoring and review.</td>
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<td>Criterion</td>
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</table>
| **A3.2 Impact on practice and service delivery**                        | **Level 1:** Ad hoc gathering of evidence - e.g. user feedback by email. Evidence should show clearly how practice or policy has been affected by the information provided. A minimum of five separate instances of impact on practice or policy should be identified, which may be at a personal or an organisational level.  
**Level 2:** Basic proactive approach to gathering of evidence - e.g. user testimonies; feedback forms. Evidence should show clearly how practice or policy has been affected by the information provided. Examples of impact should cover at least half of user groups / functions within the parent organisation, and should cover three or more types of support delivered by the service. At least one example of impact should be at an organisational rather than a personal level.  
**Level 3:** Systematic proactive approach to gathering of evidence - e.g., interviews, focus groups, questionnaires. Demonstrate how a planned approach to evidence gathering covers a variety of types of impact, encompassing all aspects of the knowledge service and a representative sample of user groups. Evidence should reflect the full range of support delivered by the service. At least two examples of impact should be at an organisational rather than an individual level.  
At this level, the service should demonstrate that its strategic approach is focused on delivering outcomes in the form of improved patient care/improved healthcare delivery. There should be evidence of a continuous improvement process to ensure that the service is constantly building up its impact on healthcare delivery. Examples might include shared workplans with clinical or management functions; involvement in production of patient-accessible information; development of clinical librarian services. |

The positive impact of Knowledge Services can be demonstrated in terms of clinical or managerial practice or policy.

**Mapping to NHS QIS Clinical Governance and Risk Management Standards:**  
3e5: Information management links clearly into clinical governance arrangements and engages clinicians and patients in the development and application of information and communication technology.  
3e6: Systems are in place to ensure that staff have access to information to support decision-making and facilitate the delivery of quality of care and services.
**Standard B. Resources**

Resources are managed to enable equity of access to the knowledge base at point of need.

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<tr>
<th><strong>Criterion</strong></th>
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| **B1. Financial management**  
Financial resources are deployed reflecting user needs in a cost-effective manner.  
*Mapping to Staff Governance Standards:*  
Resources including time and funding will be allocated to meet the training and development needs identified locally. | **Level 1:** Where no budget has been defined, proposals should be in place for resourcing and an approach made to finance or senior management on this basis.  
**Level 1:** Cash-handling policy in place where relevant.  
**Level 1:** Awareness of and adherence to Standing Financial Instructions, or equivalent in non-NHS institutions.  
**Level 2:** Defined budget in place. Forward budget plan produced extending beyond current financial year, including management of ongoing costs e.g. Information Technology.  
**Level 2:** Evidence of alignment of budget planning with user needs.  
**Level 2:** Library Services Manager is budget-holder.  
**Level 3:** Evidence of creative solutions to optimise cost-effectiveness, e.g. consortium purchasing; rationalisation of resources; negotiation with suppliers; accessing external sources of funding. |
| **B2. Coverage**  
The range of resources is being developed to meet the needs of the full spectrum of stakeholders. | **Level 1:** Evidence of basic understanding of user profile - e.g. core usage statistics or descriptive analysis.  
**Level 2:** Mapping of development plan for resources to current user profile.  
**Level 3:** Definition of plans to support groups whose needs are not met at present. |
| **B3. Physical accommodation**  
Study space and workstation access are adequate for current and projected need for staff and users.  
*Mapping to Staff Governance Standards:*  
NHS premises will be fit for purpose, and the personal safety of patients and employees will be paramount in the design and operation of the service. | **Level 1:** Evidence in management and planning of physical accommodation of awareness and compliance with Disability Discrimination Act and Health and Safety at Work Act.  
**Level 2:** Evidence (where relevant) of measurement of current usage levels and plans for future accommodation of: stock; study space; workstations. |
## Standard C. User support

Users receive the support necessary to enable them to make effective use of the knowledge base.

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<tr>
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| **C1. Customer service**  
The service adheres to customer care principles and offers services to a standard appropriate to the needs of its user base.  
*Mapping to NHS QIS Clinical Governance and Risk Management Standards:  
2c1. There are policies, developed in partnership with other agencies, that guide, monitor and improve the way that staff communicate and engage with each other and with patients, carers and the public.* | **Level 1:** Planning process underway for production of customer service policy.  
**Level 1:** Customer service training undertaken by service team (e.g. via GoodPractice.Net)  
**Level 2:** Evidence in assessment visits of staff adherence to customer service policy.  
**Level 2:** Customer service policy in place.  
**Level 3:** Evidence of successful awareness-raising of services and support. |
| **C2. Outreach and Training**  
The service offers outreach and training appropriate to the needs of its user base.  
*Mapping to Staff Governance Standards:  
• A communications strategy is developed in partnership and is audited at regular intervals.  
• A system is in place which ensures shiftworkers / part-time / night staff have equal access to information.  
All staff will have access to communication systems including IT and will be provided with appropriate training.* | **Level 1:** Training strategy under development.  
**Level 1:** Outreach strategy under development.  
**Level 1:** Training available when required.  
**Level 1:** Basic outreach activities are in place, e.g. distribution of posters, leaflets, contribution to staff newsletters.  
**Level 2:** Outreach strategy and programme in place.  
**Level 2:** Training strategy and programme in place.  
**Level 2:** Training should be linked with Knowledge and Skills Framework (or equivalent organisational learning and development frameworks for other groups and sectors).  
**Level 3:** Training and outreach plans reflect analysis of user needs.  
**Level 3:** Training and outreach plans reflect the needs of groups which have not been fully included in the past, e.g. remote staff, shift workers, non-clinical staff.  
**Level 3:** Training and outreach plans take account of the needs of hard-to-reach groups - e.g. remote staff, shift workers, night staff. |
# 9. The Framework

## Quality Improvement Scotland

### Criterion

#### C3. Extended knowledge management

The service participates in extended knowledge management activities, including for example, proactive dissemination of information; supporting Communities of Practice and Managed Knowledge Networks, promoting the sharing of tacit (personal) and internal, organisational knowledge.

Mapping to NHS QIS Clinical Governance and Risk Management Standards:

*1a7*: Information generated from local and national experience is used to drive improvement, reduce risk and stimulate learning.

Mapping to Staff Governance Standards:

- Action plans to develop communications systems including IT are in place and monitored.
- All staff receive information about their organisation at regular intervals.
- Leadership arrangements will ensure all staff have regular dialogue and communication with the opportunity to feedback on organisational issues at all levels.

#### C4. Legislation and regulations

The service complies with relevant legislation, including Fair for All principles, the Patient Focus and Public Involvement Framework, Copyright, Data Protection and Freedom of Information Acts. Online services comply with accessibility standards, e.g. W3C, BOBBY approval.

Mapping to NHS QIS Clinical Governance and Risk Management Standards:

*2b1*: All new and existing systems are reviewed, equality and diversity impact assessed, developed or improved, to ensure that every person has equal access to services.

*2b2*: Systems are in place to identify, assess and respond to the needs of groups and individuals within its population who have particular needs or preferences.

### Evidence and Accreditation Level

#### Level 2:

- Relevant knowledge management objectives defined in knowledge services strategy produced in Standard A.

#### Level 3:

- Evidence of achievement/delivery of knowledge management objectives in each area specified.

Examples might include:

- Delivery and development of current awareness and other updating services
- Facilitating communication and knowledge sharing by communities of practice
- Promoting tools and frameworks for communication and knowledge sharing, e.g. Shared Space service, other collaborative and social networking knowledge management tools
- Promotion and uptake of Managed Knowledge Networks
- Facilitating access to internal organisational knowledge, e.g. minutes and reports of meetings

#### Level 1:

- Policies and procedures to ensure compliance with relevant legislation.

#### Level 1:

- Online services comply with accessibility standards.

#### Level 2:

- During review visit, assessment of staff’s understanding and ability to apply these policies in practice.
### Standard D. Partnership

Partnership working principles and processes are applied to facilitate equity of access to the knowledge base and support an integrated approach to health service delivery.

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<tr>
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| **D1. Partnership**  
Partnership working within the organisation, and across local and national organisational and sectoral boundaries, supports equity of access to the knowledge base.  
*Mapping to NHS QIS Clinical Governance and Risk Management Standards:*  
3a4: Systems are in place to provide assurance of the quality of services provided by the NHS Board and those provided jointly with other agencies. | **Level 1:** Evidence of basic partnership working, e.g. membership of discussion lists, participation in password distribution schemes, interlibrary lending.  
**Level 2:** Systematically planned and proactive approach to collaboration, within or across organisations.  
**Level 3:** Advanced sharing of resources, systems or expertise, e.g. through use of interoperability technologies; participation in unified library management system; strategic planning on a collaborative basis; cost-effective Service Level Agreement(s) in place; participation in Managed Knowledge Networks. |
**Standard E. Enabling staff**
Knowledge Services staff are managed and supported to meet the needs of the service and to fulfil their own personal and professional potential.

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<tr>
<th>Criterion</th>
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<tbody>
<tr>
<td><strong>E1. Structure</strong></td>
<td>Level 1: Organisational chart should demonstrate clear relationships among different staff roles and areas of responsibility. Management and reporting lines should be appropriate to the needs of the service. Level 2: Allocation of lead responsibilities to staff within development plan for knowledge services.</td>
</tr>
<tr>
<td>The service has a clear management and staffing structure appropriate for its delivery and development objectives.</td>
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<tr>
<td><strong>E2. Skill mix</strong></td>
<td>Level 2: Mapping of service delivery and development areas to staff roles and skills.</td>
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<tr>
<td>Staff skill mix is appropriate for service delivery and development needs.</td>
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<tr>
<td><strong>E3. Staff development</strong></td>
<td>Level 1: Personal Development Plans (PDPs) in place for all staff. Level 1: Evidence that PDP objectives are supported and implemented. Level 1: Application of Competency Framework for Library and Knowledge Services Staff Serving NHSScotland(^5) to define learning needs. Level 2: Training Needs Analysis conducted to identify requirements to support delivery of knowledge services strategy. (This analysis may take place as part of the PDP process). Level 2: Learning Plan in place for the knowledge service.</td>
</tr>
<tr>
<td>The personal and professional development needs of staff are systematically identified and supported. For NHS staff this should be in accordance with Knowledge and Skills Framework requirements.</td>
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*Mapping to Staff Governance Standards:*
All staff will have a Personal Development Plan Local Learning Plans will be developed and implemented.
### Criterion

**E4. Creative teams**

Staff work as a team in which all members have input to service development.

*Mapping to Staff Governance Standards:*
- Regular staff meetings take place with management
- A communications strategy is developed in partnership and audited at regular intervals
- A communications strategy will include provision for the involvement of staff in decisions which affect them

### Evidence and Accreditation Level

#### Communication

**Level 1:** Regular programme of team meetings, either internally for knowledge services staff, or (for small services with only one-two staff) meetings with related departments.

**Level 1:** Evidence of two-way communication between front-line staff and management, e.g. regular meetings, email discussion.

**Level 2:** For services with more than one member of staff, evidence of consultation within the service regarding development proposals.

**Level 2:** Evidence of review of communication systems (within the knowledge service or between knowledge service and external departments).

**Level 2:** Interviews with staff to check their awareness of the communications systems in place, and their effectiveness.

#### Team ethos

**Level 1:** Evidence of awareness of common objectives among team members.

**Level 2:** Evidence of team participation and active contribution to service development plans based on common understanding of objectives.

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**E5. Inter-departmental working**

The service draws upon the complementary skills and support of staff in other departments or functional areas as appropriate to meet user needs.

**Level 2:** Portfolio of examples.
10. Guidance Notes

The following notes aim to support services compiling self-assessment reports and portfolios of evidence. Services should note that the QAF Coordinating Group and Peer Support Network are also available for advice. Queries may be sent at any time to the Programme Director for Knowledge Management within NHS Education for Scotland.

Standard A Strategy for Knowledge Services
A1 Analysis and Planning

Criterion A1.1: Mission

Level 1: Mission Statement is under development
*Examples of suitable evidence:* Minutes or report of a meeting at which the content of the Mission Statement has been substantially discussed; copy of letter submitting mission statement for approval to senior management.

Level 2: Mission Statement is in place and approved by line management or other organisational route
A copy of the mission statement is an essential piece of evidence at this level. This may be referenced within the service strategy or implementation plan. Examples of evidence of approval by line management or other organisational route would include: Copy of email, letter or meeting notes indicating formal approval; incorporation of mission statement in corporate publication. The approval process should be outlined.

Criterion A1.2: Objectives

Level 1: Objectives are under development
*Examples of suitable evidence:* Notes of meeting at which draft objectives have been discussed. A set of draft objectives should be provided.

Level 2: Objectives are in place and approved at organisational level
A copy of objectives is required. These may be referenced within the service strategy or implementation plan.
*Examples of suitable evidence:* As for A1.1 Level 2.

Criterion A1.3: Needs analysis

Level 1: Consultation mechanisms are in place on “reactive” model - e.g. usage statistics gathered through routine service processes
*Examples of suitable evidence:* Membership and service usage statistics broken down by stakeholder group and compared with potential user population.

Level 2: Basic proactive consultation mechanisms are in place
*Examples of suitable evidence:* List of suggestions from suggestion box; collection of suggestions from printed or online forms; recommendations made by user groups or management structure for the service. Evidence should detail how the service has acted upon these recommendations.

Level 3: Strategically planned proactive consultation is in place
*Examples of suitable evidence:* Strategic plan in progress or completed, defining objectives, methodology and outcomes of consultation and how these relate to service development. Consultation should cover a comprehensive range of the support provided or planned by the service.
A2 Implementation

Criterion A2.1: Implementation plan

Level 2: Plan in place and submitted for organisational approval
Documented implementation plan should be provided, reflecting all objectives within the strategy. This should include defined deliverables, timescales and allocation of responsibility to team members. Evidence of organisational approval should be provided as outlined previously for A1.1 Level 2.

A3 Monitoring and impact

Criterion A3.1: Review and evolution

Level 2: Evidence that service has considered approach to evaluation and monitoring; draft process in place
*Examples of suitable evidence:* Outline of evaluation, monitoring and review process for the strategy and details of how this draft evaluation process has been produced. Evidence should also be supplied that the process is already being applied to some aspects of the service. This evidence might take the form of a report of the outcomes of the review process, and the changes made to the strategy or implementation plan as a result.

Level 3: Evidence of a programme of ongoing monitoring and review
*Examples of suitable evidence:* Schedule of monitoring and review of full strategy and implementation plan extending over at least 2 years; report of at least one round of review, indicating how the review was conducted; findings of the review, and how these have been translated into further development of strategy and implementation plan. At this level, the review process should include external stakeholder input, i.e. it should not be solely an internal review.

Criterion A3.2: Impact on practice and service delivery
This criterion is central to the overall evaluation and will be reviewed closely by the Evaluation Panel. The evidence for this criterion needs to combine both:

a) Demonstrable positive impact and
b) A planned approach to gathering evidence of impact

Details of the types of evidence appropriate for each accreditation level are provided in the main body of the framework. For all levels, examples should cover:

a) What the service is trying to achieve (aims)
b) Process followed (how the service is provided)
c) Outcomes

For Level 1, emails saying “Thank you, that information was helpful” are not sufficient evidence in themselves. Evidence should be provided that the knowledge service followed up the emails to gather details of how the information provided impacted on practice or health service delivery.
Standard B Resources

Criterion B1 Financial management

Level 1:

a) Where no budget has been defined, proposals should be in place for resourcing, and an approach made to Finance or senior management on this basis

Examples of suitable evidence: Copy of submission to Finance or senior management should be supplied, with details of how proposals have been arrived at.

b) Cash-handling policy in place where relevant

Examples of suitable evidence: Copy of policy should be supplied; Evaluation Panel may ask staff about application in practice during site visit.

c) Awareness of and adherence to Standing Financial Instructions, or equivalent in non-NHS institutions

Examples of suitable evidence: Copy of Standing Financial Instructions should be supplied; Evaluation Panel may ask staff about application in practice during site visit. As far as possible, details should be provided of how these Instructions have been applied in practice - e.g. outline of how quotes from multiple companies are obtained and compared.

Level 2:

a) Defined budget in place. Forward financial plan extending beyond current financial year, including management of ongoing costs, e.g. Information Technology

Examples of suitable evidence: Copy of forward financial plan should be provided, with details of how ongoing costs have been calculated.

b) Evidence of alignment of budget planning with user needs

Examples of suitable evidence: Outline of how financial plan relates to the strategy and implementation plan and supports the user needs identified in those plans.

c) Library Services Manager is budget-holder

Examples of suitable evidence: Written confirmation from Finance or Line Manager.

d) Financial reporting mechanism in place

Examples of suitable evidence: Copies of financial statements; notes of financial review meetings.

Level 3 requirements:

Evidence required of creative solutions to optimise cost-effectiveness, e.g. consortium purchasing, rationalisation of resources, negotiation with suppliers, accessing external sources of funding

Examples of suitable evidence: Written details of solutions and extent of savings or increased value achieved.
**Criterion B2: Coverage**

Level 1: Evidence of basic understanding of user profile - e.g. core usage statistics or descriptive analysis
*Examples of suitable evidence: Reports of usage statistics covering a broad range of stakeholders.*

Level 2: Mapping of development plan for resources to current user profile
*Examples of suitable evidence: Documented resource development plan, outlining how different stakeholder groups will benefit from proposed improvements.*

Level 3: Definition of plans to support groups whose needs are not met at present
*Examples of suitable evidence: Documented plan to develop resources to support identified low-usage groups. It is not sufficient to present plans for future development; service should demonstrate that plans for some low-usage groups are already in progress.*

**Criterion B3: Physical accommodation**

Level 1: Evidence in management and planning of physical accommodation of awareness and compliance with Disability Discrimination Act and Health and Safety at Work Act
*Examples of suitable evidence: Health and Safety Report; planning and design documentation.*

Level 2: Evidence (where relevant) of measurement of current usage levels and plans for future accommodation of: stock; study space; workstations
*Examples of suitable evidence: Reports of usage levels and outlines of plans for future accommodation.*
Standard C User Support

Criterion C1: Customer service

Level 1:
a) Planning process underway for production of customer service policy
Examples of suitable evidence: Terms of reference for production of policy; notes of planning meetings.
b) Customer service training undertaken by service team (e.g. via GoodPractice.Net)
Examples of suitable evidence: Record of attendance at training; course evaluation forms and record of learning outcomes.

Level 2:
a) Evidence in assessment visits of staff adherence to customer service policy
Examples of suitable evidence: Responses to questions asked during site visit.
b) Customer service policy in place
Examples of suitable evidence: Documented policy.

Level 3:
Evidence of successful awareness-raising of services and support
Examples of suitable evidence: Reports of awareness-raising campaigns, including plans, implementation processes and resulting impact on service uptake.

Criterion C2: Outreach and training

Level 1:
a) Training strategy under development
Examples of suitable evidence: Terms of Reference for production of training strategy; outline of development process; notes of meetings of working group.
b) Outreach strategy under development
Examples of suitable evidence: Terms of Reference for production of outreach strategy; outline of development process; notes of meetings of working group.
c) Training available when required
Examples of suitable evidence: Records of training requests and provision.
d) Basic outreach activities are in place, e.g. distribution of posters, leaflets, contribution to staff newsletters
Examples of suitable evidence: Report of outreach activities.

Level 2:
a) Outreach strategy and programme in place
Examples of suitable evidence: Documented outreach strategy and implementation plan, with report on implementation to date.
b) Training strategy and programme in place
Examples of suitable evidence: Documented training strategy and implementation plan, with report on implementation to date.
c) Training should be linked with Knowledge and Skills Framework (or equivalent organisational learning and development frameworks for other groups and sectors)
Examples of suitable evidence: Mapping of training to Knowledge and Skills Framework detailed within training programme and individual events.
Level 3:

a) Training and outreach plans reflect analysis of user needs

*Examples of suitable evidence:* Training and outreach strategies should demonstrate how they are based on analysis of user need. Implementation reports or examples should indicate how training and outreach have been provided to meet some of these defined needs.

b) Training and outreach plans reflect the needs of low usage groups

*Examples of suitable evidence:* Details of these needs and how they will be met should be outlined in plans. Implementation reports or examples should indicate how training and outreach have been provided to meet some of these defined needs.

c) Training and outreach plans take account of the needs of hard-to-reach groups - e.g. remote staff, shift workers, night staff.

*Examples of suitable evidence:* As for b) above.

### Criterion C3: Extended knowledge management

- **Level 2:** Relevant objectives defined in Knowledge Services Strategy as produced in Standard A
  
  *Examples of suitable evidence:* Extended knowledge management objectives extracted from strategy.

- **Level 3:** Evidence of achievement/delivery of objectives in each knowledge management area specified
  
  *Examples of suitable evidence:* Outline of how objectives have been achieved, with relevant documentary evidence, links to online communities etc.

### Criterion C4: Legislation and regulations

- **Level 1:**
  a) Policies and procedures to ensure compliance with relevant legislation

  *Examples of suitable evidence:* Copies of service policies and procedures.

  b) Online services comply with relevant accessibility standards

  *Examples of suitable evidence:* Details of the accessibility standards to which online services adhere. For services based on commercially licensed software, accessibility information provided in the company literature would be appropriate; for in-house developments, confirmation should be provided of last date of compliance testing.

- **Level 2:**
  During review visit, assessment of staff’s understanding and ability to apply these policies in practice.

  Evidence will take the form of answers to questions asked by the Evaluation Panel during the review visit.
Standard D Partnership

Level 1: Evidence of basic partnership working
*Examples of suitable evidence:* Details of staff membership of discussion lists; ATHENS administration; interlibrary lending schemes for books and journals.

Level 2: Systematically planned and proactive approach to collaboration, within or across organisations
*Examples of suitable evidence:* Collaborative projects outlined within strategy and implementation plan; details of implementation of some projects.

Level 3: Advanced sharing of resources, systems or expertise
*Examples of suitable evidence:* Provision of online Portals based on interoperability technologies; use of cross-searching of online catalogues to support sharing of resources across services; involvement of partner services in collaborative planning and implementation; demonstration of added value through Service Level Agreements.

Standard E Enabling staff

Criterion E1: Structure

Level 1: Organisational chart should demonstrate clear relationships among roles and areas of responsibility, and management lines appropriate to the needs of the service
*Examples of suitable evidence:* Organisational chart and supporting narrative.

Level 2: Allocation of lead responsibilities to staff within knowledge services strategy
*Examples of suitable evidence:* Implementation plan with details of allocation of responsibility.

Criterion E2: Skill mix

Level 2: Mapping of service delivery and development areas to staff roles and skills
*Examples of suitable evidence:* Outline of how service delivery and development areas are matched to staff roles; details of how staff skills and roles are being fostered to support service development needs.
Criterion E3: Staff development

Level 1:
a) Personal Development Plans (PDP’s) in place for all staff
*Examples of suitable evidence:* Schedule confirming dates and times of PDP sessions and points at which PDP’s were signed off.

b) Evidence that PDP objectives are supported and implemented. Note that all material provided should be anonymised
*Examples of suitable evidence:* Examples of learning and development undertaken as a result of PDP’s; discussion with staff on site visits; anonymised summary notes from PDP review meetings.

c) Application of Competency Framework for Library and Knowledge Services Staff Serving NHSScotland to define learning needs.
*Examples of suitable evidence:* Record of mapping of service delivery and development needs to competency framework as a means to identify staff development needs.

Level 2:
a) Training needs analysis conducted to identify requirements to support delivery of knowledge services strategy (this may take place as part of the PDP process)
*Examples of suitable evidence:* Report of training needs analysis.

b) Learning Plan in place for the knowledge service

Criterion E4: Creative teams

**Communication**

*Level 1:*
a) Regular programme of team meetings, either internally for knowledge services staff, or (for small services with only one-two staff) meetings with related departments
*Examples of suitable evidence:* Schedule of planned meetings; notes of meetings

b) Evidence of two-way communication between front-line staff and management, e.g. regular meetings, email discussion
*Examples of suitable evidence:* Schedule of meetings; notes of meetings; regular email communications

*Level 2:*
a) For services with more than one member of staff, evidence of consultation within the service regarding development proposals
*Examples of suitable evidence:* Notes of discussions/workshops/written or email consultation on development proposals.

b) Evidence of review of communication systems (within the knowledge service or between knowledge service and external departments)
*Examples of suitable evidence:* Report of review of communication systems with recommendations for development. The service should provide a record of how recommendations have been implemented.

c) Interviews with staff to check their awareness of the communications systems in place, and their effectiveness.
The Evaluation Panel will conduct these interviews on site visits.
Team ethos
Level 1: Evidence of awareness of common objectives among team members
*Examples of suitable evidence:* Details of performance management objectives and how these relate to overarching service objectives; notes from team meetings/workshops to develop mission statement and service objectives.

Level 2: Evidence of team participation and active contribution to service development plans based on common understanding of objectives
*Examples of suitable evidence:* Notes from team meetings/workshops to develop service objectives and implementation plan.

Criterion E5: Partnership working
Level 2: Portfolio of examples
Examples of suitable evidence: Note that this criterion requires the service to demonstrate how it recognises and draws upon complementary skills and support in partner departments within the same organisation (whereas Standard D is about cross-organisational partnership working). Examples might include: Programme of training delivered jointly with IT or Training and Organisational Development; partnership working with IT to roll-out access to Library Management System or develop Library Service website; partnership with Practice Education units to incorporate information literacy training in clinical educational programmes.
11. References


12.1 Working Group membership

Juliet Brown, Library Services Manager, Vale of Leven Hospital
Margaret Buchan, Associate Director for Client Services, Robert Gordon University
Seona Hamilton, Library Services Manager, Yorkhill Hospitals Division
Elspeth Henry, Librarian, Public Health, NHS Tayside
Isla Imrie, Library Services Manager, NHS Grampian
Michelle Kirkwood, Librarian for Nursing and Midwifery, North Glasgow Division
Sandra Ladd, Library Services Manager, NHS Lothian Primary Care Division
Karen MacPherson, Senior Information Scientist, NHS Quality Improvement Scotland
Moira Mitchell, Librarian, Melrose Campus, Napier University, Borders General Hospital
Clare Scanlan, Library Services Manager, NHS 24

Dr Ann Wales, Programme Director for Knowledge Management, NHS Education for Scotland
Sarah Brown and Neill O’Shaughnessy, Senior Project Managers, NHS Quality Improvement Scotland
12.2 Services participating in the pilot of the Quality Assurance Framework

NHS Grampian Library and Knowledge Services - contact isla.imrie@nhs.net

NHS Greater Glasgow and Clyde Library Services - contact michelle.kirkwood@northglasgow.scot.nhs.uk; lynn.easton@irh.scot.nhs.uk

NHS 24 Knowledge Team - contact clare.scanlan@nhs24.scot.nhs.uk

NHS 24 Health Information Advisory Service - contact clare.scanlan@nhs24.scot.nhs.uk

NHS Tayside Public Health Library - contact elspeth.henry@nhs.net
Appendix 1: Preliminary Self-Assessment and Action Plan

The following template can be used for each criterion.

<table>
<thead>
<tr>
<th>Criterion number: ............</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which accreditation level currently applies to your service?</td>
</tr>
</tbody>
</table>

| List the evidence you currently have available to support this accreditation level. |

| What accreditation level would you like to achieve for this criterion through the quality assurance process? |

| What additional evidence will you aim to provide to support this target accreditation level? |

<p>| What actions will you take to achieve this target accreditation level and provide the necessary supporting evidence? |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Appendix 2: Final Self Assessment Report and Evidence Portfolio: Guidance on Production and Formatting

The self-assessment report comprises:

1. The evidence portfolio
1.1 The portfolio should be no larger than one A4 boxfile.
1.2 All items of evidence should be clearly numbered.
1.3 Where evidence exists in electronic form, a memory stick or CD should be provided with electronic copies. For online material, URL’s and titles should be provided.
1.4 An index listing document numbers and corresponding document titles should be presented at the front of the portfolio. This should include numbers and titles for electronic evidence items.
1.5 All items of evidence should be referred to by number in the self-assessment report. Note that the same item of evidence may apply to multiple criteria.

2. A context-setting introduction (maximum 500 words plus appendices) providing:
2.1 Details of recent history of development of the service (past 2 years) which will help the Evaluation Panel to understand the key issues.
2.2 An overview of service structure and staffing.
2.3 Summary of current statistics for user groups and usage levels for the various services (details may be provided as appendices).
2.4 Key challenges currently facing the service.

3. For each standard
3.1 Statement of the standard (copied from Quality Assurance Framework).
3.2 A summary (maximum 300 words) of:
   • The strengths of the service in relation to each standard
   • The areas where work still needs to be done
   • Future plans for development in this area

4. For each criterion:
4.1 The self-assessments for the various criteria should be listed beneath the summary statement for the relevant standard.
4.2 Statement of the criterion (copied from Quality Assurance Framework).
4.3 A statement of the accreditation level sought, with the text descriptor corresponding to that level.
4.4 A brief description of the evidence pertaining to that accreditation level. (maximum 300 words), with any explanatory narrative or examples deemed necessary.
4.5 Reference by number to the relevant evidence documents.

5. Format
5.1 The report should be written in Times New Roman font 12.
5.2 All information provided should be anonymised unless individual has given permission for their details to be provided.
5.3 Please omit from the report those criteria which the service is *not* aiming to meet at time of assessment.

6. Submission
6.1 The report should be submitted to the Evaluation Panel in electronic form and also as a bound printed document (6 copies).