NHS Fife Clinical Governance Committee

06 November 2019, 14:00 to 17:00
Staff Club, VHK

Agenda

1
APOLOGIES FOR ABSENCE
Paul Hawkins

2
DECLARATIONS OF MEMBERS' INTERESTS
3
MINUTES OF PREVIOUS MEETING HELD ON 4 SEPTEMBER 2019

(attached)

Item 3 - Unconfirmed Notes 040919 V2.pdf (13 pages)

4
ACTION LIST

(attached)

Item 4 - ACTION LIST 6 NOVEMBER 2019.pdf (5 pages)

5
MATTERS ARISING
5.1
Participation and Engagement Update

(attached)

Nicky Connor

Item 5.1 - 20191015 SBAR PEN REVIEW v1.1.pdf (4 pages)

Item 5.1 Appendix 1.pdf (5 pages)

Item 5.1 Appendix 2.pdf (2 pages)

Item 5.1 Appendix 3.pdf (3 pages)

5.2
Surgical Site Infection Update

(verbal)

Chris McKenna

5.3
Governance of the Transformation Group

(attached)

Susan Fraser

Item 5.3 - Integration Transformation Board Terms of Reference October 2019.pdf (3 pages)

5.4
Primary Care Improvement Plan - Governance Arrangements and GMS Contract

(attached)

Helen Hellewell

Item 5.4 - SBAR - CGC PCIP Risks FINAL v2 1 171019.pdf (7 pages)

Item 5.4 - APPENDIX 1 - PCIF PRIORITIES BY WTE Year 3 and 4.pdf (1 pages)

5.5

Pharmacy Input to identification of SABs

(attached)

Helen Hellewell

Item 5.5 - SBAR Report Template NHSFCGC wound management v2.pdf (3 pages)

6
REQUESTED REPORTS

6.1

Hypoglycaemia Report

(attached)

Sharon Robertson

Item 6.1 - Hypoglycaemia Report.pdf (3 pages)

6.2

Learning Disability Update

(attached)

Nicky Connor

Item 6.2 - LD 18.10.19 (2).pdf (7 pages)

6.3

Quality of Care Framework

(attached)

Chris McKenna

Item 6.3 - QoCreadiness v 0 5.pdf (5 pages)

Item 6.3- Appendix 1 QoC Executive Framework.pdf (3 pages)

Item 6.3 - Appendix 2-QoCA-Organisational-Review-self-evaluation-tool-1-0 (1).pdf (28 pages)

Item 6.3 - Appendix 3QoCA--self-evaluation-guide-1-0 (1).pdf (9 pages)

6.4

Organisational Duty of Candour (DoC) Annual Report 2018-2019

(attached)

Chris McKenna

Item 6.4 - SBAR DoC.pdf (2 pages)

Item 6.4 - Duty of Candour Annual Report 2018-19 (3).pdf (12 pages)

6.5

Hospital Electronic Prescribing & Medicines Administration (HEPMA) Outline Business Case

(attached)

Scott Garden

Item 6.5 - SBAR Report HEPMA.pdf (3 pages)

Item 6.5 - NHS Fife HEPMA OBC 1 0 (3).pdf (54 pages)

6.6

Drug Related Death Report

(attached)

Dona Milne

Item 6.6 - Fife 2018 DRD SBAR v4.pdf (7 pages)

Item 6.6 - DRD Fife Scotland 2018 Draft Report.pdf (32 pages)

6.7

Fife Elective Orthopaedic Centre - Outline Business Case

(attached)

Carol Potter

- Item 6.7 - SBAR CGC Elective Orthopaedic Centre OBC Nov19.pdf (2 pages)
- Item 6.7 - Fife Elective Orthopaedic Centre - OBC with appendices.pdf (162 pages)

7
QUALITY, PLANNING AND PERFORMANCE

7.1
Integrated Performance & Quality Report

(attached)

Chris McKenna

- Item 7.1 - IPQR Oct 2019.pdf (42 pages)

7.2
Winter Plan 2019-20 Update

(attached)

Ellen Ryabov/Nicky Connor

- Item 7.2 - SBAR Report Template Winter Plan.pdf (3 pages)
- Item 7.2 - DRAFT -Fife Winter Plan 2019-20.pdf (50 pages)

8
GOVERNANCE

8.1
Board Assurance Framework - Quality & Safety

(attached)

Chris McKenna/Helen Buchanan

- Item 8.1 - SBAR Report Template BAF Q&S.pdf (2 pages)
- Item 8.1 - NHS Fife Board Assurance Framework (BAF) V17 1 231019 - Quality Safety.pdf (1 pages)

8.2
Board Assurance Framework - Strategic Planning

(attached)

Susan Fraser

- Item 8.2 - SBAR CGC BAF 5 06112019.pdf (3 pages)
- Item 8.2 - BAF 06112019 - Strategic Planning.pdf (1 pages)

8.3
Board Assurance Framework - eHealth

(attached)

Ellen Ryabov

- Item 8.3 - SBAR Board Assurance Framework ehealth.pdf (3 pages)
- Item 8.3 - NHS Fife Board Assurance Framework 191004 - eHealth.pdf (1 pages)

8.4
Brexit

(attached)

Chris McKenna

- Item 8.4 - BREXIT Update November NHSFCGC 2019.pdf (1 pages)

9
TRANSFORMATION / REDESIGN / CLINICAL STRATEGY

9.1
Acute Transformation

(attached)

Ellen Ryabov

- Item 9.1 - SBAR Report Template NHSFCGC Oct 19.pdf (3 pages)
- Item 9.1 - TransformationCommitteeStructure Appendix 1.pdf (1 pages)
- Item 9.1 Revised - Fife ASD Transformation Efficiency Appendix 2ER.pdf (1 pages)

9.1.1

9.2
Medicines Efficiency

(attached)

Scott Garden

- Item 9.2 - Medicines Efficiency Update.pdf (7 pages)

10
ANNUAL REPORTS

10.1
Medical Revalidation 2018-2019

(attached)

Chris McKenna

- Item 10.1 - Appraisal Report 2018-19 SBAR.pdf (2 pages)
- Item 10.1 - Appraisal Report 2018-2019.pdf (11 pages)

10.2
Research & Development Annual Report

(attached)

Chris McKenna

- Item 10.2 - SBAR - Research & Development Annual Report 2018-2019.pdf (2 pages)
- Item 10.2 - R&D Annual Report 2018-19.pdf (39 pages)

10.3
Research & Development Strategy

(attached)

Chris McKenna

- Item 10.3 - SBAR - Research & Development Strategy 2019-20.pdf (3 pages)
- Item 10.3 - R&D Strategy 2019-20 plus priorities.pdf (14 pages)
- Item 10.3 - Outcomes against R&D Strategy priorities18-19.pdf (2 pages)

10.4
ADP Annual Report - c/f to a later date

Dona Milne

10.5
NHS Fife Annual Immunisation Report 2019

(attached)

Dona Milne

Item 10.5 - SBAR - Annual Immunisation Report for CGC_06_11_19.pdf (4 pages)

Item 10.5 - NHS FIfe Annual Immunisation Report 2019_FINAL.pdf (40 pages)

11
LINKED COMMITTEES

11.1
Acute Services Division Clinical Governance Committee

(attached)

Item 11.1 - Cover sheet ASD CGC 240719.pdf (1 pages)

Item 11.1 - ASD CGC Minute 240719.pdf (24 pages)

Item 11.1 - Cover sheet ASD CGC 170919.pdf (1 pages)

Item 11.1 - ASD CGC Minute 170919.pdf (20 pages)

11.2
Area Drugs & Therapeutics Committee

(attached)

Item 11.2 - Cover sheet ADTC 210819.pdf (1 pages)

Item 11.2 - ADTC MINUTES 210819.pdf (11 pages)

11.3
HSCP Clinical and Care Governance Committee

(attached)

Item 11.3 - Cover sheet CCGC 090819.pdf (3 pages)

Item 11.3 - CCGC Minute 090819.pdf (11 pages)

Item 11.3 - Cover sheet CCGC 270919.pdf (2 pages)

Item 11.3 - CCGC Minute 270919.pdf (11 pages)

11.4
Clinical Governance Oversight Group

(attached)

Item 11.4 - Cover sheet Oversight Group 110919.pdf (1 pages)

Item 11.4 - Oversight Group 110919.pdf (7 pages)

11.5
Fife Research Committee

(attached)

Item 11.5 - Cover Sheet Research Governance 120919.pdf (2 pages)

Item 11.5 - Research Governance Minutes 120919.pdf (4 pages)

11.6
Information Governance & Security Group

(attached)

Item 11.6 - Cover sheet IG&SG Minutes 290819.pdf (2 pages)

Item 11.6 - IG&S Minutes 290819.pdf (5 pages)

11.7
Integrated Joint Board

(attached)

Item 11.7 - Cover Sheet IJB 060919.pdf (1 pages)

Item 11.7 - IJB Minute 060919.pdf (8 pages)

Item 11.7 - Cover Sheet IJB 240919.pdf (1 pages)

Item 11.7 - IJB Minute 240919.pdf (4 pages)

11.8

Infection Control Committee

(attached))

Item 11.8 - Cover Sheet ICC Minutes.pdf (2 pages)

Item 11.8 - ICC Mins Oct 2019.pdf (8 pages)

11.9

Resilience Forum

Item 11.9 - Cover sheet Resilience Forum 190919.pdf (1 pages)

Item 11.9 - Resilience Forum 190919.pdf (4 pages)

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ITEMS FOR NOTING

13

ISSUES TO BE HIGHLIGHTED TO THE BOARD

14

AOCB

15

DATE OF NEXT MEETING

Thursday 16 January 2020 at 2pm in the Staff Club

MINUTE OF NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 4 SEPTEMBER 2019 at 2PM IN THE STAFF CLUB, VHK

Present:

Dr Les Bisset, Chair
Cllr David Graham, Non Exec Committee Member
Margaret Wells, Non Exec Committee Member
Paul Hawkins, Chief Executive
Dona Milne, Director of Public Health
Martin Black, Non Exec Committee Member
Rona Laing, Non Exec Committee Member
John Stobbs, Patient Representative
Dr Chris McKenna, Medical Director
Helen Buchanan, Nurse Director

In Attendance:

Lynn Campbell, ADN, ASD
Dr Rob Cargill, AMD, ASD
Gillian MacIntosh, Board Secretary
Barbara Anne Nelson, Director of Workforce
Julie Paterson, DGM H&SCP (Fife-wide) (for Item 9.1)
Dr Marie Boilson, Clinical Director (Fife-wide) (for Item 9.1)
David Heaney DGM H&SCP (East) (for Item 9.2)
Karen Gibb (for Item 9.2)
Catriona Dziech, Note Taker
Nicky Connor, Interim Director of H&SCP
Dr Helen Hellewell, AMD, H&SCP
Andy McKay (for Ellen Ryabov)
Helen Woodburn, Quality & Clinical Governance Lead
Frances Baty, Head of Psychology Service (for Item 9.1)
Dr John Kennedy, Clinical Director (East) (for Item 9.1)
Claire Dobson DGM H&SCP (West) (for Item 9.2)
Cllr Tim Brett (Observer)

MINUTE REF	ITEM	ACTION

060/19 APOLOGIES FOR ABSENCE

As members, Wilma Brown and Janette Owens. As attendees, Susan Fraser, Scott Garden, Elizabeth Muir, and Ellen Ryabov

061/19 DECLARATIONS OF MEMBERS' INTERESTS

Rona Laing declared an interest in Item 5.9 as a current patient of Lochgelly Medical Practice.

062/19 MINUTES OF PREVIOUS MEETING HELD ON 3 JULY 2019

The notes of the meeting held on 3 July 2019 were approved.

063/19 ACTION LIST

All outstanding actions are updated on separate Action List.

064/19 MATTERS ARISING

5.1 Participation and Engagement Update

Helen Buchanan gave an update on the recent review to look at the role and remit of Patient Focus Public Involvement (PFPI) and the Participation & Engagement Network (PEN) groups.

064/19 The initial review highlighted that within both groups there was duplication across their remits and a lack of consistency in the approach to public involvement across NHS Fife. We are currently looking at a model to support both. An Option Appraisal to identify the best approach is being considered within the next two weeks.

Advice is being taken from the Scottish Health Council on the preferred model and to get a steer on the best approach aligned to national developments. The proposed model to be implemented in Fife should be available for November meeting of the NHSFCGC.

Dr Bisset noted that it was very important a report / proposal is brought to the next meeting, not least since this issue was raised at the Annual Review public session last February. It was agreed we need to be ready with a refreshed model and a plan for how to take it forward. **HB**

5.2 Surgical Site Infection Update – Improvement Plan

Helen Buchanan reminded members that a full discussion had taken place previously with Keith Morris at the last meeting of the Committee.

Helen Buchanan advised Keith Morris has already had a conversation with Health Protection Scotland about the things we do in Fife which may be different from the rest of Scotland. One of the things we do that is not part of the pathway in Scotland is that all women come back to maternity services. There has been a lot of discussion whether this is the correct pathway or should it be the GPs who see these women who are potential SSIs. Helen Buchanan advised this is a conversation that she and Keith Morris are planning to have with the Obstetricians, Midwives and GP Services about the preferred pathway. **HB**

Helen Buchanan also advised that when looking at other Health Boards in Scotland, we found that not everyone collates the data as we do in Fife. NHS Fife is very open and transparent about its data reporting. Helen Buchanan advised the Improvement Plan was ongoing without a proposed end date. Keith Morris feels this may be due to the way we count SSIs and

064/19 how we put the data forward as opposed to the problem but we still report it and that is the correct thing to do.

Feedback from Health Protection Scotland was that GPs are the ones who see SSIs on a routine basis (not just for C Sections but for all surgical sites) and are best placed to treat instead of women coming back to Acute and being seen by Midwives post delivery.

Dr Bisset noted that it does look like NHS Fife are an outlier within the present figures, so it would be helpful to have an update paper for the November NHSFCGC with progress in determining the true picture. **HB**

5.3 Transformation Programme Workshop Update and Role and Remit of Joint Strategic Transformation Group

This paper provided the Committee with an update on the Transformation Programme in Fife, including a report on the recent Transformation Stocktake Workshop which took place on 23 July 2019.

The Committee noted the Workshop's recommendations to:

1 Establish a new system for Transformation with a joint meeting with H&SCP and NHS Fife to establish a review of each scheme's timelines and proposed value.
2 Disband the Joint Strategic Transformation Group and establish an Integrated Transformation Board reporting to NHS Fife Board and the IJB.
3 Established a 'stage and gate' process for approval and monitoring of programmes.
4 Escalation process to be used against delivery of programmes for NHS Fife and IJB.
5 Establish a workgroup to produce an integrated plan.

Paul Hawkins advised that further analysis will take place at the next meeting on 20 September to set out what the timelines look like. A paper will then be circulated to adopt the new procedures. There will be a Transformation Board which is accountable to both Clinical Governance committees of the Health Board and the IJB, in addition to the scrutiny of the Council. It is proposed, at the moment, the Chairs and a

064/19 nominated lead from the Council would be on that Group. The idea of the Transformation Board is to have as many of the decision makers around the table right at the beginning of the conversations, to smoothly push things through and identify for the attention of the governance committees the real issues that we wish to go forward with. This should hopefully move forward within the next six weeks.

Dr Bisset clarified we are being asked to note the comments from the recent Workshop and that nothing is being approved at this stage. Paul Hawkins confirmed this and noted that the role of the governance committees in the approval process was still being considered.

The Committee noted the update and a further paper will come to the next meeting. The position of the different Committees in the overall plan will be clarified at the next meeting of the Transformation Group. **PH**

5.4 Primary Care Improvement Plan – Governance arrangements and GMS contract

Dr Hellewell gave a verbal update on the position, stating that the scoping exercise has taken place but not all the detail was yet available for a written report to be prepared for this meeting. A report will be submitted for the next NHSFCGC in November. **HH**

Dr McKenna confirmed a meeting is being held within the next few weeks as a Primary Care team to look at the governance arrangements for Primary Care and how this sits with the requirements to implement GMS. It is hoped a robust structure will be in place by the next NHSFCGC in November. **HH**

5.5 Drug related Death Report

This item was covered within the Action List update. A report will be available for NHSFCGC in November.

5.6 Update on Pharmacy input to identifying SABs

Dr Hellewell advised she has spoken to Andrea Smith and Scott Garden, who confirmed there is nothing in place currently with pharmacies to identify infections. There is development work ongoing. A new Pharmacist is coming in to post who will lead on this work. Further detail will follow in due course.

064/19 Dr Bisset asked that Dr Hellewell bring a written paper to NHSFCGC in November which sets out the position with SABs in the Community. **HH**

5.7 Feedback from HIS following OPAH/Glenrothes HAI Report

Helen Buchanan advised she has spoken with Ann Gow and highlighted the concerns raised in the inconsistency of reports from the OPAH visit to VHK and the Glenrothes Hospital visit in comparison to the verbal feedback. Ann Gow has agreed to take back comments to her team and respond to Helen Buchanan. This feedback will then be brought back to the NHSFCGC. **HB**

Helen Buchanan advised that with the introduction of the new Quality Framework, future reporting will look different.

Dr Bisset noted that the Committee had been concerned with the inconsistencies within the report, including whether some parts of the report actually referred to Fife, and hoped HIS had taken this on board. Dr Bisset said we should not lose sight of this and that we should expect a response from HIS. Helen Buchanan agreed to go back to Ann Gow to see what actions she has taken forward with her staff at HIS. **HB**

Dr Bisset noted that a large number of the Matters Arising items were verbal updates and this was unsatisfactory. Although appreciating that verbal reports are sometimes necessary, Dr Bisset asked that members strive to bring written reports wherever possible. **ALL**

5.8 Information Governance and Security Group (IGSG) – Terms of Reference

Dr McKenna advised this report was for noting but highlighted the following:

- Carol Potter is now the new SIRO
- The key purpose of the Group is set out at Paragraph 1.3

Gillian MacIntosh advised that, at the recent meeting of the IGSG, it was agreed that under Item 3.2, quorum of the meetings, deputies of key members would be accounted for these purposes, and thus the document would be amended accordingly.

064/19 The Committee approved the amended Terms of Reference, subject to the correction of a few minor typographical clarifications as suggested by Rona Laing and Margaret Wells. **GMacI**

5.9 Kincardine/Lochgelly – Initial Agreement documents (IADs)

Nicky Connor advised these reports have been to the Capital Planning Group and officers have taken on board the previous feedback regarding the detail of the proposed model.

Authorisation was given by the Capital Planning Group to begin to look at potential capital investment to meet patient and service needs. The IADs were previously submitted to Scottish Government who requested that the model of care be articulated more fully and that Fife participate in the national pathfinder programme for Local Care, which supports transformational change that shifts the balance of care to community.

This paper relates mainly to the IAD stage for Kincardine and Lochgelly. National and local strategies have been taken into account in preparing these IADs.

The Committee:

- Approved the direction of travel following the non-financial option appraisal (subject to formal financial appraisal) for Kincardine and Lochgelly as outlined in the Assessment section; and
- Approved submission to the Finance, Performance and Resources Committee for approval to progress to NHS Fife Board and Scottish Government Capital Investment Group.

065/19 REQUESTED REPORTS

None scheduled for September Committee

066/19 QUALITY, PLANNING AND PERFORMANCE

7.1 Integrated Performance and Quality Report

Performance reporting to the board has been in the form of separate Integrated Performance Report and Quality Report (IPQR). A review was requested to bring these two reports together into one document.

066/19 This paper provides the committees with an overview of the changes that have been made to the reporting of performance and quality in NHS Fife.

The Committee noted the new Integrated Performance and Quality Report, welcoming the format changes.

Dr Bisset asked that thanks and congratulations be passed to Susan Fraser and the others who helped produce this new report.

Dr McKenna highlighted the following from the Executive Summary:
- SSI – still an outlier
- SABS – significant improvement

7.2 HAIRT Report

Helen Buchanan advised very little has changed to the HAIRT report and highlighted the challenges as set out in Para 1.2 for:
- Caesarean Section SSI
- SABs (Staphylococcus aureus Bacteraemia)
- ECBs (Escherichia coli Bacteraemia)
- Large Bowel Surgery SSI

Dr McKenna highlighted it may worthwhile keeping an eye on ecoli bacteraemia as there may be an emerging issue with the overuse or incorrect use of antibiotics in urinary tract infections which can result in the development of the bacteraemia. There is an emerging pattern of this group of infections coming in to Acute Services.

Helen Buchanan advised a group had been established looking at catheter associated urinary tract infection. This has been a successful multidisciplinary group and a report on the work can be brought to the NHSFCGC if desired.

7.3 Winter Plan Update

This paper provided the committee with an update to the draft Winter Plan for 2019/20 submitted at the last meeting, outlining arrangements being put in place to support capacity and sustainability over the winter period (focussing on the period October 2019 to March 2020).

066/19 This draft of the Winter Plan 2019/20 has been agreed following a winter planning event held on 22 August 2019 with H&SCP and Resilience colleagues and a follow up meeting with Acute colleagues on 23 August. A small working group has been taking forward the actions from the Winter Review 2018/19 over the summer months, including actions included in the Winter Plan 2019/20.

Nicky Connor advised some of the detail within the Appendices is still being finalised to ensure the actions in terms of escalation are smart, ready and specific. This is not included at present within this document but she assured the NHSFCGC it is actively in progress.

Claire Dobson advised the tracker versus placement document which is produced each year will be finalised shortly and then costed. Joint working has been undertaken to complete this.

The Committee noted the Winter Plan 2019/20 update.

067/19 GOVERNANCE

8.1 Board Assurance Framework – Quality and Safety

The Committee noted this report is an update on the Quality and Safety BAF since the last report received on 3 July 2019.

Helen Buchanan advised there were no changes to the associated risks.

Helen Buchanan advised the Risks previously highlighted to the Committee - 1502 (3D temperature Monitoring System (South Lab)) and 1524 (Oxygen Driven Suction) – that there is mitigation with both Risks and these are being worked through.

The Committee noted the changes as set out in the Quality and Safety BAF.

8.2 Board Assurance Framework – Strategic Planning

This report provides the Committee with the next version of the NHS Fife Strategic Planning BAF.

David Graham queried if the Timescale date of 31/08/2019 will be reviewed and this was confirmed.

067/19 The Committee noted the current position in relation to the Strategic Planning risk.

8.3 Brexit

Dr McKenna advised this is an update to the previous version submitted to the Committee and confirmed there has been no changes since the last report.

Dr Bisset asked that a more explicit summary other "no change" be provided for eHealth for NHSFCGC in November. **CMcK**

The Committee noted the update.

8.4 Annual Workplan

Helen Woodburn advised that during May and June 2019, a short review has been undertaken of the current work plan and structure of the agenda in order to streamline information and processes for the Clinical Governance Committee. This included a comparison to other standing committees of the Board, with a view to reduce any variation between the committees and achieve standardisation in templates, work plans and agenda structure.

The Committee noted and approved the changes as set out in the report.

Dona Milne asked that Director of Public Health Annual Report be changed on the Workplan to report annually in May. **HW**

8.5 Corporate Calendar Future Committee Meeting Dates

The Committee noted the proposed dates for the Committee for 2019 through to 2021.

068/19 TRANSFORMATION / REDESIGN / CLINICAL STRATEGY

9.1 Community Hospital Redesign

Nicky Connor advised that Community Hospital Redesign is one of the key areas of transformation within the H&SCP and will also be part of the programme to be considered by the Transformation Board.

This report is to inform and update the Committee of progress made on the redesign of Community Hospital and Intermediate Care Beds, and to set out next steps.

068/19 David Heaney, Karen Gibb, Dr Hellewell and Dr Kennedy each gave an update on the background and work undertaken on the proposed models.

Following detailed discussion by members, the following of areas of concern were highlighted:

- the rigour of the Public Consultation process, particularly at the early stages of the option appraisal process;
- the Financial Planning for the proposals and how this related to the system as a whole; and
- Too much focus on beds modelling and less about the model of care.

Nicky Connor thanked the Committee for the feedback and noted the concerns raised.

In summary, Dr Bisset thanked everyone who had put a lot of hard work in to producing these papers, which are very helpful and appreciated. It is clear from the issues raised today the Committee are uncomfortable going ahead to public consultation at the moment, until further work is done to prepare the proposals. The issues raised need to be addressed through the Transformation Group arrangements described earlier in the meeting by Paul Hawkins. Going forward, the proposal would be taken through the Transformation Group to undertake the 'stage and gate' exercise and then make sure the final papers go to the Governance Committees of both the Health Board and IJB. In light of this, the current timetable set out in the paper for its approval will need to be changed.

The Committee noted the update on progress with the Community Hospital and Intermediate Care Redesign.

9.2 Mental Health Strategy and Board Feedback Paper

Nicky Connor advised that this is another significant area of transformational change within the H&SCP. This is a progress report along with formal feedback received from the Board on the current draft of the strategy. Significant work is underway to consider these comments in consultation with clinical colleagues.

068/19

Julie Paterson advised that the H&SCP's Finance & Performance Committee considered Fife's draft mental health strategy at its meeting on 17 July 2019. The outcome from this meeting is that the Committee has requested financial information on how the strategy will be delivered, to be submitted to their meeting on 17 September 2019.

At its meeting on 31 July 2019, NHS Fife Board considered the draft mental health strategy and provided a formal response for consideration in the final draft of the strategy (included as Appendix 1 in the paper).

The H&SCP's Clinical & Care Governance Committee met on 9 August 2019 to consider the draft mental health strategy and 'enthusiastically' supported the document. They will meet again on 27 September 2019 to review any subsequent changes arising from feedback via NHS governance routes, with a view to final presentation to the Integrated Joint Board in October 2019.

As with the previous paper, it was agreed that consideration of this work would now fall under the remit of the Transformation Board. At present, the H&SCP's response to the Board's feedback was awaited, before the strategy could progress further.

Helen Hellewell assured the Committee the concerns raised were being addressed, although at this stage the response was not finalised. Dr Hellewell would ensure comments were fed back as soon as possible and hopefully in advance of the planned 'stage and gate' process. **HH/NC**

Martin Black raised a concern that there is no link to Addictions and Learning Disability within the Mental Health Strategy. Dr McKenna advised this has been discussed previously, but highlighted these areas have their own stand-alone strategies. Nevertheless, Dr McKenna has asked for greater reference to Learning Disability and Addiction Services to be raised within the overall Mental Health Strategy.

The Committee noted the progress of the draft Mental Health Strategy for Fife.

069/19 ANNUAL REPORTS

10.1 Medical Education Report

The Committee noted the report and the recommendations, commending the large amount of training and education work underway in Fife which is well-rated by participants.

Dr Bisset asked that Dr Morwenna Wood and her team should be congratulated on this report and their continuing hard work.

10.2 Prevention & Control of Infection Annual Report

Helen Buchanan advised the Executive Summary on Page 7 of the report highlights the extensive work undertaken by the Infection Control Team.

The Board considered and accepted the Annual Report.

070/19 LINKED COMMITTEE MINUTES

Dr Bisset advised that all items under this section would be taken without discussion unless any particular issues were raised.

11.1 Acute Services Division Clinical Governance Committee – 24 July 2019 – c/f to November 2019
Dr Cargill advised that the frequency of the meeting had been changed from four times per year to six and thus two sets of minutes will be available for the Committee in November.

11.2 Area Clinical Forum

11.3 Area Drugs & Therapeutics Committee (ADTC)
Dr McKenna highlighted the issues around Safe and Secure Use of Medicine Group (SSUOMG) and Biosimilar issue around Adalimumab / Trastuzumab.

11.4 HSCP Clinical and Care Governance Committee

11.5 Clinical Governance Oversight Group

11.6 Fife Research Committee – 27 June 2019 – carried forward to November 2019

11.7 Health and Safety Sub-Committee

11.8 Integrated Joint Board

11.9 Infection Control Committee

11.10 Public Health Assurance Group

11.11 Resilience Forum

071/19 ITEMS FOR NOTING

12.1. Internal Audit Report – Information Governance & eHealth Report No. B31&32/19

The Committee noted this report, which was tabled for the Committee's information.

072/19 ISSUES TO BE HIGHLIGHTED TO THE BOARD

The following issues to be highlighted to the Board:
Community Hospitals
Mental Health Strategy
Transformation Group

073/19 AOCB

There was no other competent business.

074/19 DATE OF NEXT MEETING

Wednesday 6 November 2019 at 2pm in Staff Club, VHK

TABLE OF ACTIONS FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE
UPDATED ON 4 SEPTEMBER 2019
FOR DISCUSSION ON 6 NOVEMBER 2019

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Item 59 **Quality Report**	6.3.19	Minute Ref 020/19 Reporting of items within Quality Report / HAIRT and IPR to be considered again.	HWo	~~May 2019~~ ~~July 2019~~ September 2019	4.9.19 Main agenda item 7.2 Close
	3.7.19	Minute Ref 050/19 It was noted the Diabetes Team are undertaking work to ensure patients are looked after in a standardisation way. The figures are likely to rise as reporting is rolled out across the ASD. Item to remain on Quality Report.	CMcK	September 2019	4.9.19 Diabetes Team to attend and present at NHSFCGC 6.11.19 Close
	3.7.19	Minute Ref 050/19 – Community SAB Update HH to obtain more information on the work undertaken with pharmacies to identify infections.	HH	September 2019	4.9.19 Main agenda item 5.6
	3.7.19	Minute Ref 050/19 HH in conjunction with Public Health, to prepare a report on the reasons why there is such a high number of intravenous drug users in Fife when significant finance has been spent on an Addictions Strategy.	HH	September 2019	4.9.19 Report prepared will come to NHSFCGC on 6.11.19 Close
	3.7.19	Minute Ref 050/19 DM to arrange for the Committee to have sight of the Drug Related Death report.	DM	~~September 2019~~ November	4.9.19 Full report will come to NHSFCGC 6.11.19
Item 112 **HIS Quality Framework**	6.3.19	Minute Ref 022/19 CMcK agreed to take forward with HWr and HWo the elements of the framework which come to the specific Committees.	CMcK/HWo/HB	~~May 2019~~ ~~July 2019~~ ~~September 2019~~ November 2019	8.5.19 & 3.7.19 & 4.9.19 Work complete. Paper to come to NHSFCGC 6.11.19

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Item 113 **BAF for Quality & Safety**	7.11.18	Minute Ref 069/18 Refined Flowchart for Duty of Candour to be reported to next NHSFCGC meeting.	~~FME~~ CMcK	~~January 2019~~ ~~July 2019~~ September 2019	4.9.19 Will be discussed at Private Session Close
	3.7.19	Minute Ref 052/19 CMcK to check Risks 1502 and 1524 and provide an update.	CMcK	September 2019	4.9.19 Updated at Main Agenda Item 8.1 Close
Item 130 **BAF for Strategic Planning**	6.3.19	Minute Ref 020/19 Issue of East Region H&SC Delivery Plan to be raised with PH. Nicky Connor agreed to take back and discuss further with MK.	~~FME/NC~~	~~May 2019~~ ~~July 2019~~ ~~September 2019~~ November 2019	4.9.19 NC advised she had picked up at the time but will bring back update to NHSFCGC 6.11.19
	3.7.19	MK advised an update on the diabetes work had been prepared for the Health & Sports Committee. MK will arrange to circulate to NHSFCGC.	MK	September 2019	4.9.19 DM confirmed this had been circulated. Close
Item 134 **Report from Information & Governance Security Group on Compliance with General Data Protection Regulations (GDPR)**	6.3.19	Minute Ref 022/19 Report to be brought to NHSFCGC in early March 2020.	CMcK	March 2020	
Item 138 **NHS Fife Activity Tracker - Victoria Hospital Older People in Acute Hospitals unannounced inspection report and action plan**	8.5.19	Minute Ref 040/19 HB to raise the issue of content of final report with Ann Gow at HIS and feed back to the Committee following her discussion.	HB	~~July 2019~~ ~~September~~ November 2019	4.9.19 Main Agenda Item 5.7. HB to check with Ann Gow to see what actions have been taken forward with her staff.

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Item 140 **Update Report on all strands of Clinical Strategy**	6.3.19	Minute Ref 021/19 Nicky Connor to bring an update on Learning Disability.	NC	~~September 2019~~ November 2019	4.9.19 NC will bring back to NHSFCGC 6.11.19
Item 142 **Committee Self Assessment Report**	6.3.19	Minute Ref 022/19 LB to meet with CMcK and GMacI to formulate an action plan to address the issues within the report.	LB/CMcK/GMcI	~~May 2019~~ ~~July 2019~~ ~~September 2019~~ November 2019	3.7.19 & 4.9.19 Meeting has not taken place. Still to be progressed.
Item 143 **Update on Vaping report submitted to SGHD**	3.7.19	DM advised the consultation should be available in July looking at secondary recommendations by November 2019. Hopefully the Consultation will be available for NHSFCGC in September 2019 to consider before a view is taken to the Board.	DM	~~September 2019~~ November 2019	4.9.19 DM confirmed this has been delayed due to Brexit.
Item 145 **Review of Agenda**	8.5.19	Minute Ref 031/19 Streamlined agenda to be in place by September 2019.	HW	September 2019	4.9.19 New agenda adopted. Closed
Item 146 **Annual Statement of Assurance eHealth Board 2018/19**	8.5.19	Minute Ref 038/19 ER to share revised Terms of Reference with NHSFCGC when this is produced.	ER	~~July 2019~~ ~~September 2019~~ November 2019	4.9.19 ER to liaise with LD and bring to NHSFCGC 6.11.19
Item 148 **Patient Focus Public Involvement (PFPI)**	8.5.19	Minute Ref 038/19 Following completion of Option Appraisal report to be considered at NHSFCGC in July 2019.	HB	~~July 2019~~ September 2019	4.9.19 Main Agenda Item 5.1 Closed
Item 150 **Surgical Site Infection Update**	3.7.19	Minute Ref 050/19 i) HB & CMcK to provide update on Improvement Plan	HB/CMcK	September 2019	4.9.19 Main Agenda Item 5.2 Close
		ii) HB to feedback discussion with Health Protection Scotland	HB	September 2019	4.9.19 Main Agenda Item 5.2 Close

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Item 150 Surgical Site Infection Update Continued....		iii) HB & KM to ensure reporting includes a caveat on the differences between NHS Fife reporting & National reporting method.	HB/KM	September 2019	4.9.19 Main Agenda Item 5.2 Close
	4.9.19	Minute Ref 06/19 HB & Keith Morris to liaise with Obstetricians, Midwives and GP Services about the preferred pathway. Update paper to come to NHSFCGC 6.11.19	HB	November 2019	
Item 152 Information Governance & Security Group (IGSG)	3.7.19	Minute Ref 050/19 Carol Potter to provide a report with an update on the review of the IGSG.	CP	September 2019	4.9.19 Main Agenda Item 5.8 Close
Item 153 Kincardine & Lochgelly IAD (Health Centres)	3.7.19	Minute Ref 051/19 To be taken to Capital Investment Group on 1 August and then through Governance with a view to taking IADs to the Board on 25 September 2019.	MK	September 2019	4.9.19 Main Agenda Item 5.9 Close
Item 154 Primary Care Improvement Plan	3.7.19	Minute Ref 051/19 Short paper to be prepared setting out the clear governance responsibilities / arrangements.	HH	~~September 2019~~ November 2019	4.9.19 Main Agenda Item 5.4. Written report to come to NHSFCGC 6.11.19
		Minute Ref 051/19 HH to prepare a paper setting out the issues which will come out of the Implementation Plan that will affect the GMS Contract.	HH	~~September 2019~~ November 2019	4.9.19 Main Agenda Item 5.4. Update report NHSFCGC 6.11.19
		Minute Ref 051/19 HH to pass on congratulations to all those involved in producing the Plan.	HH	September 2019	4.9.19 Close
Item 155 Participation & Engagement Update	4.9.19	Minute Ref 064/19 Refreshed model and plan to be considered at NHSFCGC on 6.11.19.	HB	November 2019	

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Item 156 Transformation Programme Workshop Update & Role & Remit of Joint Strategic Transformation Group	4.9.19	Minute Ref 064/19 Further paper will come to NHSFCGC on 6.11.19.	PH	November 2019	
Item 157 Update on Pharmacy input to Identifying SABS	4.9.19	Minute Ref 064/19 HH to bring a written paper to NHSFCGC on 6.11.19 which sets out the position with SABs in the Community.	HH	November 2019	
Item 158 HAIRT Report	4.9.19	Minute Ref 066/19 Report on the work of the catheter associated urinary tract infection group to be considered.	HB	November 2019	
Item 159 Brexit	4.9.19	Minute Ref 067/19 Explicit summary to be provided for eHealth Section.	CMcK	November 2019	
Item 160 Annual Workplan	4.9.19	Minute Ref 067/19 Director of Public Health Annual Report to be changed on the Workplan to report annually in May.	HW	November 2019	
Item 161 Mental Health Strategy & Board Feedback Paper	4.9.19	Minute Ref 068/19 HH and NC to ensure NHSGCGC comments are fed back as soon as possible and hopefully in advance of the planned “stage and gate” process.	HH/NC	November 2019	

NHS Fife
Clinical Governance Committee

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Participation and Engagement Network (PEN) Review
EXECUTIVE LEAD:	Mrs Helen Buchanan / Mrs Nicky Connor
REPORTING OFFICER:	Ms Amy Walker / Ms Donna Hughes

Purpose of the Report (delete as appropriate)		
For Decision	~~**For Discussion**~~	~~**For Information**~~

SBAR REPORT

Situation

The purpose of this paper is to update and inform NHS Fife Clinical Governance Committee of the Participation and Engagement Network (PEN) review, with a view to endorsing the proposed new structure.

Background

In 2018 NHS Fife gave a commitment to review the roles and remits of the 'Patient Focus Public Involvement' (PFPI) and the 'Participation & Engagement Network' (PEN) groups. The review commenced in January 2019.

A decision was taken to pause the PFPI and PEN groups until the review was complete. However, it should be noted that the Participation and Engagement Leads across NHS Fife and Fife HSCP continue to support the delivery of the Participation and Engagement agenda.

The review group comprised of professionals from:

- NHS Fife
- Fife HSCP
- Scottish Health Council
- Fife Voluntary Action.

Gaps were identified in terms of the model of participation required for both NHS Fife and Fife HSCP to meet their legal obligations around the national legislative and policy context for participation and engagement.

The review demonstrated that within both groups there was **duplication** across the agenda and a **lack of consistency** in the approach to public involvement across NHS Fife and Fife HSCP. This was reiterated by the public members involved in both groups. Members of the PEN and PFPI highlighted the need for **support** to help them meet the expectations around public participation and engagement. It was clear that the groups had **no agreed outcomes or action plan** in place to help provide **assurance** on its engagement and participation activity.

A benchmarking exercise of participation and engagement activity has been carried out with other health boards and organisations to inform the review. Public members were also invited to comment on their experiences within the PEN. Collated responses can be found in **Appendix 1**.

Assessment

Following these information gathering exercises a **model of participation and engagement** has been proposed for consideration. This incorporates:

- Acute Services
- HSCP Services
- Corporate Services
- Locality model

It will provide assurance to Fife NHS Board and the Integrated Joint Board of participation and engagement requirements and meet the objectives defined within the Participation and Engagement Strategy for Fife 2016 – 2019

The model will be supported by a Directory which will contain information on:

- Individuals with specific interests and experience
- Small specialist interest groups
- Equality and diversity groups, including 'hard to reach' groups
- People's Panel.

The model satisfies:

- CEL 4
  - which stipulates the board's responsibility to "routinely communicate with and involve the people and communities they serve to inform them about their plans and performance, and defines the need to keep the Scottish Health Council informed about proposed service changes"

- National Standards for Community Engagement
  - which are focused upon: inclusion, support, planning, working together, methods, communication and impact.

PROPOSED MODEL	
In July a meeting of current PEN members was convened to review the proposed model, outlined below. This was initially met with a positive response with some suggestions which have been considered. There are, however, a number of issues which members have since raised, such as terms of reference, roles and remit. As operational functions these will be addressed in the implementation plan .The action note of this meeting can be found in **appendix 2**.	
STEERING GROUP	The proposed model will be composed of a centralised group of professional staff meeting and acting as a steering group for participation and engagement activity. Membership will include a range of professionals, building on the review group members, with the addition of the Locality Planning Coordinator, the Change & Improvement Manager (carers and dementia) and the Equality and Human Rights Officer, with a public member acting as Chair. The steering group will act as a single point of contact for services seeking public participation (using form in **appendix 3**). Each group member (excluding the Chair), using their expertise, will review the application requirements (levels 2-5 only) and as a result, a bespoke action plan for each request will be developed, virtually, to allow a timely response to the service.

	The group will meet quarterly with the Chair to discuss the participation and engagement activity that has taken place and evaluate its effectiveness. The minutes of this will be reported to Clinical Governance via the Board Director of Nursing. Part of the steering group's actions will be to recruit public members where required. Members will be recruited aligning their specific skill sets, knowledge and experience to meet the needs of the service's application; i.e. recent interaction with particular service. This will be a conscious shift away from a static group of public members. Reporting structures will be through the clinical governance route and via the public member Chair to the IJB. Support will be provided to the Chair from the steering group to attend the IJB meetings. This model is, at present, being tested with current applications.
PUBLIC MEMBER FORUM	Although public members who are actively involved, in levels 2-5, should be supported by the services they are engaging with, this proposed model will be supplemented by a structured forum. The forum will be led by the Chair of the steering group and supported by the steering group members. It will provide an opportunity for all members to feedback to one another about activities they are involved in, and will provide an opportunity to seek peer input and advice. It will provide an opportunity for professional staff members to identify areas for learning and improvement and assist with any queries or difficulties raised by public members.
COMMUNITY ENGAGEMENT ASSEMBLY	In addition, a community engagement assembly will be convened. The Directory will be used to invite public members to come together to consider a range of topics or issues relating to health and social care. The communications department will be instrumental in publicising the event to a wider audience via social media accounts etc. to attract as wide a demographic as possible. Topics can be informed from forum outcomes, patient feedback, complaint themes and wider Scottish Government initiatives e.g. open visiting. This will be led and facilitated by the steering group.

Recommendation

The Clinical Governance Committee is asked to:

- approve the proposed structure for participation and engagement, as outlined above, as a suitable model to replace the previous PEN and PFPI structures.

This approach will meet the objectives defined within the Participation and Engagement Strategy for Fife (2016 – 2019), and recommendations detailed within the Ministerial Group Action Plan.

Ratifying the proposed model will result in the following steps:

- Communication strategy to inform current Chairs, members and staff
- Development of Terms of Reference for both the Steering Group and Forum
- A review of the Participation and Engagement Strategy for Fife (2016 – 2019)
- Development of appropriate staff guidance and education to support this
- Recruitment of Steering Group Chair

APPENDICES

1 Questionnaire Results.docx

2 20190704 meeting action note.docx

3 Participation Initiation Form V2 09

Objectives: (must be completed)	
Healthcare Standard(s):	National Standards for Community and Engagement CEL 4
HB Strategic Objectives:	Participation and Engagement Strategy for Fife 2016 - 2019

Further Information:	
Evidence Base:	
Glossary of Terms:	

Impact: (must be completed)	
Financial / Value For Money	
Risk / Legal:	Meets national standards
Quality / Patient Care:	Public involvement
Workforce:	
Equality:	Meets Equality and Human Rights legislation

1. Please use the boxes below to give us feedback about your role as a member of the Participation and Engagement Network (P&EN)			**2. Do you wish to continue as a public member of the P&EN?**		**3. If you would like to continue working with us please tell us more about you. Do you have any particular skills or experience which would be an asset to the P&EN? For example, being a patient, carer, service user, or living with a health problem. Other examples might include community or voluntary involvement, involvement in residents' or housing associations or Neighborhood Watch; cultural, sporting or environment interests. Giving us this information will help build a group with balanced and representative skill and experience.**	**4. Can you please list your top three areas of interest based on your knowledge and expertise**	**5. Please list any other groups you are involved in i.e. Equality and Human Rights Strategy Group (E&HRG) or Managed Clinical Network (MCN); you may want to tell us about any non-NHS/Partnership Groups such as other participation/focus/community groups.**	**6. If you want to continue to participate would you be willing to undertake any training to support you in your role**		
Which aspects were good	***Which aspects were not so good***	***From what you have said what improvements do you feel need to be made***	***Yes***	***No***	***Can you please tell us why you would like to work with us***	***I.e. cancer, dementia, mental health***		***Yes***	***No***	***Please list any training you have completed which has supported you to undertake your public members role***
I enjoy reviewing leaflets	Understanding what value the network adds apart from what I do	No idea what the big picture is!	√		Continue to review leaflets!	Literacy!				
It got people together	It all felt to be focussed on the chair	More inclusive ways of conducting meetings. Does not work with all around the one table	√		I have long term experience as a service user, patient, Carter, trainer I have 40 years experience in the Scottish voluntary sector. I am a skilled facilitator.	Disability. Patient experience. Sexual orientation and gender identity.	E&HRG. LGBTI. Fife Centre for Equalities Director. Fife Shopmobility Director.	√		Fife NHS Impact Assessment Training.
The fact that patients were given the opportunity to make their voices heard and in doing so tried to make a difference within the partnership to the benefits of all patients.	The fact that there was no clear remit as to how the group should work or be involved. If this group is there to "make a difference" for patients then there needs to be specific guidelines at to how the group can be involved. There was in my opinion also still confusion about the partnership and who does what. The remit requires to be re-set and there should be a clear difference in what this group does compared with other patients	The group needs to consist of a group of people who are committed to attending the meetings and taking part in other sub groups to feed back to the Pen. I have no idea how many people were members of this group (very few attended the few meetings I was at) and it should not be seen as a passive group. If there is a need to have members who in fact are just consulted on consultations etc then that should be made clear but of	√		• I have had diabetes type 2 for 33 years – and have been insulin dependent for 17 years. • I have been a member of the Diabetes MCN since 2002 and chaired the MCN Patient Focus Group from the time as well as a volunteer. • I recently became a member of the Western Division Clinical Governance Group. • I was in the Scout movement since a boy and then as a leader from the age of 18 to 52 – working with boys in deprived areas. • I am an Elder of the church of Scotland in touch and sit on a development committee to try to "re-shape" the way we work with people to improve the number of "not so old" people attending church • Although I have retired, I did work in the sales and marketing field as an executive manager in the food industry for a very successful	Diabetes Mental Health Cancer (no experience with this condition – but interested) My main interest with all three would be to ensure that Fife Partnership follows the pathway of care for the conditions.	I have chaired all three groups of Diabetes UK in Fife I was the instigator of Conferences for people with diabetes in Fife, which ran very successfully. I was the first patient to chair the Scottish Diabetes UK board in Scotland. I also sat on the UK wide advisory council for Diabetes UK I sit on the diabetes MCN, and chair the Fife Diabetes MCN Patient Focus Group I did sit as a patient representative on the Scottish Diabetes Group I chaired the Patient Focus Group for the Scottish Diabetes Group I was part of the QIS team that put together the standards for Diabetes for NHS Scotland I was part of the team that	√		Have attended two versions of Voices training – the last being very recent. I have had "training" through my personal journey through diabetes and attended many conferences held both by the Scottish NHS and Diabetes UK I did undertake management training through my occupation.

	groups (eg PPI?) There should be representation of the group on all relevant sub groups – this was not clear to me that it happens. The decision needs to be made as to where this group sits and if in fact it adds value.	course there are those who would require to be a more active member of the group. There needs to be clear understanding about who does what – ie the NHS or Social care – and there requires to be a bringing together of both sides in a harmonious way – both having the same of objective of working together to make a difference. Somehow communication requires to be looked at to keep people abreast of progress. Think a visit to other Pen groups in other Health Boards would board good to see how they operate and what learning's we could bring to our table. I have to say that I have sympathy with the chair of the group in trying to make this group work better – he does seem to put in the hours!			company. I have since worked as a consultant for different retail shop companies and developed a healthy living programme for the Scottish government where small retailers would offer healthier products to their customers. (These were paid pieces of work) Thanks Theresa - happy to attend if required so I can here about the new concept. final decision will depend on that!!		developed the Scottish My Diabetes My Way website to make sure that the website would be able to be used by non computer literate people Although now not a member of the three Diabetes UK Fife groups I still keep in contact with them to give any advice they may be looking for `I am an active church member I did spend many happy years in the Scout Movement.			
The fact that there were people interested enough to attend the very few meetings that were scheduled and actually ran.	Poor leadership and communication especially from the Chair; low group energy; raising historical issues that stopped things moving forward; the palpable tension between health and social care personnel that attended. Lousy meeting venues that were difficult to access by public transport.	I would suggest we need a new Chair who wants to move things on and genuinely interested in working round health/social care tensions – definitely a good communicator who has the ability to see the wider picture and keeps members in the loop.	√		I have been a complementary therapist (practitioner and tutor) or over 20 years and have experience of working with community and voluntary groups. I have also been a patient (surgery), a carer (dementia) and service user (asthma clinic). I am passionate about empowering people to maintain their own health and wellbeing and supporting their efforts to do so. I am also disappointed at the lack of ethnic representation in many of these groups (also the poor gender balance) and feel I could be a representative on both counts. I also am a qualified ESOL tutor.	Cancer (I pioneered the use of complementary therapies at the Beatson Oncology Centre, Glasgow and what I did then has been used as a blueprint for similar services in hospitals and hospices throughout Scotland); dementia (my father fell victim to this cruel disease); mental health (my ex partner is bi-polar).	I am a volunteer with Fife Migrants Forum. I am involved with the TEC Steering Group (NHS Fife) and the Falls and Frailty Group (NHS Fife). I also volunteer for patient simulation roles at the School of Nursing and Health Sciences, University of Dundee, In Kirkcaldy.	√		Golly – I can't remember! I think Fife Migrants ran a one day course (might have been Equality & Human Rights); Shirley Ballingall rang a course (again, I can't remember on what). Prior to this I have attended several personal and professional development courses at Fife College (I left to become fully self-employed about 7

										years ago).
Being able to put your own thoughts and feelings forward.	Nothing really.	None	√		Being a patient who has had a cardiac arrest I have been involved in NHS volunteer section as founder member of its Heart Buddy's. Also assist with exercises through F.S.L.T. I have passed PVQ's for both the above and also ex, police staff. I was also part of SIGN review of cardiac rehab updating.	Heart, re-hab, Buddy's (Heart Ward 21/23, VHK and in community.	Under HD-MCN Patient Participaiton Chairman and Fife Heart Buddy's. Also member of Cardiac Rehab Steering Group.	√		NHS requirement is working with i.e. wards, i.e. handling, health etc.
Getting to know NHS members and hearing about plans for the future. I felt that any suggestions from the group were listened to and some put into action. Dispersed the notion that I wrongly had, that these professionals were a race apart!	Sometimes the clinical language was difficult to come to terms with.	Continue to realise that non NHS staff should be listened to as they have lived in experience of many of the problems which were discussed.	√		I am a long time member of Al-Anon Family Groups. I have grown from a demented nobody due to my husbands drinking to a person who can now cope with and even enjoy my life. There are still so many people out there suffering because of someone else's drinking who have not heard about Al-Anon that I want to keep working to help them and also transfer some of my recovery to others. Many aspects of work that the NHS are now undertaking is similar to our 12 steps recovery programme which works world wide now. We have 27,000 groups world wide and approx. 750 groups in the UK and Eire. At an NHS meeting today I heard with delight that one area is already helping members of the public by building confidence and trust with members of the public over a cup of tea. This has to be the way forward. There are so many different problems out there but they can all be helped if their trust, self worth, confidence and many more attributes are gained and they learn how to help themselves by changing attitudes, gain self confidence, learn to trust another human being. This all takes time but is possible with the right approach.	Alcoholism / Insanity of family members of an alcoholic / recovery from complete isolation, self-loathing, fear, isolation	Only Al-Anon, but I have worked at nearly all position, e.g. Chairman, General Service Board, Chair, Literature Committee, Co-founder of 4 Al-Anon Groups in Fife	√		A life time of living with a problem drinker then recovery by working my programme – one day at a time.
It is good that the Network was prepared to seek input from outwith the organisation.	Sometimes the email links provided for responses failed to work. Feedback on the information provided by me was sporadic. The structure of the organisation isn't very clear and communication from its management, from my perspective at least, is non-existent.	It would be good to see examples of finished work, such as leaflets, once the final drafts have been produced. Most importantly, the structure of the organisation and the position of participants within it, must be made much clearer. It would be useful to know if it has ever achieved anything. Regular newsletters need to be sent to all members of the network telling them what is going on. It is no use relying on	√		I am at present a carer for my wife. I suffer from atrial fibrillation. I am a committee member of the Prospect Union North of Scotland Retired Members Group. I am a former Community Councillor and am a member of a small informal residents group. Before I retired I was Head of Scottish Affairs for a major telecommunications company. I have done freelance writing and am a member of the Society of Authors.	Cancer care; Heart problems and Mental Health. I do not claim expertise in any of these areas, or indeed in any area of medical treatment other than as a user/consumer/observer.	Committee Member Prospect Union North of Scotland Retired Members Group.		√	My participation to date has centred around providing input and suggestions regarding the layout, structure, readability and content of leaflets for specific treatments or procedures provided for patients/users that have been sent to me for comment. My suggestions have been based on many years of experience in sales and public relations

		information on websites for this. The golden rule is that if you want people to know something, communicate with them directly. Do not rely on them seeking out information.								management focused on positive communication with customers.
To be fair I have lost sight of the group following the demise of the PRG and I remain unclear of the relevance/value so I have not attended in some time. Therefore, unfair to comment.	As Point 1	As Point 1		√						
Getting people with health interest together.	The way the split of services between areas can be achieved.	Looking carefully at the areas and how services can be shared.	√		An ex elected Board members / part of Local Health ?? – A West Fife Group that has helped guide people through NHS Services.	Cancer / Old Age / Dementia / guiding people through services	Local health concern and Diabetic Groups	√		
All members of NHS staff were always very helpful and accommodating	Meetings dragged on too long and were not always well run	Short sharp meetings well chaired	√		Have worked with NHS Fife for over 5 years in Patient Relations, cleaning audits, public speaking at NHS Events also involved in Out of Hours Urgent Care review at moment.	Acute care, Patient Relations all aspects really.		√		Have been through training for P&EN and representing Patient Relations.
I have found the presentations and updates useful in giving me an overview of service aspects in Fife. I think it's particularly good to have staff present, to enable joint working. I also value the chance to comment on publications and the ability to inform my wider contacts about participation opportunities as they arise	Attendance at formal meetings has been low and always seems to be the same few public faces. It can be easy for discussion to turn into airing of grievances and become confrontational.	From the staff side, there is a tendency for policy to be presented once it's completed, rather than to stimulate joint working. Public representatives may need to be more considered at times and representation should be broadened to better reflect all users. There is a sense that the role of the group is unclear – how do public members actively participate,	√		Interested in patient-centred care in Fife. Lived experience of long-term physical and mental health conditions. Extended family living in Fife, so keen to see that services meet all our needs going forward. Professionally, as former research chemist, interested in healthcare research generally	Ileostomies and general GI/stoma care Patient-centred care and involvement Healthcare research	Chair of Fife branch of Ileostomy and Internal Pouch Association (IA) Patient representative on NHS Fife ADTC Member of Community Advisory Group for Primary Care Research Experience of Scottish Patient Safety Programme in PC/pharmacy/medicines Public Partner and member of the Scottish Health Technologies Group within HIS	√		Intermediate level Access Panel Training with SDEF (2014) Introduction to Visiting training with IA (specialism focused) GDPR requirements (presentation and worked experience) with IA Public Partner induction training with HIS

		particularly in the earlier stages of a process?								

Participation & Engagement Network

Review meeting

4 July 2019

Discussion points...

- Need to widen and strengthen links to social care colleagues and services
- Widen distribution of updates via community councils and GP surgeries
- Create opportunity for members of network to feed in – work they have been involved in or any concerns
- Strengthen role/link to carers
- Fife website out of date
- Proposed participation and engagement "hub" needs different name

Action points arising...

- Review team to look at linkages and ways of working
- Link with colleagues in Scottish Health Council and NHS communications department who hold these distribution lists
- Ask the question of members as part of the quarterly feedback/flash report
- Contact Scott Fissenden to explore his potential role moving forward within the "hub"
- Contact Head of Comms who is undertaking refresh of the website for update
- New name to be found

Participation & Engagement Network

Review meeting

4 July 2019

Discussion points...

- Develop public member forum – form and function, roles and responsibilities
- Information regarding work going on across Fife needs to be more joined up and shared
- Need for clear action plan, priorities and outcomes

Action points arising...

- Schedule public member session to devise
- Review team to look at how information is currently collected and collated
- Ensure this is clear in the terms of reference for the new structure. Review team to work to action plan and share.

Powerpoint presentation used: 20190704 publicmeeting v0.2.pp

On your doorstep : website signposting services across Fife
https://www.onyourdoorstepfife.org/

Fife Health & Social Care Partnership
Supporting the people of Fife together

NHS Fife

Participation & Engagement Initiation Form

Inform, Engage, Involve, Empower, Evaluate

Section 1

Service details

Service:	
Service Lead:	
Designation:	
Telephone No:	
Email address:	
Executive Sponsor:	

Section 2

Aim of participation & engagement work

What are you hoping to achieve? *Try using a SMART (smart, measurable, aligned, realistic, time bound) aim statement.*	
Who do you need to involve? *What specifically do you want a patient, carer, service user or staff groups to contribute through their participation? Consider how many representatives you may require.*	
When do you want to commence and complete work? *Start month year – end month year. Any planned review / refresh*	

Section 3

Work to date

Detail any work undertaken *Where/when decision taken to initiate, any initial meetings taken to progress, who has been involved to date, EQIA commenced, contact with other areas in Fife or other health board areas.*		
Have you considered what levels of participation you would like to include in your work		
1.Home based involvement *i.e. proofing patient leaflets, documentation*	☐	
2.Discussion groups *i.e. invited to take part in a specific discussion group or focus group*	☐	
3.Involvement forums *i.e. invited to attend forums run by the NHS Board or HSCP*	☐	
4.Local representation *i.e. active part in the network or working group, representing the views of other members of the public*	☐	
5.Regional, National representation *i.e. invited to become a public representative within the NHS Board, HSCP or a national project*	☐	
Detail any resource that has been identified to support this work *Staff members, any locations, budget and reimbursement of travel expenses.*		
What method will you use to provide support to the patient, carer, service user and to feedback to them on their input		

What next?
The team will be in touch and to discuss your plans and how we can help. In the meantime you might find some of the resources below helpful:

- Scottish Health Council, Participation Toolkit
- National Standards for Community Engagement
- Scottish Government, CEL 4 (2010), Informing, Engaging and Consulting People in Developing Health and Community Care Services
- LearnPro – Equality, Diversity and Human Rights

If you require any assistance to complete this form, please do not hesitate to contact me at the address below.

Please send completed form to:
Theresa Rodigan, Personal Secretary, Patient Relations Department, Hayfield House, Hayfield Road, Kirkcaldy
Or by email to Fife-UHB.ParticipationAndEngagements@nhs.net

Office Use Only

- ☐ *Date received: _____*
- ☐ *Date sent to Steering Group: _____*
- ☐ *Date comments to be returned by: _____*
- ☐ *Record on 'Project Register'*
- ☐ *Comments received and reviewed*
- ☐ *Where applicable, share with Service for clarity / additional information*
- ☐ *Prepare correspondence and circulate to identified distribution list/s*
- ☐ *Date for notes of interest to be returned: _____*
- ☐ *Input Notes of Interest on the Feedback Form and forward to Service*
- ☐ *Completed Feedback Form received from Service, update on Register of Interest*
- ☐ *Forward Evaluation Form to Service*
- ☐ *Evaluation Form received and updated on database and project closed.*

INTEGRATION TRANSFORMATION BOARD

TERMS OF REFERENCE

1 Purpose

1.1 The purpose of the Integrated Transformation Board (ITB) provides leadership and strategic direction to the overall transformation programme being delivered by NHS Fife and Fife Health and Social Care Partnership. The Transformation programmes will be aligned to the joint strategic priorities of NHS Fife and Fife's Health and Social Care Partnership, the Clinical Strategy and H&SC Strategic Plan. The Board Group will ensure pace and rigour is applied to process with a clear governance route to NHS Fife Board, Fife Council and Integration Joint Board.

2 Remit and Scope

2.1 The Integration Transformation Board is charged with the following responsibilities:

- Provide strategic direction and priorities for the strategic transformation programme across the whole health and social care system aligned with the following strategies:
  - Clinical Strategy
  - Health and Social Care Strategic Plan

- Inform, monitor and guide the broad transformation changes across Fife and its effectiveness to deliver significant change to services. Ensure the programmes undertaken address whole system changes rather than working in silos.

- Monitor progress of individual programmes in terms of impact on the service delivery to patients and clients and to the wider population in Fife, delivery against programme milestones and delivery of programme outcomes, performance, financial implications, efficiency, quality and safety of services.

- Give opportunities to discuss wider challenges in the delivery of strategy and policies

- Maintain an awareness and alignment with the developing Regional situation.

- To ensure transformation interdependencies and risks are properly considered and to remove obstacles to successful delivery

- To receive assurance delivery reports of transformation programmes (inclusive of progress and delivery)

3 Membership

3.1 The membership of the ITB is:

- Chief Executive, NHS Fife
- Chief Executive, Fife Council
- Director of Health and Social Care
- Chief Operating Officer, NHS Fife
- Chair, Clinical Governance Committee, NHS Fife (Non-executive director)
- Chair, Clinical and Care Governance Committee, IJB (Non-executive director)
- Council Lead for Health and Social Care (Fife Council Elected Member)
- Associate Director of Planning and Performance, NHS Fife

4 Meetings

4.1 The ITB will meet every 6 weeks or as agreed by the board.

4.2 The Chair shall preside at meetings of the ITB. If the Chair is absent from any meeting, the Vice-Chair will assume the responsibility for the meeting.

4.3 The meeting will be quorate with 2 directors and 1 non executive director in attendance.

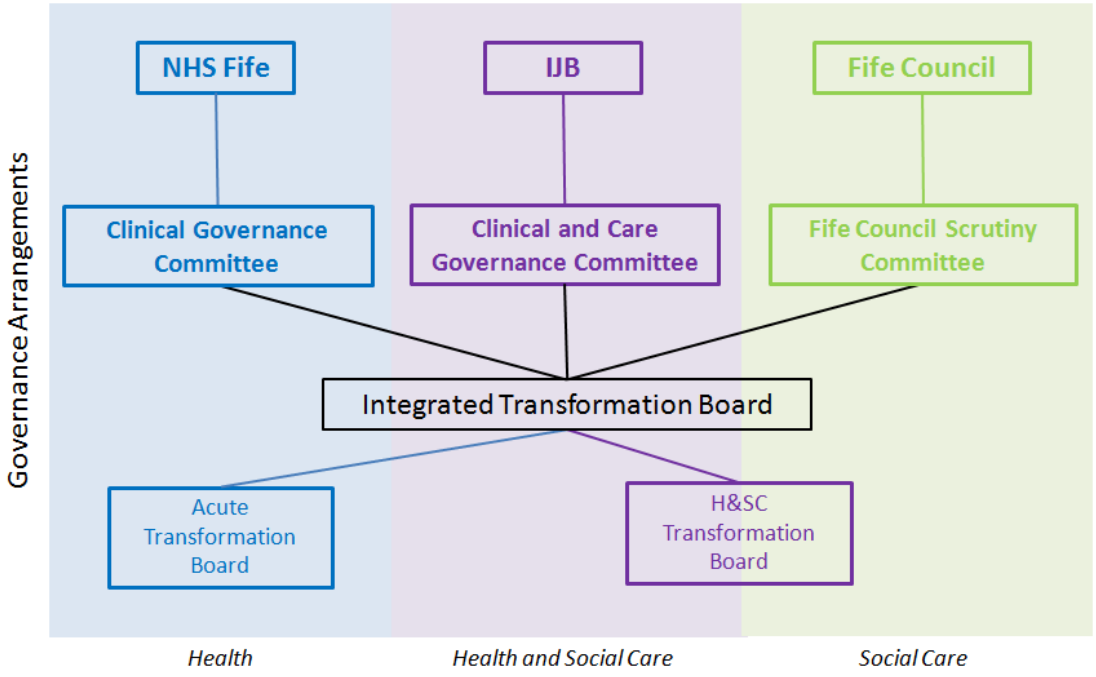
4.4 The agenda and supporting papers will be sent out at least three working days before the meeting.

4.5 Action note of the meeting will be taken and disseminated within a week of the meeting.

4.6 Meeting locations will alternate between Fife Council and NHS Fife facilities.

5 Authority and Governance Arrangements

5.1 The governance of the ITB will be to NHS Fife Clinical Governance Committee, Fife IJB Clinical and Care Governance and Fife Council Health and Social Care Scrutiny Committee. This is illustrated below:



Terms of Reference

Approved by: Integrated Transformation Board

Approved date: 2/10/2019
Review date: 1/10/2020

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Primary Care Improvement Plan (2018-2021) Risks
EXECUTIVE LEAD:	Dr Helen Hellewell
REPORTING OFFICER:	Rachel Wyse

Purpose of the Report (delete as appropriate)		
	For discussion	

SBAR REPORT

Situation

This report is being brought to the attention of NHS Fife's Clinical Governance Committee to highlight joint risks in relation to the 2018 General Medical Services (GMS) Contract Implementation in Fife. Specifically:

1. **GP Practice sustainability**
   - 1.1 There is an increasing number of Fife GP sustainability Practices. This issue has previously been addressed on a practice by practice basis but there is now a need for a more strategic approach to prevent any risk to patient safety or inequality of access or further exacerbation of health inequalities for Fife citizens. A number of steps to mitigate this are being undertaken such as the development of stronger MDT teams out with the new contract funding and the development of portfolio job opportunities. Continuing to work in this more strategic way will markedly decrease any risk of organisational reputational damage.

2. **Workforce**
   - 2.1 There is insufficient qualified multidisciplinary workforce to deliver the GMS Contract in full.
   - 2.2 The creation of 141 WTE Primary Care Nursing roles across In-Hours Urgent Care, Treatment room and Mental Health triage could potentially destabilise wider NHS Fife acute services.
   - 2.3 The scale of TUPE is a potential risk. It is not known how many existing Primary Care Nurses and treatment room staff employed by GP Practice will wish to TUPE to NHS Fife.

3. **Strategic ability**
   - 3.1 The programme is unable to progress Fife Primary Care Improvement Plan (PCIP) in Year 2 (2019/20) due to phased Primary Care Improvement Fund (PCIF) budget allocation over 3 years, with the bulk of funding not received until Year 3 (2020/21).
   - 3.2 The Fife Primary Care Improvement Fund Allocation of £10.5m by 2021/22 is not sufficient to deliver the GMS Contract in full. We estimate an £8m funding gap. The GMS Implantation Group met on 15.10.19 to prioritise service delivery by 2021/22. A summary report with recommendations will be available in due course.

The committee is asked to consider and discuss the further and better particulars provided in

this report.

Background

The 2018 GMS Contract refocuses the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. All aspects are equally important.

The aim is to enable GPs to do the job they train to do and enable patients to have better care. GP and GP practice workload will reduce and refocus under the proposals, as the wider primary care multi-disciplinary team is established and service redesign embedded by the end of the 3 year planned transition period (2018-2021).

The contract proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. Sustainable general practice is critical for better care for patients.

A Memorandum of Understanding (MOU), between Integration Authorities, SGPC, NHS Boards and the Scottish Government covers an initial 3 year period 1 April 2018 to March 2021 and sets out agreed principles of service redesign (including patient safety and person-centred care), ring-fenced resources to enable the change to happen. The scope of this programme is to deliver all priorities defined in the General Medical Services Contract (2018) and associated Memorandum of Understanding.

The MOU specifies 6 Key Points to provide guidance on what success looks like:

1. GP and GP Practice workload will reduce.
2. New staff will be employed by NHS Boards and attached to practices and clusters.
3. Early priorities will include pharmacy support and vaccinations transfer.
4. Work streams will engage all key stakeholders and involve patient/public and carer representatives to influence/ inform and agree measures for improvements in patient experience
5. Changes will happen in a planned transition over three years when it is safe, appropriate and improves patient care.
6. Transform Primary Care Service to best meet population needs

Responsibility for the delivery of the 2018 GMS Contract in Fife sits with both Fife H&SCP in terms of transformation/service delivery, and NHS Fife in terms of independent GP contractor service agreements, Section 2c managed GP Practices, premises and IT.

Assessment

GP Practice Sustainability

There is an increasing number of Fife GP Practices returning their GMS Contract to NHS Fife, becoming Section 2c GP Practices ie. managed by NHS Fife with GP and GP Practice staff salaried employees of NHS Fife. GP Practice sustainability is a Fife-wide issue, although predominantly experienced in West Fife. Three GP Practices have handed back their GMS contract to date. A fourth is due to hand back in January 2020.

There is robust data from other health boards such as NHS Forth Valley that practices which are handed back are more costly to the NHS. A recent NHS Fife case with a GP Practice patient list of approximately 3500 confirms this, costing an additional £96k per annum.

NHS Fife/Fife Health and Social Care Partnership (HSCP) has coped well to date in supporting GP Sustainability Practices by adopting a pragmatic support approach which is proportionate and takes into account the needs of individual GP Practices. In a small number of cases this has meant redirecting staff allocated to Fife GP Clusters from the Primary Care Transformation Fund (PCIF) to GP Sustainability Practices in crisis, which is not sustainable.

Workforce

The recent Audit Scotland 'NHS workforce planning – part 2' report describes significant national workforce challenges due to a lack of data on staff numbers, costs, activity and demand, making it difficult to plan effectively. The Scottish Government target of 800 more GPs over the next decade is unlikely to be achieved, because the number of staff being recruited and trained is not enough to meet the number of GPs retiring. Also, the number of qualified nurses and allied health professionals (AHPs) required to support extended GP Practice multi-disciplinary teams simply isn't there. It takes 3-4 years to feed the multidisciplinary team (MDT) workforce pipeline. This has resulted in competition for qualified staff at a local level between primary and secondary care, and with neighbouring NHS boards/HSCPs, potentially destabilising existing services.

The GMS implementation group and HSCP have discussed mitigation of this risk by considering staged recruitment but a NHS Fife system wide approach is needed to ensure this mitigation is robust enough.

Local front line managers also report lengthy recruitment delays in Fife. In excess of 6 months from recruitment to appointment. Anecdotal feedback suggests lengthy pre-employment checks and candidate notice periods as the main contributing factors. The new NHS Scotland 'JobTrain' automated recruitment system due to go-live on 28th October does not address these issues.

Primary Care Improvement Fund

The Primary Care Improvement Fund allocation for Fife is:

2018/19 (Year 1) - £2.5m (actual)
2019/20 (Year 2) - £3.7m (actual)
2020/21 (Year 3) - £7.4m (forecast)
2021/22 (Year 4) - £10.5m (forecast)

Fife anticipates a £3.7m increase in PCIF allocation in 2020/21 (Year 3) based on the Scottish NRAC formula. In year funding is issued in two tranches, an initial allocation of 70% in August, the remaining 30% is allocated in November.

Primary Care Improvement Plan Priorities Year 3 and 4

The GMS Implementation Group held a 'Service Delivery Prioritisation' workshop on 15.10.19 with a view to delivering safe, effective, equitable, person-centred services within the financial budget. The following priorities were agreed:

1. Phlebotomy
2. Mental Health Nurse Triage
3. Vaccinations (childhood, travel health)
4. In Hours Urgent Care
5. Pharmacotherapy
6. Community Treatment and Care

WTE detail can be found in **Appendix 1**, subject to finance team verification.

Conclusion

Local recruitment policy prohibits the recruit of staff until funds are received. The recruitment process for Primary Care Improvement staff cannot therefore commence until August each year, 5 months into the financial year. This is followed by a lengthy recruitment process in excess of 6 months. Successful candidates are unlikely to be in post until the end of the financial year. Both constraints cause significant delays in generating the necessary workforce pipeline to support delivery of the 2018 GMS Contract and GP Practice sustainability in Fife.

Starting the recruitment process of **125.10 WTE** Year 3 Primary Care Improvement staff in November 2019 with a start date of April 2020 will put Fife in the best possible position to ensure we have the necessary MDT staff to deliver the Primary Care Improvement Plan priorities for 2020/21, contributing to the safe and sustainable delivery of GMS services in Fife. This approach introduces a joint risk to NHS Fife and Fife HSCP, appointed staff will be in post 4 months prior to receiving funds. This is in the context of Brexit, and a potential early General Election.

GP Practice Sustainability is a very high risk to NHS Fife/Fife HSCP, with the potential for significant impact on the health and wellbeing of Fife citizens. If we don't do more to implement the 2018 GMS Contract in Fife, more GP Practices will return their GMS contract, transferring the risks and associated costs of managing GP Practices to NHS Fife. There is also a reputational risk that Fife will be considered an unattractive place to work if GP Practices continue to hand back their GMS contract.

Recommendation

- **Discussion**-. The clinical governance committee is asked to consider and discuss the implications of this report and the following recommendations:

1. A Fife-wide joined up approach to workforce planning is necessary to understand the impact of transformation across Fife, and ensure the ongoing safe delivery of existing Primary and Secondary Care services during the transition stage of 'shifting the balance of care'.

2. Support the early recruitment process of **125.10 WTE** Year 3 Primary Care Improvement staff in November 2019 with a start date of April 2020 to ensure Fife is in the best possible position to ensure it has the necessary MDT staff in post to deliver the

Primary Care Improvement Plan priorities for 2020/21, contributing to the safe and sustainable delivery of GMS services in Fife. This approach has been discussed with the chief finance officer for the health and social care partnership.	
Objectives: (must be completed)	
Healthcare Standard(s):	HSCP OBJECTIVES: PRIORITY 1 Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife PRIORITY 2 Promoting mental health and wellbeing PRIORITY 3 Working with communities, partners and our workforce to effectively transform, integrate and improve our services PRIORITY 4 Living well with long term conditions PRIORITY 5 Managing resources effectively while delivering quality outcomes
HB Strategic Objectives:	Consistent with the clinical strategy of providing care as close to home or in a homely setting

Further Information:	
Evidence Base:	1. The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018. https://www.legislation.gov.uk/ssi/2018/66/contents/made 2. General Medical Services Contract (2018). https://www.gov.scot/publications/2018-gms-contract-scotland/ 3. GP Contract Memorandum of Understanding. https://www2.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract/Memorandum-of-Understanding 4. Improving General Practice: Sustainability Working Group (2019) https://www.gov.scot/publications/improving-general-practice-sustainability-group-2019-report/ 5. National health and social care workforce plan: part two https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-2-framework-improving/
Glossary of Terms:	**AHP:** Allied Health Care Professional **GMS**: General Medical Services **HSCP**: Health and Social Care Partnership **MDT:** Multidisciplinary Team **NRAC:** NHSScotland Resource Allocation Committee **PCIF**: Primary Care Improvement Fund **PCIP**: Primary Care Improvement Plan **MoU**: Memorandum of Understanding

Parties / Committees consulted prior to Health Board Meeting:	HSCP SLT

Impact: (must be completed)	
Financial / Value For Money	The cost to fully implement the GMS Contract in Fife based on models of care approved by the GP Clinical Quality Group and GMS Implementation Group is estimated to be in excess of £17m. The 2021/22 (Year 4) Primary Care Improvement Fund allocation is estimated to be £10.5m. Given the financial deficit of £6.5m, it is unlikely the GMS Contract will be fully implemented in Fife by 2021. The Primary Care Improvement Plan therefore focuses on implementing MoU objectives within the financial envelop, guided by GP Cluster priorities and demographic need.
Risk / Legal:	The proposed recommendation in this report introduces a joint risk to NHS Fife and Fife HSCP. Appointed staff will be in post 4 months prior to receiving funds.
Quality / Patient Care:	The programme team in collaboration with Fife GP Clusters and Fife LMC/GP Sub Committee work closely to ensure equity of service provision and deployment of GMS Contract resources based on GP Practice/GP Cluster priorities and demographic need, to ensure equal access for Fife citizens and reducing health inequalities.
Workforce:	• The Primary Care Improvement Plan requires some staff previously employed by GP Practices to TUPE over to NHS Fife employment. There is the potential for clinical/staff opposition to the transfer of GP Practice employed staff over to NHS Fife. • The majority of staff appointed to Fife GMS Contract roles are internal candidates, not new staff. This creates pressures elsewhere in the system. • The pipeline/lead time for qualified clinical roles such as Advance Nurse Practitioners and Pharmacotherapy staff is approximately 18 months. Many of the staff appointed to Fife GMS Contract roles are in training, and require GP supervision/mentoring further impacting on GP and GP Practice capacity.
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? /No It is a contractual requirement • Has a full EQIA been undertaken? /No (If yes please supply copy, if no please state reason)

	• Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

APPENDIX 1

PCIF PRIORITIES BY WTE Year 3 and 4.pd

GMS IMPLEMENATION GROUP 'PRIORITISATION WORKSHOP' AGREEMENT SUBJECT TO COSTING - 15.10.19

PCIF Workstreams	Workforce	Priority	FBP	WTE Planned 2020-21 (Year 3)	WTE Planned 2021-22 (Year 4)
Vaccinations Transfer Programme	Band 8A Programme Manager	3	BG	1.00	0.00
	Band 6 Nurse		BG	0.00	5.00
	Band 5 Nurse		BG	6.90	0.00
	Band 5 Pharmacy Technician		BG	1.00	0.00
	Band 2 HCA		BG	4.90	0.00
Pharmacotherapy	Band 3 Pharmacy support workers/Admin	5	FR	10.3	15
	Band 4 technicians		FR	10	14
	Band 5 technicians		FR	4	2
	Band 6 Lead clinical pharmacy technician		FR	11	4
	Band 7 team lead pharmacy technician		FR	10	9
	Band 8a Pharmacists		FR	2	0
Community Treatment and Care Services	Band 5 Nurse	6	FR/RL		
	Band 2 HCA		FR/RL		
Phlebotomy	Band 3 Phlebotomists	1	FR/RL	5.74	12.60
Urgent Care	Band 8a Advance Nurse Practitioners (Lead)	4	FR/RL	1.00	0.00
	Band 7 Advance Nurse Practitioners (GP Triage)		FR/RL	7.00	0.00
	Band 7 Advance Paramedics		FR/RL	0.00	7.00
	Band 6 Urgent Care Practitioners		FR/RL	0.00	39.00
Additional Professional Roles (MDT)	Band 7 MSK Physio First Response		BG	1.00	0.00
	Band 6 Mental Health Nurse	2	BG	9.26	5.10
	Total			**125.10**	**149.70**

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Wound Management in Community Pharmacy
EXECUTIVE LEAD:	H Hellewell - AMD
REPORTING OFFICER:	Andrea Smith – Lead Pharmacist, Fife HSCP

Purpose of the Report (delete as appropriate)		
		For noting on progress made

SBAR REPORT

Situation

Fife HSCP is aware of the concerns around the provision of services for people affected by drugs and is keen to improve access to harm reduction and recovery services. In particular this paper is aimed at describing the potential for a service development that could impact on prevalence of wound management to reduce infection.

Background

Currently 19 Community pharmacies already provide an Injecting Equipment Provision (IEP) service for people affected by drug use. The two mains aims of the IEP service are as follows:

1. To protect individual and public health by reducing the incidence of blood-borne virus (BBV) infection and drug-related deaths amongst service users.
2. To protect the health of local communities by preventing the spread of blood-borne virus infections by providing safe disposal facilities for used injecting equipment.

The IEP service includes the provision of sterile injecting equipment and related paraphernalia, provides a facility for safe disposal of used injecting equipment and provides information and advice on BBVs, safer injecting practices and safer drug use. The service also provides clients with information on and signposting/referring clients to drug treatment and other services.

However, all 85 community pharmacies provide dispensing and supervision of Opioid Replacement Therapy (ORT).

A common complication of injecting substances is the development of wounds and infections at injecting sites.

Assessment

Community pharmacies regularly see patients at risk of developing complications associated with injecting substances, such as the development of wounds/infections at injecting sites. A group has been established using funding from the ADP to build on the work already in place and specifically add an enhanced service in community pharmacies – one element being wound management and treatment.

The proposal is an extension to the current 'Pharmacy First' service. Currently community pharmacists are able to provide Trimethoprim and Fusidic Acid under a PGD for UTIs and Impetigo. Other NHS Boards, such as Forth Valley, have supported access to flucloxacillin for soft tissue infections.

Early access to treatment with Flucloxacillin will promote a reduction in the number of patients accessing both Accident and Emergency and Out of Hours Services with cellulitis and potentially more serious wound infections.

The intention is that this is funded by Seek Keep and Treat funding which is Scottish Government Funding which is monitored through the Alcohol and Drug Partnership.

The service specification has not been finalised but the intention would be to bring further details to the committee if approval and funding secured.

Recommendation

The committee is asked to note the progress of work in this area to address this need

- **Information -** *paper is for noting only from the committee*
- **Further details will be brought back to this committee when the service specification is finalised and the service is underway.**

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Hypoglycaemia Report
EXECUTIVE LEAD:	
REPORTING OFFICER:	Sharon Robertson

Purpose of the Report (delete as appropriate)

For Decision
reach a conclusion

SBAR REPORT

Situation

In hospitalised patients hypoglycaemia (blood glucose level below 4 mmol/L) is associated with increased cost, length of stay, morbidity and mortality.
The committee raised the issue around hypoglycaemia and why incidence of this is so high in the inpatient setting.
The Diabetes Think, Check, Act national project aims to improve the care of adult patients admitted to hospital.
As part of this work NHS Fife set out to improve management of hypoglycaemia as local audit identified, despite having hypo boxes in all areas, and a protocol to follow, first line treatment and timing of rechecking the blood glucose level following this was poor.

Background

20% of hospital beds are occupied by patients with diabetes and around 50% of these patients are insulin treated
Patients with diabetes are usually admitted to hospital for a non-diabetes related complaint.
Local audit shows incidence of hypoglycaemia is around 20% for those treated with insulin – this is in line with the National Diabetes Inpatient Audit (NaDIA) (England and Wales) data.
Common causes: illness, deterioration in kidney function, liver failure, sepsis, reduced or no appetite, change in diet including fasting, medication errors and timing of medication.
All clinical areas have blood glucose meters which are connected to the IT system Cobas IT – whenever a patient has a blood glucose level checked the result is immediately available on the system.
The inpatient team review blood glucose level results on Cobas ITdaily (Monday – Friday) and review patients who have recurrent blood glucose levels below 4 mmol/L or a blood glucose level less than 3 mmol/L.
Treatment changes are made and education given as required preventing further episodes and potential delay in discharge.

Assessment

Local audit data matching NaDia data is reassuring as this shows we are comparable to what is happening nationally.

ECD has been recording episodes of hypoglycaemia on Datix since 2017 – this is now a requirement for all clinical areas so numbers will rise.
Completing Datix for these events highlights to staff that hypoglycaemia is a metabolic emergency.
More recently we have amended Datix so staff must answer 5 mandatory questions in relation to blood glucose results, treatment given and time taken for hypoglycaemia to resolve.
The questions are educational thus prompting staff to treat patients according to protocol and to document event in patient's notes.
It is also now a requirement that medical staff are informed if a patient's blood glucose level is below 3 mmol/L.
On learnPro Diabetes Think, Check, Act has 5 modules – one is 'How to Prevent and Manage Hypoglycaemia'.
Some staff are aware and have completed this however it is not mandatory.
The module takes, at most, 15 minutes to complete.

Over the last year we have seen improvements in:

	Treatment as per guideline	**Documented in notes**	**Recheck in 15 minutes**	**Recheck in 30 minutes**	**Recheck in 1 hour**
Audit 1	8.3%	25%	0%	41.7%	75%
Audit 2	15.4%	53.8%	7.7%	53.8%	92.3%

(Treatment as per guideline % is low due to lack of documentation in relation to treatment patient received).

These improvements are secondary to the introduction of the 5 educational questions on Datix.
On reviewing Datix it was noted not all 5 questions were answered.
Results should continue to improve now these questions are mandatory fields.
Completion of the learnPro module should also demonstrate improvement.

NaDia audit data over the years shows that incidence of hypoglycaemia in hospital is unchanged at around 20%.
We aim to reduce the amount of recurrent episodes of hypoglycaemia and reduce length of stay with improved adherence to the protocol and general education.

Recommendation

Quarterly audit looking at 2 identified areas for improvement.
Education targeting areas where management is poor.
Highlight areas of good practice.
Pop-up education sessions.
Possible introduction of prescribed bedtime snack to minimise risk of early morning hypoglycaemia.

- **Decision** – is it possible to make the 'How to Prevent and Manage Hypoglycaemia' module mandatory for staff to complete on an annual basis?

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
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NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Learning Disability Strategy Progress Report
EXECUTIVE LEAD:	Nicky Connor, Director Health and Social Care
REPORTING OFFICER:	Julie Paterson, DGM, Fifewide

Purpose of the Report (delete as appropriate)		
		For Information

SBAR REPORT

Situation

NHS Fife's Clinical Governance Committee has requested a progress report on the implementation of strategic intentions with specific reference to learning disability services.

Background

About 16,000 school children and young people in Scotland have learning disabilities. About 26,000 adults in Scotland have learning disabilities and need support.

The Keys to Life
The national learning disability strategy, The Keys to Life 2019 - 2021, outlines four priority areas for future service development that reflect what people with a learning disability and their families have identified as the barriers and challenges they face in achieving equality of opportunity. The four priorities are:

1. Living
2. Learning
3. Working
4. Wellbeing

Transforming Healthcare in Fife
NHS Fife's Clinical Strategy, Transforming Healthcare in Fife 2016 – 2021, makes specific reference to learning disability services and highlights the importance of:

1. Further Tier 3 multi-disciplinary intensive support teams for those in crisis with complex needs in terms of mental health, forensic or challenging behaviour with extended hours availability

2. Continuing Tier 3 best practice development and pathway work around people with challenging behaviours in order to improve quality of life and reduce restrictive interventions

3. Review of how physical needs are best met for those with Profound Multiple Learning Disability (PMLD) in adulthood

4. Review of Children and Young People's Learning Disability Services (CYPLD) so that a single CYPLD multidisciplinary team which has a single management structure and a single set of case notes which is collocated and works closely with other agencies is established**.**

Assessment

The Keys to Life

Fife's multidisciplinary Learning Disability Strategy Implementation Group (LDSIG) has established four sub groups to consider the four priorities identified in the national Keys to Life strategy published in March 2019.

1. Living

- The Housing Strategy Group with representatives from Health, Social Care and Housing services has been established to formulate a Housing Strategy for Fife Health and Social Care Partnership which will drive the development of models of care, both new and well established and understand the role technology can play in supporting people
- Fife Council and partner Housing Associations currently provide accommodation for adults with a range of disabilities. The properties consist of:

    - Small shared group homes for adults with a learning disability
    - Individual support in single tenancies
    - Core and cluster properties.
    - In addition, the Community Support Service offers day opportunities. In April 2019, following a period of extensive consultation the Social Work Community Support Service run from the Forward Centre in Glenrothes transferred to the St Clair Centre and the Forward Centre was closed. An options appraisal will now be completed in relation to the site at the Forward Centre to consider the development of specialised provision for people with LD and complex needs who currently require to be placed out with Fife. It is acknowledged that a range of housing options and models are required as highlighted in the Scottish Government's Coming Home Report, 2018.
- As recommended in the Coming Home report, 2018, Fife has identified a Clinical Service Manager who is the lead for repatriation; this is to ensure that no individuals are 'lost' because they are not in the 'line of sight' of the originating Health and Social Care Partnership.
- A Parents with LD group has been running in Fife for a number of years. A member of this group has been involved in the development of an easy read version of the N.H.S Scotland Parenting Guide "Ready Steady baby"
- Easy read information on the Looked after Children process is also being developed.
- There are a significant number of adults with learning disability supported in the community, either in single or shared tenancies, where support is provided overnight either by a waking night shift or a sleepover. It is recognised that there are issues which can arise when people are supported in a way which impacts on their privacy and risks of creating dependency. There is now technology available which can help us properly

understand the precise support people need overnight. A plan is being developed to identify situations where technology can be used to support people with overnight needs together with the development of an overnight responder service.

- We have had to adapt to the changing needs as the people we support age. Over the past 12 months we have reprovisioned 10 group homes, moving from accommodation which was no longer suitable to properties which are suitable for people now and in the future.
- This year we have developed a bespoke community service for one young person who had been in a specialist hospital setting out-with Fife and then after a failed discharge into community, had been admitted to hospital in Fife. As a result of moving into the new service in the community, the young person is now accessing community facilities, such as cinema, bowling, shops and now experiencing improved quality of life through least restrictive practice.

2. Learning

- Within Fife's Education Services the number of children with LD is not recorded as a specific category but included in the overall children with Additional Support Needs figures. Discussions are taking place on how accurate details of children with LD who access special schools and mainstream schools can be recorded.
- The Independent Living Scotland's Transition fund, to enable young people with LD to access appropriate support to enhance their opportunities for independent living, including access to further education, is being promoted within Fife's Education Services.

3. Working

- The existing material used in Fife to promote the benefits of employment and meaningful activity for people with LD is being updated.
- Funding sources are being explored to deliver a campaign that celebrates diversity in the workplace, challenges preconceived ideas and promotes the benefits for employers, individuals and families of employment for people with LD.
- In conjunction with education services the potential to develop a resource that supports young people with LD to gain better access to Adult Learning programmes and Employment programmes is being pursued.
- A model has been developed and implemented for including people with learning disabilities and their carers on interview panels for psychology posts in LD services
- Expansion of the range of employment/meaningful activities for people with LD is being considered in partnership with Fife Council and the voluntary sector.
- Fife Council's Supported Employment Service is Fife's largest pan disability employability provision.

SES provides:

- Positive Pathways (ESIF/Opportunities Fife and match funded) for people with disabilities and health issues age 25+ who wish to find work of 8 hours or more.
- Targeted provision for people with disabilities and health issues experiencing multiple

barriers (e.g. lone parents, young people, care leavers, adults 50+, ex-offenders) by working with internal partners in Community Learning Development, Health and Social Care Partnership including Adult, Community and Criminal Justice Services, Housing and Local Area Planning Groups to identify areas of employability need in the local community.

SES are a lead on the LDSIG Work Theme with actions related to:

- Communicating the value people with learning disabilities bring to the workplace
- Challenging stigma and discrimination
- Reviewing transitions from education to adulthood and outcomes being achieved

There is an increasing concern that people with disabilities/health issues known to the local authority are finding it more difficult to access opportunities in the world of work- this predominantly relates to individuals with learning disabilities, autistic spectrum disorders and physical disabilities. The voice of this concern is likely to grow considerably over the next few years as it becomes apparent that payment by outcome funded programmes such as Fair Start do not have the resources or expertise to provide supported employment in line with the government's five stage framework- the proven methodology to help people furthest from the labour market due to the complexity of their disability or health condition. This gap in provision is most likely to affect people in receipt of ESA.

Statistics for 2018/19
47 referrals for people with ASD
56 referrals for people with learning disabilities
TOTAL=103

Statistics for 2019/20 (April to September 2019)
35 referrals for people with ASD
49 referrals for people with learning disabilities
TOTAL= 84

The projected referrals for 2019/20 is 168. This is a 66% increase from the previous year. This increase may, in part, be attributed to a reduction in provision overall in Fife e.g. Capability Scotland no longer providing employment services in Fife.

<u>Wellbeing</u>

- Health passports have been standardised across Fife. This ensures consistency of information available when a person with a LD is admitted to hospital.
- The Primary Care Learning Disability Liaison nurse continues to link in with G.P. surgeries to publicise the service they offer and identify ways in which they can work more closely to enhance the experience of people with a learning disability when they access primary care services.
- The group is considering how people with LD can be better supported to access national screening programmes.
- The learning disabilities management team have supported the roll out of Trauma Training, led by clinical psychology, across all services including third sector, to establish a trauma-informed workforce. Fife LD psychology is advising colleagues in England and

Wales on trauma models for this population. ·

- Fife LD service have agreement with creators of the Decider (an emotional skills training programme for self-management) to develop and pilot an LD specific resource · A funding application has been made for a study exploring Adverse Childhood Experiences (ACEs) in in-patient populations

NHS Fife's Clinical Strategy Priorities

This includes development of tier 3 support, the physical health needs of those with Profound Multiple Learning Disability (PMLD) and review of children's learning disability services.

Tier 3 Intensive Support:

Fife now has a well established Augmented Support Team (AST) model. Work continues to improve referral pathways to ensure appropriate allocation to either the AST team or psychology rather than generic teams. Intervention also extends out of hours to those in crisis.

The AST has been developed to increase capacity within community services to provide assessment and treatment to people with a learning disability living in the community and facilitate discharge from hospital. AST support people over 18 years of age with a diagnosed learning disability, who require intensive support, are at risk of admission to hospital or require additional support to facilitate discharge from hospital. AST also support people to return from out of area placement.

In 2018 there were 17 referrals and in 2019 there were 19 referrals.

Three members of AST have commenced a diploma in Positive Behaviour Support (PBS) which includes inpatient and child LD service. There is also a training package being developed though AST which will be delivered to all levels of staff within the service and across partnership agencies. (The Scottish Government's Coming Home report recommends workforce development in PBS).

Restrictive interventions are monitored and reviewed monthly through the Reducing Restrictive Intervention Group, considering trends and any specific areas which require to be addressed within the service and actions taken. The purpose is to ensure safe, effective care whilst maintaining improved quality of life through least restrictive practice.

Physical health needs of those with Profound Multiple Learning Disability
Annual physical health reviews are undertaken by LD nursing teams and whilst there are no specialist in-patient health facilities for those with PMLD, a nursing service is provided to the social work respite facility at Broad Street, Cowdenbeath. There are five people who currently access overnight short breaks at Broad Street.

Regular meetings are held with the support organisation PAMIS (Promoting a more inclusive society) and families to ensure we remain responsive to the needs of Fife people with PMLD and their families. Health screening is undertaken by the person's GP. The community

nursing team is planning to develop a one stop shop, where people can attend to have health checks completed.

Review of children's learning disability services.
The Service for children and young people with LD (mental health/behavioural services) remains a team with 3 different management structures. The Child Health LD Development Group will address these issues. The group has the following remit:

- To provide senior operational management and strategic overview of health services for children with learning disabilities in relation to local, regional and national developments.
- To facilitate multi-agency, partnership working in collaboration with social work, education and third sector colleagues through the recently created Fife Children Affected by Disability Group (CABD).

The Children Affected by Disability Group (CABD) has been established in order to achieve a multi-agency response to the specific and complex needs of this client group. In order to facilitate this, a Project Manager has been appointed from Social Work who is supported by representatives from Education and Health. The project objectives are to:

- Increase equality within service provision, across the Health and Social Care Partnership and Education and Children's Services, for Young People with severe/complex LD, ASD with Mental Health presentations and/or emotional disturbance.
- Develop an intensive multiagency care approach to respond to Young People who are displaying, or are at future risk of displaying, high risk distressed behaviours.
- Work together across services to ensure these Young People get the right service at the right time.
- Reduce service dependence on out of authority and hospital placements to develop robust local services to meet the needs of these Young People.

A development session has been arranged for December 2019 for the Learning Disability/Autism Strategy Implementation group to take stock and to review implementation plan progress in relation to Keys to Life 2019-2021, NHS Fife's Clinical Strategy 2016-2021 and the Scottish Government's Coming Home Report 2018 recommendations.

Recommendation

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- **For Information**

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Quality of Care Reviews
EXECUTIVE LEAD:	Dr Chris McKenna/Helen Buchanan
REPORTING OFFICER:	Helen Woodburn

Purpose of the Report (delete as appropriate)		
		For Information **For noting**

SBAR REPORT

Situation

The purpose of this paper is to outline the options for NHS Fife to consider in order to be in a state of readiness for when notification of an external review visit is received, as requested by the Chair of the Clinical Governance Committee.

The implementation of the Quality of Care framework for continual self-evaluation requires thought and consideration. The aim is to bring consistency to Healthcare Improvement Scotland's (HIS) external quality assurance work and to support NHS Fife to evaluate its own care delivery.

There are two elements to this approach:

1. A continual self-assessment framework for the organisation which takes cognisance of activities, and structures which are currently in place. The process of evaluation and learning and improvement needs to become embedded and continuous. Quality Improvement activity will therefore be based upon self evaluation rather than that which is mandated by external agencies.

2. The external Healthcare Improvement Scotland (HIS) Quality of Care (QoC) review.

There are 6 stages with associated timescales in the proposed review.

Each stage will contain key process for HIS and the organisation involved.

The indicative timescales for the organisational quality of care review are as follows:

Key Stage	Indicative timescale	Output
Stage 1- Schedule planning and notification	HIS will notify CEO by email	Provisional date for visit
Stage 2- Pre-work and self-evaluation	6 weeks submit to HIS	Self assessment submission to HIS
Stage 3- Analysis phase	4 weeks	HIS team develop key lines of enquiry with NHS Board and representatives
Stage 4- On-site visit	1-2 days	Test assumptions from analysis phase - Meetings arranged with members of staff, people

		experiencing care, families, and carers. Board Senior team feedback provided
Stage 5- Output and agreement on next steps	Within 4 weeks of visit	HIS write up report. Draft shared with Board Agreed final report published.
Stage 6 – Follow-up work	Dependent on agreed next steps	Timescales discussed as part of report.

NHS Fife requires commitment from senior leadership to ensure that appropriate resources are allocated and support is provided. Leaders will have a key role to play in considering and implementing any improvement work highlighted through the self evaluation process.NHS Fife must now consider how the the self evaluation and any follow up, will be managed to ensure submissions for the QoC and the subsequent organisation of external review visit.

Given the outlined timeframe, it is important therefore for NHS Fife to consider, plan and create a framework in order to be in a state of readiness when notified for its Quality of care review.

Healthcare Improvement Scotland will periodically ask for a copy of the organisational self-evaluation to inform and guide an organisational “quality of care review”.

The completed self-evaluation should focus on outcomes rather than activities, and this could include a description of changes or improvement activities on the delivery of care.

Background

Strategic Direction

The Medical Director and Director of Nursing are the nominated executives to lead on the following corporate objective:

- Implement the Quality of Care Framework and reporting to the appropriate standing Board Committees, IPR and Board

Progress of National Implementation

There are a number of Boards who have been through the Quality of Care review process, although there are no formal reports published to date.

Organisational participation in review processes

NHS Fife has participated previously in similar frameworks with self assessment processes and reviews. More recently in November 2018 NHS Fife participated in Quality of Care Approach. Quality of Care Organisational Review – Adverse Events Baseline Exercise. Self Evaluation with the report published in September 2019.
This took 2 senior members of staff to be removed for current service and focus entirely on this for one week, with other supporting staff contributing hours per week.

The Quality of Care Approach

The Quality of Care Approach promotes regular, open and honest internal organisational self-evaluation to identify opportunities for improvement with subsequent action planning, implementation, monitoring and review of actions. The self-evaluation will provide useful information to inform operational and organisational planning as well as contributing to processes of external and internal quality assurance.

The self-evaluation should tell a story about where the organisation perceives itself to be against each of the domains and where the improvements could be. The quality of care approach promotes regular internal organisational self-evaluation complemented by external validation.

The work to design the new approach, including the Quality Framework, started in late 2014. Since then, the health and social care landscape has changed considerably with the integration of health and social care services. HIS recognised the need to adapt their approach to ensure that they best support improvement across the whole system.

The framework is intended to improve care outcomes and has quality improvement at its heart. It is also designed in such a way to facilitate the one-off collection of relevant evidence and intelligence to minimise duplication of effort in an attempt to lessen the burden of quality assurance activity on organisations.

Assessment

Initial work to create a framework to support implementation of the Quality of Care framework has begun.

Ideally, the self-evaluation process should be:

1. Led by executive directors, with a supporting governance structure beneath. Appendix 1 outlines an executive framework which identifies and links an appropriate executive director and a committee to each of the domains to take on the lead role. This is a draft first proposal for discussion and agreement.

2. Co-ordinated across the organisation. This could be supported by a nominated member of staff. This person should be able to liaise with different levels in the organisation, from senior leaders to those involved in direct care delivery. The self-evaluation exercise/s will need a small team to support the process. The leader/co-ordinator will manage the process of collecting the data and evidence, and ensure that the right people are involved in interpreting it and making recommendations.

There are a two options for NHS Fife to consider:

Option 1

Do nothing and respond accordingly when the notification from HIS is received.
Based on previous similar submissions such as Quality of Care Approach. Quality of Care Organisational Review – Adverse Events Baseline Exercise. Self evaluation November 2018, and the experiences from other health boards, this will mean in the 6 week period:

1. Locating and managing appropriate evidence and data
2. Removal of staff from current service and work to support and co-ordinate
3. Lack of comprehensive stakeholder engagement to provide a consensus view on the submission
4. Identifying who completes self evaluation tool. See Appendix 2
5. Committee dates may mean no oversight by committees

Option 2

Be prepared and develop the framework which facilitates pro-active continual self evaluation and places NHS Fife in a state of readiness for the external review process.

In order to be prepared NHS Fife should consider taking the following steps:

1. Establish a short life working group, chaired by an executive to create a framework for assessment, reporting and monitoring mechanisms. This group would focus on understanding how NHS Fife are doing against each domain, focussing on what is being done to improve the impact and outcomes on those who deliver, use or engage with NHS Fife.

2. Collate relevant data and evidence and establish current levels of performance against the indicators in the Outcome and Impact section of the framework. See figure 1.

3. Interpret the data and based on the evidence identify what NHS Fife need to do next, better or differently, create action plans and implement and monitor the changes.

4. Consider the internal reporting and monitoring of continual self assessment.

To support this SBAR please refer to the self evaluation guide. See Appendix 3.

Recommendation

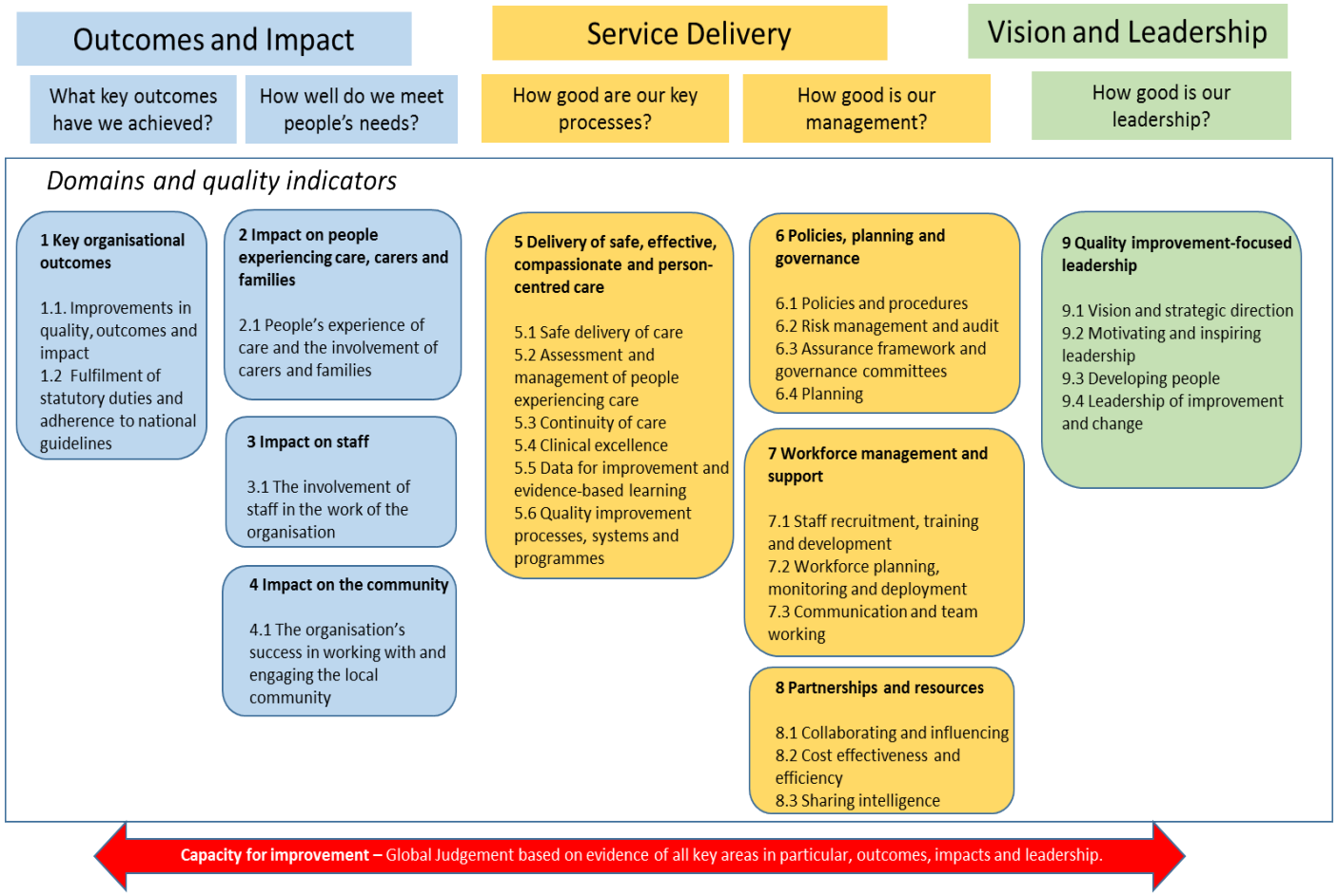
For Information

Objectives: (must be completed)	
Healthcare Standard(s):	All standards of delivery quality
HB Strategic Objectives:	Person Centred, clinically excellent

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	
Parties / Committees consulted prior to meeting:	

Impact: (must be completed)	
Financial / Value For Money	As outlined to be worked up after EDG discussion and decision
Risk / Legal:	Risk to not being in a position of readiness when notified for the Quality of care Reviews with a consequence of interruption of service delivery
Quality / Patient Care:	Support delivery of quality care
Workforce:	
Equality:	EQIA not required

Figure 1 Quality Framework outline structure



NHS Fife Quality of Care Framework 2019/20

NHS Fife

DRAFT

NHS Fife Quality of Care Framework 2019/20

Vision	Mission	Values	Objectives	Quality of Care Domains	Committee	Ref.	Corporate Objectives 2019/20	Executive Director									
								CEO	DoF	COO	DoN	MD	DoPH	DoE F	DoW	DoHSC	DoP
The people of Fife live Long and Healthy Lives	Transforming health and care in Fife to be the Best	Fairness & Transparency / Care & Compassion / Dignity & respect / Safety First	PERSON CENTRED	• 2. Impact on people experiencing care, carers, families • 4. Impact on Community • 5. Delivery of safe, effective, compassionate, person-centred care	Clinical Governance	1.1	Improve complaints process to respond more effectively and efficiently to patient issues			S	L					S	
						1.2	Improve patient, public and partner engagement and participation with on-going strategic change agenda			S	L					S	
						1.3	Reduce Health Inequalities in terms of access and services. To deliver the Local Outcome Improvement Plan for Fife and the Public Health priorities for Scotland in order to prevent and reduce health inequalities in Fife.						L			S	
						1.4	Improving equalities – Public Duties Act				L				S		
						1.5	Create and nurture a culture of person centred approach to care			S	L	S	S			S	
						1.6	Realising Realistic Medicine – embed within NHS Fife linked to transformation & sustainability		S	S	S	L	S	S	S	S	
						1.7	Ensure our services are designed to address the needs of people (link to performance / access)			L			S	S		L	
						1.8	Agree and deliver refreshed mental health strategy for Fife ensuring more people are supported in the community and that people requiring more intensive care receive that more quickly		S		S	S			S	L	
			CLINICALLY EXCELLENT	• 5. Delivery of safe, effective, compassionate, person-centred care • 6. Policies, Planning and Governance	Clinical Governance Audit and Risk	2.1	Implement the Quality of Care Framework and reporting to the appropriate standing Board Committees, IPR and Board		S	S	L	L	S		S	S	
						2.2	Maintain and audit the system of Safe & Secure Use of Medicines Management			S	S	S					L
						2.3	Fully embed the organisational duty of candour requirements in all areas of NHS Fife			S	S	L				S	
						2.4	Reduce Healthcare Acquired Harm			S	L	L	S	S		S	
						2.5	Continue to refine the NHS framework for risk management to include the Board risk tolerance and appetite and keep the Board Assurance Framework up to date		S	S	L	S	S	S	S	S	
						2.6	Continue to implement Excellence in Care to provide assurance to the organisation of nursing and midwifery care		S	S	L	S	S	S	S	S	
						2.7	Work to develop and embed systems & services to reduce avoidable admissions supporting sustainability and value			L		S	S			L	
						2.8	Develop links with St Andrews University medical school through the ScotGEM programme aspiring towards university hospital status		S	S		L			S	S	
			EXEMPLAR EMPLOYER	• 3. Impact on staff • 7. Workforce management and support • 8. Partnership and resources	Staff Governance	3.1	Review and update the existing workforce strategy which supports the strategic and transformational plans of Fife			S	S	S	S	S	L	S	S
						3.2	Develop arrangements which support effective Talent Management and Succession Planning requirements		S	S	S	S	S	S	L	S	S
						3.3	Implement the 'Once for Scotland' policies as appropriate and prioritise the development of plans to support 'Promoting attendance at work' and the 'Health and well being of the workforce' policies						S		L		
						3.4	Ensure compliance with Staff Governance standards and the principles and values of the 2020 / everybody matters strategy in line with national policy.		S	S	S	S	S	S	L	S	S
						3.5	Ensure NHS Fife has the appropriate infrastructure and training environment to continue to meet professional standards for all staff		S	S	S	S	S	S	L	S	S
						3.6	Increase and sustain participation in the iMatter staff engagement tool to ensure feedback received informs an action plan for 2020/21		S	S	S	S	S	S	L	S	S
						3.7	Ensure effective staff communications – develop and implement an effective internal communications strategy			L						L	
						3.8	Implement statutory safe staffing across all wards in accordance with new legislation			S	L				S	S	
			SUSTAINABLE	• 1. Key organisational outcomes • 4. Impact on Community (4.1,4.2,4.3,4.4) • 6. Policies, Planning and Governance • 8. Partnership and resources • 9. Quality Improvement focussed leadership	Finance, Performance and Resources Staff Governance Audit and Risk	4.1	Refresh and embed the Transformation plan for NHS Fife to deliver the triple aim supporting sustainability and value		L	S	S	S	S	S	S	S	S
						4.2	Deliver the objectives of the NHS Fife / Health & Social Care joint transformation plan		S	L			S			L	S
						4.3	Develop the Property and Asset Management Strategy to support strategic transformation & performance		S	S	S	S	S	L	S	S	
						4.4	Deliver the Outline Business Case for the Fife Orthopaedic Elective Centre		L	S				S			
						4.5	Develop the eHealth, Information & Digital Strategy to support strategic transformation & performance		S	L			S			S	
						4.6	Deliver statutory financial targets		L	S	S	S	S	S	S	S	S
						4.7	Deliver agreed targets for performance delivery			L	S	S	S		S	L	S
						4.8	Deliver effective corporate governance to the organisation		L	S	S	S	S	S	S	S	S
						4.9	Ensure NHS Fife is in full compliance with Health and Safety legislation and best practice including governance			S	S	S	S	L		S	
						4.10	Based on the Audit Scotland 2018 Report on Integration and the Ministerial Steering Group Review of Integration, engage with partners to ensure the success of health & social care integration in Fife.		S	S	S	S			S	L	

KEY:

L – Lead

S- Support

Version 1.0 150519

	Framework Domains	Executive Directors									
		CEO	MD	ND	DoF	DoW	DPH	DEF	COO	DHSCP	Committee
1	Key organisational outcomes	*	*	*	*	*	*	*	*	*	FP&R
2	Impact on people experiencing care, carers, families	*	*	*					*	*	CG (CCGC)
3	Impact on staff	*	*	*		*					Staff
4	Impact on community	*		*			*		*	*	CG (CCGC)
5	Delivery of safe, effective, compassionate, person-centred care	*	*	*			*	*			CG (CCGC)
6	Policies, Planning and Governance	*			*						A&R
7	Workforce management and support	*	*	*		*	*	*	*	*	Staff
8	Partnership and resources	*	*	*	*						FP&R
9	Quality Improvement focussed leadership	*	*	*	*	*	*	*	*	*	Staff/CG

This table identifies a lead executive to a domain.

This needs to be considered alongside reading the Quality of care Framework document which is attached with this sbar

KEY:

L – Lead

S- Support

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Quality of Care Approach

Quality of Care Organisational Review

Self-evaluation Tool

September 2018

We are committed to equality and diversity. This self-evaluation tool is intended to support improvements in healthcare for everyone, regardless of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socio-economic status or any other status. Suggested aspects to consider and recommended practice throughout the Quality Framework should be interpreted as being inclusive of everyone living in Scotland.

First published September 2018

www.healthcareimprovementscotland.org

Contents

Introduction to using the self-evaluation tool

Quality of care approach

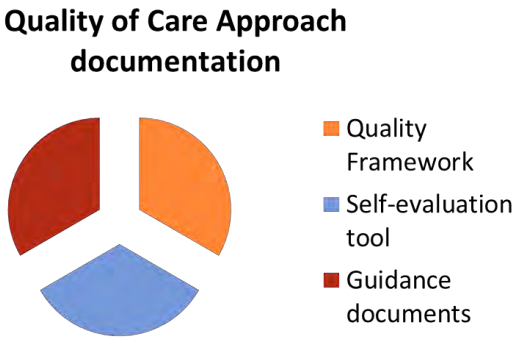
The quality of care approach aims to bring consistency to Healthcare Improvement Scotland's external quality assurance work and to support service providers to evaluate their own care delivery. The approach includes a framework, called the 'Quality Framework – Evaluating and improving healthcare', to guide people through this evaluation.

This self-evaluation tool has been developed to enable organisations to self-evaluate their performance against nine areas of focus, called domains, which are outlined within the Quality Framework. The nine domains are listed below.

1. Key organisational outcomes
2. Impact on people experiencing care, carers and families
3. Impact on staff
4. Impact on the community
5. Delivery of safe, effective, compassionate and person-centred care
6. Policies, planning and governance
7. Workforce management and support
8. Partnerships and resources
9. Quality improvement-focused leadership

The tool has been created based on an evidence search of existing national and international self-evaluation methodologies.

Guidance is also available on our website to advise on how to undertake evaluation using the Quality Framework and self-evaluation tool.



The self-evaluation should tell a story about where you perceive your organisation to be overall against each domain in the framework. The tool highlights the quality indicators for each domain and the following key questions to guide responses:

- How are you doing in respect of this domain?
- How do you know this?
- What do you need to do better or differently? (For example what are the key next steps or areas for improvement the organisation needs to take forward to improve care?)

The tool prompts people to provide summary statements within each domain to highlight where they perceive their organisation to be. The summary statements should reflect the following:

- result (what you aim to achieve)
- approach (what you do to achieve results)
- deployment (how you do it)
- assessment (how and when you review what you do), and
- refinement (what you do to refine the above and improve outcomes for people).

A comments section is available at the end of each domain for service providers to highlight additional relevant information.

It is the responsibility of service providers to be open and honest in their response and to consider the self-evaluation in collaboration with relevant staff and stakeholders. This will provide opportunities to:

- review what progress has been made and what development and learning has happened
- provide assurance to the service providers, the Board and the public about the quality of care provided across the service
- highlight areas of good practice for sharing both internally and externally, and
- highlight areas for improvement and levels of priority.

Those completing the self-evaluation are encouraged to use information from different sources to triangulate evidence of the quality of service delivery. For example, direct observation of care delivery, discussions with staff and people experiencing care, and comparison against other services or relevant data.

The completed self-evaluation should focus on outcomes rather than activities. This could include a description of the impact of changes or improvement activities on the delivery of care, or information on how potential impact is being monitored. Healthcare Improvement Scotland will use the submitted self-evaluations to inform their quality assurance conversations with service providers and assessment of key aspects of care.

Self-evaluation context

Organisation name:

Please use the box below to highlight relevant contextual and background information about the organisation.

For each of the following quality of care domains, please provide a succinct narrative outlining how you perceive your organisation to be, how you know this and what you need to do better or differently.

The narrative should focus on the impact and outcomes on those accessing healthcare services. This should include examples that demonstrate the impact of improvements made for those who use or deliver healthcare services.

The accompanying guide to self-evaluation provides further information on how best to complete this self-evaluation tool.

Domain 1: Key organisational outcomes

Quality indicators:

1.1 Improvements in quality, outcomes and impact

1.2 Fulfilment of statutory duties and adherence to national guidelines

Q. How are you doing in respect of achieving key organisational outcomes?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How does the organisation measure its performance to continually improve the quality of care and achieve the best possible outcomes for its service users?
- How are statutory requirements of relevant finance legislation, national standards and guidance taken into account and implemented?
- Are measures outcomes-focused rather than activity-focused?
- Are outcomes of quality improvement activity embedded and sustained?

Q. How do you know this?

- What evidence is there of improved outcomes?
- What evidence is there of compliance with statutory responsibilities?
- Can you demonstrate examples of the impact of quality improvement activities?

Q. What do you need to do better or differently?

- What are the key next steps or areas for improvement the organisation needs to take forward to improve key outcomes and statutory compliance?
- How do you anticipate what the quality of care will be like in the future?

Any further comments about key organisational outcomes?

Domain 2: Impact on people experiencing care, carers and families

Quality indicator:
2.1 People's experience of care and the involvement of carers and families

Q. How are you doing in respect of impact on people experiencing care, carers and families?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How do you identify and meet the individual needs of people experiencing care?
- How do you communicate with them and provide personalised care?
- How do you ensure people experiencing care have all the information that they need?
- How do you work with people experiencing care, carers and families when planning and making decisions about their care?
- How do you support people to provide feedback on their experience of care?
- What is done with feedback, how is it shared and who is it shared with?
- How is feedback used to drive improvement?

Q. How do you know this?

- What evidence do you have about the quality of care delivered to people?
- Can you demonstrate that people have confidence in your service?
- Can you show examples of feedback from people being used to improve the quality of care?

Q. What do you need to do better or differently?

- What are the key next steps or areas for improvement the organisation needs to take forward to improve the impact on people experiencing care, carers and families?

Any further comments about impact on people experiencing care, carers and families?

Domain 3: Impact on staff

Quality indicator:

3.1 The involvement of staff in the work of the organisation

Q. How are you doing in respect of impact on staff?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How do you involve staff in planning and delivering the organisation's vision, values and aims?
- How do you measure and monitor staff views over time to identify whether they feel engaged, supported, motivated and valued?
- How do you use feedback from staff to drive improvement and how do you inform staff of changes made in response to their feedback?

Q. How do you know this? • What evidence do you have about how staff feel and is the evidence up to date? • Can you demonstrate feedback from staff being used to improve the quality of care?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving the impact on staff?
Any further comments about impact on staff?

Domain 4: Impact on the community

Quality indicator: **4.1 The organisation's success in working with and engaging the local community**

Q. How are you doing in respect of impact on the community?
Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer. Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this. • How do you engage with local communities about the care delivered? • How do you assess whether local communities feel sufficiently engaged? • How do you know whether local communities have confidence in your organisation or its services? • How do you use feedback from local communities to drive improvement?
Q. How do you know this? • What evidence do you have about how local communities feel about your organisation or its services? • Can you demonstrate feedback from local communities being used to improve the quality of care?

Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving the impact on the community?
Any further comments about impact on the community?

Domain 5: Delivery of safe, effective, compassionate and person-centred care

Quality indicators:

- **5.1 Safe delivery of care**
- **5.2 Assessment and management of people experiencing care**
- **5.3 Continuity of care**
- **5.4 Clinical excellence**
- **5.5 Data for improvement and evidence-based learning**
- **5.6 Quality improvement processes, systems and programmes**

Q. How are you doing in respect of safe, effective, compassionate and person-centred care delivery?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How do you ensure the service delivery is safe today and will be safe in the future?
- How do you ensure appropriate assessment of people in your care and accurate completion of documentation and handovers?
- How are recognised standards and agreed best practice taken into account and implemented, and how are outcomes measured?
- How do you ensure you continuously review and learn from adverse events, complaints, audits, evaluations, data and feedback?
- How do you empower people to manage their own care?
- How do you work with partner agencies to ensure a smooth journey of care?
- What improvement data is collected and how are lessons learned from data analysis shared and who are they shared with?
- Do you have embedded processes to drive improvement in your organisation?

Q. How do you know this?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving safe, effective, compassionate and person-centred care delivery?
Any further comments about safe, effective, compassionate and person-centred care delivery?

Domain 6: Policies, planning and governance

Quality indicators:

6.1 Policies and procedures

6.2 Risk management and audit

6.3 Assurance framework and governance committees

6.4 Planning

Q. How are you doing in respect of policies, planning and governance?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How is the effectiveness and implementation of policies and procedures assessed and improved?
- How do you know if risks to people are appropriately identified, assessed, recorded and reviewed?
- What controls are in place to reduce harm from these identified risks?
- How do you know if your governance structures provide appropriate assurance of safe, effective, compassionate and person-centred care delivery?
- How do you ensure effective design of services in collaboration with internal and external stakeholders?

Q. How do you know this?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving policies, planning and governance?
Any further comments about policies, planning and governance?

Domain 7: Workforce management and support

Quality indicators:

7.1 Staff recruitment, training and development

7.2 Workforce planning, monitoring and deployment

7.3 Communication and team working

Q. How are you doing in respect of workforce management and support?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How effective is workforce planning? How well does it demonstrate a flexible and responsive approach?
- How do you know if your processes for recruitment, induction, training and development are safe and effective for all staff and volunteers?
- How well do leaders and staff demonstrate accountability for their roles and responsibilities?
- Can you demonstrate staff working together to solve problems and make improvements?

Q. How do you know this?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving workforce management and support?
Any further comments about workforce management and support?

Domain 8: Partnerships and resources

Quality indicators:

8.1 Collaborating and influencing

8.2 Cost effectiveness and efficiency

8.3 Sharing intelligence

Q. How are you doing in respect of partnerships and resources?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- How effective are processes in encouraging collaboration with stakeholders?
- Can you demonstrate effective outcomes/improvement from collaboration with external stakeholders or partner organisations?
- What challenges to cost effectiveness and efficiency have been identified and are these being overcome?
- How effectively is learning from adverse events, complaints and safety alerts spread throughout the organisation, including actions and improvements?
- How is learning and intelligence shared with external stakeholders? How effective are mechanisms for doing this?

Q. How do you know this?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving partnerships and resources?
Any further comments about partnerships and resources?

Domain 9: Quality improvement-focused leadership

Quality indicators:

9.1 Vision and strategic direction

9.2 Motivating and inspiring leadership

9.3 Developing people

9.4 Leadership of improvement and change

Q. How are you doing in respect of quality improvement-focused leadership?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

Provide summary statements to highlight where you think you are against the domain in terms of result, approach, deployment, assessment and refinement. Consider the following to help you decide this.

- Can you demonstrate that staff and stakeholders understand and value the organisation's purpose, values and aims?
- How effective are processes for staff development, training and learning for improvement?
- How do you enable staff to feel motivated, empowered and supported to contribute to quality improvement and development of the organisation?
- Can you demonstrate staff feeling confident and empowered with knowledge and skills to respond effectively to complaints and adverse events?
- Can you demonstrate assurance that the organisation is well led?
- How is an improvement culture encouraged within the organisation? What processes are in place to innovate and improve the organisation?
- How are service user outcomes considered when developing innovative improvement ideas?

Q. How do you know this?
Q. What do you need to do better or differently?
• What are the key next steps or areas for improvement the organisation needs to take forward in improving quality improvement-focused leadership?
Any further comments about quality improvement-focused leadership?

Summary of priorities

Q. Having reflected on all nine domains, what are your overall three key priorities for what you need to do better or differently?

(For example what are the priority next steps or areas for improvement you need to take forward to improve the quality of care and outcomes for people?)

1.

2.

3.

DOCUMENT CONTROL SHEET			
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Version Number			
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Quality of Care Approach

Quality of Care Organisational Review

A Practical Guide to Self-evaluation

September 2018

We are committed to equality and diversity. This guide is intended to support improvements in healthcare for everyone, regardless of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socio-economic status or any other status. Suggested aspects to consider and recommended practice throughout the Quality Framework should be interpreted as being inclusive of everyone living in Scotland.

First published September 2018

www.healthcareimprovementscotland.org

Contents

About this document

This document is a practical guide for undertaking self-evaluation against the Quality Framework – evaluating and improving healthcare using the Quality of Care Self-evaluation Tool. It provides advice and suggestions about how to manage the self-evaluation process in your organisation or within a particular service. It is written primarily for the manager(s) or staff member(s) with responsibility for co-ordinating the self-evaluation process.

The guide should be read in conjunction with the Quality of Care Approach organisational review methodology which gives more detail about how self-evaluation feeds into this process.

The benefits of self-evaluation

Having quality information about the outcomes and impacts being achieved can help an organisation to better understand the needs of the people using the service and its staff. Self-evaluation contributes to continuous quality improvement by providing a structured opportunity to assess performance, and based on this, identify opportunities for improvement. Regular self-evaluation forms part of good internal governance and is a key driver for local improvement work. Using self-evaluation for quality improvement, rather than undertaking evaluation only in response to external scrutiny, can inspire greater local ownership of issues and design of more effective solutions.

The quality of care approach promotes regular internal organisational self-evaluation complemented by independent external validation, challenge and intervention, as required, as key drivers for improving healthcare.

The Quality Framework has been developed primarily to help organisations to undertake self-evaluation. It contains a range of indicators that support a holistic approach, allowing an organisation to 'tell its story'. Each quality indicator is further broken down into themes and factors to consider how to guide and support the process. These are neither exhaustive nor prescriptive. The framework also allows scope for organisations to self-evaluate and develop the narrative about the quality of the care that they provide using measures that are meaningful and important to staff locally.

Self-evaluation will identify opportunities for improvement. However, this improvement will only happen if there is a subsequent action plan, the identified actions are implemented, and impact monitored and regularly reviewed. Healthcare Improvement Scotland will periodically ask for a copy of the organisational self-evaluation to inform and guide an organisational 'quality of care review'. However, this should not be the only reason for undertaking self-evaluation. The outcomes of the activity should also be used internally on an ongoing basis to drive improvement.

Preparing for self-evaluation

It is up to you how self-evaluation is carried out and who should be involved. There is no 'one-size-fits-all' approach to the process; it will depend largely on the size and structure of your organisation and the resources available. The process can be split into three broad stages.

The following are suggestions to guide each stage of self-evaluation. These are not prescriptive and you may choose to follow alternative or additional courses of action that are more relevant locally.

Stage 1: Planning the self-evaluation

The self-evaluation process against the Quality Framework has been designed to gauge the appropriateness of governance structures, systems and procedures to support staff to consistently deliver safe, effective, compassionate and person-centred care. It is a process of diagnosis and reflection, leading to action where areas for improvement are identified. People's experience of services is a culmination of the combined efforts of all staff in the organisation, from the executive team to those directly delivering care to patients. Capturing information from these different sources, and from service users, will ensure that a range of perspectives and experiences are considered in the self-evaluation. Creating the right conditions for self-evaluation can save time and increase the rewards from the process by increasing the likelihood of an end product that is jointly owned and identifies relevant improvement areas. The following are suggestions for important factors to consider in the planning stage.

Organisational commitment and buy-in

Before starting the organisational self-evaluation process, it is important to inform and get commitment from senior leadership. This commitment and buy-in to the process gives leaders the opportunity to ensure that appropriate resources are allocated and support is provided as required. Leaders will have a key role to play in considering and implementing any improvement work highlighted through the self-evaluation process. Sharing the background information with the leadership team can help with organisational buy-in and support.

Co-ordination and operational leadership

Ideally, the self-evaluation process should be led and co-ordinated by a nominated member of staff who can liaise with different levels in the organisation, from senior leaders to those involved in direct care delivery. Depending on the size and structure of

the organisation or service, the leader of the self-evaluation exercise may need a small administrative team to support the process. The leader/team will manage the process of collecting the data and evidence, and ensure that the right people are involved in interpreting it and making recommendations.

Understanding the framework and the self-evaluation process

It is important to understand the Quality Framework before starting the process of self-evaluation. The framework provides those responsible for leading and co-ordinating the self-evaluation with information and prompts to stimulate discussion. The framework should be read alongside this supporting guidance and the self-evaluation tool before starting the self-evaluation.

Agreeing an approach that is right for your organisation

It is up to you how the self-evaluation is carried out and who is involved. The most important thing is that information is drawn from a range of sources, perspectives and experiences. The time required to do this will vary between organisations due to size, structure and how services are organised.

Deciding on the range and number of people who need to be involved and their needs

To get a comprehensive picture, it is important to triangulate relevant information, facts and data from different sources, systems or databases. A range of people also need to participate to ensure the self-evaluation process is comprehensive. This could include people experiencing care, carers and families if appropriate, staff providing frontline care, leaders across the organisation and those in administrative roles. The number of people that you may wish to involve will vary depending on the size of the organisation.

Various mechanisms and approaches can be used to capture the views and experiences of groups of stakeholders, including focus groups, questionnaires and interviews. Guidance is available from the quality of care project team on how to undertake surveys, focus groups and interviews to capture feedback.

Agreeing a plan

A defined plan with key milestones and nominated responsible leads can help to keep the process moving and make best use of the available resources. The self-evaluation will provide useful information to inform operational and organisational planning as well as contributing to processes of external quality assurance. Scheduling the process to coincide with key internal planning milestones may be of benefit.

Stage 2: Conducting the self-evaluation and interpreting the results

The self-evaluation should tell a story about where you perceive your organisation to be overall against each domain in the framework, how you know this, and where there could be improvement. The following are suggestions for important factors to consider as you work through Stage 2.

Communicate the process

Effective communication is critical to the success of self-evaluation. How people hear about it will influence how they approach and engage with the process. Those involved need to understand the following:

- the purpose of the self-evaluation
- how it will be undertaken
- how people will be involved
- the timescales involved
- the steps and activities, and
- how the information will be used.

Collate relevant data and evidence

Performance outcomes and impact information is essential to robust self-evaluation. The first task is to establish current levels of performance against the indicators in the 'Outcomes and Impact' section of the Quality Framework. The framework includes examples of the types of data that may be useful to look at here. This information will likely be a combination of 'hard' data (from performance information systems and formal mechanisms for capturing feedback from staff and people experiencing care) and 'soft' data that may be captured through specific engagement activity with individuals and groups. When thinking about the data and information to include in the self-evaluation process, it is useful to ask the following questions within each of the framework domains:

- How are you doing in respect of the domain?
- How do you know this?

Interpreting the data and evidence

Interpretation of the data and evidence is best done by a group of stakeholders, that way a range of perspectives and knowledge are included leading to a more objective view of current performance and priorities. The aim, based on the data and evidence, is to come to a consensus view and begin to answer the next question:

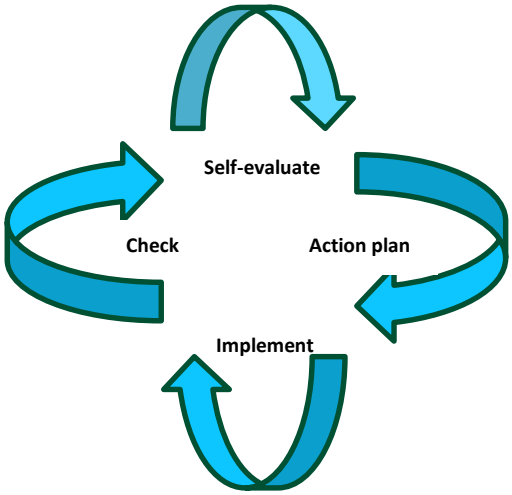
- What do you need to do next, better or differently?

The group should focus on the outcomes of activities such as evaluation or audit results, outputs from tests of change or lessons learned. These will help to identify challenges and steps required to address areas for improvement as well as areas of good practice. In developing the narrative against each domain, it may be helpful to think about:

- the outcome, for example what happened as a result of implementing a particular policy, service change or improvement activity
- what was the impact on those in receipt of care, those delivering care or those supporting care provision
- what (if any) learning was achieved and how was learning shared with relevant people to support ongoing quality improvement, and
- what plans are in place to implement further improvement.

Stage 3: What next?

The self-evaluation drives reflection on the quality of care provided and provides opportunities to identify areas for improvement. It is just the beginning, however, and must be followed up with action planning and implementation for change and improvement to be effective locally.



The data collected for the purposes of self-evaluation will inform and should complement other ongoing internal quality improvement work. As mentioned previously, Healthcare Improvement Scotland will periodically ask for a copy of the organisational self-evaluation to inform and guide an organisational 'quality of care review'. This will help to build a more robust, shared understanding over time of the strengths and challenges faced within the organisation, the maturity of its various systems and the capacity for improvement locally. This will allow Healthcare Improvement Scotland to better support improvement in NHSScotland through its range of activities.

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NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6TH November 2019
TITLE OF REPORT:	Organisational Duty of Candour Annual Report
EXECUTIVE LEAD:	Dr Chris McKenna
REPORTING OFFICER:	Helen Woodburn

Purpose of the Report (delete as appropriate)		
	For discussion	**For Information** for noting

SBAR REPORT

Situation

In accordance with legislation the attached report is the first NHS Fife Organisational Duty of Candour (DoC) Annual Report for the period 1 April 2018 -31 March 2019. This report details the numbers of events in NHS Fife known to have activated the organisational duty of candour procedure to be followed, the outcomes associated with such events and the details on how well the procedure has been followed.

Background

The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The guidance for the Organisational duty of candour legislation states that as part of the legislation The Act sets out that a responsible person that provides a health, care, or social work service during a financial year must prepare an annual report, as soon as reasonably practicable after the end of that financial year.

Organisations must set out in an annual report the way that the duty of candour procedure has been followed for all the cases that they have identified.

The DoC procedure applies to incidents that the responsible person becomes aware of after 1 April 2018.

Assessment

Summary

NHS Fife summary for the period 1 April 2018 -31 March 2019 46 events reported to have activated organisational duty of candour.

The specific detail of the number of events per outcome is detailed on page 2 of the report.

Compliance with the procedure

Overall NHS Fife complied with the procedure well. This means the people affected were informed, apologies were given, an account of the event was provided very quickly at the time of the event, and a full review was undertaken.

Areas of strength in compliance with the procedure have been identified, and there are a number areas identified to improve upon.

Sharing the report and information

The annual report is in the process of going through Board governance routes, once complete

Scottish Government will be sent a copy and the report will be made available on NHS Fife public facing website. Individual summary sheets by division are being prepared which will provide details on numbers, types of outcomes resulting from the incident, types of adverse events and the compliance with the procedure. These will be shared with the divisional units once completed to support further improvements in the next coming year.
Recommendation Clinical Governance Committee are asked to • discuss and note the content of the report.

Objectives: (must be completed)	
Healthcare Standard(s):	Organisational Duty of Candour legislation
HB Strategic Objectives:	

Further Information:	
Evidence Base:	none
Glossary of Terms:	none
Parties / Committees consulted prior to Health Board Meeting:	none

Impact: (must be completed)	
Financial / Value For Money	none
Risk / Legal:	none
Quality / Patient Care:	none
Workforce:	Understand the guidance and implement changes
Equality:	n/a

Annual Duty of Candour Report 2018 -19

NHS Fife

Annual Duty of Candour Report 2018 -19

NHS Fife

1. Introduction and Background

NHS Fife serves a population of approximately 368,000 people. Our vision is to enable the people of Fife to live long and healthy lives. We strive to achieve this by transforming health and care in Fife to be the best.[1]

As of 1st April 2018, all health and social care services in Scotland have an organisational Duty of Candour (DoC). The overall purpose of the duty of candour is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition. This is a legal requirement which means that when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to be followed is set out in the Duty of Candour (Scotland) Regulations 2018.

An important part of this duty is that NHS Fife provides an annual report about how the duty of candour is implemented in our services. This report describes how NHS Fife has implemented the duty of candour during the period 1 April 2018 to 31 March 2019. This includes as attached in appendices 1and 2 reports from the two managed general practices in NHS Fife.

This is the first year of the duty of candour being in operation and as such it has been a time of learning and development. In particular, refining our existing adverse event management processes to include all elements of the duty of candour and the identification of outcomes

2. Duty of Candour Outcomes

The Organisational Duty of Candour guidance[2] outlines the procedure which must be activated as soon as

reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:

(a) the incident appears to have resulted in or could result in any of the outcomes below (see Table 1)

(b) the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

3. How many adverse events happened to which the duty of candour applies?

Between 1 April 2018 and 31 March 2019, there were 46 adverse events where the duty of candour applied. NHS Fife identified these events through its adverse event management processes. The organisation supports a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and is in accordance with a national framework .

Table 1 overleaf details the outcomes which have occurred across NHS Fife after 1 April 2018 to 31 March 2019.

[1] NHS Fife Strategic Framework. 2015.
[2] Organisational Duty of Candour guidance. The Scottish Government. March 2018.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred
A. The death of the person	<5
B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5
C. Harm which is not severe but which results in one or more of the following criterion:	
• an increase in the person's treatment	30
• changes to the structure of the person's body e.g. loss of digit or limb, removal of wrong kidney	<5
• the shortening of the life expectancy of the person	<5
• an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	<5
• the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	6
D. The person requiring treatment by a registered health professional in order to prevent: • the death of the person, or • any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5

The most common outcome which these events have resulted in is an increase in the person's treatment; this may include for example an additional stay in hospital, or the need to be prescribed additional medications such antibiotics.

4. To what extent did NHS Fife follow the duty of candour procedure?

Of the 46 identified cases to activate the duty of candour procedure, the cases have been reviewed to establish the extent to which the organisation complied with the procedure.

Overall NHS Fife has carried out the procedure well, the people affected were informed, apologies were given, an account of the event was provided very quickly at the time of the event, and a full review was undertaken. A number of areas of strength have been identified. These are:

- Notifying the person and providing details of the incident

[3] Learning from adverse events through reporting and review: A national framework for Scotland, revised July 2018, NHS Fife review all adverse events.

- Provision of an initial apology
- Reviewing all cases

There are also areas for improvement. NHS Fife will work to improve these over the next year.

The key areas for improvement are to:

- raise the awareness to the offer of a written apology to the relevant person in addition to any apology offered at the time of the event
- continue to embed the processes to be followed once a written apology has been requested.
- improve documentation of the procedure to demonstrate that each of the steps of the procedures have been taken
- offer further support and education to staff

We know that witnessing or being involved in an adverse event can be distressing for staff as well as people who receive care. Support is available for all staff through our line management structure as well as through Staff Wellbeing and Safety.

5. Information about our policies and procedures

Every adverse event which occurs is reported through our local reporting system as set out in our Adverse Events policy and associated processes. Through these, we can identify events that activate the duty of candour procedure.

The policy contains a section on implementing the organisational duty of candour, and a detailed section about supporting staff and persons affected by the adverse events, with examples of the types of support available.

Each adverse event is reviewed to understand what happened and the actions we can take to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the review, and local management teams develop action plans to meet these recommendations.

The decision on whether an event activates the duty of candour procedure has been taken by senior clinical staff including the Board Medical Director, Board Director of Nursing, Director of Pharmacy, Associate Medical and Nurse Directors, Associate Director of Allied Health Professionals, Clinical Directors and Heads of Nursing.

To support implementation of duty of candour, staff have been encouraged to complete the NHS Education Scotland on line learning module. This has been made available to staff through the intranet. In addition to the above policy to ensure our practice and services are safe, the organisation has clinical policies and procedures. These are reviewed regularly to ensure they remain up to date and reflective of current practices. Training and education are made available to all staff through mandatory programmes and developmental opportunities relating to specific areas of interest or area of work.

6. What has changed as a result?

We have made several changes following review of the duty of candour events. These include the following:

a) A focus on the requirement to complete all essential documentation, from a nursing and medical perspective. In particular associated with vascular access devices and procedures. Within some areas, measures have been put in place to monitor this frequently.

b) Review and update of current policies specifically to reflect new practice and to provide clarity in any areas

which are ambiguous.

c) Development of new standard operating procedures to support consistent reliable practice

d) Review and development of clear defined pathways to improve the safety of management and transfer of patients.

e) Many reviews identified knowledge gaps and in each instance there was a focus to ensure all staff attend training and complete learning modules, for example AIMS and ILS training

If you would like more information about this report, please contact

Board Medical Director Office

Victoria Hospital

Kirkcaldy

KY2 5AH

Telephone 01592 648077

Appendix 1

Linburn Road Health Centre

124 Nith Street

Dunfermline, KY11 4LT

Tel: 01383 733490 Fax: 01383 748758

Email: Fife-UHB.F20502Linburn-Road@nhs.net

Fife Health & Social Care Partnership
Supporting the people of Fife together

DUTY OF CANDOUR REPORT

REPORT PERIOD : 1st April, 2018 to 31st March, 2019

COMPLETED BY : Sharon Duncan, Practice Manager (Job Share) and Catherine Dunn (Job Share)

Linburn Road Health Centre provides Health Care to patients within the Dunfermline and Rosyth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

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 2018 and 31 March 2019)**
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

To what extent did Linburn Road Health Centre follow the duty of candour procedure ?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary . Procedures to be followed: (a) to notify the person affected (or family/relative where appropriate) (b) to provide an apology (c) to carry out a review into the circumstances leading to the incident (d) to offer and arrange a meeting with the person affected and/or their family, where appropriate (e) to provide the person affected with an account of the incident (f) to provide information about further steps taken (g) to make available, or provide information about, support to persons affected by the incident (h) to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on http://intranet.fife.scot.nhs.uk/

What has changed as a result ?	N/A

Other Information	N/A

Dr Louise Dalton	MBChB (Glasgow 1999), MRCGP, DCH, DRCOG
Dr Ellen Klauz	MBChB (Glasgow 2007), MRCGP
Dr Celine O'Brien	MBChB (Glasgow 2006), MRCGP, DRCOG, DFSRH
Dr Fiona Ritchie	MBChB (Aberdeen 1994) MRCGP
Dr Alison Caldicott	MBChB (Edinburgh 2006) MRCGP

Appendix 2

THE LINKS PRACTICE

Masterton Health Centre

74 Somerville Street

Burntisland

Fife

KY3 9DF

Dr J A Duncan
M.B.,Ch.B.,D.C.H., M.R.C.G.P.

Dr C Fleming

M.B., Ch.B., M.R.C.G.P.

This short report describes how our care service has operated the duty of candour during the time between 1st April 2018 and 31st March 2019. We hope you find this report useful.

Our Practice serves a population of 1872 patients within the Burntisland, Kinghorn, Aberdour area.

How many Incidents happened to which the duty of Candour applies?

In the last year, there have been no incidents to which the duty of candour applied.

Information about our policies and procedures.

Where something has happened that triggers the duty of candour, our staff report this to the Practice Manager who has responsibility for ensuring that the Duty of candour procedure is followed. The Practice Manager records the incident and reports as necessary the Health Board. When an incident has happened, the Manager and staff set up a learning review. This allows everyone involved to review what happened and identifies changes for the future.

If you would like more information about The Links Practice, please contact us using these details.

The Links Practice

Masterton Health Centre

74 Somerville Street

Burntisland

Fife

KY3 9JD

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2019

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Hospital Electronic Prescribing and Medicines Administration (HEPMA)
EXECUTIVE LEAD:	Chris McKenna
REPORTING OFFICER:	Scott Garden

Purpose of the Report (delete as appropriate)		
For Decision **reach a conclusion**		

SBAR REPORT

Situation

Hospital Electronic Prescribing Medicines Administration (HEPMA) is currently being implemented across NHS Scotland. NHS Fife Outline Business Case is submitted for approval.

Background

The primary aim of (HEPMA) is to remove paper based processes from prescribing and medicines administration and significantly improve patient safety and quality of care. In addition, an electronic system will improve our medicines management processes and enhance medicines optimisation. This will enable greater control over what is prescribed, how it is prescribed and how it is administered. This will enable monitoring and feedback to prescribers and those administering medicines to address variation, minimise inefficiency and improve quality.

A National Business Case was developed in 2016, agreement was reached that HEPMA would be available as a National Framework with NHS Boards calling off the agreed framework.

Assessment

NHS Fife have undertaken an options appraisal to agree the short list of options. Under the current multi-supplier Framework agreement there are currently three accredited suppliers:- JAC/Wellsky, EMIS and Dedalus. The existing NHS Fife pharmacy stock control system is provided by EMIS.

The HEPMA Programme Board agreed NHS Fife should undertake a mini competition subject to sign off in principle of the Outline Business Case to ensure best value.

The Scottish Government has confirmed that central eHealth funds will be made available to NHS Boards to fund non-recurrent revenue and capital costs (but not local hardware costs). This funding equates to £1.4m for NHS Fife – the profile over financial years is yet to be confirmed. In recent discussions with Scottish Government they advised there is the potential for £500k capital to be allocated to NHS Fife 2019/20 subject to NHS Fife agreement to proceed with HEPMA and spend within the financial year.

There is a need for NHS Fife to identify the source of both Capital and Revenue funding for this project.

Recommendation

NHS Fife Clinical Governance Committee is asked:-

- To agree this Outline Business Case subject to agreement on Funding
- To support progression to mini competition
- To support delivery of HEPMA within NHS Fife 2020 onwards.

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

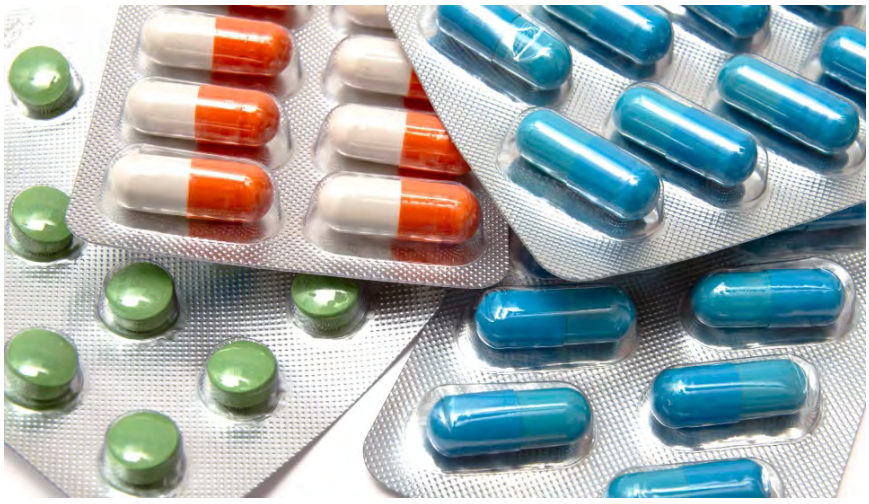
Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

NHS Fife

Hospital Electronic Prescribing and Medicines Administration (HEPMA)

Outline Business Case



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0.1	2019/10/14	Created from Full B Case	MR	N
0.2	2019/10/22	Updated following discussion with Finance	MR	N

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Name	Date:	Version:
Dr Chris McKenna, Chair of HEPMA Programme Board and eHealth Board		
Mrs Lesly Donovan, General Manager, eHealth		
Area Drugs and Therapeutics Committee	23/10/19	
Financial Planning and Resource	05/11/19	
NHS Fife Clinical Governance Committee	06/11/19	
NHS Fife Board	27/11/19	

Distribution: This document has been distributed to

Name	Date of Issue:	Version:
HEPMA Programme Board	14/10/19	V0.1
Area Drugs and Therapeutics Committee		
eHealth Board		
Financial Planning and Resource		
Clinical Governance Committee		
NHS Fife Board		

Equality and Diversity Impact Assessment:

TBC

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Table of Contents

1 Executive Summary

1.1 Strategic Case

Medicines represent the most frequent healthcare intervention – there are approximately 34 million prescriptions and 122 million administrations of medicines per year in NHS Scotland. However, the vast majority of medicines used in hospitals are still prescribed, and their administration recorded, using a paper based chart system, and with the increasing range and complexities of medicines available, the safe and effective prescribing and administration of medicines is challenging.

The strategic case is founded on the national Outline Business Case, and has been updated to take account of recent reports and strategies and is focused on four key themes:

Patient Safety. The Scottish Patient Safety Programme (SPSP) has a strategic commitment to reduce the harm associated with high risk medicines and recognised that HEPMA is a key building block. In 2015, Healthcare Improvement Scotland (HIS) released a publication outlining the scale of medication incidents and medication incidents related harm in NHS Scotland. It highlighted that 15,000 patients admitted to acute hospitals experience adverse drug events due to medicines (ranging from no harm to death). Research indicates that 72% are preventable and there are up to 280 preventable deaths across all acute hospitals due to medicines.

Strategic Alignment. The Scotland eHealth strategy 2014-2017 committed to the need for electronic prescribing and medicines administration systems, and described the future state of all NHS Boards will be where they have *'implemented some elements of electronic prescribing and medicines administration (EPMA) systems with integral clinical decision support interfaced with other clinical eHealth systems by 2020*'. In addition, Achieving Excellence in Pharmaceutical Care and the Lord Carter Review, focusing on Hospital Productivity both recommend the implementation of electronic prescribing.

Electronic Patient Record and Paperless Vision. The vast majority of medicines used in hospitals are prescribed and administered using a paper-based system and until these records are recorded digitally it will be impossible to complete a patient's electronic record. Electronic prescribing is the '*largest missing piece of the EPR jigsaw'* as it is the last major area of clinical information not available electronically.

Digital Maturity. Electronic prescribing is a key determinant of digital maturity and implementing a system such as HEPMA will ensure NHS Fife remains at the forefront of prescribing practice and does not fall behind other health systems who have already invested in the implementation of HEPMA.

1.2 Benefits Case

Drug related adverse events are the second largest cause of harm within the acute sector within the UK and account for around 15% of all adverse events. NHS Scotland, and indeed NHS Fife, is no different – for example, a recent prospective observational study which analysed 50,000 prescription items across eight Scottish hospitals found an overall error rate of 7.5%. The number and scale of errors is significant, whilst most have little or no patient impact, a number cause permanent harm to the patient.

A wide range of benefits from HEPMA were identified during the development of the National OBC and FBC. These were identified by a multidisciplinary Clinical Reference Group consisting of clinicians, nurses, pharmacists and GPs and were grouped as set out below.

HEPMA Benefit Categories and Associated Evidence

Benefit Category	Evidence and Impact
Accurate prescribing and administration of medicines	Reduction in Adverse Drug Events (60-66% reduction with evidence sourced from NHS England business cases). Reduction in missed doses (Reduction from 14% to 8%, NHS Lanarkshire audit). Reduction in harm. Reduction in nursing administration errors. For example alerts to prevent too frequent administration of a medicine. e.g., analgesics. Supports complex prescribing and medicine administration regimes out with standard dosing schedules e.g., Parkinson disease. Legible medicine prescription chart for both prescribing and administration.
Better communication between and within settings and improved medicines reconciliation	Compliance with discharge prescribing documentation (40 to 100% improvement). Sourced from NHS Ayrshire and Arran research study. Reduction in prescribing errors at discharge (99% to 23%) and omitted medications (42% to 11%). Sourced

Benefit Category	Evidence and Impact
	from NHS Ayrshire and Arran research study. Improved medicines reconciliation at all points of transfer from admission through downstream wards (including Critical Care areas) and onto Primary Care. Reduction in need to manually transcribe between medicine prescription charts thereby minimising transcription errors.
Greater consistency of clinical decision-making	Improved formulary compliance. Controlled access to prescribing and administration rights. Enhance the governance of role specific prescribing. e.g., will support non-medical prescribing. Active decision support at point of prescribing.
Releasing time to care and efficiency	50% reduction in ward drug round time (from NHS Lanarkshire audit). Reduction in time looking for misplaced charts – 20 minutes per team member per shift (Lancaster Teaching Hospital). Direct access for Nurses to clinical decision support (e.g., eBNF) at point of administration. Ability to direct clinical pharmacy resource to target high risk patients, existing service cover is insufficient to meet current and increasing needs.
Better use of information to improve the use of medicines and optimise patient care	Easier switching of antibiotics and an improvement in antimicrobial stewardship and reducing variation. Savings identified by better prescribing intelligence and performance data. Improved stock management and identification of stock requirements within ward areas. Key enabler to support the delivery of NHS prescribing quality and efficiency programme by providing key data on harm, variation and waste in the use of medicines.

In the national business case an estimate was made of the number of prescription errors that could be prevented by the implementation of HEPMA based on a synthesis of research evidence. It was estimated that just over 150 prescribing errors per 500 beds caused some patient harm and resulted in an additional 3 bed days per error which could have been averted through the implementation of a HEPMA system.

There is clear evidence that a HEPMA system provides an important foundation for improving the safe and effective use of medicines. It is also reasonable to expect that improvements in the safe and effective use of medicines will ultimately deliver efficiency benefits. Most of the benefits will not be realisable in quantifiable monetary terms, but will release time or resources to improve clinical practice and create capacity to meet increased demand, therefore improving patient flow by simplifying the discharge process both at ward level and in the pharmacy department. As a consequence, these quantified benefits have not been included in the economic or financial appraisal elements of this business case, although it has been estimated that these benefits could be significant.

1.3 Risk Assessment

It is important to recognise that as well as delivering additional benefits, there will also be a number of risks associated with implementing HEPMA. These include risks associated with running paper and electronic systems in parallel, inadequate change management and/or leadership impacts adoption of HEPMA, concerns about the complexity and scope of the training requirements as well as the requirement to operate an on-going robust and scalable (24/7/365) support and governance plan.

1.4 Commercial Case

Under the current multi-supplier Framework agreement there are currently three accredited suppliers JAC/Wellsky, EMIS and Dedalus. The existing NHS Fife pharmacy stock control system is provided by EMIS.

NHS Fife have opted to undertake a mini competition subject to sign off in principle of the Outline Business Case.

1.5 Financial Case

In this section a number of cost assumptions have been presented.

All Boards in the East Region are at different stages of planning implementation of HEPMA and have different pharmacy stock control systems currently. It has been agreed that each board will progress a

local business case and implementation plan, collaborating to share experience and learning across boards.

A summary of the Non Recurring Capital Cost and Affordability is shown below. The Recurring Revenue summary and Affordability is shown overleaf.

Non Recurring Capital Cost and Affordability

£'000'S	2019/20 £k	2020/21 £k	2021/22 £k	2022/23 £k	TOTAL COST IMP
HEPMA System	444	0	0	0	**444**
Hardware – NHS Fife Infrastructure	110	0	0	0	**110**
Hardware – Workstations / PC's	0	104	104	104	**312**
Hardware – Pharmacy Mobile Devices	0	18	0	0	**18**
External Integration Costs	0	15	15	0	**30**
Implementation Resource	62	861	870	940	**2,733**
Legal Fees	25	0	0	0	**25**
VAT	111	27	24	21	**183**
Total Non Recurring Capital	**752**	**1,025**	**1,013**	**1,065**	**3,855**
NHS Scottish Government HEPMA Funding	**500**	**500**	**400**	**0**	**1,400**
NHS Fife Capital Funding Required	**252**	**525**	**613**	**1,065**	**2,455**

Recurring Revenue

£'000'S	2020/21 £k	2021/22 £k	2022/23 £k	2023/24 £k	2024/25 Onwards £k	TOTAL COST £k
eHealth Infrastructure and Support	66	66	66	66	66	**330**
Ongoing BAU Support	0	0	0	729	751	**1,480**
Training	246	249	256	0	0	**751**
Recurring Support	96	96	96	96	96	**480**
Depreciation (7 years)	107	254	434	622	658	**2,075**
Total Additional Recurring Resource	**515**	**665**	**852**	**1,513**	**1,571**	**5,116**
AVAILABLE BUDGETS						
NHS Fife Depreciation	107	254	434	622	658	**2,075**
Medicines Prescription Chart Procurement Savings	7	4	3	14	14	**42**
CNORIS Costs Avoided	TBC	TBC	TBC	TBC	TBC	**0**
Total Available Budgets	**114**	**258**	**437**	**636**	**672**	**2,117**
NHS Fife Additional Funding Requirement	**401**	**407**	**415**	**877**	**899**	**2,999**

The Scottish Government has confirmed that central eHealth funds will be made available to NHS Boards to fund non-recurrent revenue and capital costs (but not local hardware costs). This funding equates to £1.4m for NHS Fife – the profile over financial years is yet to be confirmed. In recent discussions with Scottish Government they advised there is the potential for £500k capital to be allocated to NHS Fife 2019/20 subject to NHS Fife agreement to proceed with HEPMA and spend within the financial year.

The Non Recurring Revenue illustrates that while a reasonable proportion of the initial implementation cost will be funded centrally, there will remain a cost pressure. It may be possible to reduce the funding gap further by collaborating with other NHS Boards or agreeing at a regional level that this would be supported as a use of transformation funds.

The Recurring Revenue identifies the additional recurring requirement for system support and pharmacy staff. Cash releasing benefits are anticipated but have not been assumed, given the lack of an evidence base nationally. Corporate support is requested for 2 years following implementation, to allow time for additional data to be assessed and opportunities for cash releasing savings to be better understood.

1.6 Management Case

It is recommended that an overarching Programme Board and Project Team structure are established to govern and manage the roll out programme. Operational teams will be established within each site to align with the roll out of the programme.

Representation from clinical, pharmacy and eHealth areas will all be required throughout the programme.

2 Introduction

This document sets out the Business Case for the implementation of a Hospital Electronic Prescribing and Medicines Administration (HEPMA) system within NHS Fife. The primary aim of (HEPMA) is to remove paper based processes from prescribing and medicines administration and significantly improve patient safety and quality of care. In addition, an electronic system will improve our medicines management processes and enhance medicines optimisation. This will enable greater control over what is prescribed, how it is prescribed and how it is administered. This will enable monitoring and feedback to prescribers and those administering medicines to address variation, minimise inefficiency and improve quality.

HEPMA will combine three functions to provide all clinical staff with an integrated view of a patient's medication history, through: electronic communication of a prescription or medicine order aiding the choice, administration and supply of a medicine through knowledge and decision support providing a robust audit trail for the entire medicines use process. Medicines represent the most frequent healthcare intervention; Healthcare Improvement Scotland reported that each year in an average 500 bedded acute hospital approximately 435,000 items are prescribed resulting in 2 million doses of medicine being administered to patients[1]. Treatment with medicines saves lives, controls and cures diseases and provides symptom control. However, the majority of medicines used in hospitals are still prescribed and administered using a paper-based chart system. The safe and effective prescribing and administration of medicines is thus limited by legibility challenges, multiple handover points, poor integration with clinical systems especially in primary care and a lack of data on medicine usage. Experience following the introduction of electronic prescribing systems in general practice over 2 decades has demonstrated improvements in quality of care, medicines utilisation and prescribing practice.

In the remainder of the Business Case we set out the case for investment in this technology. It has been prepared in conjunction with a small Project Team comprising eHealth, pharmacy and clinical colleagues and sets out the benefits, risks and costs of implementing HEPMA.

[1] http://www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Medicines/20150828%20Safer%20use%20of%20medicines%20v%201.0.pdf

3 Strategic Case

The strategic case for HEPMA was outlined in the National Business Case (2016). The National case showed how the programme will support organisations to meet their strategic priorities as well as setting out the national policy context. The NHS Fife strategic case was largely based on the original National OBC, with sections updated to take account of more recent reports and strategies.

3.1 National Policy Context

Medicines represent the most frequent healthcare intervention – there are approximately 34 million prescriptions and 122 million administrations of medicines per year in NHS Scotland. Treatment with medicines saves lives, controls and cures diseases and provides symptom control. In NHS Scotland, medicines account for 12% of the total NHS spending and in the year 2014-2015, approximately £390 million of this was spent in the hospital setting.

However, the majority of medicines used in hospitals are still prescribed and administered using a traditional paper-based chart system and with the increasing range and complexities of medicines available, the safe and effective prescribing and administration of medicines is challenging. Although the current paper based system is part of a structured approach to prescribing and medicines administration, it is recognised there are a number of limitations, including:

- legibility challenges;
- multiple transcription/handover points;
- unavailability or loss of paper records/forms;
- no evidence of prescribing advice and decision support;
- lack of seamless medicine reconciliation;
- no link with an increasing number of IT clinical systems; and
- no ability to collate data on medicine usage.

3.1.1 Key Strategic Drivers

Implementation of HEPMA across Scotland would be a major achievement towards improving the quality of health care in Scotland. This is clear from the fact that it would be a key step towards meeting the NHS Scotland quality ambitions, of preventing harm and providing the most appropriate treatment. However, digitising hospital medication records has an additional benefit as it would also greatly improve communication, allowing us to take better account of each individual patient's response to treatment and facilitate shared decision making.

Implementation of HEPMA would help realise the aims of several key Scottish Government policies. These include:

National Clinical Strategy	The CMO Annual Report 2014-15 and the new National Clinical Strategy for Scotland both place great emphasis on the importance of reducing overprescribing and removing harmful variation. This would be difficult to achieve without HEPMA implementation.
eHealth Strategy	The eHealth Strategy 2014-2017 commits Scotland to introduce electronic prescribing and medicines administration systems as safe as the current paper-based system whilst providing a foundation for improving the safe and effective use of medicines.
Closing the Loop	The 'Closing the Loop' project, commissioned by Scottish Government to help improve the electronic exchange of patient information between primary and secondary care, identified a HEPMA solution as a critical component of medicine reconciliation to enable electronic exchange of important clinical information in a timely, consistent and efficient way. Closing the Loop stated that by improving the electronic exchange of medicines information, HEPMA would reduce transcription risks and make better use of a clinician's time.
Prescription for Excellence	Prescription for Excellence aims for all patients to receive high quality pharmaceutical care from clinical pharmacist independent prescribers, delivered through collaborative partnerships with the patient, carer, GP, and other relevant health, social care, third and independent sector professionals so that every patient gets the best possible outcomes from their medicines, and avoiding waste and harm. Within this plan, the implementation of electronic prescribing and medicines administration in secondary care is a key aim to allow for electronic capture of prescribing data and sharing of information for the development of pharmaceutical care.

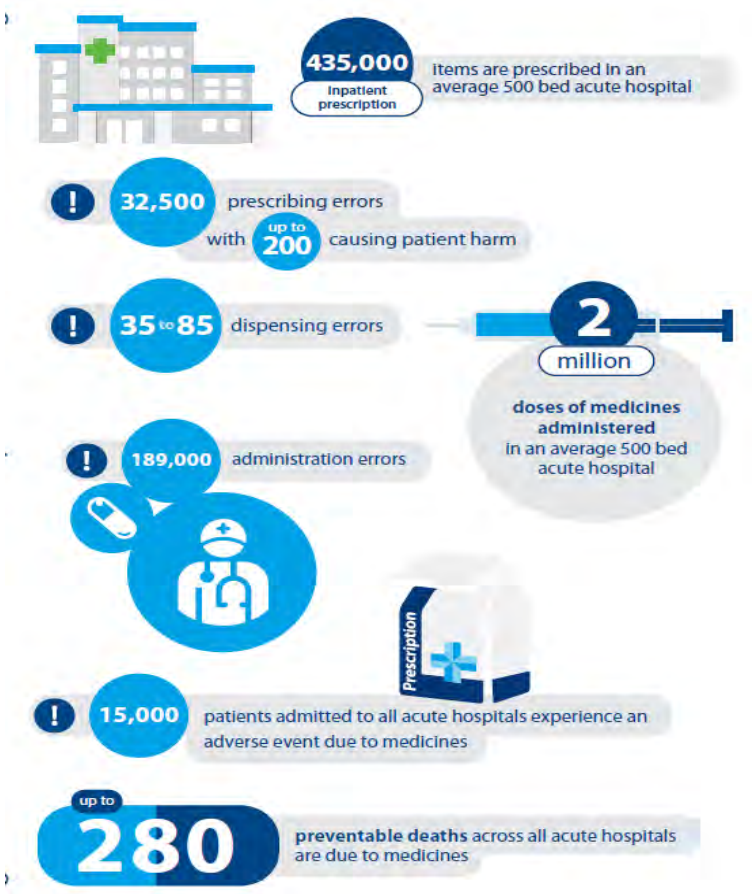
Investment in HEPMA on a national level will aid in the delivery of safe, effective person-centred pharmaceutical care beyond hospitals alone, and support the electronic capture of prescribing data and sharing of information on patients' medicines within and between care settings.

Strategic Benefits: Patient Safety and Effective Use

The Scottish Patient Safety Programme (SPSP) has a strategic commitment to reduce the harm associated with high risk medicines and to improve medicine reconciliation at all patient handovers. The SPSP programme highlights the need for safe and effective recording and transfer of information on patients' medicines across and within all care settings. It was recognised that HEPMA is a key building block to achieving this across NHS Scotland given the number of medication incidents that

occur on an annual basis. Improving patient safety has always been the primary objective of investment in a HEPMA system for Scotland.

In 2015, Healthcare Improvement Scotland (HIS) released a publication outlining the scale of medication incidents and medication incident related harm in NHS Scotland. It highlighted that 15,000 patients admitted to acute hospitals experience adverse events due to medicines (ranging from no harm to death) of which research indicates that 72% are preventable (Pirmohamed M, James S, Meakin S et al. (2004)) and there are up to 280 preventable deaths across all acute hospitals due to medicines (Ryan C, Ross S, Davey P, Duncan EM, Francis JJ, Fielding S et al; (2014)).



Electronic prescribing and medicines administration systems have the potential, once interoperable with other key health IT systems, to enhance patient safety and effective use by:

- reducing the number of transcription, prescribing and administration errors;
- keeping better track of missed doses and polypharmacy;
- contributing to accurate and efficient medicine reconciliation and communication of medicines information at all points of patient transfer, including on admission and discharge;

- contributing to the efficient transfer of accurate medicines information through removal of transcribing on admission and at discharge allowing prescribers to concentrate on the professional review of suitability of medication as part of the medicines reconciliation process;
- supporting greater consistency in clinical practice, reduce harmful variation and limit overprescribing;
- strengthened information governance by providing a robust audit trail;
- completing a key component of the integrated electronic patient record; and
- the collection, collation and analysis of patient and population level data on medicines use in secondary care to build intelligence on patient response to therapy, to manage medicine effectiveness and efficiencies, monitor prescribing patterns, improve clinical practice, enhance patient safety, and support clinical research.

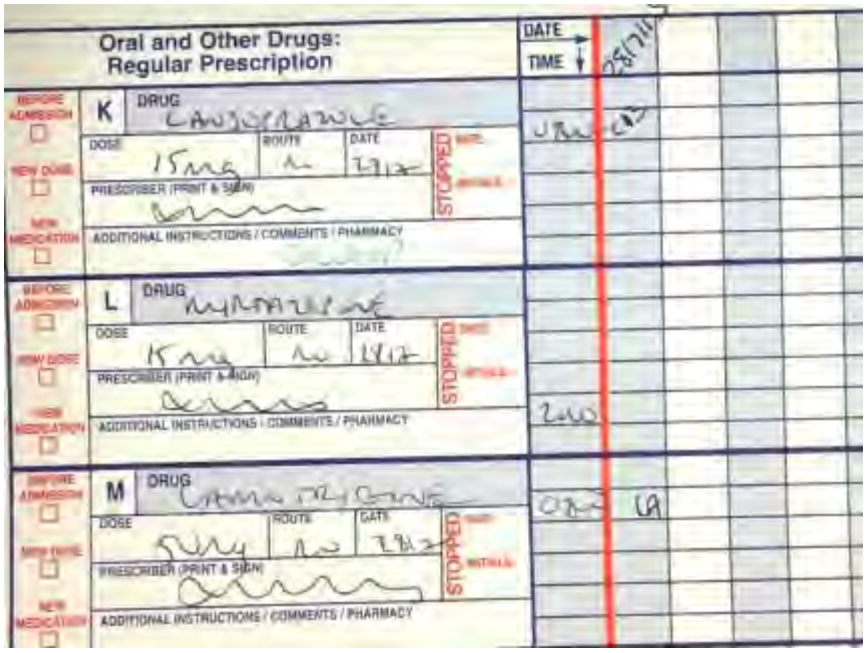
The electronic prescribing and medicines administration system will underpin how medicines governance is delivered within an organisation.

Strategic Benefits: Digital Maturity and Paper-light working

The vast majority of medicines used in hospitals are prescribed and administered using a paper-based system and until these records are recorded digitally it will be impossible to complete an integrated patient's electronic patient record.

Electronic prescribing is the 'largest missing piece of the EPR jigsaw' as it is the last major area of clinical information not available electronically.

The figure overleaf illustrates one of the problems associated with paper based systems – the 'legibility challenge'.



Electronic prescribing has been common place in primary care for many years and provides a blueprint of how it supports clinicians professionally, how it streamlines working practices and how consistent, good quality data can be used to support feedback to clinicians to drive public health insight, manage prescribing costs and manage performance. Without HEPMA it is difficult to implement an efficient and systematic approach to audit, reporting and performance management in the acute setting.

HEPMA is a key part of the National eHealth Integrated Safer Medicines Programme endorsed by the National eHealth Strategy Board. It is an important building block of an integrated Electronic Patient Record, and would support several of the Scottish Government's policy aims on the future use of electronic health records. This includes providing each citizen in Scotland with a summary view of their electronic patient record by 2020 and improving access to key patient information for appropriate staff.

Strategic Benefits: Health Intelligence

The capture, aggregation, analysis and visualisation of patient and population level data on medicines use in secondary care would be extremely valuable to support stratified care, to manage medicine effectiveness and efficiencies, monitor prescribing patterns, improve clinical practice, enhance patient safety, and support clinical research at regional and national levels.

HEPMA implementation would support meeting the policy recommendation for Scotland from the 2016 OECD "Review of Health Care Quality in the UK" that we improve how health system information is used to drive quality improvement. In addition, it would take account of the Scottish Government "2015 Public Health Review for Scotland" which placed an emphasis on data, information, intelligence, research and evidence as a basis for public health decision-making and action. In this respect, HEPMA implementation can be expected to underpin both the planned Population Health Strategy for Scotland and the developing Health and Social Care Information Strategy for Scotland.

3.2 Organisational Overview

NHS Fife is situated in the East of Scotland with a coastline of 170 kilometres (105 miles) bounded by the Firth of Forth to the South and the Firth of Tay to the North. NHS Fife is served by Victoria Hospital in Kirkcaldy (27 wards) and Queen Margaret Hospital (6 wards) in Dunfermline, Stratheden Mental Health Hospital alongside a variety of essential Community Health Partnership hospitals, day hospitals, primary care facilities and general practitioners.

- 370,000 Residents
- 10 Hospitals
- 56 GP Practices
- 10,500 Supported Staff

3.3 Strategy & Aims

3.3.1 Local Strategic Context

Realising the benefits attributable to a HEPMA system is a strategic fit with NHS Fife's aim to transform health and care in NHS Fife to be the best and the values of safety first, care and compassion, excellence and fairness and transparency.

The NHS Fife Clinical Strategy (2016) noted the need for a pharmacy strategy aligned to the clinical strategy which supports patient safety and reduces harm and variation in the use of medicines. In addition the strategy noted the need to promote effective, efficient prescribing and use of medicines to enable patients to achieve the best outcomes from their medication. The Clinical strategy further recognised the need to build capacity across primary and secondary care settings to support the safe and effective use of medicines and ensure the role of the pharmacist and pharmacy team is maximised.

The Digital and Information Strategy 2019-2022 recognised the alignment of HEPMA to joined up care and the need to ensure all relevant information is available at point of contact, this linked closely to the national digital strategy objectives of service transformation and workforce capability and recognised the linkage of HEPMA to the clinical strategy objectives of person centred care and ongoing support/follow up.

The Area Drug and Therapeutics Committee are supportive of HEPMA and appreciate the potential benefits in supporting patient safety, reducing harm to patients and promoting effective and efficient prescribing of medicines in NHS Fife.

3.3.2 Strategically Aligned National Activities

A number of activities have been progressed, in collaboration with the Safer Medicines Steering Group (SMSG) in support of the implementation programme.

Regional Working: The Scottish Government's Head of eHealth wrote to the Regional Implementation Lead Chief Executives in December 2017 to reiterate the requirement for a regional approach to HEPMA implementation and confirm that Boards will need to demonstrate regional collaboration at a number of levels.

Multi Supplier Framework: The process to establish a National Multi-supplier Framework for HEPMA has been undertaken and three suppliers are currently active on this framework:

- EMIS Health (previously Ascribe)
- JAC
- Dedalus (NoemaLife)

Shared Learning: Healthcare Improvement Scotland (HIS) are in the process of developing proposals for Shared Learning on a national basis using a 'Knowledge into Action' approach to allow the experience of implemented Boards to be shared across Boards and to feed into planning, system configuration and benefits realisation.

A number of documents have been published on their website and for the purposes of planning for NHS Fife the following documents were referred to:

- HEPMA – A Good Practice Guide
- HEPMA in NHS Forth Valley – Key Learning from Rapid Roll-Out

Data Strategy: NSS Public Health and Intelligence have been commissioned to develop a national HEPMA Data Strategy, setting standards for HEPMA data coding and collection to ensure that HEPMA data will be usable at national level alongside existing primary care data. NHS Fife will ensure that any data coding and collection remains in line with the National plan for delivery.

3.4 Investment Objectives

The investment objectives for this programme have been developed from the strategies noted within section 3.

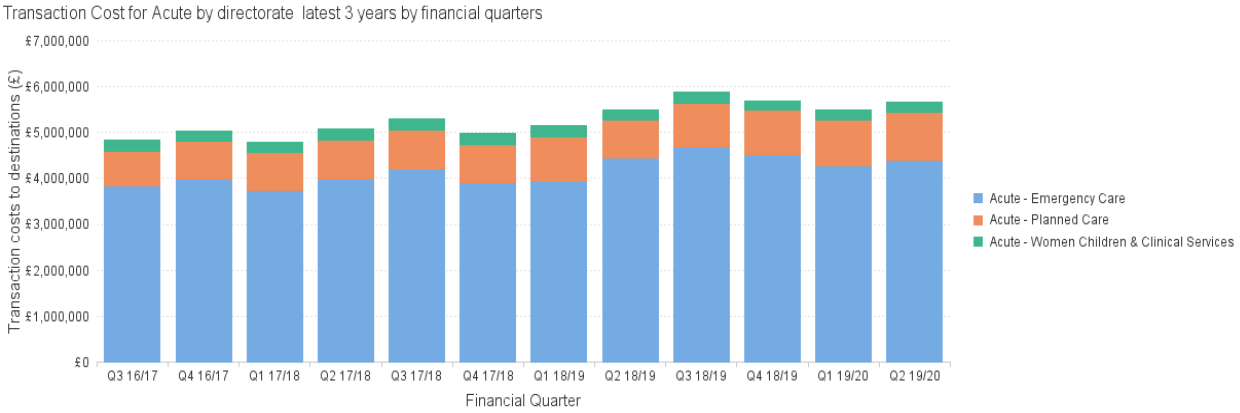
Strategic Objective	Summary of Strategic Project Objectives	Strategic Link to
1	Patient Safety and Effective Use	Clinical Digital Strategy National Clinical Strategy Prescription for Excellence Closing the Loop
2	Digital Maturity and Paperlight Working	National Digital Strategy Digital and Information Strategy
3	Health Intelligence	National Digital Strategy Digital and Information Strategy

3.5 Existing Arrangements

3.5.1 Summary of History

The Pharmacy department has been a major part of delivery within NHS Fife. In NHS Fife £103 million was spent on drugs in 2018/19, of which £22 million was in the acute hospital setting.

Figure 1 Acute Hospital Drugs Expenditure (NHS Fife)



Over the last 7 years, there has been some change to how pharmacy is delivered within NHS Fife. These include:-

- Move of the majority of patients from 2 hospitals (VHK/QMH) to 1 hospital (VHK)
- Changed from 2 Aseptic units to 1
- One stop model – use of overlabelled packs to facilitate discharge
- Clinical model- Use of clinical coordinator to triage workload and focus on high risk patients
- 7 day pharmacy service
- Introduction of Clinical Pharmacy Technicians
- Introduction of Dispensing Assistants

3.5.2 Current Situation and Limitations

The majorities of medicines used in NHS Fife are still prescribed and administered using a traditional paper-based chart system which has been unchanged for many years. With the increasing range and complexities of medicines available and the challenges to service provision, the safe and effective prescribing and administration of medicines is increasingly challenging. Although the current paper based system is part of a structured approach to prescribing and medicines administration, it is recognised there are a number of limitations to service delivery these are reflected within the strategic benefits noted above.

- Management of Expenditure – Understanding the cost of pharmacy within NHS Fife
- Lack of frontline pharmacy staff to carry out medicines reconciliation
- Continued and increasing risks to patient safety due to increasing complexity of medicines
- Lack of patient specific data in secondary care
- A continued use of paper records makes it impossible for a complete integrated patient record to be created.

3.6 Business Needs – Current & Future

As more patients are being treated with complex therapies ensuring patient safety and best outcomes from medicine use is a key component of safe and effective healthcare. Pharmacy is already facing increasing workload demand and is not able to provide a clinical pharmacy service to all wards/beds with current resource and so has to prioritise which wards and departments receive clinical pharmacy input and support. On a weekly and daily basis the pharmacy teams undertake critical analysis of what service capacity they have based on staff availability and a high level risk assessment of patient need based purely on which clinical areas and wards are priorities for cover. Once within the ward, pharmacy staff identify individual patients through discussion with medical and nursing colleagues and from visual inspection of each medicine chart and access to lab results etc with the support of business intelligence reports. A consequence of this is that high risk patients in wards not covered by pharmacy are not able to be identified and so receive no input from pharmacy unless specifically requested by other clinicians.

HEPMA will support improved patient safety and service efficiency by enabling clinical pharmacy services to wards/departments to be targeted to at risk patients. Reports can be generated from HEPMA which will identify patients who meet pre-defined criteria. The criteria can be varied to meet requirements, e.g. patient age profile, patients on specific high risk medicines, patients who have had new medicines added to their regime etc. These reports can be tailored for each clinical speciality. Patients where there have been no changes to their therapy since they were last seen by a pharmacist can also be identified as well as patients being discharged etc.
Accurate and early identification of high risk patients will enable pharmacy staff to take more specific action that will potentially reduce risk of readmission and increase patients' concordance with their medicine therapies.

3.6.1 NHS Fife Operating Constraints and Pressures

Pharmacy is an important part of the NHS Fife Healthcare family. Community Pharmacies provide a walk-in resource for help and advice on medicines and health across the whole of Fife.

Pharmacy in NHS Fife includes a network of community pharmacies, hospital pharmacists, practice pharmacists and Primary Care Development Pharmacists, as well as medicines management support staff.

Pharmacy Services are also responsible for supporting the roll out of the new Community Pharmacy Contract, including services such as the Minor Ailments, Acute Medications, Public Health and Chronic Medication.

Pharmacy Services provide administration support, event management, remuneration, training and development of services provided in community pharmacies such as:

- Smoking Cessation
- Emergency Hormonal Contraception
- Chlamydia Testing
- Weight Management
- Supervised consumption of Methadone and needle exchange
- Palliative Care Network.

10,500 staff are employed across NHS Fife. Delivery of service is to 370,000 .

The Key Constraints for NHS Fife are:-

- Workforce pressures
  - Pharmacy vacancies in both Primary and Secondary Care
  - Unable to provide a clinical pharmacy resource to all areas to meet current demand
- Funding
  - Increased funding pressures due to high cost medicines and increased incidence of chronic disease.
- Governance
  - Lack of a central document repository.
- Technology
  - Costs of IT solutions to deliver the services required
  - Time taken to implement new IT solutions to deliver services.

3.6.2 Pharmacy Re-design

HEPMA is a key deliverable for service improvement within NHS Fife. Acknowledgement is also made of a separate business case under development for the introduction of automation within pharmacy. This will result in a re-design of pharmacy service provision. HEPMA will support delivery of this re-design through improvements in electronic medicines management and administration. The business case is submitted for HEPMA however there will be considerable benefit to the overall delivery of service if both HEPMA and Pharmacy redesign/automation are introduced within NHS Fife.

3.7 Business Scope & Key Service Requirements

3.7.1 Business Scope

- Successful Procurement of the most appropriate HEPMA solution for NHS Fife from the National Framework.
- Integration of HEPMA solution with Pharmacy Stock Control System
- Integration of HEPMA solution with existing eHealth systems e.g. Trak, Portal
- Rapid Rollout approach to delivery of HEPMA solution within NHS Fife throughout 2020/21.
- Training and support to ensure HEPMA is integrated into working practice.
- Ratification of Processes to ensure HEPMA integrates well into working practice.

3.7.2 Resultant Service Requirements

- Capacity to deliver HEPMA within relevant service areas
- Support for delivery of HEPMA from within eHealth and Pharmacy
- Ensure appropriate Infrastructure is in place to support HEPMA delivery.
- Training and Support for introduction of HEPMA
- Time to review processes to ensure fit for HEPMA purpose

4 Economic Case

4.1 Review of Economic Case

The economic case for HEPMA was outlined in the National Business Case (2016). The following section outlines the options considered within the National OBC and the approach taken to agree the preferred option for NHS Fife. Short List of Options

4.2 National Business Case Options

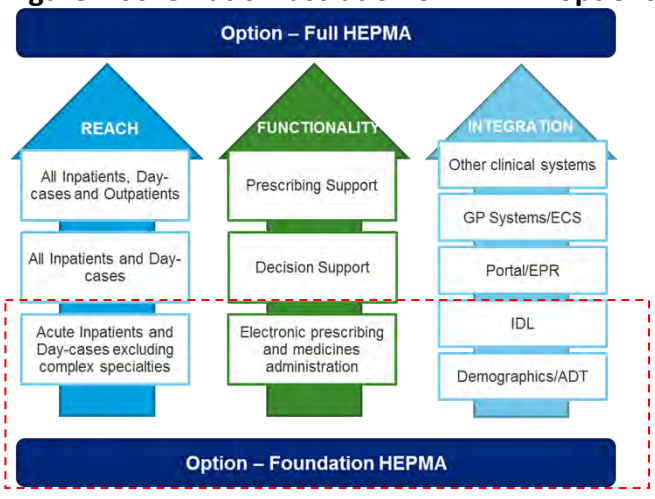
The National OBC identified three categories or 'pillars' which were selected to characterise the range of alternative scenarios that a Board will face when implementing HEPMA. These pillars were:

- **Reach**: how widely HEPMA is rolled out within a Board;
- **Functionality**: which HEPMA functions (Electronic prescribing and medicines administration, Decision Support and / or Prescribing Support) are implemented and used;
- **Integration**: the level of integration with other clinical systems such as the PAS system, Admissions/Discharges/Transfers (ADT), Immediate Discharge Letter, Clinical Portal/Electronic Patient Record (EPR) and/ or Lab systems.

Two alternative HEPMA options were set out, a Foundation HEPMA option which describes a 'basic' level of implementation; whilst at the other end of the spectrum it described what a full HEPMA solution would look like. The variation between these options reflects the maturity of the current systems and the investment required to achieve full HEPMA. The options to a large extent represent an incremental approach to adopting HEPMA, rather than a list of mutually exclusive options.

The figure overleaf illustrates the different levels between Foundation and Full HEPMA.

Figure 4 Schematic Illustration of HEPMA options



Foundation HEPMA

4.2.1 Foundation HEPMA

Foundation HEPMA was specified as a solution that includes the basic scope required to result in the successful implementation of HEPMA. In terms of system 'reach', this would include rollout to inpatient and day-case beds across each acute hospital, though not including outpatients. A number of specialties that may provide greater implementation challenges (due to differences in type and nature of the prescribing model in 'non-ward' based specialties) including Theatres, Maternity, A&E, Mental Health, ICU, and Renal Dialysis outpatients, though not included in Foundation HEPMA, could be implemented at a later date.

In terms of 'functionality', it would provide electronic prescribing and administration, as well as electronic medicines reconciliation functionality, whilst in terms of 'integration', it would be required to populate the Immediate Discharge Letter and be integrated into the Patient Management System to provide patient demographics and patient movements information

4.2.2 Full HEPMA

The Full HEPMA option includes all the components of Foundation HEPMA but with extended reach, greater functionality and integration. Extended reach would imply the system covers all inpatient and day-case beds including outpatients departments. There is potential for a gap to remain in relation to Community Nursing and Special Schools for children with additional support needs.

The full functionality of the system would be exploited, including decision support; and additional prescribing support (e.g. local formulary, prescribing protocols). In terms of integration, this option would include further integration with the Clinical Portal/EPR (real-time and/or summary information), the population of HEPMA with medication information from GP systems/Emergency Care Summary and integration with other clinical systems e.g. diagnostics to provide additional clinical information to inform decision support and other HEPMA functions.
It was considered that at this point in time given current technology, Full HEPMA represents an advanced HEPMA model.

4.3 Options Appraisal

Following review of the National Business Case NHS Fife completed an Options Appraisal in order to assess whether a Hospital Electronic Prescribing and Medicines Administration (HEPMA) system within NHS Fife was required.

As part of the Long List of options it was felt there was a need to consider whether NHS Fife should remain with the current Stock Control supplier, as this would potentially affect the outcome of discussions or whether there is benefit in migrating across to a supplier that links directly with proposed HEPMA suppliers. The HEPMA Programme Board therefore agreed based on the National Outline Business Case the long list of options for HEPMA within NHS Fife were as follows:-

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	Option	Stock Control	HEPMA Provider	Outcome
1	**Do Not Implement**	EMIS	NONE	Not Viable
2	**Foundation HEPMA**	EMIS	EMIS	Not Viable
3		EMIS	JAC	Not Viable
4		EMIS	Dedalus	Not Viable
5		JAC	EMIS	Not Viable
6		JAC	JAC	Not Viable
7		JAC	Dedalus	Not Viable
8	**Full HEPMA**	EMIS	EMIS	Shortlist
9		EMIS	JAC	Shortlist
10		EMIS	Dedalus	Shortlist
11		JAC	EMIS	Shortlist
12		JAC	JAC	Shortlist
13		JAC	Dedalus	Shortlist

Initially the Board considered HEPMA when moving from Long list to Short List.

Option 1 Do Not Implement (Do Nothing) – Not Viable

The 'do nothing' option would involve NHS Fife continuing with a paper based prescribing and medicines management process across the acute sector. NHS Boards would gradually move towards electronic approaches in line with local priorities. Given the current financial climate and severe constraints on investment expenditure this may be a realistic short term option, although in the long run it is unlikely that a paper based system would be sustainable given the move towards electronic health records.

The 'do nothing' option would offer no improvement to the current situation and none of the associated benefits would be realised. Whilst some systems are in place to manage the risks associated with adverse drug events, evidence suggests that medication incidents will persist and some of these would have been avoidable through investment in HEPMA. Staff would in turn continue to operate an inefficient paper-based process, which uses valuable time that could be spent on other

aspects of patient care. There may also be an impact on staff satisfaction and morale given the level of clinical support for the HEPMA system.

HEPMA is also a key missing component of an electronic health record and if not adopted NHS Fife will fall behind other health systems in relation to digital maturity, public health intelligence and medicine related research.

In addition, HEPMA has been successfully implemented in a number of other Health Boards in Scotland and non implementation within NHS Fife would result in an inequality of service delivery for service users within the Health Board area.

Options 2-7 Foundation HEPMA – Not Viable

The Foundation HEPMA would be a viable 1st step on the implementation journey for HEPMA, however when considering reach, functionality and clinical systems it was felt there were key benefits in delivery of Full HEMPA which would not be realised if Foundation HEPMA was the preferred option as detailed below.

Reach – Extending the reach of HEPMA to include all inpatients, Day Cases and Outpatients was seen as valuable for NHS Fife. A number of services who provide day cases and outpatient prescribing have highlighted to eHealth the need for an electronic solution these services prescribe and administer complex specialist medicines that need to be delivered in context with the other aspects of patient care. NHS Fife is also committed to an integrated patient journey, with clarity of reporting in all areas of care.

Functionality - currently Prescribing and Decision Support have been identified as 'gaps' within NHS Fife and there would be a real benefit both in terms of patient safety and the consistency of clinical decision making if this was implemented within NHS Fife.

Integration – NHS Fife are committed to ensuring a complete patient record is visible for those within its care, therefore integration with GP Systems, Portal and Other Clinical Systems would be fundamental to ensuring a complete record which increases clinical safety and patient care.

Options 8-13 Full HEPMA – To be shortlisted and investigated further.

This includes all components of HEPMA identified as realistically implementable in the medium term. It was considered that at this point in time given current technology, and the reasons provided above, Full HEPMA represents an advanced HEPMA model and this should be aspired to within NHS Fife.

Therefore Full HEPMA was agreed as the preferred solution and Options 8 – 13 were taken forward into the shortlist.

It was noted at this time that if the selected provider was not the same as the incumbent for stock control this would need to be taken into consideration as clinical advice noted it would be beneficial to have the same supplier for both stock control and HEPMA for continuity of care.

4.4 Short-List Options

Initial discussions noted the primary objective was to ensure the HEPMA Solution delivered for NHS Fife was fit for purpose. NSS Procurement identified there were 3 potential suppliers for HEPMA in Scotland all of which are within the national contract: - JAC, EMIS Health and Dedalus.

Discussions with National Procurement into the best method to engage with suppliers and the options for NHS Fife highlighted the need to ensure a fair and transparent procurement. Advice from National Procurement noted the key objective was the most appropriate Full HEPMA solution, therefore procurement should initially consider only this area.

If the preferred solution for HEPMA then required a change to the stock control system this should be undertaken after decision on an agreed supplier for Full HEPMA.

Following this advice the shortlisted options were agreed as Full HEPMA without stock control system as a factor. The shortlisted options therefore were:-

Option 1 – Full HEPMA supplied by EMIS
Option 2 – Full HEPMA supplied by JAC
Option 3 – Full HEPMA supplied by Dedalus

4.5 Preferred Option

At present there is no preferred option for NHS Fife, NHS Fife wish to undertake a mini tender to assess the best option. Further information is detailed within Section 4 Commercial Case.

4.6 Benefits

A number of benefits from HEPMA were identified during the development of the National OBC. These were identified by a multidisciplinary group of clinicians, pharmacists and GPs and were grouped into a number of categories. We have presented a summary of these below along with an estimate of the likely impact in quantitative terms based on variety of sources including experience from NHS Ayrshire and Arran, a pilot in NHS Lanarkshire and the NHS England e-Prescribing Toolkit, which provides case study information and guidance on business case development.

4.6.1 Safer and Effective User of Medicines

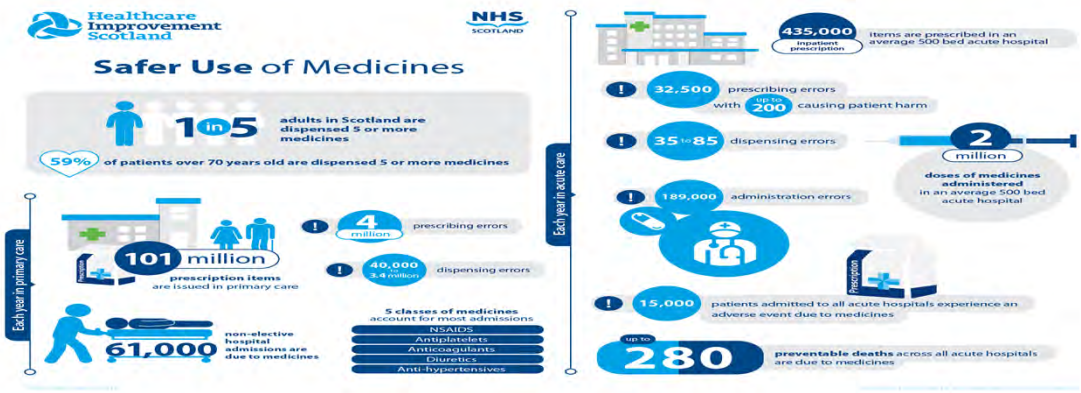
In 2014, Healthcare Improvement Scotland (HIS) developed *'Implementing an Electronic Prescribing and Medicines Administration System: A Good Practice Guide'* which provided clarity on current evidence and expert opinion on benefits realisation. It included a systematic review of the literature and reported that HEPMA systems provide an important foundation for improving the safe and effective use of medicines.

There is clear evidence that HEPMA systems reduce the incidence of medication errors.

'HEPMA systems are most likely to generate quality benefits (releasing time to care, avoiding errors, improving communication, improving decision-making), achieving the quality ambitions of person-centred, safety, efficiency and effectiveness of care.'

As HEPMA systems reduce the incidence of medication errors which are associated with significant morbidity and mortality, the resultant improvement in patient safety is likely to be significant.

Healthcare Improvement Scotland outlined the concerns in relation to Safer Use of Medicines.



4.6.2 Reduce Incidence of Hospital Prescribing Errors

Drug related adverse events are the second largest cause of harm within the acute sector (after surgery) and account for around 15% of all adverse events (De-Vries et al., 2008). NHS Scotland is no different – for example, in 2014 a prospective observational study which analysed 50,000 prescription items across eight Scottish hospitals found an overall error rate of 7.5% (Ryan et al., 2014).

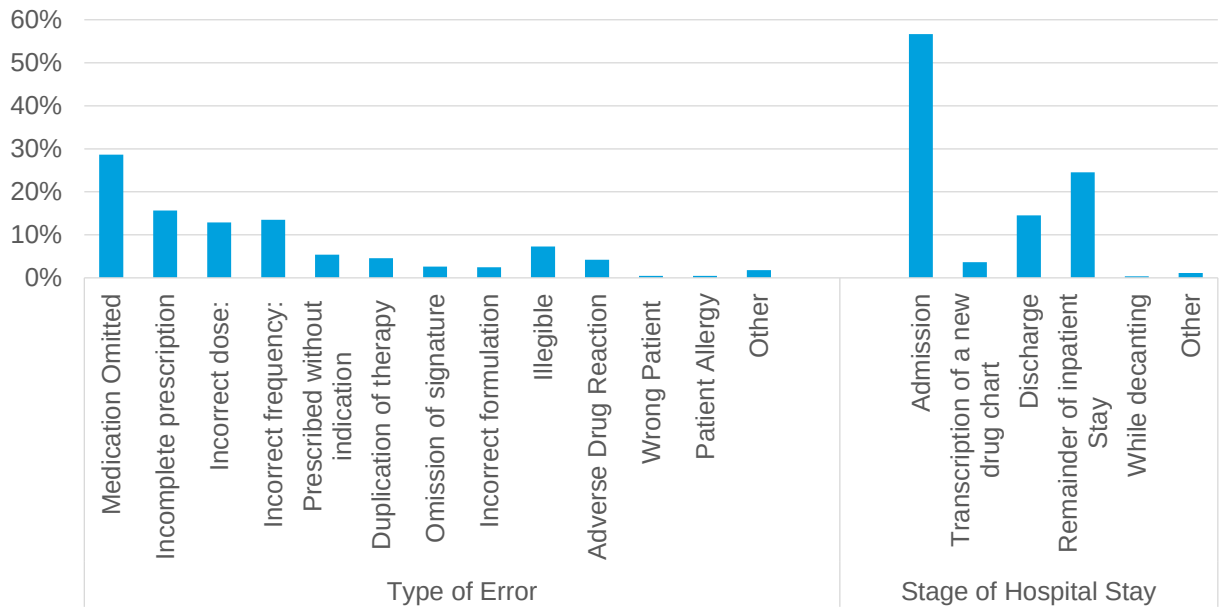
Indicative Prescribing Error Rates in Scotland and Fife (per annum)

Prevalence of Error	%	NHS Scotland	NHS Fife*
Inpatient Prescription Item Error	7.5%	1,070,000	73,295
Inpatient Chart Error	36%	377,000	25,824
Errors Reaching Patient	32-60%	-	-
Errors Causing Harm, estimated consequences	1.0 – 4.1%	3,370 – 15,500	230 – 1,061
Temporary harm and intervention required	80%	3,016-12,400	206 – 849
Prolonged Hospitalisation	15%	505 – 2,320	34 – 159
Permanent patient harm	5%	168 – 770	12 - 53

(*NHS Fife figures calculated pro rata from the national business case)

The table adapted from this study provides indicative prescribing error rates in Scotland and Fife based on these estimates. The study found that teaching hospitals, surgical wards and those wards with a high turnover had the highest error rates. The number and scale of errors is significant, whilst most have little or no patient impact a number cause permanent harm to the patient. The figure below provides a breakdown of these error rates.

Types of Error and Location



In 2015, Healthcare Improvement Scotland (HIS) released a second publication focusing on the benefits of HEPMA highlighting the results of this study. It also outlined a number of opportunities to drive improvement nationally.

4.6.3 Accurate prescribing and administration of medicines

HEPMA is pivotal in achieving a complete medication prescribing and administration record for an individual patient containing up-to-date historical and current prescribing and clinical information (including allergies and adverse drug reactions and interactions). This medication record would be instantaneously accessible to a range of healthcare professionals and is a key step to delivering person-centred, safe, effective and efficient care.

Impact and Evidence

One of the main benefits relates to a reduction in Adverse Drug Events (ADEs). A range of estimates have been stated by Trusts in NHS England, indicating that a HEPMA system would reduce ADEs by around two thirds. South Manchester University Hospitals NHS Trust estimated a 60% reduction in preventable ADEs, Guys and St Thomas estimated a 62% reduction and a Trust in the North West estimated the reduction would be 66% (HSJ 2014).

The Sheffield School of Health and Related Research (ScHARR) estimated that there would be a 31% potential cost avoidance from preventable ADEs.

Evidence from the pilot within NHS Lanarkshire has demonstrated:
- a reduction in missed doses from 14% to 8%
- a reduction in clinical interventions for high risk medicines
- 36% of interventions required on paper based discharge letters would not be required with HEPMA

Evidence from NHS Ayrshire & Arran demonstrated a significant improvement in the administration of Parkinson's disease medication, as show below:

4.6.4 Better communication between and within settings and improved medicines reconciliation

By providing a single shared patient medication record containing current and historical medicines, the HEPMA system would enable (i) more accurate and efficient medicines reconciliation and (ii) better communication of information between and within settings.

On a patient's admission to hospital, their medication record on HEPMA would in the future be populated from the Primary Care electronic care summary. Similarly, on discharge, the HEPMA system would populate the discharge communication (e.g. immediate discharge letter) and be immediately available to Primary Care for medicines reconciliation post-discharge.

The medication records can be accessed remotely from the ward, enabling remote prescribing which is safer than telephone prescribing. In addition, view-only access rights can be set up for other healthcare professionals who need to be aware of a patient's medication for purpose of review or supply of medicines.

Impact and Evidence

A recent DPharm thesis within Ayrshire and Arran estimated the impact HEPMA has had on discharge communications. It found that compliance with discharge prescribing documentation increased from 40 to 100%, with a corresponding reduction in prescribing errors from 99% to 23% and omitted medications from 42% to 11%.

Evidence from the pilot within NHS Lanarkshire has demonstrated:

- improved compliance with SIGN 128, more detailed clinical information for GPs
- instantaneous delivery of discharge letter to GP (previously anything from 1 day to never delivered)
- reduction in medicine omissions on discharge prescriptions

4.6.5 Greater consistency of clinical decision-making

Prescribing decisions for individual patients can be improved through the access of a complete medication prescribing and administration record which contains up-to-date historical and current information. Clinical decision support available within the HEPMA software can produce real-time alerts at the point of patient care, including linking proposed prescribing decision to previous drug allergies or adverse drug reactions reported for that patient, drug interactions and therapeutic duplication alerts.

In addition, fully utilising prescribing support functionality within the HEPMA system can potentially extend the benefits further by providing greater consistency of clinical decision-making. This type of rules-based, protocol-driven prescribing support which is built in to the HEPMA system includes limiting choice to local drug formularies, preferred medicines, and to pre-determined prescribing protocols and aims to simplify, standardise and avoid inappropriate prescribing.

However, the electronic system does not replace human knowledge and clinical judgment. It is the users of the clinical system who are accountable for making clinical decisions (e.g. on the appropriate selection of medicines), not the HEPMA system itself.

Impact and Evidence

NHS Boards without HEPMA only have data on medicines purchased and ward issues, we have no data as to what has been prescribed or administered to patients. At a national level only high level hospital purchase data is available, it is crude with many caveats, HEPMA would resolve this.

NHS Lanarkshire's HEPMA Pilot demonstrated a number of benefits:
-improved safety of antimicrobial prescribing
- empirical policy antibiotics can be prescribed by indication recommended durations for oral therapy
- ALERT antibiotics are highlighted to prescribers and access is provided to NHSL form for supply
- Allergy status is mandatory and alerts are presented when a contraindicated medicine is prescribed, 107 prescriptions for penicillin were averted in allergic patients in pilot wards.
- for high cost antibiotics and non formulary medicines the system can suggest more cost effective options
- Ward 22 (HEPMA pilot ward) achieved 100% in respect of a pilot of a national quality indicator requiring duration of every oral antibiotic prescription. In NHS Lothian current compliance with this indicator is Surgery 47% and Medicine 75%

Within the pilot wards a number of treatment protocols (e.g. helicobacter eradication regimen) have been set up to aid prescribers of multiple drugs for a single indication; this helps speed up the prescribing process whilst assuring accuracy and adherence to protocols.

4.6.6 Releasing time to care and efficiency

With a HEPMA system, more medicines are administered on time to benefit the patient, as well as efficiencies in nurse time spent administering medicines, releasing more time to care. This should improve patient flow through the hospital and facilitate earlier discharge providing additional efficiencies across the acute hospital system.

Once an accurate inpatient chart has been created on HEPMA, this moves with the patient through all stages of their inpatient care negating the need for multiple transcriptions during inpatient stay and discharge. This data entry reduces the time taken to prescribe and increases both the efficiency and quality of the prescribing process, supporting a smoother discharge with improved medicines reconciliation and clearer more complete information to primary care.

Medicine prescription charts frequently need to be rewritten for longer stay patients due to lack of prescribing and administration space. A study conducted within NHS Lothian concluded, junior doctors in Medicine of the Elderly estimated it takes between 10 – 30 minutes to rewrite a medicine prescription chart and there is an average of 5 per week in each ward. This view was supported by NHS Fife.

Impact and Evidence

Estimating time releasing efficiency savings can be difficult. The literature from the business cases we have reviewed have made relatively arbitrary time saving estimates, for example, one business case estimated that up to 20 minutes per shift could be released from electronic prescribing (for pharmacists, technicians, nursing and medical staff).

Based on the latest evidence from the HEPMA pilot in Lanarkshire the clinical team estimates that the system reduces by 50% the time required to undertake drug rounds (i.e. from two hours to one hour per drug round. There are four drug rounds per day).

GP feedback supports claim of improved discharge letter.

Evidence from Ayrshire and Arran of automatic medicine ordering at point of prescribing demonstrates that there was an improvement on the delay of orders getting to pharmacy, no transcription errors, no duplicate requests, reducing rework for nursing and pharmacy staff, clear view for nurses of stock and non stock, reduction in out of stock medicines and nursing time freed up as no paperwork required.

4.6.7 Better use of information to improve the use of medicines

Electronic capture of secondary care prescribing and administration data provides an opportunity to improve the safe and effective use of medicines and optimise patient care. The use of a HEPMA system also strengthens information governance through a robust audit trail and improved clinical accountability.

Impact and Evidence

The availability of rich patient level data on medicines use with the possibility of linkage to diagnoses and outcome in secondary care could be utilised to better understand patient response to treatment, manage medicines effectiveness, monitor prescribing patterns, improve clinical practice and patient safety and support clinical research. These are levers of change to drive improvements in healthcare delivery and specifically the quality and efficiency of prescribing, as demonstrated by the use of similar data available in primary care. Given the inexorable rise in volumes and costs of hospital medicines, the accumulation of prescribing data at a Board, nationally, by specialty and condition when linked to patient records, will enable improved understanding and planning of medications use and budgeting associated to outcomes.

A key benefit from a HEPMA system relates to how better information on acute prescribing will be used. NHS Fife spends £22m on medication in the acute hospital sector and yet has relatively little information on what is prescribed and by whom. This information should support hospitals to manage this expenditure more closely and identify opportunities for improvement.

4.6.8 Better use of information to support optimisation of patient care

As more patients are being treated with complex therapies ensuring patient safety and best outcomes from medicine use is a key component of safe and effective healthcare. Pharmacy is already facing increasing workload demand and is not able to provide a clinical pharmacy service to all wards/beds with current resource. Pharmacy is unable to meet the current workload demand and is not able to provide a clinical pharmacy service to all wards/beds with the current resource. Therefore the current clinical pharmacy resource is prioritised to high risk patients. HEPMA will enable the identification of patients that are at high risk of harm form their medication across the whole hospital, allowing pharmacy to prioritise those patients for early pharmacy review. This will allow pharmacy to move to a more patient focused service rather than the current ward focused service. Pharmacist workload will be prioritised using data extracted from HEPMA based on risk stratification/categorisation of a number of different pharmaceutical care factors, including age, number, type and duration of treatment of medicines and allergy status. This “electronic medicines early warning system” will identify which patients require the clinical pharmacist’s attention and regular review by the multidisciplinary clinical team.

HEPMA provides an opportunity to facilitate an improvement in patient flow by reducing the potential for length of stay to be extended by avoidable medication errors and missed doses.

4.6.9 Benefits Attributable to HEPMA

The table below provides an estimate of the number of preventable prescription errors and those that could be prevented by the implementation of HEPMA based on a synthesis of research evidence.

Estimated Reduction in Prescribing Errors and Bed Days

Reduction in ADE's (Number)	Prevalence			NHS Scotland			NHS Fife*		
	Base	Low	High	Base	Low	High	Base	Low	High
Number Errors causing patient harm	2.6%	1.0%	4.1%	9,635	3,770	15,500	660	258	1062
Preventable errors causing harm*	72%	72%	72%	6,937	2,714	11,160	475	186	764
ADEs prevented by HEPMA **	60%	60%	60%	4,162	1,629	6,696	285	111	459
Additional bed days per error*	3.0	3.0	3.0	12,487	4,886	20,088	855	335	1376

(*NHS Fife figures calculated pro rata from the National Business Case)
* Costing Statement. Implementing the NICE guideline on medicines optimisation (NICE, 2015), ** as described above
*** a base, low and high case estimate has been presented to provide an indicative range based on the figures in the table above.

Using the lowest estimate the table illustrates that 475 prescribing errors that cause patient harm could be averted through the implementation of a HEPMA system, as well as averting approx. 855 unnecessary bed days per annum in NHS Fife.

4.6.10 Economic Benefits

There is clear evidence that a HEPMA system provides an important foundation for improving the safe and effective use of medicines. It is also reasonable to expect that improvements in the safe and effective use of medicines will ultimately deliver efficiency benefits. However, translating these quality benefits to cash-releasing savings is not easy.

Most of the benefits will not be realisable in cash terms, but will release time or resources to improve clinical practice and create capacity to meet increased demand.

The National Safer Medicines Steering Group considered all the benefits carefully and the evidence that supports these. Their guidance is that the benefits to patients in terms of improved quality of care and safety of medicines should be clearly set out as the principal drivers for this investment. The likelihood of non-cash releasing savings in time and resources can be described but are unlikely to be accurately quantifiable and the longer term cash releasing savings after implementation are only beginning to be assessed. As a result these benefits have not been included in the economic or financial appraisal elements of this business case.

4.7 Risks

A full risk register for the project will be developed at project inception and when Full Business Case is complete and will be managed in line with NHS Fife's governance procedures and recorded in Datix. Risks will be reviewed on a regular basis.

It is important to recognise that as well as delivering additional benefits, there will also be a number of risks associated with implementing HEPMA across NHS Scotland. These include risks associated with running paper and electronic systems in parallel, inadequate change management and/or leadership impacting adoption of HEPMA, concerns about the complexity and scope of the training requirements as well as the requirement to operate a robust and scalable (24/7/365) support plan. Suggested mitigating actions are outlined.

Risk	Mitigation	Impact	Likelihood	Score
HEPMA requires robust 24/7/365 technical and clinical support. Inadequate resource will impact on organisations ability to reliably perform other safety clinical activities.	Dedicated eHealth / Pharmacy / Clinical Support structure.	Major	Possible	12
Affordability	Solid Business Case, working collaboratively, rapid rollout to minimise delivery timescale	Moderate	Possible	9
Dual Running of paper and electronic systems	Robust SOP's, Rollout rapidly whilst ensuring clinical safety within capacity.	Moderate	Possible	9
Given the low number of active suppliers currently on the framework there is a risk that supplier resource constraints may dictate the timing of implementations both locally and nationally	Close collaboration with suppliers and other boards.	Moderate	Possible	9
Inadequate leadership / change management support	Comprehensive Communication Plan Engagement with Staff Clear Clinical Leadership	Moderate	Unlikely	6

Complexity and scope of training. Training must: - consider the needs of all staff - be delivered in a timely manner - be accessible to maintain competence - be scalable to address BAU competence	Training Needs Analysis (TNA) carried out at project inception. Comprehensive training plan developed collaboratively with staff. Dedicated training capacity both during implementation and BAU Ongoing support delivered as core part of induction programmes.	Moderate	Unlikely	6

Many of the risks identified relate to how the HEPMA solution would be implemented and these would need to be monitored and managed as part of the roll out programme.

5 Commercial Case

5.1 Procurement Strategy

5.1.1 Governance

A process to establish a National Multi-supplier Framework for HEPMA has been undertaken. Patient safety requirements were paramount to the evaluation process and only suppliers who met stringent safety requirements were eligible to be active on the framework. Suppliers who did not meet these requirements, but were able to demonstrate a credible plan to meet them within the following year, were designated inactive on the framework. They are not available to NHS Boards to contract with, until they have been fully re-assessed, at which time they would become active on the framework.

Currently three suppliers are active on the framework (EMIS, JAC/Wellsky and Dedalus)

5.1.2 Contract Structure

Under the current multi-supplier Framework Agreement there are currently three accredited suppliers JAC/Wellsky, EMIS and Dedalus. The existing NHS Fife pharmacy stock control system is provided by EMIS.

Informal supplier days were held to review the HEPMA offering from each of the three prospective suppliers:- Dedalus, JAC/Wellsky and EMIS who are currently accredited to provide a HEPMA solution in Scotland on the multi-supplier Framework Agreement for Hospital Electronic Prescribing and Medicines Administration (HEPMA). The informal days were an introduction to their HEPMA solution. Prior to the meeting suppliers were advised NHS Fife were in the process of creating a HEPMA Business Case and Full HEPMA would be the preferred route for NHS Fife. No further detail was provided.

2 of the 3 suppliers attended the informal days (JAC and EMIS) unfortunately Dedalus chose not to attend. Prior to the supplier days being held NHS Fife were notified of all other Boards (exc. Borders) intention to select JAC as their supplier and NHS Fife Procurement advised there was the potential for call off from a single supplier on the basis of incumbent provider of stock control system or synergy with other boards. Alternatively NHS Fife could complete a mini competition, this would allow NHS Fife to fully assess each option and there was the potential for best value to be achieved.

The HEPMA Programme Board met on 11th October to discuss the most appropriate way forward. It was agreed, in order to ensure the best solution for NHS Fife and to ensure best value a mini competition would be undertaken

NHS Fife Procurement have been fully engaged with the process and it has been agreed that following approval in principle of the Outline Business Case a mini competition will be undertaken as soon as possible to ensure best value for NHS Fife.

Following advice from clinical colleagues it was noted the outcome of the mini tender may result in the need to replace NHS Fife Stock Control System, currently supported by EMIS. Clinical colleagues note the importance of a joined up 'one system' approach and therefore suppliers will be advised that dependent on outcome, the stock control system may be replaced.

5.1.3 Procurement Plan and Timescales

The National Framework provided a detailed specification for delivery of HEPMA within NHS Scotland. NHS Fife have reviewed the requirements specification and created a supplementary NHS Fife specific specification which focuses on the key deliverables for NHS Fife. Following agreement of the outline business case, the mini competition will begin with a completion date of around 16 weeks.

6 Financial Case

6.1 Financial Model

All Boards in the East Region are at different stages of planning and implementation of HEPMA and have different pharmacy stock control systems currently. It has been agreed that each board will progress a local business case and implementation plan, collaborating to share experience and learning across boards.

A full business case will be completed following completion of the mini competition for HEPMA. In order to progress to procurement, a commitment by NHS Fife to support HEPMA delivery is required.

6.1.1 Assumptions

In order to ascertain costs for NHS Fife, costs detailed within the National Business Case and in the Business Case for NHS Lothian were extrapolated for delivery of Full HEPMA within NHS Fife. In addition, a resourcing profile was created based on profiles detailed within each of the Business Cases. It is expected, following mini competition the figures will be updated to reflect final costs.

6.1.2 Economic Appraisal Principles

Key overarching assumptions in the development of the cost model included:-

- It has been assumed that there is no cost under the 'do nothing option'
- Costs were constructed for NHS Fife undertaking HEPMA locally
- Non Recurring Costs are assumed to be capital funded. When non recurring costs are treated as revenue, capital budget will be transferred to the revenue fund.
- VAT assumed on all external costs at 20%. VAT advisors will be consulted during negotiations with suppliers.
- Depreciation calculated on assumption closing Q4 each year, and depreciating over 7 years.
- Hardware costs include a small contingency

6.2 Non Recurring Capital Cost

Non Recurring Capital costs for design, procurement and implementation of the preferred option are summarised in the table below.

£'000'S	2019/20 £k	2020/21 £k	2021/22 £k	2022/23 £k	TOTAL COST IMP
HEPMA System	444	0	0	0	**444**
Hardware – NHS Fife Infrastructure	110	0	0	0	**110**
Hardware – Workstations / PC's	0	104	104	104	**312**
Hardware – Pharmacy Mobile Devices	0	18	0	0	**18**
External Integration Costs	0	15	15	0	**30**
Implementation Resource	62	861	870	940	**2,733**
Legal Fees	25	0	0	0	**25**
VAT	111	27	24	21	**183**
Total Non Recurring Capital	**752**	**1,025**	**1,013**	**1,065**	**3,855**
NHS Scottish Government HEPMA Funding	**500**	**500**	**400**	**0**	**1,400**
NHS Fife Capital Funding Required	**252**	**525**	**613**	**1,065**	**2,455**

The Scottish Government has confirmed that central eHealth funds will be made available to NHS Boards to fund non-recurrent revenue and capital costs (but not local hardware costs). This funding equates to £1.4m for NHS Fife – the profile over financial years is yet to be confirmed. In recent discussions with Scottish Government they advised there is the potential for £500k capital to be allocated to NHS Fife 2019/20 subject to NHS Fife agreement to proceed with HEPMA and spend within the financial year.

HEPMA Supplier Costs

Hardware Costs

A number of costs that are not HEPMA specific have been included in the economic appraisal. These costs include hosting hardware, database software, and devices.

Implementation Resources

Just less than three quarters of the costs associated with the deployment of HEPMA relate to local implementation resource. These are based on National and NHS Lothian Business Cases and have been agreed with eHealth and Pharmacy colleagues. They include:-

- **HEPMA Project Team.** A Project Team will be put in place to govern and manage the roll out. This will include a range of clinical, pharmacy and eHealth representatives. This team will be responsible for the preparatory work, ward go live and immediate support in the week following go live. This team will also include senior nursing and medical resource to provide clinical leadership to the programme. It is anticipated that wider leadership support will be provided by the senior team in NHS Fife
- **eHealth Infrastructure Team.** Will work with the supplier and include systems, infrastructure and interface leads as well as additional support for systems administration and testing. The majority of this team will operate from implementation to business as usual.

The time periods associated with each stage of implementation are considered reasonable based on experience of other Boards and NHS Fife's expertise in project roll out. This timetable has been based on a 'rapid rollout' of full HEPMA. It is anticipated that this timetable will represent a 'worst case' scenario and some contingency may be released from the capital requirement.

6.2.1 Statement of Capital Affordability

The Scottish Government national FBC agreed a contribution towards non recurring design, procurement and implementation. Additional capital support will be required from NHS Fife and will be included within the Property and Asset Management Investment Programme, however as the National Business Case was developed over 5 years ago a case will be made for additional investment from the Scottish Government.

6.3 Recurring Costs

Anticipated recurring revenue costs per annum are summarised in the table below. There will be no recurring cost within 19/20 as spend within this year will be on Implementation Costs which are detailed above as Capital Funded.

£'000'S	2020/21 £k	2021/22 £k	2022/23 £k	2023/24 £k	2024/25 Onwards £k	TOTAL COST £k
eHealth Infrastructure and Support	66	66	66	66	66	**330**
Ongoing BAU Support	0	0	0	729	751	**1,480**
Training	246	249	256	0	0	**751**
Recurring Support	96	96	96	96	96	**480**
Depreciation (7 years)	107	254	434	622	658	**2,075**
Total Additional Recurring Resource	**515**	**665**	**852**	**1,513**	**1,571**	**5,116**
AVAILABLE BUDGETS						
NHS Fife Depreciation	107	254	434	622	658	**2,075**
Medicines Prescription Chart Procurement Savings	7	4	3	14	14	**42**
CNORIS Costs Avoided	TBC	TBC	TBC	TBC	TBC	**0**
Total Available Budgets	**114**	**258**	**437**	**636**	**672**	**2,117**
NHS Fife Additional Funding Requirement	**401**	**407**	**415**	**877**	**899**	**2,999**

Anticipated recurring costs are anticipated post implementation, in financial year 23/24; they have then been added for 24/25 and will be ongoing thereafter.

Resource Justification

The Implementation resource was developed based on information contained within the national HEPMA Business Case and review of NHS Lothian Full Business Case. The training for HEPMA cannot be capital funded and therefore this has been included as revenue.

- **Training Team.** Comprising pharmacy and eHealth project staff to undertake the preparation of training materials.

The ongoing support team will comprise both Pharmacy and eHealth resource. The eHealth team will provide ongoing technical support with pharmacy providing ongoing clinical support. They will:-

- Support the review and re-design of work practices to ensure the efficiencies available by using a HEPMA solution are realised, driving out the efficiency benefits available from having a HEPMA solution, e.g. analysis of information on drug prescribing, monitor and improve prescribing practice, identify and address inexplicable variation, reviewing medicines and usage and monitoring of medicine waste;
- Manage and maintain all drug files and clinical protocols on the system to ensure safe prescribing and medicine administration at all times. Each new drug needs to be added to the system, populated for prescribing and validated for accuracy in a timely manner.
- The system requires to be updated on rapidly changing medicines information, for example the safety recalls and MHRA drug safety updates.
- Manage the decision support tools available on the system to support best practice in prescribing by all health care professionals.
- Ensure compliance with legal frameworks governing medicines use and the ability to mandate it at the point of prescribing.
- Provide advice and assistance to HEPMA users on an ongoing basis.
- Undertake acceptance testing and implementation of the HEPMA software as new upgrades become available in conjunction with eHealth
- Integration of HEPMA with the pharmacy stock control system to ensure accurate levels of both ward-held and pharmacy-held drugs to reduce overstocks;
- Review of information available at transfer of care across multiple patient pathways;
- Assist with the provision of a 24/7 clinical help desk support for all HEPMA enquires raised by system users.
- The additional pharmacy recurring resource is required to embed safe practices within the use of the system, however it is also essential to analyse additional data available and understand potential cash releasing benefits.

6.4 Statement of Affordability

Estimated capital costs exceed available Scottish Government funding by £3,160k, due to an increase in supplier costs and staff agenda for change pay costs since the national FBC (2016) was completed.

If approved, provision will be made, from the NHS Fife Property and Asset Management Investment Programme (assuming Scottish Government funding called down first).

Cash releasing revenue benefits are anticipated but have not been assumed, given the lack of an evidence base nationally. Corporate support is required for 2 years following implementation – estimated to be financial year 2023 / 24, to allow time for additional data to be assessed and opportunities for cash releasing savings to be better understood.

6.5 Stakeholder Support

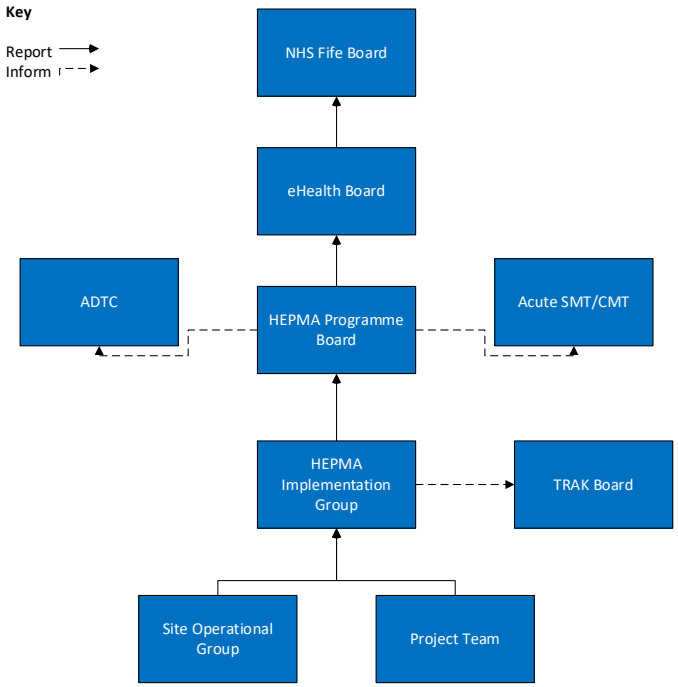
All relevant stakeholders will review the Outline Business Case before final approval by the NHS Fife Board. Stakeholder engagement will be a key deliverable of the HEPMA Programme and has been recognised as fundamental to successful delivery.

7 Management Case

7.1 NHS Fife Governance

The project will be delivered using Prince 2 methodology with solid governance. A formal project structure will be put in place. A HEPMA Programme Board has been established to provide overall governance to the project, chaired by Dr Chris McKenna, Executive Medical Director for NHS Fife as illustrated below.

Project Governance Structure



The composition and group membership of the HEPMA Programme Board is set out in Appendix 1. The reporting structure will be through LCIG / F&R and to SG as required

7.2 Implementation Scope

It is proposed that HEPMA would be rolled out across all NHS Fife acute beds including mental health beds in a number of phases taking a site based approach. It was agreed within the Project Team that the following approach to implementation should be adopted; however this will be agreed and confirmed by the Programme Board taking into account any future re-provisioning works across the sites:

Phase 1: Victoria Hospital

Phase 2: Queen Margaret Hospital

Phase 3: Community Hospitals

The table below illustrates the proposed scope of the roll out across NHS Fife.

Implementation Scope

Hospital	Wards and Bed / Chairs / Trolleys / Cots	Outpatient Attendances 2017/18	Day Cases 2017/18	Inpatient Attendances 2017/18
Victoria Hospital	660	200,109	13,713	50,870
Queen Margaret	90	152,178	1,232	1,390
Community Hospitals	586	46,977	1	1,748
Total	1336	399,264	14,946	54,008

Source: - NHS Fife Information Services

7.2.1 Training

500 Prescribers – including all medical staff, pharmacists and nurse/AHP Prescribers

2919 Administrators – includes all band 5 and above nurses, and some AHP's.

7.2.2 Project Recruitment Needs

NHS Fife eHealth and Pharmacy are currently operating at maximum capacity, therefore recruitment of resource for implementation and business as usual will be required.

7.2.3 Project Plan and Key Milestones

The project will be managed in line with Prince 2 methodology. Following completion of the Full Business Case a detailed project plan will be developed which will include the key milestones for NHS Fife.

7.2.4 Integration

The proposed solution would be integrated with core clinical systems including:-

- TrakCare Patient Management System
- Ensemble integration engine

- Labs (this would be via Ensemble)
- Pharmacy Stock Control
- Orion Health and Social Care Portal
- GP Systems
- Emergency Care Summary
- SCI Store

7.2.5 Decision Support

To maximise the benefits from the HEPMA system it is intended that in addition to core electronic prescribing and the electronic recording of medicines administration the system will:

- use automatic decision alert functionality; and
- support local prescribing initiatives e.g. when additional rules are built into the system in relation to local formulary and prescribing protocols.

Experience from other boards that have implemented HEPMA demonstrates that an appropriate resource is required to maximise the benefits described.

A dedicated team is required to implement and maintain the system, to analyse and interpret data and work with clinical teams to utilise this data to improve patient care and realise efficiencies, for example review guidelines, decision support and reduce variation in prescribing. This will require additional resource to maintain and run these protocols on an ongoing basis and to monitor trends and interpret data; this has been incorporated into the resource requirements detailed earlier in the business case.

7.2.6 Disaster Recovery

The disaster recovery plan for HEPMA will be completed as a key objective of the overall project.

7.3 Change Management Arrangements

7.3.1 Operational and Service Change Plan

As part of the project changes to Standard Operating Procedures (SOP's) will be captured and progressed through relevant governance. In addition, an Operational Support Guide for eHealth will be completed to ensure adequate ongoing support of the system.

7.3.2 Stakeholder Engagement and Communications Plan

As part of project delivery a detailed stakeholder engagement and communications plan will be developed. Support with media and communications will be sought from NHS Fife Communications Team.

7.4 Benefits Realisation

7.4.1 Benefits Register

The project manager will ensure benefits are captured in line with governance procedures. Benefits will be captured utilising DOAM (describable, observable, attributable and measurable) and set timescales for review will be implemented

7.4.2 Benefits Realisation Plan

The pharmacy lead will have responsibility for ensuring the benefits realisation plan is undertaken following completion of the project.

7.5 Risk Management

NHS Fife manages risks on the Datix system, this system has been created to ensure solid governance around management of risks within NHS Fife. Risks will be managed on a Monthly basis, with risks being discussed initially at project level, then at board level and all high level risks will be reported to eHealth Board.

7.6 Project Evaluation

Project Evaluation will be undertaken by eHealth Head of Strategy and Programmes at regular intervals to ensure continuity of practice.

Appendix 1 – Membership of HEPMA Programme Board

Name	Role
Chris McKenna	Chair, Medical Director
Lynn Campbell	Associate Director of Nursing (Acute)
Claire Dobson	Divisional General Manager
Lesly Donovan	General Manager, eHealth
Scott Garden	Director of Pharmacy
Andrew Hay	Procurement Planning Manager
Mark Porter	Senior Project Manager
Carol Potter / Rose Robertson	Director of Finance / Deputy Director of Finance
Marie Richmond	eHealth Head of Strategy and Programmes
Carol-Anne Rougvie	Programme Support Officer
Miriam Watts	General Manager Emergency Care

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Drug-related Deaths Report 2018
EXECUTIVE LEAD:	Dona Milne, Director of Public Health
REPORTING OFFICER:	Paul Madill

Purpose of the Report (delete as appropriate)		
	For Discussion consider the options and any impact	

SBAR REPORT

Situation

This report provides an update on Drug Related Deaths as requested by NHS Fife Clinical Governance Committee.
The National Records Of Scotland published the 2018 data on drug-related deaths in Scotland in July of this year (attached at Appendix). Some key points are outlined below:

- Drug- related deaths (DRDs) in Scotland are at an all-time high. The total in 2018 was 1187 – an increase of 27% on the previous year, and more than double the number who died in 2008
- 5-year aggregated data show an increase of 212% in female deaths in 2014-18 compared to a decade previously, and a 75% increase in male deaths over the same period.
- The largest increases in numbers were for the 35-44 and 45-54 age groups.
- The vast majority of drug-related deaths are of people who took more than one substance
- Opiates or opioids were implicated in, or potentially contributed to 86% of deaths; benzodiazepines in 67%; Gabapentinoids in 31% and cocaine and similar stimulant drugs in 23%

In addition, Fife Alcohol and Drugs Partnership has just completed a local report (attached as appendix) which compares the Scotland and Fife data, and draws conclusions on the key issues for Fife.

Summary:

- DRDs have more than doubled in Scotland and in Fife in the last decade. The five-year aggregated data show an increase of 108% in Scotland and 121% in Fife between 2004-8 and 2014-18.
- Many of the people dying had not been accessing treatment for their drug problems
- Across Scotland, even amongst those accessing services, deaths have been increasing
- There has been a demographic shift in drug deaths, with an increasing number of female deaths, and a marked increased in deaths in the 35-44 and 45-54 age groups
- There are some differences in drugs implicated in DRDs in Fife as compared to Scotland, with gabapentinoids present in 81% of DRDs in Fife, v. 31% in Scotland

- Cocaine and related drugs are more frequently present than previously, in both Fife and Scotland
- 20% of those who died had been in custody within 6 months of their death
- In 53% of deaths, a friend or family member was present in the house, often in the same room
- In only 3 cases is it recorded that Naloxone was present, and it was only administered in 1 of those (may be a data recording issue)

Background

The attached report summarises the number, demographic and geographical distribution of drug-related deaths in Fife in 2018, and outlines recent national and local trends in drug-related deaths.

In response to these national trends, the Scottish Government has set up a national taskforce. Its primary role is to co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death.

The Scottish Directors of Public Health issued a position statement in July 2019 describing drug and substance misuse in Scotland as a public health emergency.

The Dundee Drugs Commission report into high numbers of drug-related deaths in that city was published in August this year. It looked at evidence from local residents and organisations, but also sought examples of good practice from elsewhere, and expert advice from across Scotland. The commission made 16 recommendations, including the requirement for improved leadership and governance, the need to challenge and eliminate stigma; a common level of accountability for all provider organisations; a holistic system, including integrated primary care provision; integration of mental health and substance misuse services. There is no reason to suggest that if this report had been prepared for Fife that it would say anything different.

In Fife, at the request of the ADP, Public Health has produced a draft report comparing local provision to the evidence base. The emerging recommendations mirror many of those in the Dundee Commission report. Some of the key documents referred to are listed in the evidence section of this report.

Assessment

The overall picture of rising numbers of drug-related deaths in Fife is similar to that of Scotland as a whole, however there are some differences. For example gabapentinoids are much more commonly found at toxicology in Fife as compared to Scotland as a whole.

Over approximately the last decade in Fife, although estimated prevalence of drug use hasn't changed significantly, drug-related hospital admissions have doubled, and (5-yearly aggregated) annual deaths have gone up from 24 to 53 (a rise of 121%). Annual numbers fluctuate much more, so the drop in Fife numbers from 66 to 64 in 2018, while welcome, is not statistically significant.
There has been a change in the demographic of the population who are dying from drug use in Fife and across Scotland. We have seen an increase in females and an aging population. In addition, whilst prevalence of drug use has remained relatively static, the severe consequences

of drug use in terms of deaths and hospital admissions has increased.

The harm caused by drug use is disproportionately borne by areas of Fife with high levels of deprivation. Most DRDs in Fife in 2018 occured in the person's own home and in the presence of another person.

Learning from drug-related deaths in Fife is limited to those who were engaged with addictions services within 6 months of their death. This has historically been a minority of all deaths in Fife.

Collaborative working with police and the criminal justice system will be crucial, given that 20% of cases had recently left custody.

The attached report outlines a number of projects in Fife aimed at reducing drug-related harm and deaths, including

- Addaction Harm Reduction Team have been running a harm reduction project since 2012 which addresses
    - Injecting equipment
    - BBV testing
    - Treatment signposting
    - Education and training

- A Pilot project led by ADP/ADAPT in partnership with Scottish Ambulance Service started in April 2019 to respond to near fatal overdoses (NFOs). This team has provided support for more than 90 individuals to date.

- There is a newly commissioned multidisciplinary Hospital Liaison Team, based within Victoria Hospital to improve access to and retention in services for at risk patients attending the hospital.

- Fife Naloxone Strategy is complete and an action plan developed . It aims to increase understanding of drug related death risk and increased distribution of naloxone, a drug which, if delivered shortly after an overdose is taken, can greatly reduce the risk of death.

- New pathways of care and focus on physical and mental health care within Addictions services.

Nonetheless the Public Health report commissioned by the ADP compares the evidence base against current provision and concludes that we need to respond to the drug-related deaths crisis and the pattern of drug harms in Fife with significant changes in our service provision and delivery.

These conclusions are in part based on the 2018 needs assessment carried out by Fife Council, and a previous review of local services in Fife. It also considered, national guidance and evidence.

The draft recommendations in the Public Health report include the need to:

- Consider how we can adopt a whole systems working approach to drug use in Fife. Service users and people with experience of drug/ alcohol use should be closely involved in formulating this workplan.
- In the shorter term, address workforce issues, in terms of training, communication and support. We should work to eliminate silo-ed approaches in service delivery and aim to have an 'ADP workforce' rather than an NHS, third sector and council workforce.
- Training should include trauma informed training for everyone in all organisations and support should be in place to enable people to enact this training and adopt this approach into their practice)

In addition to the above report, the Alcohol and Drugs Partnerships has conducted a self-assessment against the Partnership Delivery Framework to reduce the use of and harm from alcohol and drugs to identify areas for improvement.

A group of local clinicians have begun to look at the local impact of certain prescribed medications – opioids, gabapentinoids and benzodiazepines - and this work should inform and complement drug-related deaths work in the future.

There is in Fife a sense of urgency about drug-related deaths, but also an appetite to take a fresh, whole-systems approach to drug-related harm. It will be important to pool the findings of these three local reviews, as well as the Dundee Drugs Commission report, to agree and deliver priority short-term actions and to develop an effective medium and long-term approach.

There are clearly significant population health risks to not taking effective action to systematically tackle drug-related harm and especially deaths. We know that in Fife most DRDs occur in the presence of others, that the toxicology picture is different to Scotland, and that hard-pressed communities, especially in mid-Fife, are particularly vulnerable. But the detailed knowledge that will allow us to effectively tackle drug related deaths is not available in the absence of a systematic review process for **all** DRDs.

Whilst this is a multifactorial problem with many of the modifiable risks outwith the gift of health and social care, it is clear that part of the solution lies in improving access to health and social care services, and also that government has a clear expectation that leadership on this issue will come from health and social care partnerships.

There are significant considerations for all stakeholders, especially service providers (including mental health and primary care), service users and people who use drugs but are not engaged with services.

It will be crucial that any significant shift in service provision is developed in conjunction with all of these and wider stakeholders.

<u>Evidence Base for this SBAR</u>

Fife Public Health Evidence Review (Draft, 2019)

Fife Drug-Related Deaths 2018 (Fife ADP)
Drug Related Deaths in Scotland in 2018 (NRS)
Dundee Drugs Commission Report (2019)
Rights, Respect and Recovery (2018)
Fife ADP's Needs Assessment (2018)
Drug-Related Deaths Rapid Evidence Review (2017)
Staying Alive in Scotland (2016)
The Development of an Integrated Approach to the Delivery of Substance Misuse Services in Fife: An Options Appraisal (2016)
Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services (2014)

Next steps:

- Learning from all drug-related deaths is paramount and we need to ensure that there is a robust local system to achieve this.
- The Dundee Drugs Commission identified ADP governance as a crucial element of reducing drug-related deaths. Local governance is already under review. This is welcome, but we should also learn from any appropriate findings from this commission.
- The draft Fife Public Health report, though it was written before the publication of the Dundee report, made many similar findings. Its recommendations should also inform the development of not only drug and alcohol services, but also "mainstream" services in Fife, such as mental health, general practice, housing and criminal justice.
- The disproportionately high impact of drug-related deaths in areas of high deprivation in Fife, the increase in female deaths, and the ageing population in this group need to be addressed in designing and delivering service responses.

Recommendation

- Discussion – Clinical Governance Committee are invited to note the content of this report and discuss the next steps.

Objectives: (must be completed)	
Healthcare Standard(s):	Safe and Effective Care
HB Strategic Objectives:	Clinically Excellent Person Centred (Reduce Health Inequalities in terms of access and services)

Further Information:	
Evidence Base:	Fife Public Health Evidence Review (Draft, 2019) Fife Drug-Related Deaths 2018 (Fife ADP) Drug Related Deaths in Scotland in 2018 (NRS) Dundee Drugs Commission Report (2019) Rights, Respect and Recovery (2018) Fife ADP's Needs Assessment (2018) Drug-Related Deaths Rapid Evidence Review (2017) Staying Alive in Scotland (2016) The Development of an Integrated Approach to the Delivery of Substance Misuse Services in Fife: An Options Appraisal (2016) Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services (2014) Martin, Lynsey (unpublished) Alcohol and Drugs Service Provision in Fife: a systhesis of policy recommendations for Fife
Appendix	Drug Related Deaths in Scotland in 2018 (2019) National Records of Scotland
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Director of Public Health Divisional General Manager HSCP (Fife-wide) Consultant Psychiatrist/Clinical Lead in Addictions Medicine Consultant Psychiatrist /Clinical Director Fife-wide HSCP Alcohol & Drug Partnership Coordinator Clinical Services Manager, Whyteman's Brae Hospital

Impact: (must be completed)	
Financial / Value For Money	This report has no immediate financial impact or capital requirements
Risk / Legal:	This paper aims to address a significant current risk to the health of individuals and vulnerable communities. Reputational risk to NHS Fife and Fife HSCP could result from a failure to find new ways of addressing the issues outlined in this paper.
Quality / Patient Care:	This report addresses the need to provide care according to the needs of a highly vulnerable population. There are significant consequences of not managing to engage and retain in treatment people who use substances. These consequences can be severe for the health of individuals, but they also include reputational risk for the organisation .

Workforce:	It is hoped that by addressing the training requirements of existing staff, the quality of their working lives can be improved. There is always the potential for staff opposition to changes in service provision.
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? No. This report does not in itself alter service delivery. It does anticipate changes that will address inequalities in access to, and retention in, services. • Has a full EQIA been undertaken? No. See above. • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • This paper aims to ensure equitable access to and retention in drug and alcohol and other health and care services, especially for women and for people living in areas of high deprivation • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • The report identifies inequalities in outcomes and in service access and aims to reduce such inequalities • Any potential negative impacts identified in the EQIA documentation - No (if yes please state)

Fife Drug-Related Deaths 2018

Fife Alcohol and Drug Partnership
Promoting Recovery. Reducing Harm.

Acknowledgements

Overdose Prevention & Drug Death Monitoring Group 2018

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Colin Baptie, Custody nurse, NHS Lothian
Chris Mutter, Police Scotland
Dawn Wrigley, Scottish Prison Service
Greg Henderson, Service Manager, Area Housing Operations
Jim McSpurren, Scottish Ambulance Service
Louise Bowman, Scottish Drugs Forum
Paul Raynor, Scottish Ambulance Service
Scott Cunningham, Police Scotland
Stuart McArthur, Team Manager, Education, Children's Services and Criminal Justice, DTTO, Groupwork Services
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Norma Westland, NHS Fife Addiction Services
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Special Thanks

We would like to take this opportunity to acknowledge all agencies that have completed questionnaires and contributed to the data collection for the Overdose Prevention & Drug Death Monitoring Group. The continued dedication and support are greatly appreciated.

Contents

Executive Summary

2018 saw a rise in drug-related deaths across Scotland. During 2016, 867 people died from a drug-related death rising to 934 in 2017. The total rose again in 2018 to 1,187 people, 64 of whom died in Fife.

This upward trajectory across Scotland has been the focus for many policy makers and public health officials across government, local authority, health boards and third sector organisations. Campaigns such as Scottish Drugs Forum's (SDF) #StopTheDeaths, sought to energise public awareness and highlight the drug-related harm that was being reported primarily among those living in areas of multiple deprivation.

Fife Alcohol and Drugs Partnership (ADP) Policy Officers have the responsibility of reviewing each death and maintaining the National Drug-related Death Database (NDRDD) held by NHS Information Services Division (ISD).

Fife's Overdose Prevention & Drug Death Monitoring Group (OPDDMG) meet quarterly to discuss and act upon trends in drug-related deaths as well as target areas of high mortality to address service gaps and provision.

Whilst the national picture seems ever increasing, 2018 saw a slight reduction in drug deaths in Fife from 66 in 2017 to 64 in 2018. Although this total mortality figure fell, it would be dangerous to view this as a trend or stabilisation and the work of groups like the OPDDMG as well as efforts by other bodies such as Public Health and wider ADP services, is as valuable and urgent as ever. Any attempt to stabilise and reduce Fife's drug-related deaths cannot rely on ADP funded services alone and will require action across systems as well being shaped by the voice of lived experience as individuals, families, communities.

This report is concerned with outlining the trends and themes to provide an overview and limited history of the drug-related deaths that occurred in Fife during 2018. The data used in primarily taken from Police Sudden Death Reports and Pathology reports. More on the data collection methods can be found in the appendices.

Most of Fife's drug-related deaths are amongst males from the 35 - 44 age range who are polydrug users. There has been a substantial reduction in the number of female drug-related deaths with 15 cases compared to 26 in 2017. However, when compared to 2008 when only 4 female deaths were recorded, this represents a 3-fold increase in 10 years.

In terms of general health, a significant amount of drug-related death victims had both physical and mental health conditions. 51% suffered from depression (not necessarily diagnosed) and 33% suffered from generalised anxiety. 18% of people had been diagnosed with Hepatitis C, and 11% of victims suffered from epilepsy.

Drug-related deaths occurred largely in places of high economic deprivation. This is true across Fife and influenced some of the direction of work of the OPDDMG during this period.

From the data presented, it is relatively straightforward to describe the common characteristics of an average drug-related death victim in Fife:

Single, white, Scottish male aged 39 living alone in their own rented or owned accommodation in an area of high economic deprivation, with a diagnosis of depression and suffering from anxiety. Unemployed or long-term sick, primarily using opiates but with a history of polysubstance misuse, on a regular basis.

There appears to be an increase in the prevalence of stimulant type drugs being used in Fife, notably cocaine and crack cocaine. During 2018, cocaine and crack cocaine featured in 25% of all drug-related deaths, up from 12% the previous year. This anecdotal evidence from commissioned services provided by service users in some areas across Fife, will be investigated more fully by SDF in 2019 with funding from the Scottish Government Challenge Fund.

This report does not offer any recommendations to influence future work plans. However, the data contained can be used as an adjunct for groups to design pathways and responses that may halt the rise or raise awareness of the loss of life across Fife.

It is the intention of the OPDDMG to develop a comprehensive work plan in partnership with all appropriate agencies, considering findings from the Dundee Drug Commission report *Responding to Drug Use with Kindness, Compassion and Hope* and SDF's refresh of their *Staying Alive in Scotland* published August 2019 as well as local drivers and needs.

In October 2019, the OPDDMG held a workshop event bringing together stakeholders from across services to identify gaps in current strategy and service provision. This work plan will underpin Fife's drug-related death response for the coming year.

Phillip Heaton,
Policy Officer, Fife ADP

Methodology

This report is a retrospective analysis of trends, similarities and common themes occurring within victims of DRD in Fife over the past year (2018). The information contained in this report is descriptive in nature and does not infer that the presented information necessarily identifies risk factors attributable to a DRD. To accomplish such a task, one would require a controlled sample of a living, drug taking and general population. Instead, the trends and patterns in this report can be treated as factors which commonly precipitate a DRD, rather than cause it.

Throughout this report comparisons are made between Fife 2018 data and Scotland wide 2018 data. Unless specifically mentioned, both datasets have been taken from the National Records of Scotland report on Drug-Related Deaths in Scotland 2018[(1)].

Local data for 2018 was entered into NHS Scotland Information Services Division (ISD) National Drug-related Death Database (NDRDD). This is a national requirement and largely matches the NRS dataset, therefore, some comparative data has been used from the NDRDD for this report. ISD has a different timeframe than NRS and works to financial years rather than calendar years; this can obviously cause some anomalies in reporting. ISD and NRS performed three information exchanges during the reporting period to ensure comprehensive data collection. More information on the differences between the two databases can be found here:

http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drugs-Misuse/Drug-Related-Deaths-Database/

In 2018, Fife ADP Support Team considered a total of 75 cases which were either highlighted by the police at the time of death as a suspected drug death or highlighted later following the release of the post-mortem report. 64 of these were confirmed by NRS as official 2018 DRDs.

NRS confirms a DRD by pathology and toxicology reports. If the death occurs near the end of the data collection period, there is a chance these reports will not be available in time and the death then gets attributed to the following year. NRS can also treat deaths from other areas differently depending on the situation. More information on how NRS classify DRDs can be found in their 2018 report which can be downloaded from here:

https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2018

The number of Drug-related Deaths in Fife in 2018 consisted of 64 individuals, the circumstances of which are described in detail in Section 1 of this report.

Section 1: Results

1.1 Demographic Characteristics

This section describes patterns surrounding the incidence and location of drug deaths. It also considers gender, age and ethnicity of drug death victims.

1.1.1 Incidence and Prevalence of Drug Deaths

There were 64 drug-related deaths recorded by National Records of Scotland in Fife during 2018. *Figure 1*, below, shows the pattern of drug-related deaths in Fife since 2008.

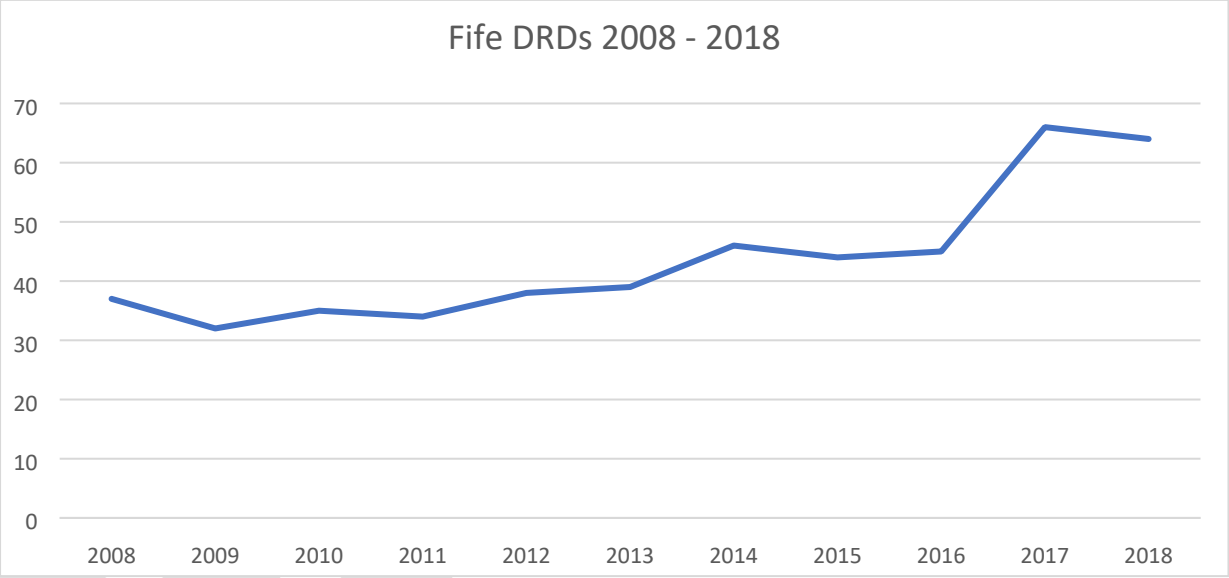


Figure 1

Since 2008, there have been a total of 480 drug deaths in Fife and a 72.9% increase against a national rise of 106%. The increase in 5 yearly average deaths in Fife between 2004-8 and 2014-18 was 121% (from 24 to 53)

Fife's Female deaths have risen 275% from 4 in 2008 to 15 in 2018, however, have reduced by 42.3% from 2017.

Figure 2 shows the number of deaths per 1000 population for all NHS board areas across Scotland. Fife has the fifth highest death rate per 1000 population joint with Forth Valley and Lothian over annual averages for 2014 – 2018.

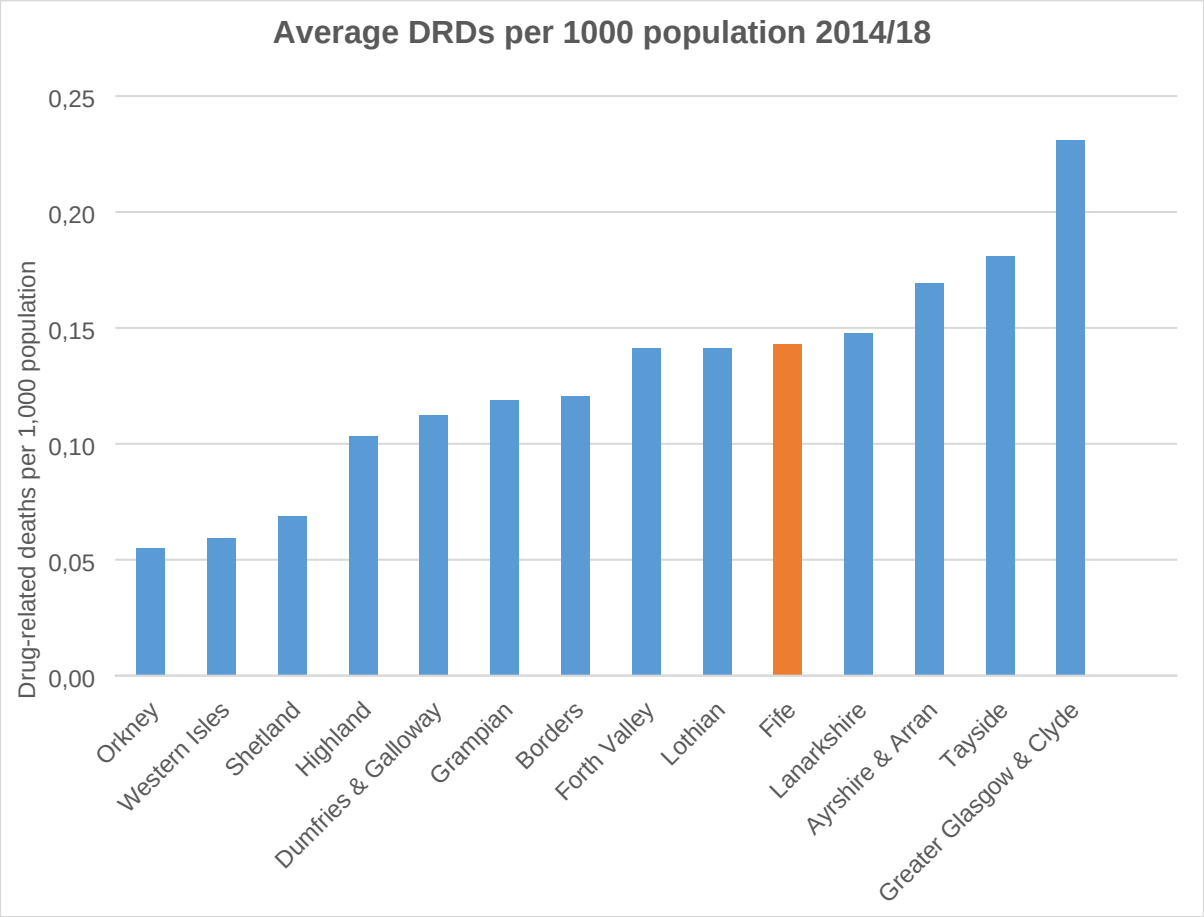


Figure 2

Fife's death rates per 1000 population for 2014-2018 is 0.14 against a national average for this period of 0.16.

Key Points

- Fife had a total of 64 drug-related deaths in 2018
- In 2018, Fife had a 3.03% decrease of drug-related deaths over the previous year.
- All health board areas in Scotland saw an increase of drug-related deaths in 2018 except for Dumfries & Galloway, Fife, Shetland and Western Isles.
- Of those health board areas who saw an increase of drug-related deaths in 2018, the average increase was 30.9% over 2017 figures.

1.1.2 Residency of Drug Death victims within Fife

It is important to recognise that when mapping areas of drug-related deaths that location of death does not always correspond to area of residency. This can cause discrepancies within the NRS data compared to the ISD NDRDD. NRS has its own criteria for inclusion which has already been covered earlier in this report. It therefore is not unusual for drug death coordinators to liaise with each other for deaths which may occur across neighbouring health board areas.

Figure 3 shows the location of where the drug deaths occurred.

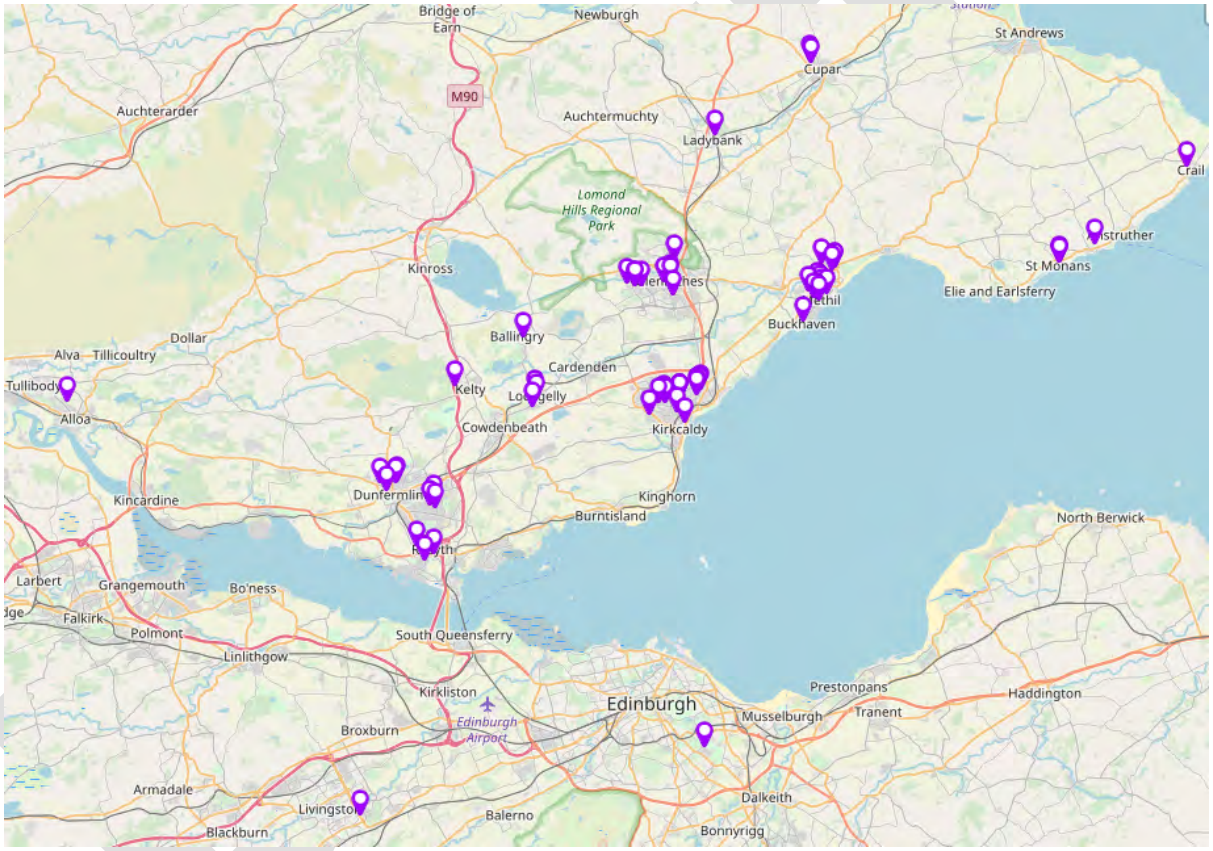


Figure 3

The deaths indicated in Alloa, Livingston, and Edinburgh were Fife residents who died out with the boundary lines. These deaths, although not occurring in Fife were attributable due to the person's residential status.

Figure 4 shows deaths according to residential post codes.

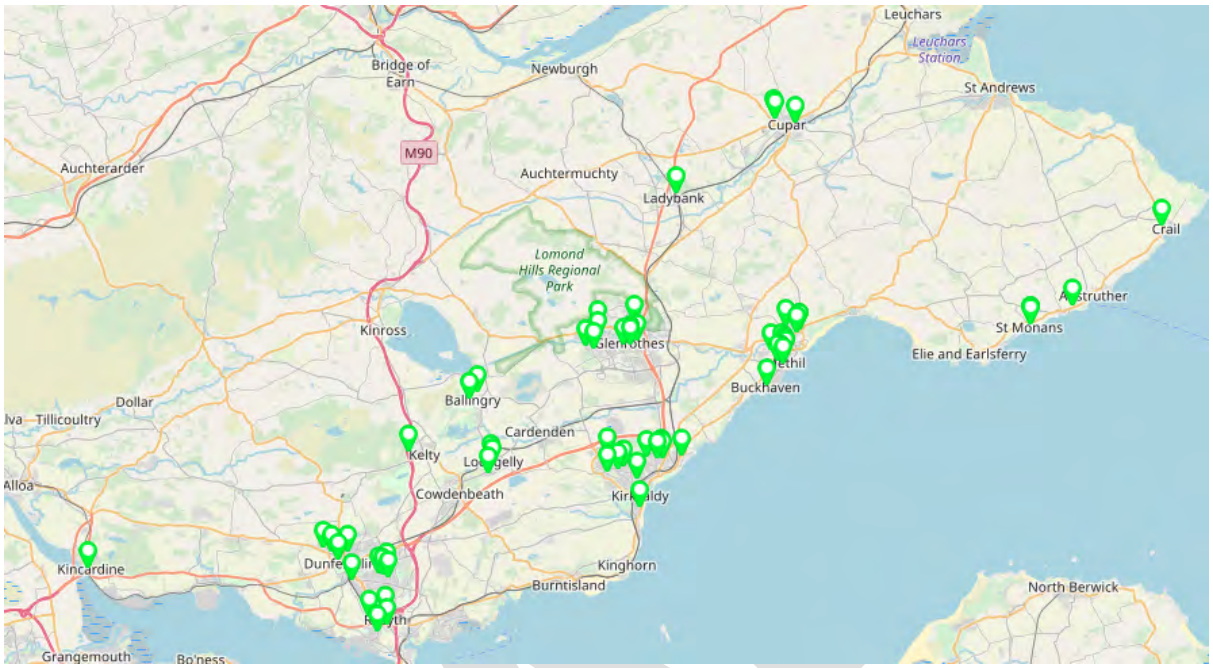


Figure 4

It is clear from the above maps that the deaths largely occur in clusters and it is not surprising that these clusters tend to be in urbanised areas such as Kirkcaldy, Glenrothes, Dunfermline, and Leven. It may also be unsurprising that these clusters largely match areas of high deprivation as described by the Scottish Index of Multiple Deprivation (SIMD16) studies.

Figure 5 shows the areas of highest deprivation according to the SIMD 2016 data

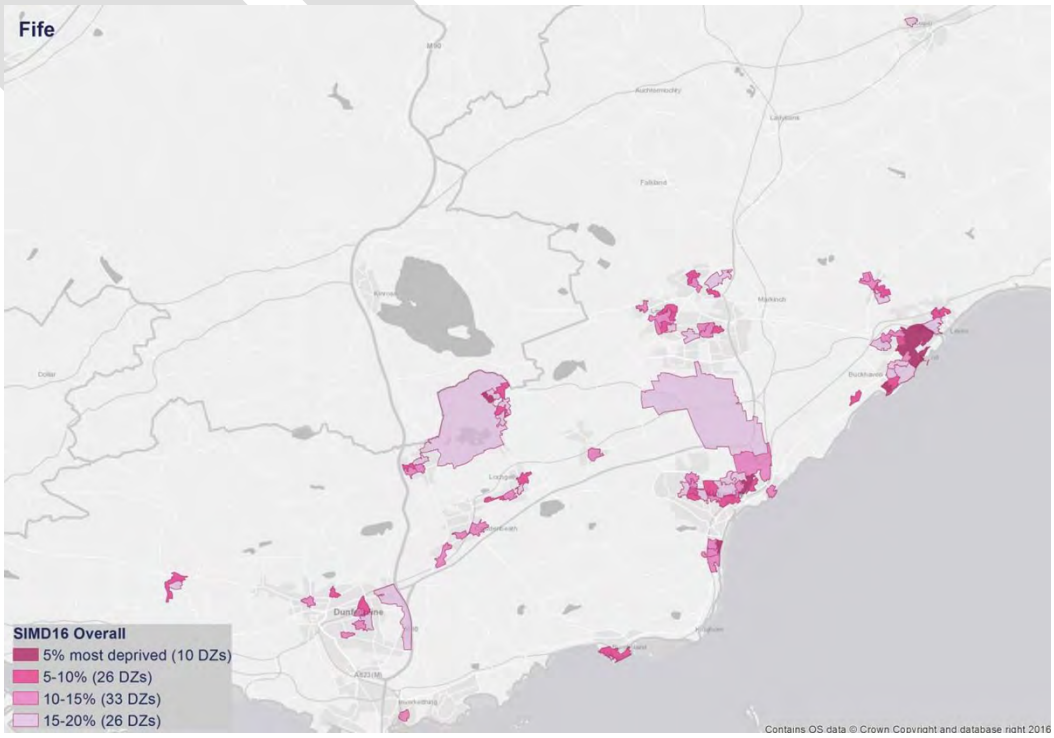


Figure 5

Most deaths occurring in 2018 were pronounced life extinct in their own home. 5 people died in hospital, 2 people died outdoors, and the remainder died at friend's or relative's homes.

Key Points

- Fife's drug deaths are largely occurring in places of high economic deprivation.
- Most deaths are occurring in people who are using drugs in their own homes.

1.1.3 Age, Gender and Ethnicity

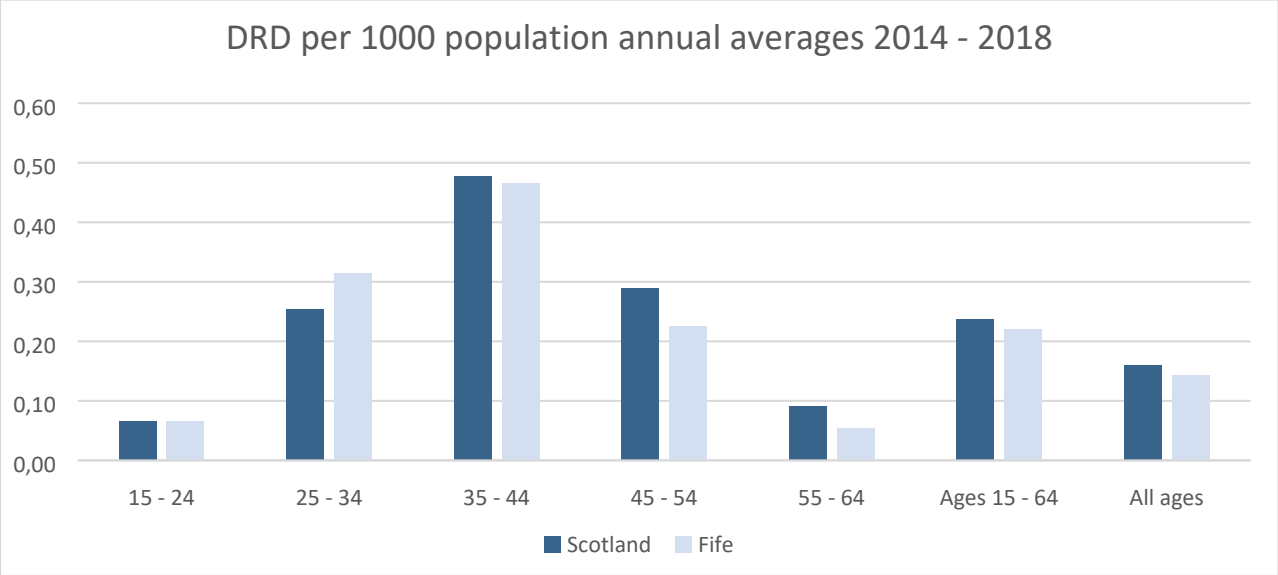


Figure 6

Figure 6 shows the average age of deaths in Fife compared to those nationally. The figures are taken as an average over the years 2014 – 2018. From this data, it is evident that the age group with the highest death rate is the 35 – 44-year olds

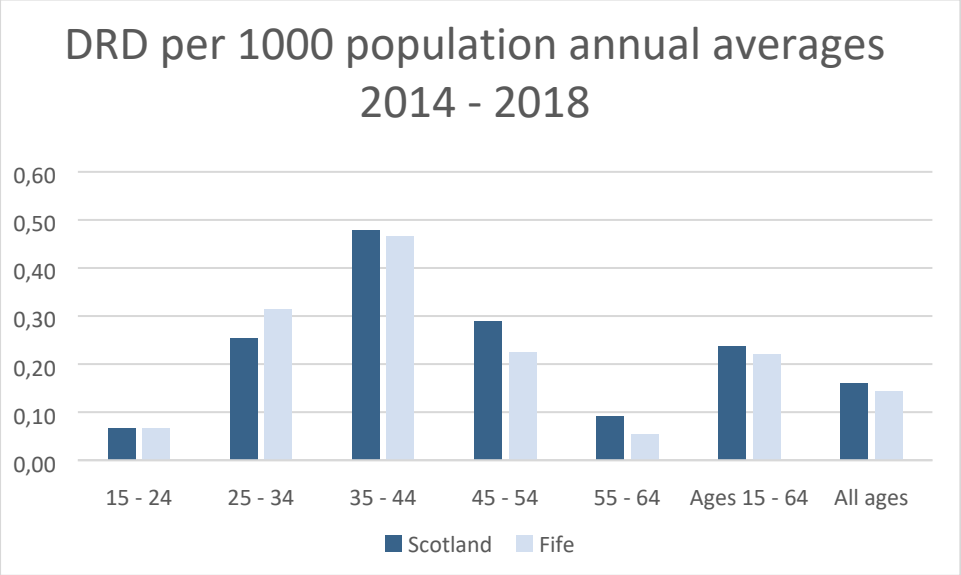


Figure 7

Figure 7 again demonstrates that the most drug-related deaths occur in the 35 – 44-year-old age bracket. This data is from the drug deaths which occurred in 2018 only.

When considering the Scottish age ranges compared to Fife, Fife drug-related deaths occurred at a younger age than Scotland as a whole. It was highlighted in the Fife Needs Assessment (2018) that Fife had a larger share of males aged 15-24 who use drugs than the Scottish average which may be relevant here. However, the increase in the age of the average Fife drug-related death individual is consistent with the national trend to an older age profile. This pattern of an increasing average age of fatal drug overdoses is also reflected Europe wide, as detailed in the EMCDDA's 2019 European Drug Report the European mean age at death was 37 years. Indicating that there is an aging cohort of vulnerable illicit drug users.

Sex	**Cases 2018**	**%**
Male	49	76.5
Female	15	23.5
Total	64	

Most of Fife's DRD victims in 2018 were male (76.5%). In comparison with this, across the whole of Scotland in 2018, 72.5% of all drug death victims were male.

Compared to previous years, the percentage of female to male victims had been increasing in Fife; in 2012 8.7% of drug death victims were female, in 2013-14 this rose to 10.4%, in 2015 it was 38.7% and in 2017 it was 39.3%. This increased proportion of female deaths was the result of an overall increase in female numbers rather than a reduction in male ones. The drop from in both percentage and numbers of female deaths in 2018 is substantial, but time will tell if this is a significant trend.

Ethnicity	Cases 2017	%
White Scottish	60	93.75
Unknown/unrecorded	4	6.25%
Total	64	

Most of Fife's drug-related death victims were classified as White Scottish and had spent all, or the majority, of their life in Scotland. This is not reflective of the Fife ethnicity as per the 2011 census where a lower 85.7% respondents indicated they were White Scottish and 11.9% White British. A large number of the cohort did not have their ethnicity reported.

Key Points 2018

- The mean age of the Fife drug death victims increased slightly to 41 years (2013-2014 was 36 years and in 2015 it was 37.)
- Most drug death victims were aged between 35 – 44 years of age. This is in line with the national trend of an older drug using population.
- 23.5% of the victims were female – this represents an overall increase in the number of females who are dying over the years.
- At least 93% of Fife drug death victims were ethnically White Scottish

1.2 Life Context and Social Functioning

This section describes drug-related death victims' accommodation and living arrangements at the time of their death and in the six months preceding their death. This section also considers information relating to employment, both directly after school and at the time of death and patterns surrounding the individuals' relationships with both family and friends.

1.2.1 Housing and Living Arrangements

Living arrangements *at the time of death*	**Cases 2018**
Own/Rented home	48
Lived with relative(s)	5
Homeless/NFA/Hostel	6
Living with friend(s)	3
Supported accommodation	2

When considering the housing status of the drug-related death victims, it is important to recognise that in many cases the living arrangements varied frequently, and the lifestyles of a number of these individuals could be described as chaotic.

During the analysis of these cases, it became clear that these deaths had been unintentional and, in theory, preventable if partners/friends, and relatives were able to spot tell-tale signs of overdose situations.

1.2.2 Relationship and Family Information

The relationship status of the drug death victims at the time of their deaths was also considered, since it provides an indication of the level of social support available to them.

Relationship status at the time of death	**Cases 2018**
In a relationship	15
Single	36
Other	13

To determine relationship status at the time of death was not straightforward. If the individual was in a relationship with a partner <u>*at the time of death,*</u> they were classified as '*in a relationship'*. If there was no partner mentioned in the <u>*six months prior to death,*</u> they were classified as '*single'*. However, a single individual could arguably be classified as been in a relationship depending on the time between changes of circumstances and several individuals had separated just prior to their death. These more fluid relationships of individuals who had separated immediately prior to their death, and those in 'on-off relationships' made determining relationship status difficult.

1.2.3 Education and Employment Status

Employment status at time of death	Cases 2018	%
Employed	6	9.37
Retired	1	1.5
Unemployed	49	76.5
Long term sick/disabled	6	9.37
Unknown	3	4.68

It was difficult, given the information presented, to determine the exact occupation or benefits the deceased were in receipt of. Whilst many were simply classed as "unemployed" it may be that they were in receipt of benefits which would suggest a disability or long-term sickness. Regardless, the fact remains that the overwhelming majority of cases were not in active employment at the time of death and were known to the benefits system in some fashion.

Targeting overdose awareness training, including the use of naloxone, to individuals at risk of an overdose and their acquaintances in the wider community, may reduce incidences and consequences of non-fatal/fatal overdoses. Also, considering non-traditional avenues such as DWP officers for basic drugs awareness training may be useful. Partnerships with such agencies may also be fruitful in terms of directing people into treatment.

Key Points

- We know from previous analysis earlier in this report, that the majority of people died in their own home
- Those who died whilst another person was present may have survived if the partner/friend/relative had a basic understanding of overdose and associated signs and an understanding of what to do.
- It was difficult to assess whether naloxone was present in most cases as it was rarely mentioned in reports. The presence of naloxone and the ability of family/friends to use it may have reduced the death rate considerably.
- Most drug-related death victims were not in training, education or employment at time of death.

1.3 Significant Life Events and Physical/Psychological Health

This section explores the types of physical and psychological/psychiatric suffered by the drug-related death population in Fife, with a particular emphasis on co-morbidities and adverse life events.

1.3.1 Significant Life Events

Given the information available, this report is unable to comment on events such as Adverse Childhood Experiences or other traumatic events which may have occurred in the early or informative years of the cohort in any meaningful way. Whilst such events were mentioned in some reports, it was not a feature of the reporting format and as such would not provide an accurate representation that any conclusions could be drawn from. There is evidence to show that ACE's do feature in chronic substance misuse and it may be useful for more work to be carried out to identify the level at which ACE's feature in Fife's drug-related deaths.

There are, however, several recent adverse life events which happened in the six months prior to death that can be reported on with more confidence.

Adverse Life Event (6 months prior to death)	No. of individuals	% of individuals
Breakdown of a significant relationship	6	11%
Bereavement	6	11%
Loss of child custody	1	2%
Job loss	1	2%
Ill health/recent diagnosis	9	16%
Relapse	2	4%
Released from prison	0	0%
Recent homelessness/housing problems	4	7%
Recently assaulted	7	13%
Arrested, charged, witness, awaiting sentence	2	4%
Child custody hearings	2	4%
Other	1	2%
No known event	8	

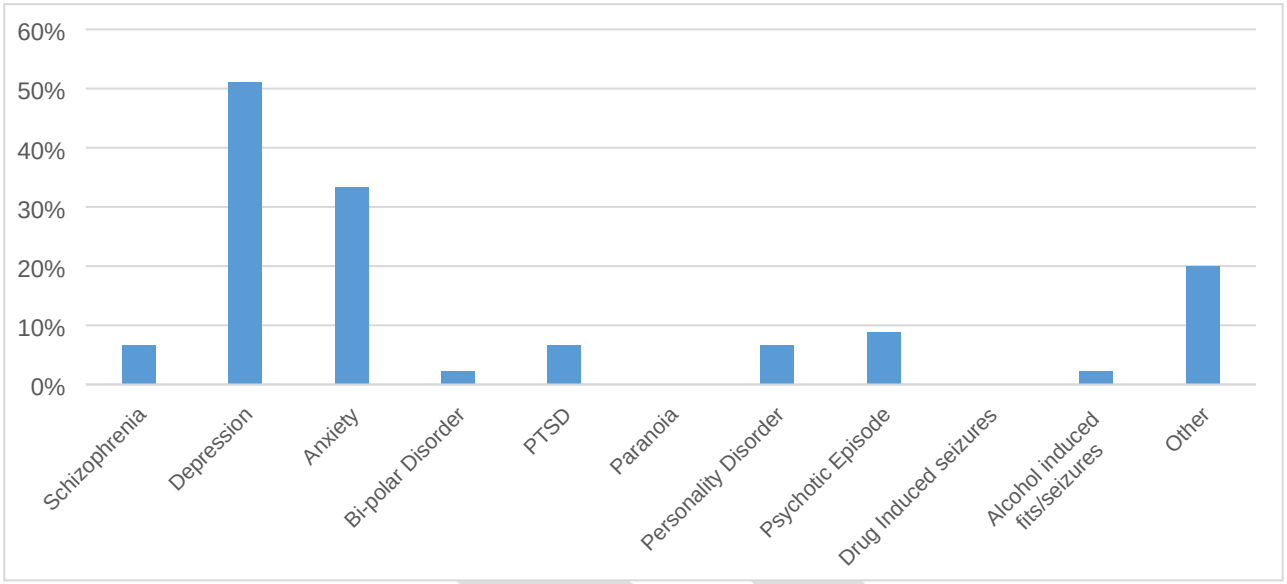
One person may have experienced several events in the six months prior to death. By subtracting those who reported no adverse events from the total deaths, it can be said that 54 people experienced 49 traumatic events as a group, six months prior to their deaths.

In some cases, the drug-related death victims' siblings, parents or other family members were substance users. The adverse life events experienced by drug-related death victims convey a sense of vulnerability, which may have led to the formation of coping by means of substance use and therefore impacted negatively upon their abilities to manage adversity in their adult lives.

At a basic level, the above information provides an indication of the level of instability of these individuals in their lives. Their personal histories show that these drug-related death victims experienced abuse, sexual/physical and/or emotional, significant losses/life events, which may have in turn been precipitating, maintaining and/or consequential factors of their substance use.

1.3.2 Psychiatric/Psychological Problems

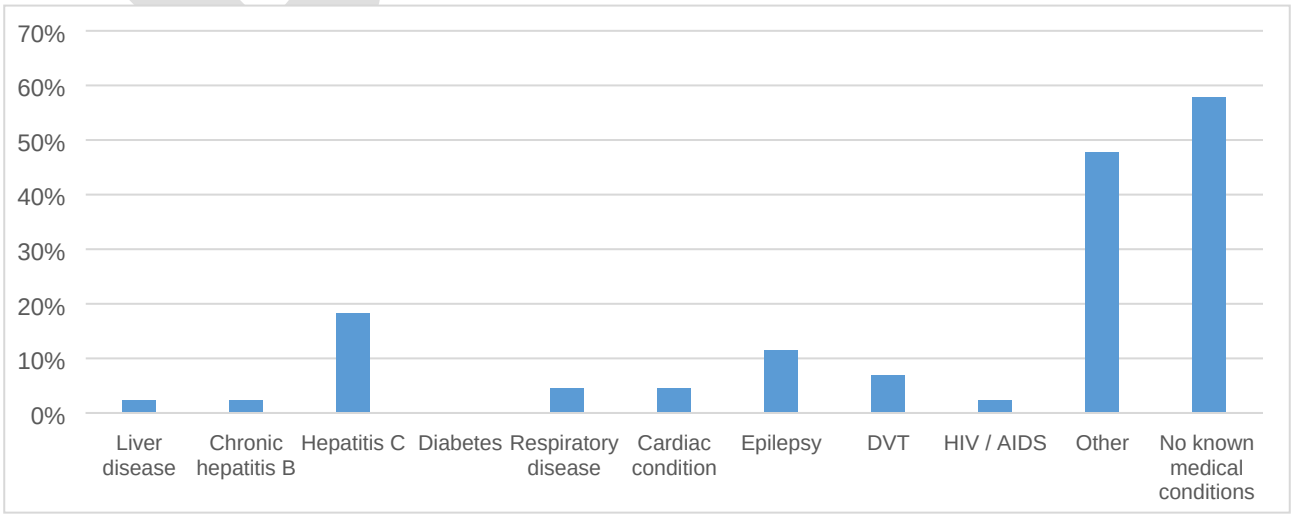
By far the most common problems experienced were mood disorders. Several individuals suffered from anxiety-related problems, in combination with depression. Only 20 people had no known psychiatric conditions at the time of their deaths:



Furthermore, 14% of drug-related death victims (compared to 7.5% in 2017) were known to have self-harmed at some point in the past, and 16% (compared to 13.6% in 2017) were noted to have attempted suicide at least once. These figures need to be taken with caution however due to the quality of reports available; they may not represent a true picture of the situation. Nevertheless, given the seemingly large percentage increases, it would be prudent to investigate this further and may provide scope for more detailed partnership working with mental health services.

1.3.3 Physical Health Problems

Physical health problems are also highlighted within this cohort. Of those with known physical health problems,18% of people had a diagnosis of Hepatitis C at time of death and 11% suffered from epilepsy.



These types of illnesses, especially respiratory and cardiac, would increase the likelihood of succumbing to opioid overdose due to the mechanism of opiate type drugs and how they act upon the body.

1.4 Substance Use Histories

The present section further examines the substance use histories of the drug-related death victims; including the age at which they started using illegal substances, lifetime injecting characteristics and overdose histories.

The chart, *Figure 9*, shows the different substances reported in police reports and pathology reports that were used by this cohort. There is little information to discern how habitual use was and these reports are taken from statements given at the time and by evidence discovered at the scene. It does, however, give an indication of the most commonly used substances which may be implicated in a drug-related death.

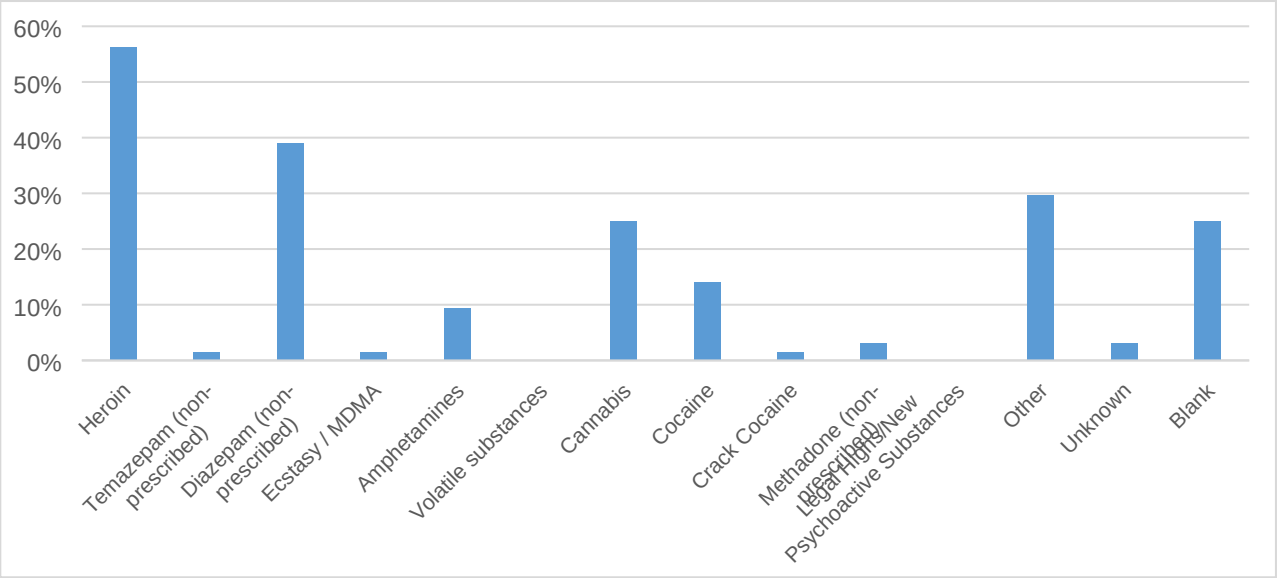


Figure 9

Unsurprisingly, CNS depressants such as heroin and diazepam feature prominently in the types of substances used. If these types of substances are taken by someone who is also suffering from poor medical health such as discussed previously then this will heighten the chance of death from overdose occurring.

The rise in stimulant drugs such as cocaine is consistent with anecdotal reports of increased usage in some parts of Fife during the reporting period.

1.5 Contact with Criminal Justice

People with problematic substance use are far more likely than average to encounter our justice system. Offences are typically low level, acquisitive offending (e.g. shoplifting, burglary, robbery).

20% of drug-related death victims had been in police custody within 6 months prior to death.

Of those that are known to have been in prison previously, all died within 7 months of being released.

1.6 Circumstances of Death

The present section summarises the circumstances of the drug-related deaths in Fife in 2018, including the months of the year and days of the week that the deaths occurred, as well as specific information concerning the scene of the death, such as the presence of others and attempted interventions.

1.6.1 Month of the Year

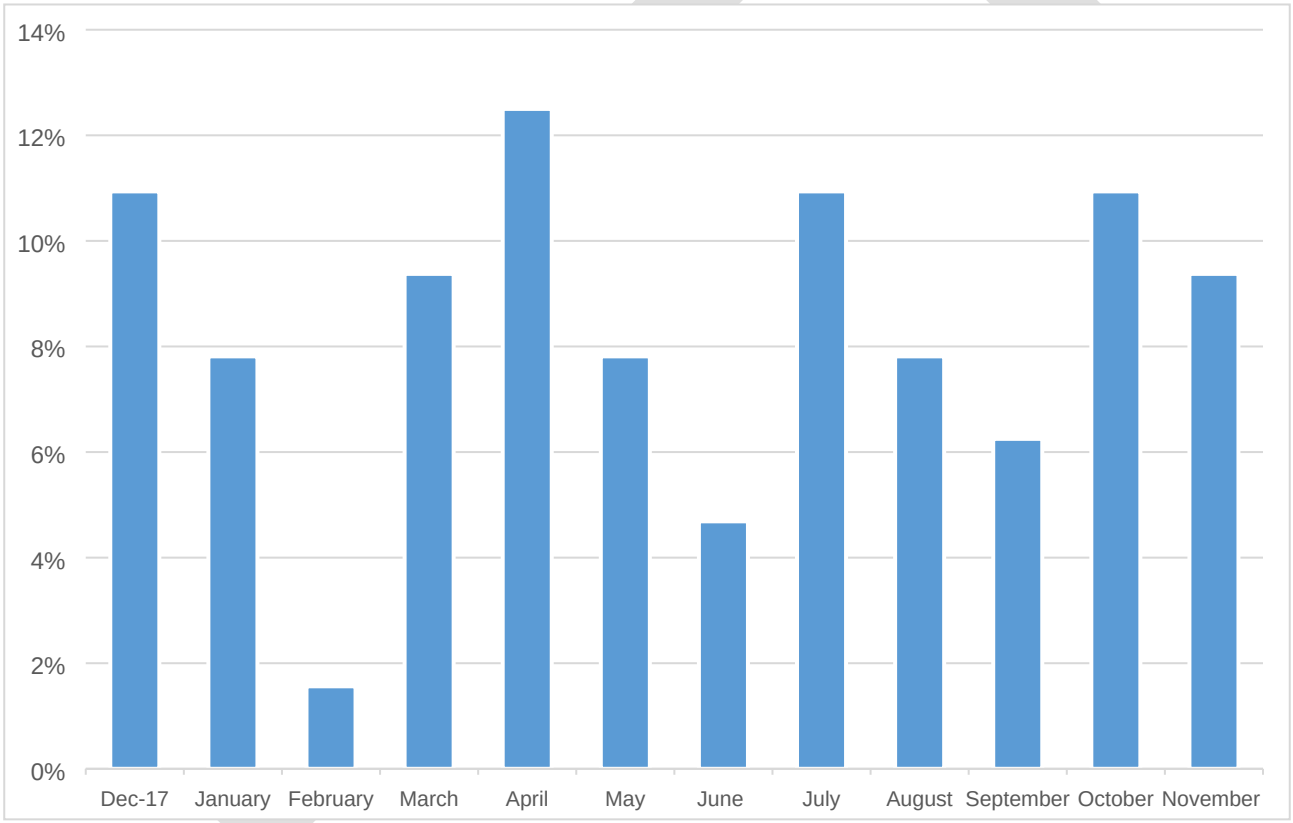
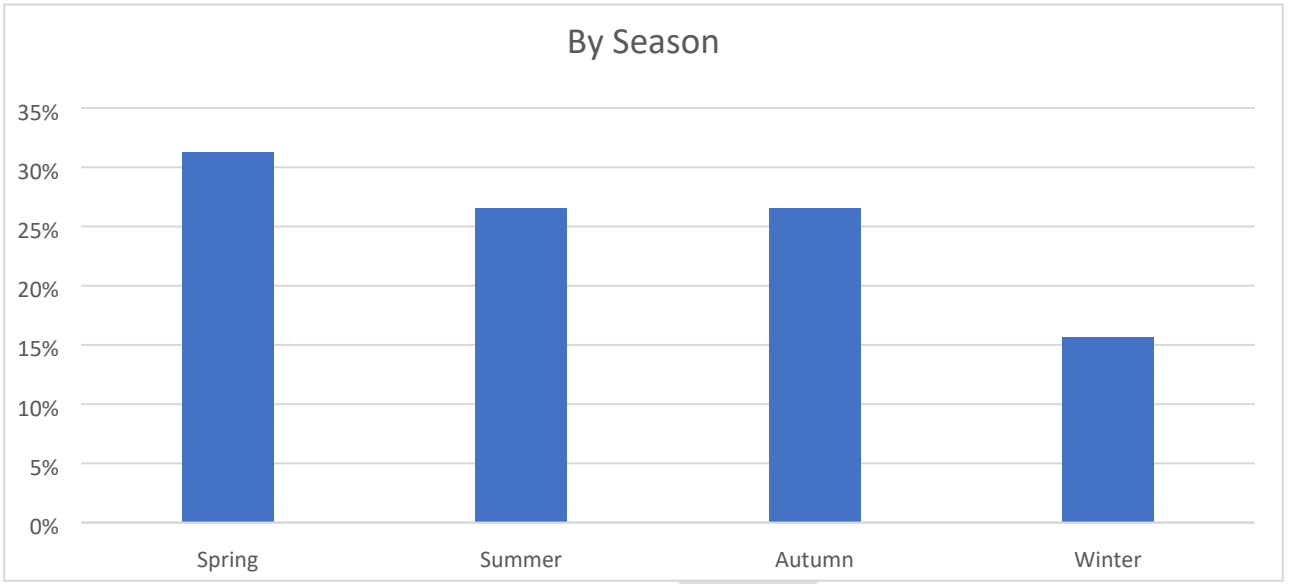
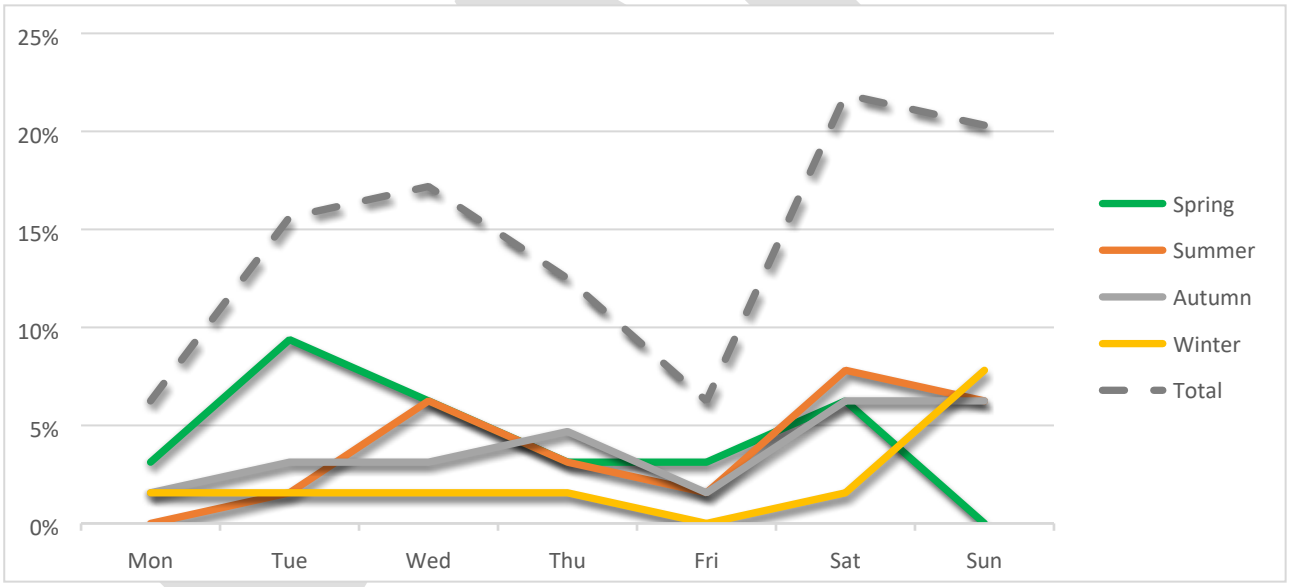


Figure 10

As can be observed from the above, there appeared to be no discernible monthly trend in the number of drug deaths during 2018 although there are months where a peak can be seen. The lead up to summer may suggest a trend, however May and June where one may expect the peak to plateau, a drop is seen. Similarly, a peak can be witnessed on the lead up to Christmas which drops off immediately before, in December. There could be many reasons behind this pattern but without substantiating evidence can only be offered as conjecture and therefore not outlined within this report.

April saw the largest number of deaths (13%), followed by December, July and October (11%). Tuesdays, Wednesdays and Saturdays being the days of the week when most deaths occurred.





1.6.2 Circumstances of Death

The circumstances surrounding the individual deaths were considered, including whether others were present at the time of death, if bystanders recognised common signs of overdose and what, if any intervention was employed.

From reports, we know that someone else was present in 53% of the deaths This means that others were at least present in the same premises as the victim during the episode of their death. As many as 28 of the 64 deaths occurred whilst someone known to the victim was in the same room. In all cases, the individuals present were known to the victim. The relationships of those persons present were: friends, partners or close family members.

1.6.3 Snoring Immediately Prior to Death

It has been noted that individuals often are observed to be snoring prior to a visible adverse reaction to the drugs they have consumed, however, whilst this was mentioned in several death reports, the witnesses assumed the person was simply asleep and, tragically, left them sleeping.

Individuals present were known to have checked on the drug-related death victims, sometimes on several occasions, under the assumption they were sleeping.

Whilst most cases did not report information on snoring, it may well be that it did not appear significant to those who were present (and of course would not have been identified in those cases where individuals died alone). However, awareness of such warning signs of an overdose may assist individuals in identifying overdose and intervening to prevent them becoming a drug fatality.

1.6.4 Interventions Attempted at the Scene

Of cases in 2018, just under half (45.3%) had some form of cardio-pulmonary resuscitation (CPR) attempted. It is unclear whether this was performed by Ambulance staff or by witnesses. It was clear from many of the sudden death reports that the victim's heart would have been stopped for a while before CPR was attempted, and CPR was unlikely to be successful.

Evidence of the victim having supplies of Take-Home Naloxone can only be gleaned from police sudden death reports and can only be confirmed in 3 cases. In 1 of those 3 cases, the THN kits were used prior to Ambulance staff attending the scene.

1.7 Toxicology Results of Drug-Related Deaths in Fife 2018

This section describes the post-mortem toxicology findings of all 64 drug-related death cases in Fife in 2018. This section also highlights the prevalence of prescribed medication in the drug-related deaths occurring in Fife.

Table of implicated/contributory drugs

Drug group	Fife	Scotland
Benzodiazepines	61%	67%
Gabapentinoids	81%	31%
Cocaine & related	25%	23%
Opioids	83%	86%

Post mortem toxicology reports of all 64 individuals were analysed to gain a greater insight into the types of substances that led to the fatal overdoses.

Forensic toxicologists currently conduct blood/urine tests for the substances believed to be implicated in the drug death. A typical blood test usually tests for; basic drugs, acid/neutral drugs, benzodiazepines, non-steroidal anti-inflammatory drugs (NSAIDS) and Morphine. Urine samples are analysed for opiates, amphetamines, cannabinoids, cocaine, benzodiazepines, methadone, barbiturates, tricyclic antidepressants (TCA), MDMA and methamphetamine. Other tests can be performed if the pathologist feels it is an appropriate test; for example, presence of identified substances found at the scene, known presentation of the victim, circumstances around the death etc. Not all misused substances can be tested for, and this is a particular issue when considering the NPS whose structure is continually being modified. Consequently, only those substances tested for are likely to be detected in the toxicology, potentially biasing the outcome of toxicology findings.

Where an identified NPS is detected in toxicology, the relevance of the presence of these substrates to contribute to fatalities is currently not well understood. Further research on this would improve understanding on the toxic levels of NPS.

1.7.1. Toxicology results

Toxicology reports generally include a reference for the “therapeutic” and “fatal” ranges of a substance, based on existing literature available to the toxicologist. However, these are often based on relatively small sample sizes, and do not consider the possibility of poly-drug use. The latter is particularly important, as the entire drug deaths in Fife occurred as a result of multiple substances.

An individual’s own tolerance to a substance should also be considered when interpreting toxic substance levels as this will vary depending on the history of illicit drug use in any particular individual.

The actual amounts of the drugs observed in drug deaths victims in Fife are often lower than the published fatal and even therapeutic ranges of any given drug. This highlights the

importance of the cocktail effect, and the above values continue to raise questions about the clinical utility of the designated 'fatal' and 'therapeutic' levels. Furthermore, as the age of individuals who die of a drugs death is increasing, personal underlying pathology may make the individual more susceptible to death at a lower level of substance exposure.

Figure 11 shows all substances which were present in the toxicology results of the drug-related death victims in Fife, 2018. The graph shows the number of victims who were found with each substance in their toxicology results. In cases multiple substances were present in toxicology hence the sum of all substances found is greater than 64.

Gabapentinoids were the most common substances other than opioids present in drug deaths in Fife in 2018 (present in 81% of all DRDs). Only 2 people had one detectable substance present in their system at time of death, the majority of DRD's testing positive for multiple substances.

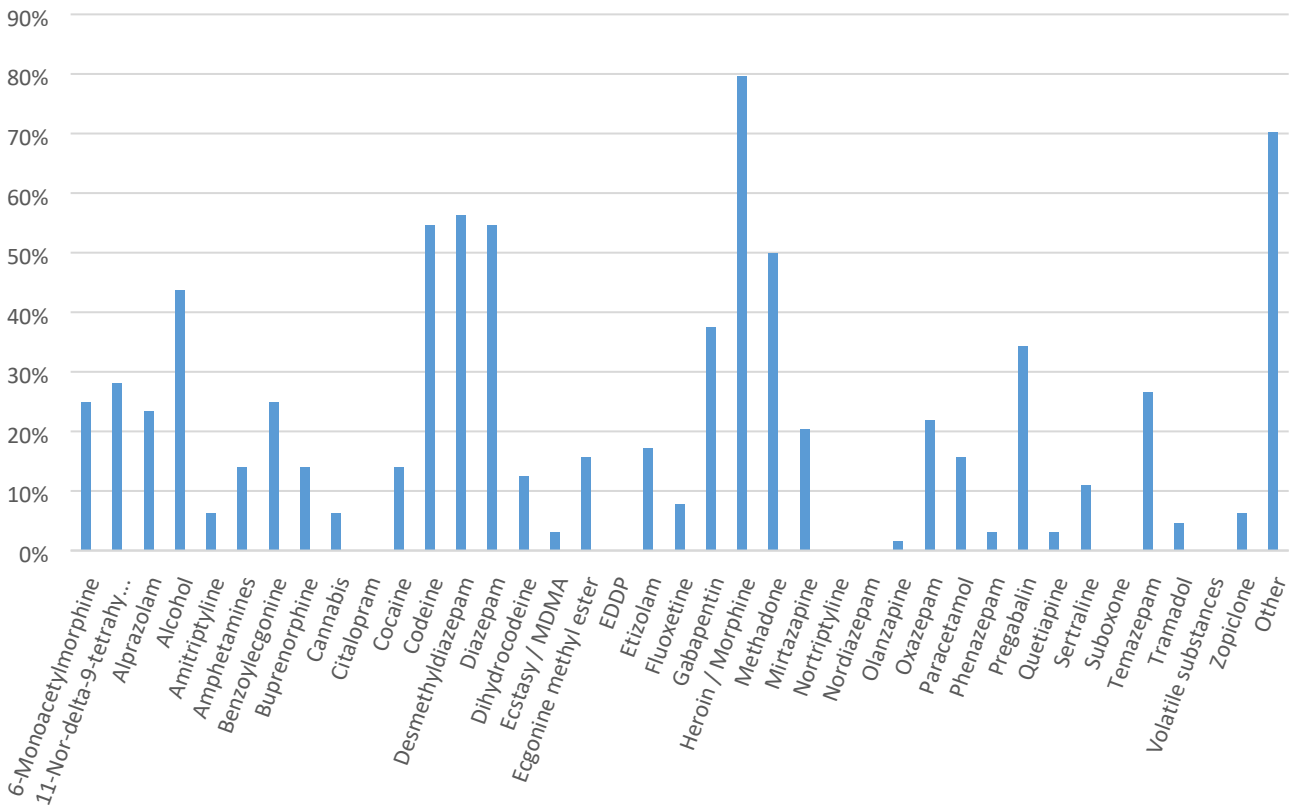


Figure 11

1.8 Conclusion and Reflection

There is currently a national focus on reducing drug-related deaths in Scotland. As well as the introduction of a human rights-based approach to drug and alcohol treatment services by the Scottish Government with the publication of their *Rights Respect, Recovery* policy document, a number of associated publications and social events have attempted to direct this work.

In 2019, the Dundee Partnership published the Dundee Drugs Commission paper, *Responding to Drug Use with Kindness, Compassion and Hope* and The Scottish Drugs Forum refreshed their *Staying Alive* document and *#StopTheDeaths* campaign. Other groups have held candlelit remembrance vigils for those who suffered a drug-related death to raise public awareness and reduce the associated stigma surrounding addiction and drug use.

Fife ADP, through its Overdose Prevention and Drug Death Monitoring subgroup have put in place several strategies to stabilise and reduce drug-related deaths in Fife. The most prominent of these are listed below:

1. Near-fatal overdose response
   Evidence shows that those people who go on to suffer a drug-related death have previously experience a near-fatal overdose. Since April 2019, Fife ADP has been working in collaboration with Scottish Ambulance Service and ADAPT to identify those people who suffer a near-fatal overdose and provide an assertive outreach service with the intention of introducing treatment options. This pilot has so far introduced 25 people into treatment with another 26 with pending appointments. Out of 82 total referrals, only 6% have opted out. This pilot will continue to be monitored for efficacy and financial viability.

2. REACH Hospital Liaison Team
   Due to start in December 2019, Fife ADP commissioned a multi-disciplinary co-located service based at Victoria Hospital. This team will identify those people who frequently access hospital services including Accident and Emergency due to their substance use.

3. Naloxone
   Fife ADP has developed a naloxone strategy for Fife and created an associated workplan. Naloxone is a fundamental part of Fife's harm reduction strategy and nationally, is a key component in the fight to reduce drug-related mortality. Fife ADP are working closely with locally commissioned services and the Scottish Drugs Forum's National Naloxone Lead to implement the strategy.

4. Drug-Related Death Database Coordinator
   In 2019, Fife ADP recruited a dedicated drug-related death coordinator in order to gain a better understanding of the demographics and attributes of those who may go on to suffer a drug related death as well as assist in the development of strategic responses.

Fife ADP and its partners will continue to work with local and national organisations to reduce the number of drug-related deaths in Fife.

Report End

Section 2: Appendices

2.1 Fife Overdose Prevention & Drug Death Monitoring Group

2.1.1 Background

The Fife Overdose Prevention & Drug Death Monitoring Group (OPDDMG) is a multiagency strategic group reporting to the Fife Alcohol & Drugs Partnership (ADP). It combines the previous Overdose Prevention Group and the separate Drug Death Monitoring Group, and its aim is to make a major contribution to the reduction of drug-related deaths (DRDs) and non-fatal overdoses (NFOs) in Fife. The group will identify, support and develop initiatives that improve the quality of services and reduce the risk of drug-related death and non-fatal overdose in vulnerable people.

This report summarises the findings of drug deaths that occurred in Fife in 2018.

2.1.2 Aims and Objectives

The principal aim of this report is not to scrutinise individual drug deaths but to look at trends in terms of substances used, demographics, gender, age, and service engagement to gain an overview of the current picture affecting people in Fife. All data is taken from Police Scotland sudden death reports, pathology reports, service responses, and National Records of Scotland (NRS) Drug-related Deaths in Scotland 2018 publication.

This report will be discussed by the OPDDMG to develop recommendations and a strategic response which will be reported to the ADP for consideration.

2.1.3 Methods

The population of DRDs in Fife in 2018 consisted of 64 cases. Information about these deaths were collected via dissemination of the Fife Drug Deaths Questionnaire and/or case notes held by social care services, specialist addiction services, general practice, prison and police services e.g. Scottish Criminal Records Office (SCRO). Data relating to the specific cause of death, post-mortem and toxicology was obtained from the Forensic Medicine Unit, Laboratory Medicine Edinburgh Royal Infirmary. Due to unavoidable staffing and capacity issues within the ADP Support Team at the time, the data within this document was mainly gathered from police and pathology reports.

2.1.4 Governance and structure

Due to nationally and locally rising drug-related deaths and new challenges such as the increasing availability of novel psychoactive substances (NPS) including the increased use and availability of gabapentinoids and non-traditional benzodiazepines, Fife's two groups merged to form the current Overdose Prevention and Drug Death Monitoring Group. This group reports directly into the ADP Committee and during 2018 subsumed Fife's Naloxone Group (***Figure 12***)

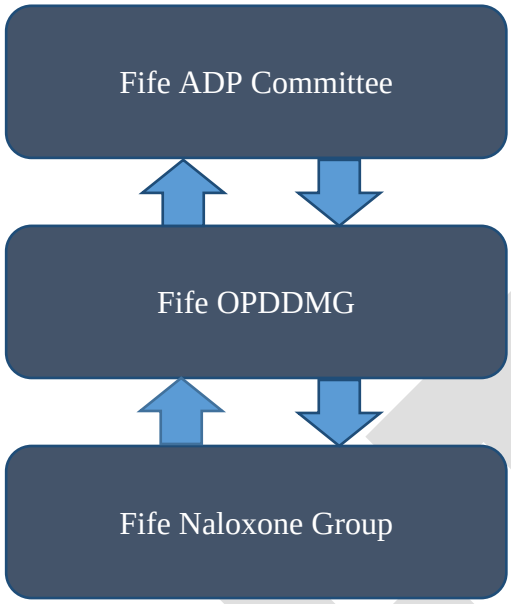


Figure 1

2.1.5 Mission Statement

The mission statement of the Fife OPDDMG is to facilitate a **"Fife wide multi-agency approach to understanding and preventing drug-related deaths**."

2.1.6 Ethos and Philosophy of Fife OPDDMG

The group has two principal functions:

The first aims to determine common demographic, social, criminal offending, substance misuse, physical, psychiatric/psychological, service use characteristics and circumstances of drug deaths. This is accomplished through the dissemination of an in-depth questionnaire to all agencies. All services are notified of a suspected drug death and are asked to provide information about those individuals that they have had contact with. Therefore, all agencies involved in the provision of a service to the Drug Death (DD) victim form the *monitoring* component of the group.

The second element uses the information gathered to draw upon trends, similarities, and key themes arising from the drug deaths and aims to formulate strategic action plans to address these issues to reduce the number of drug deaths in Fife. This aim fulfils the purpose of the strategic component of the group. Thus, in line with national recommendations, the strategic and/or overdose prevention group endeavours to inform and disseminate good practice and enhance the provision of care to reduce the growing number of Drug Deaths in Fife.

2.1.7 Recommendations arising from the OPDDMG

Section 3 considers the information gathered on all 64 individuals who died of a drug death in Fife 2018. This section is split into 8 sub-sections to allow different characteristics to be examined separately; key points are identified at intervals during each section to summarise the information.

I The OPDDMG will discuss this report and make recommendations for future strategic development. All recommendations, when identified will be reported to the ADP Committee for final approval.

2.2 Definition of a Drug-Related Death

The definition of a DRD is complex, with individual studies adopting specific definitions, which vary depending upon the focus of the study.

The NRS definition includes instances in which toxicological findings indicate the presence of a controlled substance, but where this substance may not necessarily have been a factor contributing to the individual's death.

Any deaths directly resulting from the overdose of a drug listed under the Misuse of Drugs Act 1971 and relevant amendments in the year 2017 have been included and considered in this report. In 2014, tramadol and zopiclone became controlled substances under an amendment to this Act, similarly, due to their rapidly increasing usage and contributions to DRDs, the UK Government plans to make gabapentinoids controlled substances following a public consultation in 2019.

The ICD-10 inclusion and exclusion criteria of what constitutes a drug-related death presented below are used by various national investigations into drug deaths, e.g. The National Investigations into Drug-Related Deaths 2003, Drug-related Deaths in Scotland in 2016 (National Records for Scotland) and Drug Misuse Statistics Scotland (Information Services Division, 2008). Subsequently, this report adopts that definition. A full explanation of the definition NRS uses to classify DRDs can be found here: *DRD definition NRS*

2.2.1 Inclusion criteria: ICD-10

Drug Deaths, where the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use';
a)

(i) opioids (F11)
(ii) cannabinoids (F12)
(iii) sedatives or hypnotics (F13)
(iv) cocaine (F14)
(v) other stimulants, including caffeine (F15)
(vi) hallucinogens (F16); and
(vii) multiple drug use and use of other psychoactive substances (F19)

b) Deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death:

(i) accidental poisoning (X40-X44);
(i) intentional self-poisoning by drugs, medicaments and biological substances (X60—X64);
(ii) assault by drugs, medicaments and biological substances (X85) and
(iii) event of undetermined intent, poisoning (Y10-Y14)

2.2.2 Exclusion Criteria

(a) deaths coded to mental and behavioural disorders due to the use of alcohol (F10), tobacco (F17) and volatile substances (F18)

(b) deaths coded to drug abuse which were caused by secondary infections and related complications (e.g. septicaemia)
(c) deaths from AIDS where the risk factor was believed to be the sharing of needles;
(d) deaths where a drug listed under the Misuse of Drugs Act was present because it was part of a compound analgesic or cold remedy, e.g.:
    - Co-proxamol: Paracetamol, dextropropoxyphene
    - Co-dydramol: Paracetamol, Dihydrocodeine
    - Co-codamol: Paracetamol, codeine sulphate

All three of these compound analgesics have, particularly co-proxamol, been used in suicidal overdoses

2.3 Step-by-step Guide to Data Collection

Step 1.

A suspected Drugs Death occurs in Fife, police attend and carry out investigation into the circumstances surrounding the death. The length of the investigation depends upon the individual circumstances and can vary from a few days to several months. Police Scotland also request toxicology from the Procurator Fiscal.

Step 2.

Police informs NHS Fife via the secure Drug Death e-mail address. ADP Support Team email relevant agencies to inform them of suspected DRDs in order they may complete internal or outstanding paperwork.

Step 3.

Agencies check records to see if the individual has accessed their respective services. If the individual is known to a particular agency, the Drug Death Questionnaire is completed by that agency and returned to the ADP Support Team.

If Individual is not known to the agency, a nil return is sent.

The Forensic Medicine Unit, Laboratory Medicine Edinburgh Royal Infirmary send post-mortem/toxicology reports of all deaths where the individual was a known drug user to the secure Drug Death e-mail address.

Step 4.

ADP Support Team enters all collected data into ISDs NDRDD.

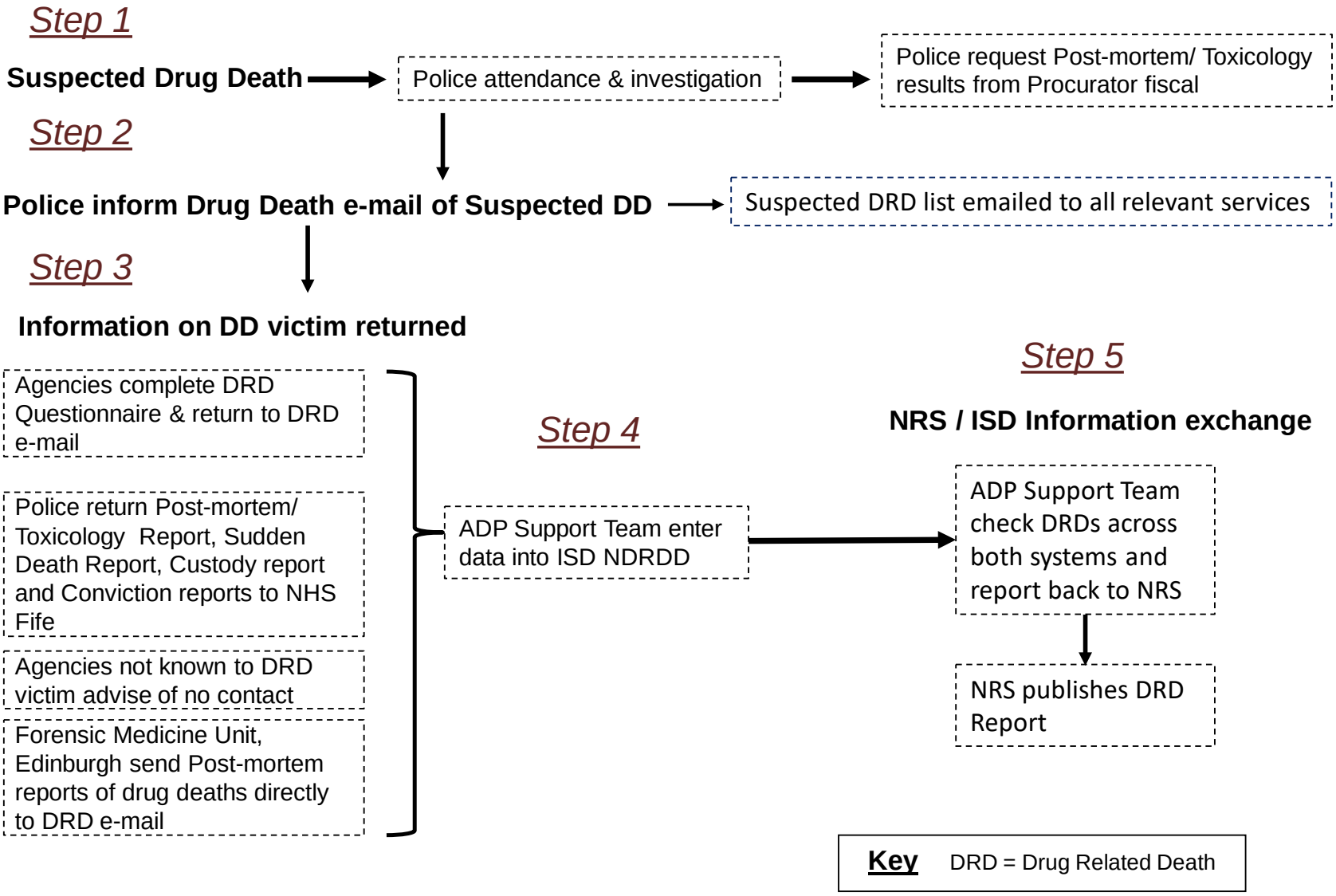
Step 5.

Three times a year, NRS publish interim drafts of data they hold on DRDs to date. Fife ADP Support Team cross reference this data with locally held data which has been submitted to ISD NDRDD and inform NRS of any additional or missing information.

NRS publish their report approximately six months after the year end. The NRS report runs from January to December.

ISD will publish their report on the years 2017 – 2018 in 2020.

Guide to the information gathering process 2018



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Abbreviations

ADP – Alcohol & Drug Partnership
NHS – National Health Service
ISD – NHS Information Services Division
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction
DWP – Department for Work & Pensions
NRS – National Records of Scotland
SDF – Scottish Drugs Forum
ADAPT – Alcohol & Drugs Assessment Partnership Team
DRD – Drug-related Death
NFO – Near-fatal Overdose
OPDDMG – Overdose Prevention & Drug Death Monitoring Group
NDRDD – National Drug-related Death Database
SIMD – Scottish Index of Multiple Deprivation
ACE – Adverse Childhood Experiences
NFA – No Fixed Abode
CPR - Cardio-pulmonary Resuscitation
THN – Take-home Naloxone
NPS – Novel Psychoactive Substance

Clinical Governance Committee

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Fife Orthopaedic Elective Centre Outline Business Case
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Alan Wilson, Project Director

Purpose of the Report (delete as appropriate)		
For Decision	~~**For Discussion**~~	~~**For Information**~~

SBAR REPORT

Situation

NHS Fife has instigated the next stage of the Scottish Capital Investment Manual (SCIM) process for the development of a new Elective Orthopaedic Centre. This involves the production of an Outline Business Case (OBC) that needs to be submitted to the Scottish Government Health & Social Care Directorates (SGHSCD) Capital Investment Group (CIG) for consideration at their November meeting, in line with the current programme.

The OBC is presented to the Finance, Performance & Resources Committee to provide overall assurance and governance of the project, with particular reference to the management, financial, commercial and economic cases.

The OBC is presented to the Clinical Governance Committee for consideration of all clinical, quality and safety issues, with particular reference to the strategic and management cases.

Background

The new Elective Orthopaedic Centre construction project has key milestones set out within the Outline Business Case to deliver the project within the time/financial requirements.

Assessment

The Outline Business Case has now been completed and is presented through the NHS Fife internal governance processes for approval. The new facility has been designed to the level needed at this stage of the Scottish Capital Investment Manual (SCIM) process and signed off by all relevant stakeholders.

The current design has now been frozen and a cost plan has been produced and agreed with the Principal Supply Chain Partner to provide assurance on affordability. The costs are still within the original budget albeit there has been an inflationary increase to cover the period from when the original cost plan which was done in October 2017 until anticipated construction completion in March 2022.

The OBC incorporates the addition of outpatient, pre-assessment and radiology services within the design that will support elective orthopaedic service. This was not originally anticipated at the Initial Agreement stage but we have managed to achieve this within the financial envelope.

Recommendation

Members are asked to:

- **Note** the Outline Business Case has been submitted to SGHSCD Capital Investment Group for consideration at their 12 November meeting, subject to formal approval by the NHS Board on 27 November.
- **Recommend** approval of the Outline Business Case to the NHS Board on 27 November.

Objectives: (must be completed)	
Healthcare Standard(s):	All
HB Strategic Objectives:	All
Further Information:	
Evidence Base:	
Glossary of Terms:	SCIM – Scottish Capital Investment Manual OBC – Outline Business Case CIG – Capital Investment Group IAD - Initial agreement Document HFS – Health Facilities Scotland JCA – Joint Cost Advisor PSC – Professional Service Contract PSCP – Principal Supply Chain Partners
Parties / Committees consulted prior to Committee Meeting:	Fife Capital Investment Group Executive Directors Group
Impact: (must be completed)	
Financial / Value For Money	Increase in costs/ unable to meet all service needs if costs increase.
Risk / Legal:	Failure to meet key milestones causing delay in business case process.
Quality / Patient Care:	Potential quality issues/ Delays leading to inadequate facilities.
Workforce:	Ability to recruit extra staff needed to utilise facility to its maximum potential.
Equality:	Potential failure to meet equality standards needed for new facility through funding issue

October 2019

OBC

Fife Elective Orthopaedic Centre
NHS Fife

Proposed Fife Elective Orthopaedic Centre (Image provided by Norr Achitects)

Alan Wilson, Project Director

Victoria Hospital, Kirkcaldy

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Contents

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Appendix K – Cost Plan Extract

Appendix L – Benefits Register

Appendix M – Benefits Realisation Plan

Appendix N – Risk Register

Appendix O – Communication Plan

Rev	Originator	Approved	Date
0 – DRAFT / Comment	Ben Johnston	Draft for comment	4 October 2019
1 – DRAFT / Comment	Ben Johnston	Draft for comment	10 October 2019
2 – DRAFT / Comment	Ben Johnston	Draft for comment	14 October 2019

Glossary of Terms

AEDET	Achieving Excellence Design Evaluation Toolkit
HAI	Healthcare Associated Infection
IA	Initial Agreement
DC	Day Case
IP	In patient
FBC	Full Business Case
GIFA	Gross Internal Floor Area
GIRFT	Getting it Right First Time
GP	General Practitioner
HFS	Health Facilities Scotland
KPI	Key Performance Indicator
MSK	Musculoskeletal
NDAP	NHSScotland Design Assessment Process
NEC	New Engineering Contract
OBC	Outline Business Case
PSC	Professional Services Consultant
PSCP	Principal Supply Chain partner
QMH	Queen Margaret Hospital, Dunfermline
SA	Strategic Assessment
SCIM	Scottish Capital Investment Manual
TTG	Treatment Time Guarantee
VHK	Victoria Hospital, Kirkcaldy
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

This proposal sets out the strategy for re-provision of the elective orthopaedic service at Victoria Hospital, Kirkcaldy (VHK). The existing orthopaedic service provides a dedicated environment in which patients within the catchment of Fife can be treated. The service currently performs extremely well, demonstrating a high level of attainment against relevant benchmarks and KPI's but is held back by condition and functionality of the existing environment in which the service is provided from. The investment proposal therefore seeks to maintain current performance levels whilst safeguarding the service over the longer term via the provision of a sustainable healthcare environment. This will be delivered by providing a standalone Fife Elective Orthopaedic Centre at Victoria Hospital in Kirkcaldy incorporating theatres, inpatient and outpatient accommodation.

The accommodation has been developed from the IA (IA) stage in collaboration with stakeholder representatives. Notwithstanding the introduction of two new radiography rooms (previously unscheduled) to support the service, net usable area has been controlled within the original allocation. Gross area has increased marginally however to accommodate a covered rooftop plantroom accommodating critical equipment. Given the recent climate in respect to mechanical and electrical systems, this measure is considered a sensible investment.

In respect to cost, whilst there has been an inflationary rise since IA, taking account of this, the costs are reported to be on budget at this stage with reasonable contingencies allocated to control development of the design through FBC.

1.2 Strategic Case

The Strategic Case remains valid and has not changed since the IA.

1.2.1 Existing Arrangements

The existing service consists of 2 laminar flow theatres and a dedicated 24 bed ward provided from the "phase 2" tower bock within VHK. Over and beyond, orthopaedic outpatient services are provided from Queen Margaret Hospital in Dunfermline and VHK.

Currently, surgery time runs from 09:00 to 17:00 Monday to Friday with additional provision on Saturdays where demand dictates. Two 3.5 hour sessions are scheduled each day. To provide a general perspective, 4 major joint operations can be performed in a day. Through working on Saturdays up to 22 sessions can be performed in a week.

From a utilisation and performance perspective the service performs extremely well against all benchmarks and KPI's – further details in this respect can be found at Section 2.2.

The condition and functionality of the existing assets is below the standard expected and is non-compliant in respect to current healthcare guidance (SHTMs and HBNs). The tower block at VHK was constructed in 1967 and the existing main services infrastructure is showing signs of age, increasingly risking service provision and continuity. The service is regularly disrupted because of infrastructure failures. There is no quick fix available (i.e. localised refurbishment) that would allow the service to remain in its current location over the longer term. This investment proposal has therefore been initiated to maintain the current service via the provision of the most effective long-term sustainable solution available within the constraints imposed.

1.2.2 Strategic Context

Through dealing with the need for change, this investment proposal will realise a number of important benefits and these are summarised in the table below:

Need for change	Anticipated benefits
▪ Current ward provision does not support infection control, safety and the overarching strategy to move towards single room accommodation.	▪ Positive patient experience and dignity respected
▪ Current accommodation does not support effective patient pathways / flow with bottle-necks arising. Situation affects efficiency of service provision.	▪ Maintain support to allow people to live independently together with life quality. Overarching benefit
▪ Current provision compromises patient dignity and quality of experience overall.	▪ Improves the healthcare state (condition, quality, perception, statutory, back-log and lifecycle)
▪ Condition of existing facilities are below the required standard to support the service over the longer term.	▪ Minimises readmissions (post operation complications) and optimises timely discharge ▪ Optimises resource usage (theatre and bed utilisation) ▪ Improves HAI and patient safety ▪ Community benefits realised from implementation of the investment proposal.

Table 1 - Need for change and benefits

1.2.3 Opportunities

In reviewing the current arrangements and considering the need for change surrounding this investment proposal potential opportunities were highlighted.

1.2.3.1 Capacity to meet future demand

In dealing with the underlying need for change, this investment proposal also seeks to take advantage of an opportunity to increase service capacity to cater for future local demand projections and in doing so reducing any Regional strain particularly in respect to separate elective provision that is being considered. In high-level terms the following accommodation is anticipated to cope with future demand over the next 20 years.

Theatres Current	Theatres Proposed
2 laminar flow theatres	3 laminar flow theatres
Wards Current	Wards proposed
24 beds	33 beds
Outpatient Department Current	Outpatient Department Proposed
11 consulting rooms (variable use)	12 consulting rooms (fully utilised)

Table 2 - Proposed accommodation

1.2.3.2 Colocation of outpatients

Currently Orthopaedic services are delivered across multiple sites within NHS Fife. Working in this manner means there are expected inefficiencies and inconsistency in how some parts of the service is delivered. Clinical time is also lost in asking clinical staff to travel between facilities during the working day. The opportunity to centralise MSK OPD activity within a purpose build facility is appealing and has a potential number of benefits in ensuring the service is delivered in the most efficient way. These benefits are set out at Section 2.2.1.

This investment proposal seeks to pursue this opportunity by making allowance for an outpatient department within the Fife Elective Orthopaedic Centre.

1.2.3.3 Estate rationalisation

In addition to the opportunities noted above another key aspect relates to the long-term benefit of being able to progressively re-provide all clinical services currently within the tower block at VHK. The condition and clinical functionality of the tower block is unsustainable over the longer term. The estimated capital cost to deal with significant clinical backlog within the tower block is £25m, of which £20m relates to repairing the external fabric which has reached the end of its life. Through re-providing clinical services, the Board will be better positioned to implement an option appraisal for the tower block within the context of a VHK masterplan.

1.3 Economic Case

The Economic Case builds upon the initial work presented within the IA where a long-list of options were rationalised into a shortlist of five. The OBC appraises these options in more detail - the non-financial benefits for the options are measured against cost estimates to identify which option represents best value for money. A summary of the results following this exercise is set out in the table below:

	Option 1	Option 2	Option 3	Option 4	Option 5
	As Existing	Refurb. Existing	Refurb other	Modular	New build
Net Present Cost (NPC) - £m	226.7	237	300.1	337.1	303
Weighted Benefit Points (WBP)	545	660	1,250	1,785	2,000
NPC per WBP - £000	416	359	240	189	151
Rank	5th	4th	3rd	2nd	1st

Table 3 - Cost per benefit point for each option

The net present value/cost has been calculated using discounted cash flow techniques on the capital and revenue costs associated with the options as entered into the generic economic model (GEM).

The recommended preferred option as identified at IA stage remains the same for this OBC.

Option 5 – preferred way forward (new-build facility at VHK to meet the current requirements together with added capacity for future demand projections)

1.4 Commercial Case

The Commercial Case has been developed significantly since the IA demonstrating that the proposal is commercially viable. The commercial case covers the following areas:

- The procurement strategy and appropriate procurement route for the Project;
- The scope and content of the proposed commercial arrangement;
- Risk allocation and apportionment between public and private sector;
- The payment structure and how this will be made over the lifetime of the Project; and
- The contractual arrangements for the Project

The project is being delivered using HFS Frameworks Scotland 2 (FS2) which operates using the NEC3/ECC3 form of contract.

1.5 Financial Case

The Financial Case considers the affordability of the scheme, sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment);
- Non-recurring revenue costs associated with the project;
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline; and
- Recurring revenue costs (pay and non pay) for the preferred option.

The assumptions within the Financial Case will continue to be challenged and refined through development of the FBC to ensure capital and revenue affordability.

1.5.1 Capital Costs

A capital cost summary is provided in the table below. More detailed information can be found within the Financial Case (Section 6).

IA Initial	Updated IA* (B)	OBC Cost Plan (C)	Difference (B-C)**
£28,258,368	£30,000,000	£32,155,999	-£2,155,999

Table 4 - Summary of capital costs

* There was agreement between NHS Fife and SCIG to increase the IA budget to take account of car parking re-provision and NHS Fife direct labour costs (previously not accounted for).

** The £2,155,999 difference between the updated IA budget and OBC cost plan is attributed to an inflationary increase (construction costs only) from IA to construction. The Cost Advisor's calculation in respect to inflation can be provided upon request.

Given the notes above, the project is reported as being on budget.

1.5.2 Revenue Costs

A summary of the revenue costs is provided in the table below. Further detail can be found within the Commercial Case at Section 6.

Overall Revenue Costs Summary		**Proposed Option**		
	Baseline	**2025**	**2030**	**2035**
Service Costs	8,379,221	8,953,832	9,847,671	10,901,125
Property Costs	477,452	605,711	664,459	733,698
Total	**8,856,673**	**9,559,543**	**10,512,131**	**11,634,823**

Table 5 - Summary of revenue costs

1.6 Management Case

The Management Case identifies the actions that will be required to ensure the successful delivery of the scheme; it covers:

- Project management arrangements, reporting structure, key roles and responsibilities and project recruitment needs;
- Project Plan;
- Change management arrangements;
- Stakeholder engagement and communication;
- Benefits realisation;
- Risk management;
- Commissioning arrangements; and
- Post project evaluation

The management case confirms that the project is achievable and can be delivered. Key milestones for the project are identified in the table below:

Description / Activity	Date
▪ OBC Approval	Nov. 2019
▪ FBC Approval	Sept. 2020
▪ Construction start	Oct. 2020
▪ Construction completion	March 2022
▪ Completion	March 2022

Table 6 - Milestone dates

1.7 Conclusion and Recommendations

This investment proposal is a key priority for NHS Fife, to safeguard the provision of a high performing, essential clinical service over the longer term. The preferred option will provide the Board with an opportunity to plan for the future, ensuring that the service is robust enough to offer the necessary supply to meet the projected local future demand and to provide a safe, effective and person-centred orthopaedic service. In addition, the preferred option will contribute towards decanting clinical services from within the tower block at VHK unlocking future options within the context of the site masterplan.

A robust stakeholder focussed outline design has been developed that encompasses all of NHS Fife's requirements. The accommodation requirements have broadly been controlled within the constraints set out at IA and notwithstanding some inflationary impact in respect to cost, the project remains affordable and within budget.

The OBC has been delivered within a challenging programme but on time and within budget providing confidence in respect to delivery of subsequent stages. Approval of this OBC will ensure that progress can be made at pace towards the development of this critical project.

2 Strategic Case

2.1 Introduction

The main purpose of the Strategic Case at OBC stage is to confirm that the background for selecting the preferred strategic / service solution(s) at IA stage has not changed. It will do this by revisiting the Strategic Case set out in the IA whilst responding, as appropriate, to the following questions:

- Have the current arrangements changed?
- Is the case for change still valid?
- Is the choice of preferred strategic / service solution(s) still valid?

Section 2.2 responds to each of these questions providing an overview in respect to any key changes since IA.

2.2 Revisiting the Strategic Case

2.2.1 Outpatients

Generally, the Strategic Case has not changed since IA. The key change relates to the inclusion of the outpatient department within the narrative. Previously the strategic case focussed on theatres and wards as the main emphasis of the investment proposal was concerned with re-providing this accommodation due to problems with the building's infrastructure and condition. Orthopaedic outpatient services are provided across Fife at Queen Margaret Hospital in Dunfermline and at Victoria Hospital in Kirkcaldy and are not subject to the same risks.

The schedule of accommodation included within the IA, did however reference outpatient accommodation and through implementing this project there is a great opportunity to combine and collocate the planned orthopaedic service into one facility.

Currently Orthopaedic services are delivered across multiple sites within NHS Fife. Working in this manner means there are expected inefficiencies and inconsistency in how some parts of the service is delivered. Clinical time is also lost in asking clinical staff to travel between facilities during the working day. The opportunity to centralise all MSK OPD activity within a purpose build facility is appealing and has a potential number of benefits in ensuring service is delivered in the most efficient way.

1. Maximising potential efficiencies in new patient flow management;

2. Fulfil aims of the Scottish Access Collaborative and Modern Outpatient Programme

3. Rationalise how some services are delivered (currently trauma fracture clinics are delivered in 10 individual consultant's clinics and capacity is impacted by consultant leave etc). There is potential to rationalise fracture clinic care by the provision of generic clinics five times a week. This is enabled by running clinics from a centralised facility. This will improve the sustainability and planning for of fracture clinic service, allowing greater flexibility in managing variable trauma demand;

4. MDT development. All clinical staff contributing to MSK service delivery will benefit from working within a single facility.

5. Clinical pathway consistency – working form a single clinical hub will ensure pathways are consistently applied to the benefit of the patient;

6. Working from a single unit will promote staff development within the MSK service. By working is a single speciality area staff can be encouraged to upskill and perform enhanced roles (e.g. nurse led fracture clinics); and

7. Staff may be able to be trained to contribute to a number of roles (OPD staff contributing to the pre assessment of patients).

This centralised working is likely to lead to efficiencies in how orthopaedic new patient assessment is undertaken.

2.2.2 Have the current arrangements changed?

The current arrangements have not changed. The strategic case has however been updated to include outpatients as referenced at Section 2.2.1.

The backlog maintenance figures have been updated to reflect the movement in costs since IA.

2.2.3 Is the case for change still valid?

Yes – the case for change remains the same as set out within the IA. The need for change and investment objectives remain unaltered.

2.2.4 Is the choice of preferred strategic / service solution(s) still valid?

The strategic case has not changed therefore the preferred service solution remains valid. In fact, with the decision taken to incorporate outpatients strengthens the case for the preferred service solution as many of the other options could not have accommodated this proportion of accommodation. A standalone new elective orthopaedic centre is therefore the obvious solution.

2.3 Description of Existing Service

The service affected by this proposal is the Fife Elective Orthopaedic Centre which caters locally for the community of Fife providing elective orthopaedic treatment.

The service is located within "Phase 2" of the Victoria Hospital Tower Block in Kirkcaldy and includes 2 orthopaedic laminar flow theatres on the 3rd floor with supporting ward accommodation (24 bed) on the 4th floor. The two floors are connected by a dedicated lift and an adjacent staircase.

Figure 1 – VHK Tower Block

Figure 2 – VHK Tower Block

Plan drawings capturing the existing theatre and ward layouts are referenced in Appendix B for information.

Orthopaedic Outpatient and Pre-assessment services support the overall care provision. These services are currently spread across two sites at Queen Margaret Hospital (QMH) in Dunfermline and Victoria Hospital in Kirkcaldy (VHK). Resources are diluted and duplicated across sites. Staff travelling time compromises clinical time efficiencies. Opportunities exist to improve the efficiency of OPD service by centralising the majority of service within a single purpose-built facility.

Queen Margaret Hospital Outpatient Facilities

- OPD 1 (Ortho)
- OPD 2 (GPwSI)
- OPD 5 (Hands)
- Physio department (ad hoc)
- Treatment room
- Venepuncture room

Victoria Hospital Outpatient Facilities

- OPD 5 (ortho)
- OPD 3 and 4
- Preassessment clinic (Level 8) – 3 rooms/venepuncture facilities/communal education area
- VFC Triage room
- Physio department (ad hoc)
- Two treatment rooms

2.4 Existing Service Arrangements

The service currently performs extremely well, demonstrating a high level of attainment against relevant benchmarks and KPI's as demonstrated below.

2.4.1 Care Pathways

The patient journey is normally initiated through a GP referral. Thereafter specialist clinics triage the patients prior to listing for surgery. The twelve-week Treatment Time Guarantee (TTG) sets out the requirement for patients to receive treatment within twelve weeks from the point of being diagnosed and agreeing to treatment.

The beds allocated for the service are protected which facilitates an improved patient flow and as a result ensures fewer cancellations. NHS Fife have recently introduced advanced nursing practitioners to support the ward, therefore the ward is not reliant on either rotating junior doctors or locum medical staff. This ensures standardised and consistent care. The clinical and financial benefits of protected beds are well documented (GIRFT Report, March 2016), these include; reduced infection, shorter length of stay and better patient flow with fewer cancellations. As testament to this, NHS Fife is one of the 40% high performing hospitals which manage four daily knee or hip replacements through its elective theatre lists.

From the point of receiving elective orthopaedic treatment in Fife the patient can stay on the ward for circa four days for major joint replacements (hips/knees). This is however amongst the shortest lengths of stay in Scotland (refer to figures 3 and 4 below) demonstrating the excellent service efficiencies.

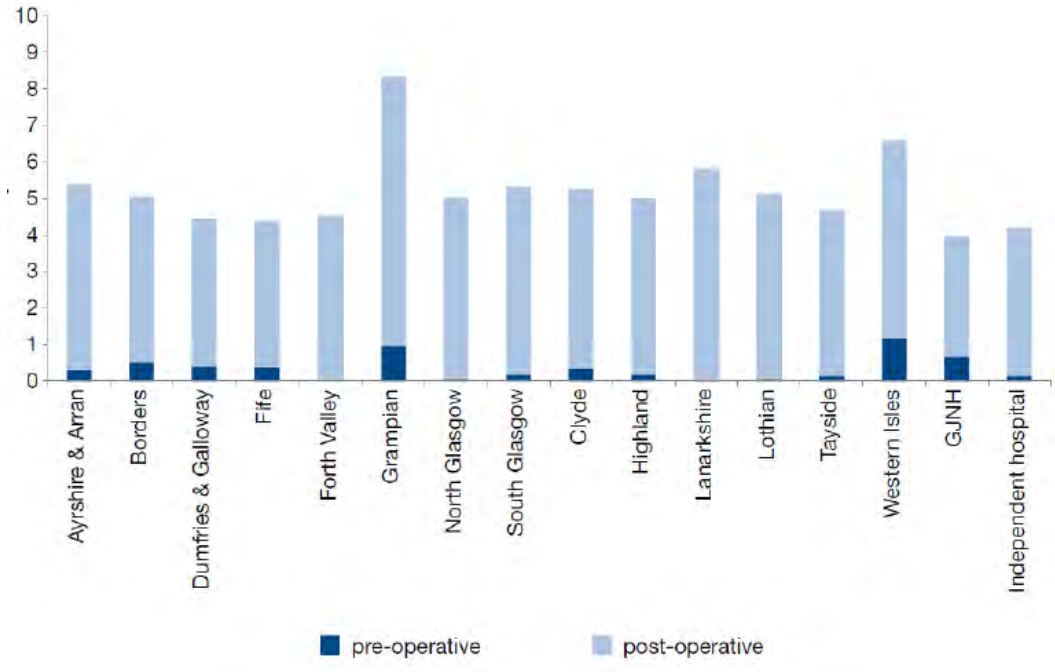


Figure 3 – Average (days) Pre/Post Operative Length Stay – Hip Replacements (2015)

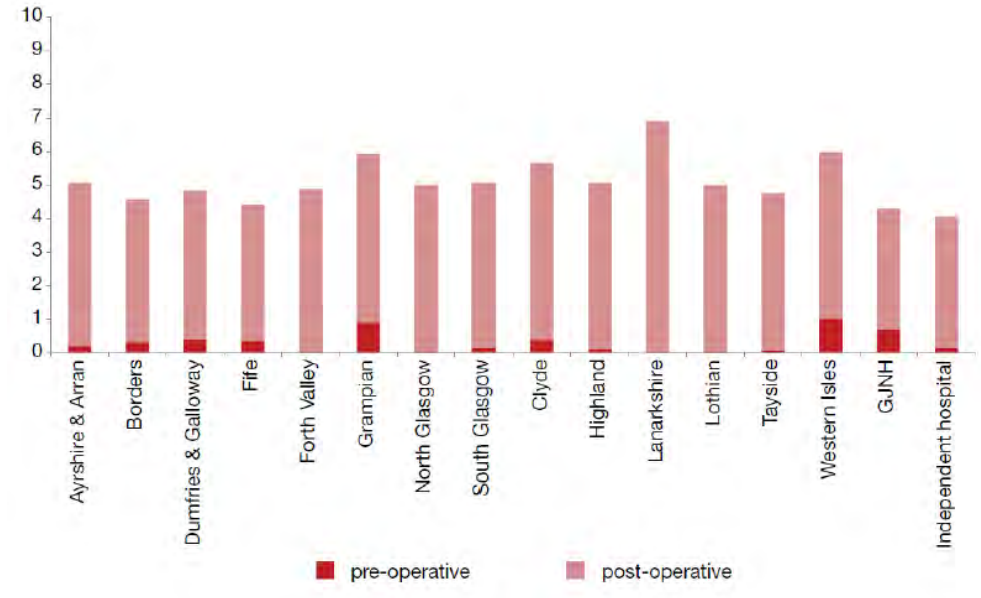


Figure 4 – Average (days) Pre/Post Operative Length Stay – Knee Replacements (2015)

2.4.2 Patterns of Working

2.4.2.1 Theatres

Currently, surgery time runs from 09:00 to 17:00 Monday to Friday with additional provision on Saturday's where demand dictates. Two 3.5 hour sessions are scheduled each day. To provide a general perspective, 4 no. major joint operations can be performed in a day. There are 22 sessions running from Monday to Saturday and the Whole Time Equivalent (WTE) is 16.6 (currently short of 1.0 WTE based on number of sessions covered).

2.4.2.2 Outpatient Department

Total clinic room usage is summarised in the graph below. There are 91 sessions per week. The current job plans have a disproportionate number of sessions at the beginning of the week.

Pre assessment clinics currently accounts for 28 sessions of clinic room utilisation. These clinics run 5 days a week and require approximately 3-4 clinic rooms all day Monday to Friday.

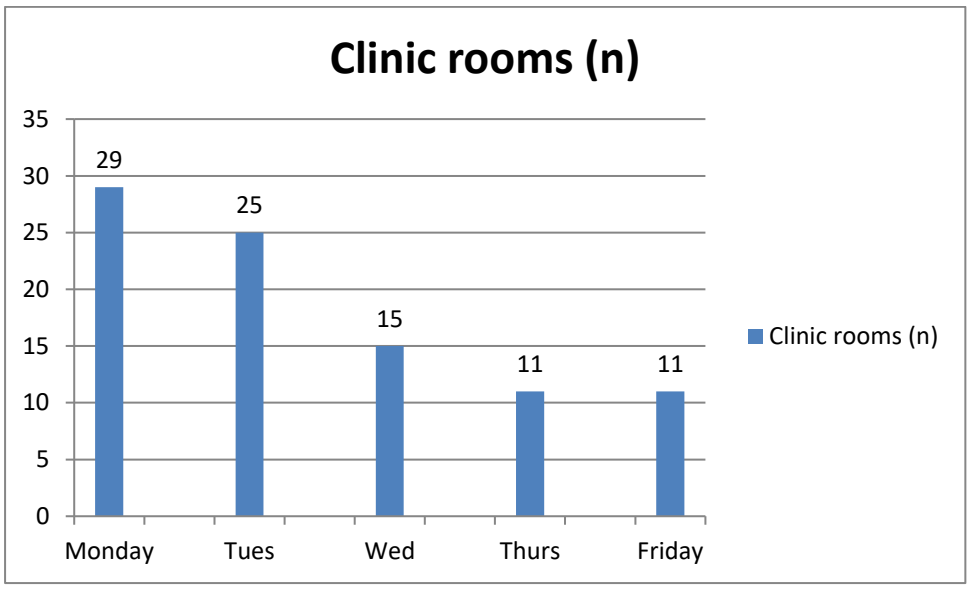


Figure 5 - Clinic room utilisation by day of the week. Each clinic room corresponds to a session (hrs) of clinical activity. Two sessions equates to a clinic room being utilised all day.

2.4.2.3 Wards

The wards facilitate orthopaedic theatre activity and function 24 hours per day, 7 days a week. The available bed numbers reduce from 24 to 16 at weekends. Currently the wards cater for inpatient activity predominantly (90%) as there is no dedicated support for day case activity.

2.4.3 Staffing

2.4.3.1 Theatre Staff

There are currently 22.04 whole time equivalent theatre staff, comprising:

- Band 7 – 1.00
- Band 6 – 1.00
- Band 5 – 11.88
- Band 3 – 2.76
- ODP theatres (band 5) – 2.9
- Anaesthetist – 2.5

2.4.3.2 Ward staff

There are currently 32.46 whole time equivalent ward staff, comprising:

- Band 7 – 1.00
- Band 6 – 1.00
- Band 5 – 17.96
- Band 3 – 1.00
- Band 2 – 6.22
- Physio / OT – 5.28

2.4.3.3 Consultants

There are currently 13.7 whole time equivalent orthopaedic consultants.

2.4.4 Existing Service Capacity

2.4.4.1 Theatres

Based on patterns of working and staffing noted under Section 2.2.2, the theatres are capable of accommodating 22 sessions per week. Two theatres run Monday to Friday (20 sessions) whilst one theatre operates on a Saturday (2 sessions).

No of theatres	Days per week	Sessions per day	Sessions available per week
2	5.5	2	22

Table 7 – Existing service capacity

2.4.4.2 Outpatient Department

Current OPD capacity for NP attendances based on clinic templates for 2018-2019 equate to 12,987 appointments. This includes NP appointments offered by all clinical staff (Cons, ESP, Podiatry, GPwSI). It also includes Virtual Fracture Clinic (VFC) NP referrals.

2.4.4.3 *Wards*

There is currently access to 24 beds within ward 10 made up of six 4-bedded bays. Capacity can be affected by male/female ratios. Furthermore, day cases are restricted due to a lack of dedicated support.

2.4.5 Existing Service Utilisation

2.4.5.1 *Service Utilisation*

The theatres and supporting ward accommodation currently run at capacity utilising the proportion of available hours. Table 1 demonstrates the utilisation rate for all specialities, the figures are an accumulation of both VHK and QMH activity.

	June 2019		July 2019		August 2019	
Session Holder	Unutilised Hours - %	Utilised Hours - %	Unutilised Hours - %	Utilised Hours - %	Unutilised Hours - %	Utilised Hours - %
Cardiology	16.9%	83.1%	7.9%	92.1%	7.6%	92.4%
Ear, Nose & Throat	14.3%	85.7%	15.3%	84.7%	11.7%	88.3%
General Surgery	-1.9%	101.9%	-0.3%	100.3%	-0.2%	100.2%
Gynaecology	3.3%	96.7%	13.2%	86.8%	5.3%	94.7%
Obstetrics	54.7%	45.3%	53.4%	46.6%	55.5%	44.5%
Ophthalmology	10.1%	89.9%	10.4%	89.6%	16.1%	83.9%
Oral-Maxillofacial Sugery	-2.9%	102.9%	-28.7%	128.7%	11.1%	88.9%
Paediatric Surgery	-5.0%	105.0%	-22.0%	122.0%	-1.1%	101.1%
Plastic Surgery	16.0%	84.0%	30.5%	69.5%	22.8%	77.2%
Respiratory Medicine	27.5%	72.5%	21.1%	78.9%	41.8%	58.2%
Trauma and Orthopaedics	-2.0%	102.0%	-0.1%	100.1%	1.0%	99.0%
Urology	6.0%	94.0%	0.9%	99.1%	11.6%	88.4%
Vascular Surgery	39.0%	61.0%	24.9%	75.1%	29.2%	70.8%
Total	17.2%	82.8%	17.5%	82.5%	20.4%	79.6%

Table 8 – Existing service utilisation

2.4.6 Future Projections

2.4.6.1 Theatre demand

Projected future sessional demand for elective surgical in-patient (IP) and day case (DC) activity within NHS Fife is set out below. It should be noted that IP care is currently provided from Victoria Hospital Kirkcaldy whilst DC procedures are delivered from Queen Margaret Hospital in Dunfermline. A more detailed table providing context and assumptions used to project future demand is contained at Appendix C.

	Current	2025	2030	2035
Session demand	1,459	1,722	1,868	1,940
Percentage change	0%	18%	28%	33%

Table 9 - Projected future sessional demand for elective surgical activity

From table 5 it can be seen that by 2035 it is projected that there will be a requirement for an additional 481 sessions representing an increase of 33% against current demand.

2.4.6.2 Outpatient demand

Future demand for OPD NP capacity formed part of the Regional Orthopaedics workgroups 2017-2018, where DCAQ activity for the South East Scotland (NHS Fife, NHS Borders and NHS Lothian) was calculated.

Population demographics described population expansion in all areas. Population expansion was expected to be greatest for the cohort of the population with age of greater than 65. This is important as it is this cohort who form the majority of referrals to MSK services for degenerative musculoskeletal problems. The population changes are described in fig. 6.

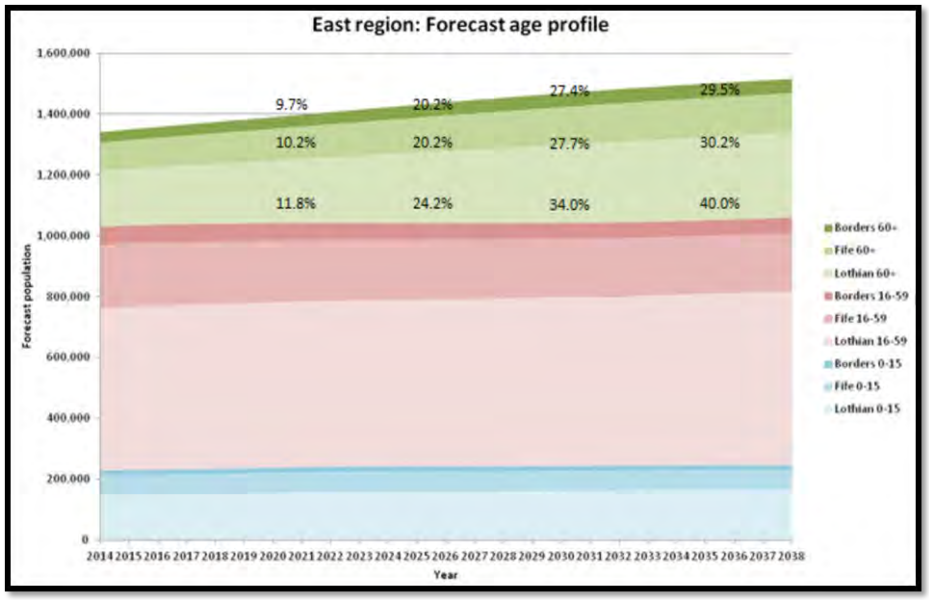


Figure 6 - East Region: Forecast Age profile (presented C Meyers, Acute Workstream Sub Group: Orthopaedic Project Group Workshop 6th Feb 2018)

This is expected to result in an increase in OPD New patient activity (Fig 7). An increase of approximately 6.5% to 10% can be anticipated over the next 20 years. This would equate to an additional 1-2 sessions of NP clinical activity per day across the MSK service if service was to continue to be delivered as it is currently.

Based on growth of arthroplasty in >60 and growth in other demand for <60 years, we feel this is likely to underestimate the increase in new patient attendances for NHS Fife. The true value is likely to be between the 6.5% increase and the 17% indicated for NHS Lothian. For the purpose of projections an increase of 10% is suggested.

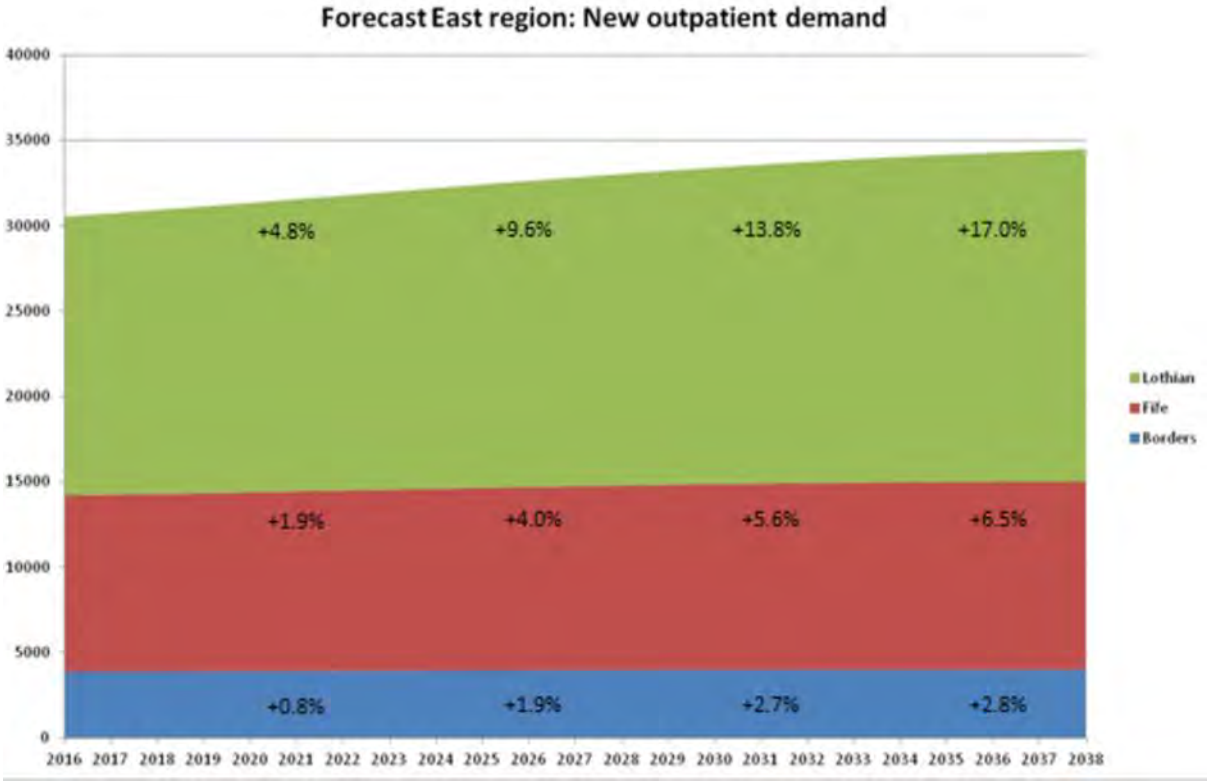


Figure 7 - Forecast East Region: new outpatient demand (presented C Meyers, Acute Workstream Sub-Group: Orthopaedic Project Group Workshop 6th Feb 2018).

2.4.6.3 Wards

In 2022, the Fife Elective Orthopaedic Centre will have a third theatre. This will accommodate hands which is largely a day case activity. Normally they require up to 10 day beds for a full day list. Therefore, the FEOC needs sufficient beds to accommodate:

1. Current and projected elective activity inpatient beds; and

2. A significant increase in day case activity through a dedicated area (hands, day case arthroplasty and other day case procedures).

Inpatient beds need to accommodate increased activity over the next 20 years, but with a decreased length of stay. In respect to total patient bed days it is assumed that these forecast

changes can be accommodated within the current footprint (24 beds). It is projected that an additional 9 beds will be adequate to accommodate increased day case activity over the next 20 years. A spilt of single beds and 4-bedded bays will enable inpatient capacity whilst offering flexibility for an increase in day case demand.

2.4.7 Service Performance

The service is able to demonstrate excellent performance data via a variety of local and national key performance indicators. A high-level overview of relevant performance data is set out below.

2.4.7.1 Getting it Right First Time (GIRFT)

A highly respected peer review (GIRFT NHS Fife Feedback Repot, 26 November 2015) acknowledged and commended the efficient use of orthopaedic theatres in Fife – "the Health Board should be commended for their orthopaedic advanced recovery programme".

2.4.7.2 Bed Optimisation

NHS Fife has lower than average orthopaedic (mixed emergency and elective) beds per consultant and lower beds per 100,000 population. Despite this the Board and Service are able to maintain excellent theatre efficiency.

Indicator	NHS Fife	Scotland
Available beds per consultant	4.6	5.4
Available beds per 100,000 population	16.4	23.2

Table 10 – Table 2: beds optimisation, T&O Dashboard Report

2.4.7.3 Treatment Time Guarantee (TTG)

As a result of current theatre efficiency, NHS Fife is able to demonstrate a significantly better performance than its peers in respect to meeting the Scottish Government's TTG for patients listed for surgery.

Indicator	NHS Fife	Scotland
% of patients not meeting 12 week TTG	0.8	21.7
% of patients not meeting 18 week TTG	9.2	21.5

Table 11 - Inpatient and day case capacity optimisation, T&O Dashboard Report

In respect to the outpatient department, NHS Fife currently performs well against Scottish outpatient waiting times standards. There is a 0.8% failure to meet the 12-week target. The national mean is 30.8%. In addition, NHS Fife has the lowest time to clear its outpatient queue in Scotland.

2.4.7.4 Theatre Capacity Optimisation

The Service is able to demonstrate superior efficiencies in theatre capacity optimisation when compared against its peers.

Indicator	NHS Fife	Scotland
Late starts (>15 min) as % of used theatre hours (scheduled planned sessions)	1.7	4.5
Theatre cancelled session time - % of planned session hours cancelled (scheduled planned sessions)	0	11.8

Table 12 – Table 4: Theatre capacity optimisation, T&O Dashboard Report

2.4.7.5 Workforce

For trauma and orthopaedic services, NHS Fife are able to demonstrate an efficient use of their workforce.

Indicator	NHS Fife	Scotland
Consultants per 100,000 population	3.5	4.5

Table 13 – Table 5: Trauma and orthopaedics WTE headcount, T&O Dashboard Report

2.5 Future Arrangements

2.5.1 Theatres

Referring back to Section 2.4.6.1, it was noted that by 2035 an additional 481 sessions will be required representing an increase of 33% against current demand.

In terms of total orthopaedic care within NHS Fife (IP and DC) there are currently 1,664 sessions available at 100% utilisation. A realistic percentage for session availability is considered to be 85%, therefore if one assumes that 1,414 sessions are available currently and the demand by 2035 is calling for 1,940 sessions then the deficit is 526 sessions. A theatre running 5 days a week for 52 weeks a year would provide 520 sessions. As a result there is considered to be a solid case supporting the requirement for a third theatre.

The above noted projections combine orthopaedic activity at VHK (IP) and QMH (DC). Further detail supporting this analysis can be found at Appendix C.

2.5.2 Wards

The clinical team are projecting a requirement for a further 9 beds which takes the ward accommodation from 24 beds to 33.

2.5.3 Outpatient Department

It is anticipated that twelve consulting and four treatment rooms will provide the required capacity to deliver a centralised orthopaedic OPD services over the next 20 years.

Twelve consulting rooms will allow current activity to be accommodated, however in order to ensure sustainability of the OPD service over the next 20 years other strategies will be developed as part of the transition of services. It is recognised there will be an increase in OPD activity of approximately 10% over the next 20 years (see Section 2.4.6.2). These strategies will link into initiatives being proposed by the MSK Quality improvement Project in relation to how outpatient services in MSK are delivered. The aim of these strategies is to limit the number of patients who are required to attend for face to face consultant appointments. Strategies include:

- Active Clinical Referral Triage (ACRT): Patients are triaged by trained clinical staff, and where appropriate before patients are offered a face to face new patient appointment, the patient is provided with information which describes treatment options.
- Patient Initiated Follow up (PIFU): This allows patients to be discharged with guidance on how they can access secondary care again if there is a problem, rather than arranging a routine review.
- Remote Consultation via NHSNearMe: This is a video conferencing platform that can allow patient to access clinical appointment remotely by their phone or home PC.

2.5.4 Projected Staffing

Following on from the proposed increase in accommodation, initial staffing projections have also been contemplated and these are set out in the tables below. Staff increases will not be realised straight away, but are likely to be phased to meet demand from 2022 to 2035.

2.5.4.1 Theatres

	Current Staff (WTE)	Projected Staff (WTE)	Difference (WTE)
Band 7	1.00	1.00	0
Band 6	1.00	2.46	1.46
Band 5	11.88	16.88	5.00
Band 3	2.76	4.76	2.00
ODP Theatres – Band 5	2.90	4.36	1.46
Anaesthetist	2.5	3.75	1.25
Total	22.04	33.21	11.17

Table 14 - Theatre Staffing

2.5.4.2 *Ward Staffing*

	Current Staff (WTE)	Projected Staff (WTE)	Difference (WTE)
Band 7	1.00	1.00	0
Band 6	1.00	1.00	0
Band 5	17.96	24.13	6.17
Band 3	1.00	1.00	0
Band 2	6.22	15.61	9.39
Physio / OT	5.28	8.5	3.22
Total	32.46	51.24	18.78

Table 15 - Ward staffing

2.5.4.3 *Consultants*

Current Staff (WTE)	Projected Staff (WTE)	Difference (WTE)
13.7	15.7	2

Table 16 - Consultant staffing

2.6 Service Provider

The service is currently provided exclusively by NHS Fife.

2.7 Condition and Performance

2.7.1 Condition

The condition of the existing facilities from where the service is provided is commensurate with the age of the building and supporting infrastructure. The building was erected in 1967 and the last major refurbishment took place circa 20 years ago. The internal fabric of the facilities are showing signs of age which requires to be replenished. The external fabric is in extremely poor condition having reached the end of its useful life. The replacement of the curtain walling would be a significant and costly undertaking due to the location of the tower block within the site.

- Internal fabric condition rating: B (acceptable) / C (requires capital)
- External fabric condition rating: D (not acceptable)

The primary supporting infrastructure (electrical and mechanical) within the tower block is reaching the end of its useful life and requires to be replaced. There are now a number of recurring environmental problems arising from the tower block infrastructure – flooding/leaks and electrical issues. These will continue to occur regardless of any localised upgrade undertaken. Intermittently the service has lost activity within theatres due to drainage problems. In respect to the existing arrangements, it is considered that there is no sustainable

solution for this service to be provided from the tower block in the medium to longer term. Meanwhile the current conditions represent a significant threat to service continuity.

- Engineering condition rating: D (not acceptable)

2.7.2 Safety

The facilities are generally considered to be safe when taking recent HAI reports into consideration. Safety performance is considered to be achieved through good management and staff commitment in respect to following mandated processes and procedures. The building fabric and layout does not currently maximise opportunities to support the provision of a safe environment in which to treat patients effectively. This is evidenced via the following statements and photograph.

- The bed accommodation within the wards is provided via open plan bays off the main corridors which is not conducive to best practice infection control;
- The scrub area within the theatres is open plan and can be viewed from the theatre main reception area (Figure 5); and
- The laminar flow within theatres it currently too small to enable all of the trays to be accommodated within the clean air flow.

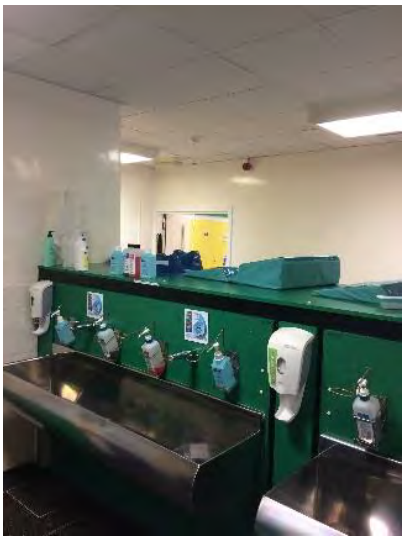


Figure 9 - Scrub area

Figure 8 - Existing bed accommodation

2.7.3 Backlog Maintenance

The summary in respect to the current back-log for the theatres and the ward accommodation is outlined below.

Theatres	£1.185m
Ward 10	£0.954m
Total	£2.139m

Table 17 - Backlog maintenance

The estimated capital cost to deal with significant clinical backlog within the tower block is £36.5m, of which £21.4m relates to repairing the external fabric which has reached the end of its life.

2.7.4 Functional Suitability

The ward and theatres may have been functionally suitable at a point in time, however the facilities are now inhibited on a number of fronts.

The patient journey from the ward to the theatre and vice-versa is functionally unsuitable as there is a bottle-neck when patients arrive at the theatre reception. Patients arriving have to be parked to the side whilst outgoing patients pass-by. There is a privacy curtain, however the current situation does little to contribute towards patient assurance and dignity. Furthermore this staggered approach to patient arrival and departure is inefficient where time is lost transferring patients affecting theatre productivity.

Figure 10 - Lifts to theatre (congested)

Figure 11 - Theatre reception lobby

With advances in surgery and complexities in revision surgery, the theatres area is no longer suitable or compliant in terms of current technical guidance in respect to size. This means that currently the area of the laminar flow is too small to allow all of the trays to be accommodated inside the clean air flow. To mitigate this stacking arrangements are used which is inefficient. In addition, circulating areas are also less than recommended. There is a general lack of storage within the theatre accommodation. The effect is that storage has to be found in rooms/spaces that were not designed for this purpose. The knock on effect is that rooms and corridors are cluttered contributing towards inefficiencies in these spaces.

Figure 13 - Existing theatre

Figure 12 - Circulation storage

2.7.5 Space Utilisation

Both the ward and theatre accommodation is currently running at capacity and the space is fully utilised to meet this demand.

2.7.6 AEDET Review of Existing Facilities

An AEDET review of the existing facilities was undertaken where the Stakeholders considered the facilities against the predefined scoring criteria. A summary of the scoring is set out in fig. 14 below.

Note: scoring ranges from "1 – virtually no agreement" to "6 – virtually total agreement".

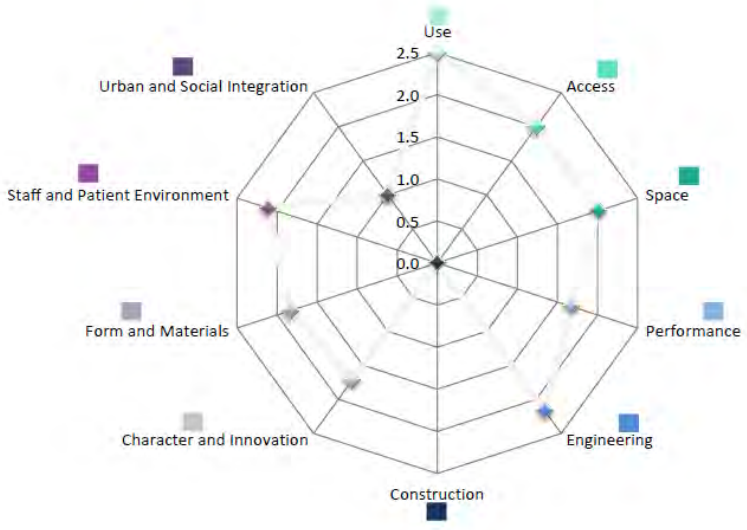


Figure 14 - Existing facility AEDET score

Figure 15 - Existing facility AEDET score

A score of 3 is "little agreement". It can be seen that all of the scores are 2.5 or less which demonstrates that in the Stakeholder's collective view, the existing facilities are below expectations across all categories.

2.8 Supporting Statement

The current services are still needed and they need to be provided in a similar manner to build upon what is an excellent and efficient service, serving the community of Fife. Wide ranging options were considered as part of the option appraisal exercise and this process helped to reinforce this view.

If the current arrangement is maintained with little or no investment, then there will be significant risks in respect to safety and service continuity due to the condition of the existing accommodation and supporting infrastructure. The VHK tower block is unsustainable as a clinical environment over the longer term, therefore a strategy is required to decant clinical activity to environments that are more suitable. In addition to service risk, the current arrangements fail to contribute sufficiently towards patient dignity and theatre access flows are inefficient counteracting against what is otherwise a very efficient high performing service.

This business case was initially conceived in response to dealing with the condition of the current environment. The problems flowing from the existing situation are not currently performance, demand/supply or patient pathway related. It is more concerned with improving the current condition, functionality and safety of the environment whilst considering other opportunities arising from this principle requirement. In taking forward this investment proposal the following opportunities are being incorporated:

- To increase capacity to cope with future demand on the service.
- To create a standalone Fife Elective Orthopaedic Centre incorporating theatres, inpatients and outpatients.

3 Strategic Context

3.1 The Need for Change

3.1.1 Problems Associated with the Current Arrangements

The problems associated with the current arrangements all primarily flow from the condition and performance of the current facilities as set-out and described in Section 2.7. In addition the key needs for change are summarised within the Strategic Assessment which is contained as Appendix A. A summary of the need for change is outlined below.

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
Current ward provision does not support infection control, safety and the overarching strategy to move towards single room accommodation.	Existing arrangements are contributing towards increased levels of infection risk.	To mitigate the existing risk and in doing so seek to contribute towards NHS Scotland's policy of providing single room accommodation across the NHS Estate.
Current accommodation does not support effective patient pathways / flow with bottle-necks arising. Situation affects efficiency of service provision.	Whilst the service is very efficient making the best of the existing situation, the current arrangements are affecting the service's ability to maximise its potential.	With demand for elective orthopaedic procedures set to increase in the future, any additional efficiencies that can be created maximising supply will be of benefit in protecting the sustainability of the service over the longer term.
Current provision compromises patient dignity and quality of experience overall.	The existing situation contributes towards a negative perception from patients diminishing the quality of work/care administered by staff.	Person Centred care is one of NHS Scotland's strategic investment priorities with "positive experiences" and "dignity" at the core.
Condition of existing facilities are below the required standard to support the service over the longer term.	Space constraints are affecting the services potential to work more efficiently and the existing fabric/infrastructure has and will continue to cause disruptions to service continuity.	Building condition and performance risks will continue to deteriorate if action isn't taken now.

Table 18 – Summarising the Need for Change

3.1.2 Opportunities for Improvement

Opportunities for improvement relate to aspects of the current arrangements that are not necessarily causing a problem but may still present an opportunity to improve as a consequence of instigating the investment proposal. Potential opportunities are noted below.

1. Increased supply through additional beds and/or theatres protecting supply v demand over the longer term;
2. An increase in beds and/or theatres, may permit additional capacity and flexibility for trauma and/or general day surgery;

3. Through increasing supply to meet local future projected demand it may be possible to reduce strain on services from a Regional perspective.
4. A significant increase in capacity may be able to do all of the above plus offer Regional utilisation (i.e. use by other Boards).
5. There may be an opportunity to improve the Board's quality of estate generally by removing clinical care from the VHK tower block. This is turn would assist with the strategy of removing clinical services from the tower block to enable a tower block option appraisal to be conducted.
6. There is an opportunity to "spend to save". A refurbishment or new-build option could omit the requirement for back-log costs in the order of £2m overall.
7. There is an opportunity to create a dedicated Fife Elective Orthopaedic Centre incorporating theatres, wards, outpatients and pre-assessment.

The above noted opportunities were considered as part of the option appraisal exercise and have been reflected within the 5 no. shortlisted options where appropriate.

3.1.3 Other Drivers for Change

National, local and service strategies are also contributing towards the need for change. Key strategies are outlined below:

3.1.3.1 National Strategies

- The Healthcare Quality Strategy for NHSScotland, May 2010: Quality Ambitions include "safe" and "effective" care.
- 2020 Vision for Health and Social Care: the 2020 vision describes a healthcare system where "care will be provided to the highest standards of quality and safety" and where "there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk to readmission".

3.1.3.2 Local Strategies

- NHS Fife Clinical Strategy, 2016: the strategy discusses the intention to continue the ongoing review into theatre efficiency across all sites (i.e. increase efficiencies within the current capacity). For elective orthopaedics this many involve investigating options for seven day working and longer days whilst continuing to protect beds. The strategy also mentions the requirement for "efficient, fit-for-purpose facilities" and the intention to "reconfigure the estate to provide safe, high quality, person centred care from the most suitable locations".

3.1.3.3 Service Strategies & Reports

- GIRFT, Trauma and Orthopaedic ACCESS Review, March 2016 (for NHSScotland): the report focuses on sustainably embedding quality patient pathways of care, optimising the use of existing capacity (theatres and beds), determining if there is sufficient capacity and addressing gaps to deliver safe and timely care for patients now and in the future – having the services in the right place with the patient at the centre.
- MSK and Orthopaedic Quality Drive: five priority work-strands, each with a clinical evidence/best practice base, have been identified to have the greatest impact. The work-strands relevant to theatre redesign are:
    - *Enhanced Recovery - Optimising patient recovery after joint replacement*
    - *Demand and Capacity Planning and Management - Supporting strategic and operational decisions*

- GIRFT, Trauma and Orthopaedic ACCESS Review, November 2015 (for NHS Fife): The report commends the Board's orthopaedic enhanced recovery programme, acknowledging the efficient use of the theatres. However the report also notes the risks to theatre efficiency over the longer term due to the age of the existing facilities.

3.2 Organisation's Goals

3.2.1 Investment Objectives

The existing arrangements and the associated need for change have been set in previous Sections. The table below summarises the key problems flowing from the current arrangements together with what needs to be achieved to overcome these problems – i.e. investment objectives.

Effect of the need for change on the organisation:	What has to be achieved to deliver the necessary change? (Investment Objectives)
Existing arrangements are contributing towards increased levels of infection risk.	Improve infection control and safety risk.
Whilst the service is very efficient making the best of the existing accommodation, the current arrangements are affecting the service's ability to maximise its potential.	Improve patient pathways / flows.
The existing environment contributes towards a negative perception from patients which potentially may lead to reputational damage for the Board.	Improve patient perception.
Space constraints are affecting the services potential to work more efficiently and the existing fabric/infrastructure has and will continue to cause disruptions to service continuity.	Improve accommodation in respect to space standards and physical condition.

Table 19 - Investment Objectives

Each of the identified investment objectives is described in further detail below outlining how they may be achieved.

3.2.1.1 Improve Infection Control and Safety Risk

This investment objective could be achieved by improving the condition of the facilities, utilising best practice finishes, fixtures and fittings to achieve a modern environment that can be cleaned and maintained efficiently. In addition functionality of rooms and spaces can be improved to reduce infection risk – as discussed previously single room accommodation and segregated scrub areas are key examples of where improvement can be sought.

3.2.1.2 Improve Patient Pathways / Flows

This can be achieved by reviewing the accommodation requirements and planning spatial adjacencies in such a way that maximises efficiencies in respect to the patient throughput. The patient journey from the ward to theatre and vice-versa will be important considerations.

3.2.1.3 Improve Patient Perception

This objective can be realised by improving the condition of the facilities generally and by planning the accommodation, flows and adjacencies in such a way that patient dignity can be respected in a passive manner.

3.2.1.4 Improve Accommodation in Respect to Space Standards and Physical Condition

This can be achieved ensuring that any new facilities are designed and constructed in accordance with current healthcare guidance in respect to space planning and technical requirements.

3.2.2 Benefits

If the investment objectives can successfully be realised then it is anticipated that the associated benefits will also be generated.

A summary of the key benefits flowing from the investment objective is outlined below:

- Positive patient experience and dignity respected;
- Maintain support to allow people to live independently, together with life quality;
- Improves the healthcare state (condition, sustainability, quality, perception, statutory, back-log and lifecycle);
- Minimises readmissions (post operation complications) and optimises timely discharge;
- Optimises resource usage (theatre and bed utilisation);
- Improves HAI and patient safety; and
- Community benefits flowing from the need for a project necessary to implement the changes.

The Benefits Register is located at Appendix M and the Benefits Realisation Plan can be found at Appendix N.

3.2.3 Risks

Risk is now covered within the Commercial Case (Section 5) and Management Case (Section 7). The project's Risk Register can be found at Appendix O.

3.2.4 Constraints and Dependencies

3.2.4.1 Constraints

Constraints are limitations on the investment proposal. Key constraints relating to this particular investment proposal are noted below:

- Financial – given the current climate it is recognised that the project is likely to be constrained financially. Once the project budget it is set, the project will require to be delivered within this.
- Programme – given the risks associated with the current arrangements, there is a need to deliver the project as quickly as possible.
- Quality – the project will require to comply with all applicable healthcare guidance and achieve the AEDET pre-defined target criteria across all categories.
- Sustainability – as the preferred option is a new-build there will be a requirement to achieve BREEAM "Excellent".

- Site – as the preferred option is within a live environment, delivery of the project may be restricted and constrained depending on the preferred location. Careful planning will be required to plan how the project can be delivered efficiently and safely with minimal disturbance to adjacent areas of the hospital.

3.2.4.2 Dependencies

Dependencies are where action from others is required to ensure success of the investment proposal.

The preferred option is a new-build facility at Victoria Hospital Kirkcaldy. The new facility will be constructed on existing car parking spaces in order to provide a physical connection to the existing building for an ICU adjacency. The car parking spaces will be re-provided at Whyteman's Brae and must be in place in advance of the main building works to ensure there is no deficit in parking provision.

This car park enabling project is considered to be the only dependency project, however it is controlled by the Project Team helping to mitigate any associated programme risk.

4 Economic Case

4.1 Introduction

The purpose of the Economic Case is to undertake a detailed analysis of the costs and benefits of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the IA.

The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

4.2 Revisiting the Economic Case

Within the IA, the Economic Case established a long list of possible options from which a short list of five options were established. The IA contemplated the advantages and disadvantages associated with each option and established budget costs for comparison purposes. Based on this information the IA selected the best option and this was:

> Option 5 – preferred way forward (new-build facility at VHK to meet the current requirements together with added capacity for future demand projections)

The OBC seeks to analyse the options in greater detail to evidence if the preferred option is in fact the correct decision. It does this by using benefits and costs to evaluate each option. Sensitivity analysis is then carried out to validate the result.

4.3 Stakeholder Engagement

An important aspect of considering options and developing them in subsequent business case stages is Stakeholder engagement. The following table summarises the current status in respect to Stakeholder engagement for the project.

Stakeholder Group	Engagement	Support
Patients / service users	As outlined in Section 4.9 the proposed option relates to providing the same service at the same hospital. As such patients and service users will not materially be affected by the proposal. Patient surveys are underway to understand views, opinions and experiences so that key themes can be addressed particularly in respect to briefing and design development. Patient surveys will also be used as part of the benefit measurement criteria. To date patient representatives have been actively involved in developing the Design Statement. They have also	To date patient participation has been gained through the Design Assessment process where patient representatives provided views on the important characteristics of the proposed facility from their perspective. They have also recently participated in the OBC AEDET workshop where they were able to critique the design proposals. Overall, there has been enthusiastic support for the project and praise in connection with the design proposals.

Stakeholder Group	Engagement	Support
	recently participated in the OBC AEDET workshop.	
General public	Given the proposed option, the general public are unlikely to be negatively affected by this proposal from a clinical perspective. General public may become involved in any statutory planning activity. The Project Team may hold an open day as this has been a tried and tested successful means of engaging with the public on other new-build projects implemented by the Project Board in the recent past.	Not applicable Advanced planning consultation with Fife Council has been applied for at OBC. Discussions and actions will become clear within the FBC period.
Staff / resources	Staff are well represented at Project Board and Project Team level. In order to develop this OBC, several collaborative workshops have taken place to develop the design proposals. Workshops have included 1:500 (site/departmental adjacency) and 1:200 (room adjacency).	The staff consultation process has been robust with staff attending all key workshops to date. This has culminated in an agreed set of plans for OBC.
Other key stakeholders and partners	Elective services at Phase 3 – based on the preferred option, no impact envisaged. Anaesthetic services – no impact envisaged. Hospital at night – require to be consulted as a change of location may have an impact on their service. Ambulance/transport service – require to be consulted as drop-off arrangements are likely to change. Note: drop-off arrangements likely to improve under preferred option.	 Consultation established. No significant impact envisaged. Consultation established. Proposals offer a betterment compared to the status quo.

Table 20 – Stakeholder engagement

4.4 Long List of Options

A Stakeholder workshop was arranged to review a long list of possible options. Options were generated against 3 no. headings:

- Scope of Services
- Service Solution
- Potential Delivery Options

The feasibility of the options were considered and either noted as "preferred", "possible" or "discounted". For detail in respect to the long list of options considered, please refer to Appendix D.

In contemplating the long list of options against the needs for change and investment objectives, the Stakeholders also considered the opportunities arising through contemplating change. Whilst the fundamental initial need for change could be tackled by providing like for like facilities it was considered to be remiss not to take cognisance of future orthopaedic care requirements and what this might mean in terms of demand and supply. A decision was taken to present this business case on the basis of re-provision whilst taking advantage of the opportunity to plan for future demand. Whilst this will result in an increase in accommodation, staffing and overall affordability, the key benefits are as follows:

- Additional accommodation would provide NHS Fife with additional surgical capacity to manage NHS Fife patients locally now and well into the future;
- The theatres would be used flexibly offering in-patient and day case capacity;
- It is important to maintain a robust core orthopaedic service (i.e. provision of care for low volume complex work such as ankle replacements, shoulder replacements, elbow replacements). This will support the increasing trauma demand for fragility fractures over the next 20 years; and
- A robust orthopaedic service within Fife will reduce strain on any interconnected Regional offer.

In addition to building in capacity to meet future demand, the opportunity to develop a standalone Fife Elective Orthopaedic Centre was pursued. This involves providing theatres, inpatients and outpatient services via one standalone facility.

4.5 Short List of Options

From the long list of options, the Stakeholders subsequently consolidated a blend of feasible options to arrive at a shortlist of five main options.

The shortlist of options were considered in detail, together with their advantages and disadvantages and to what extent they met the investment objectives. High level affordability was also considered before determining whether the shot listed option was "preferred", "possible" or "rejected". All of the detail in respect to the option appraisal is clearly set out in Appendix D, however a high-level summary is provided below for ease of reference.

Option	Description	Meets Investment Objectives?	Preferred / Possible / Rejected
Option 1 - Do minimum (as existing)	Elective orthopaedic centre as per current arrangements	No	Rejected
Option 2 – Refurbishment of existing	Elective orthopaedic centre as per current arrangements provided from its current location	Partially but not sufficiently	Rejected
Option 3 – Refurbish other estate at VHK	Services to be provided at VHK within a refurbished area of the existing Estate Elective orthopaedic centre as per current arrangements but with added capacity to meet future local service demand projections	Partially	Possible
Option 4 – VHK modular new-build	Service would be provided within a dedicated new modular building on the VHK site. Elective orthopaedic centre as per current arrangements but with added capacity to meet future service demand projections	Yes, but not to the same extent as option 5	Rejected
Option 5 – VHK new-build	Service would be provided within a dedicated traditional new building on the VHK site. Elective orthopaedic centre as per current arrangements but with added capacity to meet future service demand projections	Fully	Preferred

Table 21 - Shortlist of options

4.5.1 Option 1 – do minimum (as existing)

This option is the base option where the existing service would be provided in the same way from the same facilities. It is considered that some work (minimal) would be required to improve the existing condition of the facilities, however this would not be sufficient to overcome the wider systemic issues present within the VHK tower block which is no longer fit for clinical use as a consequence of risks within the existing supporting infrastructure which cannot be resolved locally. In addition, this option fails to realise the opportunity to remove clinical services from the tower block, restricting the Board's ability to consider longer term options for the tower block within the context of the site masterplan. Option 1 does not sufficiently deal with the needs for change or meet the investment objectives and thus has been discounted.

4.5.2 Option 2 – refurbishment of existing

This option is similar to option 1, in that the existing services would continue to be provided in the same way from the same facilities. The existing accommodation would undergo a more significant refurbishment under this option which would go some way to improving conditions at least in the short term. Ongoing risks with the VHK tower block would continue to threaten service provision under this option and it is considered that the existing footprint would do little to improve accommodation adjacencies or space standards. In addition, this option fails to realise the opportunity to remove clinical services from the tower block, restricting the Board's ability to consider longer term options for the tower block within the context of the site masterplan. Option 2 does not sufficiently deal with the needs for change or meet the investment objectives and thus has been discounted.

4.5.3 Option 3 – refurbish other estate at VHK

This option is based on the same service but anticipates additional accommodation to meet local future demand projections. Additional capacity will also help the orthopaedic service to work more flexibly servicing in-patient and day case to meet spikes in demand. The accommodation would be offered through refurbishment of the Board's existing assets elsewhere within the VHK estate. Space has been identified at Phase 1 of the hospital that would be suitable for refurbishment, however the space is inadequate to accommodate a third theatre, additional ward space and supporting accommodation. This option is the best in terms of utilising the Board's existing estate and reducing back-log, however decant and space re-provision costs would need to be offset against this benefit. This option would assist with enabling clinical services to be removed from the tower block and this is of value to the Board in the context of the long-term site masterplan at VHK. This option overall is worthy of consideration for a like for like service solution. However, in contemplating additional accommodation to meet future demand, this option is inadequate as sufficient and suitable space is not available.

4.5.4 Option 4 – VHK modular new-build

This option is based on the same service but anticipates additional accommodation to meet local future demand projections. Additional capacity will also help the orthopaedic service to work more flexibly servicing in-patient and day case to meet spikes in demand. This option would assist with enabling clinical services to be removed from the tower block and this is of value to the Board in the context of the long-term site masterplan at VHK. The accommodation would be offered through a modular new building at VHK. This option is quite attractive in that it meets most of the investment objectives and being modular could be delivered more quickly than a conventional building. Although the quality of modular buildings have improved in recent years there is a concern that a modular facility would not offer the required quality over the longer term (FM and lifecycle) when compared to a conventional building and being

modular compromises might require to be accepted in terms of the design, layout, future flexibility and adjacencies. Initial cost projects also suggest that a modular building might be more expensive than a traditional building due to the scale. This option is a possibility but due to compromises on quality and initial cost projections it has been discounted.

4.5.5 Option 5 – VHK new-build

This option is based on the same services but anticipates additional accommodation to meet local future demand projections. Additional capacity will also help the orthopaedic service to work more flexibly servicing in-patient and day case to meet spikes in demand. This option would assist with enabling clinical services to be removed from the tower block and this is of value to the Board in the context of the long-term site masterplan at VHK. The accommodation would be offered through a conventional new building at VHK. The option would meet all of the investment objectives and stands the best chance of realising all of the briefing criteria set out within the Design Statement. It is the second most expensive option, but money spent on this option will not be compromised to the same extent that it might be if another option was to be pursued − as such it is the preferred option.

4.6 Indicative Costs

Indicative costs for each of the proposed solutions is demonstrated in the table below.

Description	Option 1	Option 2	Option 3	Option 4	Option 5
	As existing (GIFA − 1,992m/2	Refurb. of existing asset GIFA − 1,992m/2	Refurb of other asset GIFA − 5,920m/2	New-build modular (GIFA − 5,920m/2	New-build traditional (GIFA − 5,920m/2
Capital cost	£63,386	£12,154,400	£25,611,943	£44,166,612	£33,637,272
Life cycle costs (60 years)	£7,627,913	£8,627,913	£23,669,300	£89,358,224	£7,967,369
Operating costs (FM) (60 years)	£539,081,109	£550,156,954	£715,999,520	£797,150,669	£706,985,364
Estimated net present value of costs (60 years)	£226,669,632	£236,964,794	£300,090,439	£337,129,911	£302,982,384

Table 22 - Indicative costs

The net present value/cost has been calculated using discounted cash flow techniques on the capital and revenue costs associated with the options as entered into the generic economic model (GEM).

4.7 Option Appraisal

The non-financial benefits for the options are measured against cost estimates to identify which option represents best value for money.

4.7.1 Benefits Criteria and Weightings

The benefits criteria and associated weightings were established at a workshop in August 2019. Service Leads, the Clinical Lead and Service Manager were in attendance. The table provided below summarises the benefits and agreed weightings.

Benefit	Weighting (%)
Positive patient experience and dignity respected	20
Maintain support to allow people to live independently together with life quality	10
Improves the healthcare estate (condition, quality, perception, statutory, back-log and lifecycle)	20
Minimises readmissions (post operation complications) and optimises timely discharge	15
Optimises resource usage (theatre and bed utilisation)	15
Improves HAI and patient safety	15
Community benefits	5
	100

Table 23 - Benefits and weightings

4.7.2 Option Scoring

Following the exercise to weight the benefits, the group systematically scored the options using a scale of 0 to 20. A score of 0 indicates that the option offers no benefits at all in terms of the relevant criterion, while a score of +20 indicates that it represents some "maximum" or "ideal" level of performance. Scores between 0 and +20 indicate intermediate levels of performance. Net scoring of the options prior to applying the benefit weighting criteria is presented in the table below.

Benefit	Option 1	Option 2	Option 3	Option 4	Option 5
	As Existing	Refurb. Existing	Refurb other	Modular	New build
Positive patient experience and dignity respected	5	7	10	13	20
Maintain support to allow people to live independently together with life quality	15	15	16	19	20
Improves the healthcare estate (condition, quality, perception, statutory, back-log and lifecycle)	0	2	12	18	20
Minimises readmissions (post operation complications) and optimises timely discharge	12	12	18	20	20
Optimises resource usage (theatre and bed utilisation)	5	5	12	20	20
Improves HAI and patient safety	2	4	10	20	20
Community benefits	2	3	10	15	20
Total	41	48	88	125	140
Rank	5th	4th	3rd	2nd	1st

Table 24 - Non financial benefits scoring (net scores)

The net scores were then multiplied by the agreed benefit weighting criteria to arrive at a total weighted score. The results are summarised in the table below:

Benefit	Option 1	Option 2	Option 3	Option 4	Option 5
	As Existing	Refurb. Existing	Refurb other	Modular	New build
Positive patient experience and dignity respected	100	140	200	260	400
Maintain support to allow people to live independently together with life quality	150	150	160	190	200
Improves the healthcare estate (condition, quality, perception, statutory, back-log and lifecycle)	0	40	240	360	400
Minimises readmissions (post operation complications) and optimises timely discharge	180	180	270	300	300
Optimises resource usage (theatre and bed utilisation)	75	75	180	300	300
Improves HAI and patient safety	30	60	150	300	300
Community benefits	10	15	50	75	100
Total	545	660	1,250	1,785	2,000
Rank	5th	4th	3rd	2nd	1st

Table 25 - Non financial benefits scoring (weighted scores)

4.7.3 The Preferred Option

This section presents the case for the selection of the preferred option. The first step merges the results of the NPV/NPC calculations and non-financial benefits. In line with HM Treasury guidance, the NPC is divided by the weighted benefits (WBP) score to determine the cost per benefit point for each option.

	Option 1	Option 2	Option 3	Option 4	Option 5
	As Existing	Refurb. Existing	Refurb other	Modular	New build
Net Present Cost (NPC) - £m	226.7	237	300.1	337.1	303
Weighted Benefit Points (WBP)	545	660	1,250	1,785	2,000
NPC per WBP - £000	416	359	240	189	151
Rank	5th	4th	3rd	2nd	1st

Table 26 - Cost per benefit point for each option

These results demonstrate that although option 5 has second highest NPC, it has the highest WBP and also the lowest cost of providing each weighted benefit point. Option 5 is therefore confirmed as the preferred option.

4.8 Sensitivity Analysis

Sensitivity analysis is a technique used to assess the impact of uncertainty over the assumptions being made within the evaluation. The basic procedure is to alter an assumption and recalculate the NPC for each option, to test how these uncertainties may affect the choice between options. This tests the rigour of the appraisal conclusions to consider how options are affected relative to each other by reasonable variations in each assumption.

Sensitivity analysis of both costs and non-financial benefits has been carried out to understand how reactive the results are to change in the underlying assumptions. This tests whether changes to any of the capital or revenue costs have a significant impact on the option rankings. The following scenarios/tests were undertaken for each option:

- Capital costs increased/reduced by 20%; and
- Service costs increased/reduced by 20%.

Sensitivity Scenario	Option 1		Option 2		Option 3		Option 4		Option 5	
	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank
No changes	416	5	359	4	240	3	189	2	151	1

Sensitivity Scenario	Option 1		Option 2		Option 3		Option 4		Option 5	
Capital costs increased by 20%	416	5	362	4	243	3	193	2	154	1
Capital costs decreased by 20%	416	5	356	4	237	3	185	2	149	1
Service costs increased by 20%	498	5	427	4	284	3	219	2	179	1
Service costs decreased by 20%	333	5	291	4	196	3	158	2	124	1

Table 27 - Sensitivity Analysis (costs)

The ranking is unchanged in all cases and Option 5 remains ranked above all other options.

Sensitivity analysis has also been undertaken in relation to the changes in the weights and scores used to evaluate non-financial benefits. The following scenarios have been evaluated:

- Equal weighting applied to all criteria; and
- Scores with the highest weighted criterion excluded.

Sensitivity Scenario	Option 1		Option 2		Option 3		Option 4		Option 5	
	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank	NPC per WBP £000	Rank
No changes	416	5	359	4	240	3	189	2	151	1
Equal weight	395	5	353	4	244	3	193	2	155	1
Exclude top rank score	509	5	494	4	370	3	289	2	252	1

Table 28 - Sensitivity analysis non-financial benefits

The ranking is unchanged in all cases and Option 5 remains ranked above all other options.

4.9 Conclusion

The recommended preferred option as identified at IA stage remains the same for this OBC.

Option 5 – preferred way forward (new-build facility at VHK to meet the current requirements together with added capacity for future demand projections)

5 Commercial Case

5.1 Introduction

This section outlines the commercial arrangements and implications for the Project. This is done by responding to the following points:

- The procurement strategy and appropriate procurement route for the Project
- The scope and content of the proposed commercial arrangement
- Risk allocation and apportionment between public and private sector
- The payment structure and how this will be made over the lifetime of the Project
- The contractual arrangements for the Project

5.2 Revisiting the Commercial Case

The commercial case has generally been updated and expanded since IA in accordance with SCIM OBC guidance. In particular, the design of the preferred option has been progressed allowing for a detailed overview on the status of the design to be provided.

5.3 Procurement Strategy

To enable the project to be delivered in accordance with NHS Scotland construction procurement policy, NHSScotland Frameworks Scotland 2 (FS2) has been selected as the most appropriate option. This procurement route operates via capital funding where a single contractor (including design team) is appointed to deliver the project within agreed time, cost and briefing parameters. FS2 has been used successfully by NHS Fife for many years and there is a clear organisational understanding of the process.

The following are the key features of the proposed procurement route for the delivery of this Project:

- The Framework Agreement is managed by Health Facilities Scotland (HFS) (a division of NHS National Services Scotland) on behalf of the Scottish Government Health Directorate (SGHSCD).
- The Framework embraces the principles of collaborative working, public and private sectors working together effectively, and it is designed to deliver on-going tangible performance improvements due to repeat work being undertaken by the supply chains.
- The form of contract is likely to be the Engineering and Construction Contract (NEC3), Option A or C.
- The general principle of the Framework is that risks are passed to 'the party best able to manage them', subject to value for money.

This capital procurement route is consistent with the other elective care developments currently being progressed across Scotland as part of the national elective care programme.

Under FS2, there is no need to advertise in the Official Journal of the European Union (OJEU). The five PSCPs on the Framework have been selected via a compliant OJEU tender process in 2012 / 2013 for capital investment construction schemes across Scotland up to 2019. Appointment of a PSCP is made following a mini-competition process.

The same form of process applies to the NHSScotland Consultants Frameworks (PSCs) for Project Manager and Joint Cost Advisor.

The summary table below provides an overview in respect to procurements to date:

Framework	Appointment	Status
Contractor, designers and Principal Designer (PSCP)	Graham Construction	Appointed to OBC
Project Manager	Thomson Gray	Appointed to OBC
Joint Cost Advisor	Gardiner and Theobald	Appointed to OBC
NEC3 Supervisor	TBC	To be appointed at FBC

Table 29 - Consultant procurement status

Upon approval of the OBC, NHS Fife would look to extend the above appointments to cover the FBC stage of the project.

5.4 Scope of Works

5.4.1 Overview

The project involves designing and constructing a new Fife Elective Orthopaedic Centre at Victoria Hospital in Kirkcaldy. The new building is currently scheduled to be 6,142m2 in size and will be physically connected to the existing buildings to enable a direct route to the Intensive Care Unit. The facility will include 3 no. operating theatres, a 33-bed ward, an outpatient department, radiology rooms and supporting staff areas. The overall complement of accommodation will serve to provide a dedicated Fife Elective Orthopaedic Centre.

In order to facilitate the connection to ICU, the new building will be located on an existing car park. The displaced car parking space will be re-provided as part of the project and costs relating to this aspect have been included and set out within the Financial Case. A conceptual image is provided below to aid context and understanding of the proposed development.

Figure 16 - Proposed development (Norr Architects)

The scope of the project entails designing and constructing the Fife Elective Orthopaedic Centre. The operation of the new facilities following completion and handover of the

construction phase will be undertaken directly by NHS Fife and fall out with the scope of the project.

5.4.2 Current Design Status

The design has been completed to RIBA Stage 2 which aligns with OBC and NDAP requirements. The table referenced below provides an overview of how the project is performing against predefined OBC requirements.

OBC Design Requirements	Project Status
Concept Design incl. Arch, M&E, C&S, Fire, Landscape	Complete
Outline drawings (≥1:200, key ≥1: 50) & specifications	Complete
Outline sustainability strategy	BREEAM Pre-assessment completed
Outline construction strategy incl. HAI, CDM H&S Plan	Complete
3D sketches of key Design Statement spaces	Complete
Completed Design Statement OBC self-assessment	Complete – assessed through AEDET workshop
Completed AEDET OBC self-assessment	Complete
Photographs of site showing broader context	Complete
Evidence of Local Authority Planning consultation and/or alignment with Local Development Plan.	Pre-planning engagement has been sought from Fife Council via a formal application and fee. Consultation and feedback will be received early within the FBC period.
Extract of draft OBC detailing benefits & risks analysis	Provided within this OBC.
Evidence of HAI & CDM consultation	HAI SCRIBE Stage 1 has been completed on draft – awaiting ground investigation results to conclude. A Principal Designer is in place.
Evidence Sustainability commitments will be met. e.g. accurate & NCM models (DSM). BREEAM, .CAB files and BRUKL; show how design will be optimised	This has been achieved through regular consultation with HFS where the approach to modelling was agreed.

OBC Design Requirements	Project Status
Evidence Equality & access commitments will be met	Complete.
Evidence of VfM e.g. WLC on key design options	Value against the brief has been monitored throughout the OBC programme.
Evidence Activity Data Base (ADB) use optimised	Room data sheets and 1:50 layouts have been produced for repeatable rooms (bedrooms and consulting rooms etc). Remaining room data sheets and 1:50 layouts will be developed and finalised within the FBC programme.
Evidence NHS guidance & technical standards will be met; list any derogations, with their technical reasons	Complete – refer to Section 5.4.5 below.
OBC design report evidencing all above & IA brief met ≥1:500, ≥1:200, key ≥1: 50; diagrams, sections plans, 3Ds, specs, comfort & energy DSMs, to RIBA Stage 2 Concept plus key elements developed to Stage 3	Complete – NDAP submission made on 26 September 2019.

Table 30 - OBC design status

5.4.3 Schedule of Accommodation (SoA) Development

A SoA was developed at the IA stage of the project. Whilst the schedule was tested with stakeholders at this stage to inform budgetary costings it was very much a working draft. The schedule was developed further within the OBC stage in parallel with the concept design.

The table below compares the IA SoA to the OBC "as drawn" outturn. As it can be seen there is an increase of 222m2 overall. The net area (usable rooms) has actually decreased against the original schedule despite adding two radiology rooms. The gross area has increased due to a requirement for a link corridor and a rooftop plantroom.

Description	IA SoA (m2)	**OBC "as drawn"** (m2)	Difference (m2)
	5,920	6,142	222

Table 31 - SoA Development

5.4.4 Inpatient beds

The initial schedule of accommodation (presented as part of the IA) set out the requirement for 34 beds made up of 16 single rooms, 7 double rooms and 1 4-bedded rooms (47% single beds).

At commencement of the OBC Stage the schedule of accommodation was reviewed and refined. A decision was taken to omit the double rooms and provide 14 single rooms and 5 4-bedded rooms (41% single rooms).

Through engagement with HFS and NHS Fife's internal infection control department, notwithstanding clinical preference, the Project Team was requested to increase the proportion of single rooms. As things stand the schedule of accommodation now allows for 33 beds comprising 17 single rooms and 4 4-bedded rooms (52% single beds). Two of the 4-bedded rooms are likely to be used for day cases initially so shall be furnished with chairs as opposed to beds. As time moves on it is likely that the third and eventually fourth 4-bedded bays will be used in this manner also.

Current guidance for new healthcare facilities in Scotland suggests that 100% single rooms should be provided unless there is a justifiable clinical reason for not doing so. To this end, our Clinical Lead has prepared a report setting out the key reasons why a mix of room accommodation is most appropriate for planned Orthopaedic care. Key reasons are summarised below for ease of reference:

- The facility is being designed exclusively for planned orthopaedic care where patients are medically well – there are admission requirements for MRSA screened patients and high-risk patients are not admitted;
- The existing ward configuration is made up of 6 4-bedded bays with 4 side rooms and the ward has very low surgical site infection rates for major joint surgery;
- A mix of accommodation will provide flexibility aligned with changing requirements for elective orthopaedics where patients are increasingly being treated as day cases;
- Through engaging with patients, there is a preference for a mix of accommodation – some patients prefer single rooms offering privacy where others favour 4-beded bays which tend to be more sociable;
- Ward staff have advised that a mix of beds will be more efficient to manage offering patients more face-to-face time; and
- 4-bedded bays will support patients to rehabilitate more quickly through peer support and encouragement.

It is important to note that the Project Board have carefully reviewed the Clinical Lead's paper and are supportive of it together with the current room configuration. We have discussed the matter with HFS and are hopeful that they will positively support the planned strategy also.

5.4.5 Standards

The brief for the design process is that the proposal must conform to all statutory requirements. In addition, the design proposals must meet all relevant Healthcare Guidance as published by HFS on their website.

The PSCP is required to schedule all relevant healthcare guidance and identify any associated derogations against that guidance. The OBC draft derogation schedule is located at Appendix J.

In respect to governance, the Project Team will be charged with reviewing and agreeing proposed derogations. Thereafter the Project Board have assumed responsibility for sanctioning any proposed derogations. This will be an iterative process culminating in formal acceptance of derogations in advance of Stage 4 (construction). The Project Team will liaise with Health Facilities Scotland for support and guidance where necessary when contemplating derogations.

Please note that the derogations schedule contained in the Appendix to this document is a draft working version and no derogations have been formally accepted to date in line with the process outlined in the paragraph above. This will be undertaken during FBC up to FBC submission where derogations will be formalised.

5.4.6 NHSScotland Design Assessment Process (NDAP)

The purpose of NDAP is to promote design quality and service. It does this by mapping design standards to the key investment deliverables, including Scottish Government objectives and expectations for public investment, then demonstrating their delivery via self, and independent assessments. NDAP is made up of personnel from Health Facilities Scotland (HFS) and Architecture Design Scotland (A&DS).

During the IA Stage, A&DS helped to facilitate a Design Statement workshop. This document forms part of the Project Brief, setting out design objectives for the Project Team. The project's design statement is located at Appendix I.

At commencement of OBC shortly after PSCP appointment, the Project Team met with HFS and A&DS to discuss the project, principles and expectations. This helped to provide a framework for development of the design during the OBC Stage.

The OBC NDAP submission was issued on 26 September 2019. The Project Team met with HFS and A&DS on 9 October 2019 to present the proposals. This forum helped to inform HFS and A&DS aiding their independent assessment of the design.

HFS and NDAP's report is currently awaited at the time of concluding this OBC.

5.4.7 Achieving Excellence Design Evaluation Toolkit (AEDET)

In accordance with SCIM guidance and the investment objectives, AEDET will be used throughout the development of the Project to help NHS Fife manage the design from initial proposals through to detailed design and will continue to do so through to Project Evaluation.

The AEDET toolkit has three key dimensions (functionality, build quality and impact) and outlines 10 assessment criteria. Each of the 10 areas is assessed using a series of questions which are scored on a scale of 1 - 6.

AEDET assessments are to be undertaken at predefined stages throughout the project's lifecycle. The stages are outlined in the table below together project progress against these to date.

Stage	Project Progress
Benchmark – assessment of current asset(s)	Completed at IA
Target – aspiration for project	Completed at IA
OBC – assessment of design proposals	Complete
FBC – assessment of design proposals	To be completed at FBC

Table 32 - AEDET status

On 26 September 2019, an AEDET workshop was held to review the OBC stage design against the agreed target scores. This workshop involved a wide range of participants including staff, service users and the PSCP. During each AEDET assessment, an effort was made to achieve a consistent approach in terms of who was involved in the workshops. A core of people has been involved in all three AEDET workshops to date. The OBC AEDET scores are included in the table below together with the benchmark and target scores.

Category	Benchmark	Target	OBC	FBC	POE
Use	2.5	4.2	4.5	0.0	0.0
Access	2.0	2.0	3.4	0.0	0.0
Space	2.0	4.1	4.5	0.0	0.0
Performance	1.7	4.1	2.1	0.0	0.0
Engineering	2.2	3.4	0.0	0.0	0.0
Construction	0.0	4.0	0.0	0.0	0.0
Character and Innovation	1.7	3.4	3.3	0.0	0.0
Form and Materials	1.8	3.7	2.1	0.0	0.0
Staff and Patient Environment	2.1	3.9	4.0	0.0	0.0
Urban and Social Integration	1.0	3.0	4.5	0.0	0.0

The "performance", "engineering", "construction" and "innovation and character" sections could not be fully completed at this stage of the design process and will be reviewed again at the FBC stage when the design is fully detailed. The design scored well across all other categories at this stage with opportunities to improve the scoring further at FBC.

5.4.8 BREEAM

Projects requiring capital investment through the Scottish Government are required to demonstrate sustainable credentials in order to contribute towards the development of a sustainable NHS estate.

The project has been assessed using BREEAM UK New Construction 2018. The assessment took place at a workshop on 15 August 2019 with representation from the Project Team and HFS. The collaborative workshop allowed all the criteria to be discussed and debated. A bespoke

approach was adopted where criteria offering value to NHS Fife was targeted. Following the exercise an initial target score of 34.44% was identified which equates to a PASS rating. A number of additional credits have been identified as possibilities, so the target score has opportunities to increase further at the FBC stage.

BREEAM UK New Construction 2018 is in its infancy – initial benchmarks for other recent healthcare projects in Scotland are generating target scores between 30-40%. As a comparison the Fife Elective Orthopaedic Project currently sits within this range with opportunities to increase the target further at FBC.

5.4.9 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE)

HAI SCRIBE is a risk management process aiding the identification and mitigation of design and construction related infection risks within the built environment. There are four stages within the process – these are identified in the table below together with project progress against these stages to date.

Stage	Project Progress
Stage 1 – Site Selection	Draft complete within OBC stage. Ground investigation required to complete in final format.
Stage 2 – Design	To be completed at FBC stage.
Stage 3 – Construction	To be completed at FBC stage.
Stage 4 – Occupation	To be completed post completion.

Table 33 - HAI SCRIBE status

5.4.10 Building Information Modelling (BIM)

Building Information Modelling (BIM) describes the process of designing and constructing a building collaboratively using one coherent system of digital models and linked non graphical data, as opposed to separate sets of drawings and documents. These models and data also incorporate information which will be carried over and used in the operational phase.

NHSScotland is supporting the adoption of Level 2 BIM maturity following the SG mandate in support of the recommendations of the "Review of Scottish Public Sector Procurement in Construction" which endorsed that "BIM will be introduced in central government with a view to encouraging adoption across the public sector. The objective states that, where appropriate, projects across the public sector adopt BIM level 2 by April 2017."

The NHSScotland BIM strategy is intended to ensure the creation of a digitised information management process which all Boards and teams working on NHSScotland programmes should follow to maintain consistency and facilitate collaborative working, which will in turn reduce waste and non-conformances.

The Project will use BIM as a key design tool during the design and construction phases of the project helping to facilitate coordination and mitigate risks. Another benefit of BIM is that NHS

Fife will have true "as built" records along with the project specific asset tagging that will assist with the operation, maintenance and replacement of components.

An NHS Fife Employers Information Requirements (EIR) has been developed and offered to the PSCP as part of the Project Brief. The EIR in turn has helped to inform the BIM Execution Plan (BEP) which has been developed by the PSCP. These two documents control how BIM will be utilised on the project.

5.4.11 eHealth

Consultation has been ongoing with eHealth during the OBC phase of the project. Initial efforts have largely focussed on ensuring the IT infrastructure will be sufficiently robust and flexile to accommodate a number of wider initiatives that will help to support the service over the longer term during the operational phase. Such initiatives (subject to separate funding sources) include:

- Pre appointment system via internet / mobile phones
- Self check-in facilities
- Virtual clinics
- Waiting management solutions for OPD
- Theatre cameras for education
- Theatre sound system
- General information screens
- Trak care
- Flexible/efficient patient entertainment system
- Pharmacy fridges security controlled like "hotel fridges" (to identify user)
- Theatre robot

5.5 Risk Allocation

Framework Scotland 2 stipulates the use of the NEC, Engineering and Construction Contract (ECC). The ECC is a collaborative form of contract that encourages good management, flexibility and ease of understanding. The contract endeavours to allocate risk fairly via its Compensation Event procedure where the Contractor is compensated if a predefined event occurs. The risk table below provides a high-level overview in respect to the likely risk profile through utilising this form of contract.

	Potential allocation of risk		
Risk Category	Public	Private	Shared
Client / Business risks (title, ground conditions, where not disclosed)	100%	0%	
Design	0%	100%	

	Potential allocation of risk		
Risk Category	Public	Private	Shared
Development and Construction (note dark ground and contamination remain with the public)	50%	50%	√
Transition and Implementation (commissioning and migration Board responsibility)	100%	0%	
Availability and Performance (during operation)	100%	0%	
Operating	100%	0%	
Revenue	100%	0%	
Termination	40%	60%	√
Technology and Obsolescence	80%	20%	√
Control	100%	0%	
Financing	100%	0%	
Legislative	100%	0%	
Other Project risks	50%	50%	√

Table 34 - Risk allocation

The risk register established at IA has been developed in greater detail during the OBC stage. A copy of the updated project risk register is contained at Appendix O.

5.5.1 Key Risks

Key risks have been extracted from the risk register and set out in the table below for ease of reference.

Risk	Mitigation
Building Size/Configuration (Clinical Pathways) New clinical pathways may impact on schedule of accommodation — pre-assessment, radiology and outpatient require further clarification.	Patient flows, demand and future operational design to be better understood and planned.

Risk	Mitigation
The project becomes unaffordable.	Complete and agree stage 2 cost plan.
Project Plan. The Project Plan does not adequately reflect required tasks and timescales.	A Project Plan is in place and accepted. The pace is fairly aggressive however the Project Team is assembled and motivated to meet the objectives. Progress currently in line with programme.
Risks associated with ground conditions.	Undertake ground investigation. OBC design based on reasonable volume of existing information meantime.

Table 35 - key risks

5.6 Payment Structure

Under Frameworks Scotland 2 Consultants and the PSCP are appointed under the NEC form of contract – Options A or C. Under option A, a fixed price is submitted and payment is made on completion of each activity in an activity schedule. Option C is a target price paid monthly up to a target cap.

For the OBC stage of the project, consultants have been appointed under Option A whilst the PSCP has been appointed under Option C. If the OBC is approved, it is envisaged that this arrangement would be extended to cover the FBC stage of the project.

In respect to construction phase it is envisaged that the consultants will remain on Option A contracts. Further consideration on the most appropriate option for the PSCP will be undertaken during the FBC stage of the project. This decision would depend on the maturity of the design and cost information at a point in time. Where the design is practically complete and robust market testing has been undertaken, then an Option A might be more appropriate for the PSCP. Where the design and costs are more fluid then an Option C could be more beneficial helping to encourage collaboration and the joint pursuit of value for money resulting in "share gain" for both parties.

Payments are generally made on a monthly basis in line with the NEC contract provisions.

5.6.1 Project Bank Account

The Project will operate a Project Bank Account (PBA), consistent with Scottish Government Guidance for public sector construction projects. A Project Bank Account is a ring-fenced bank account from which prompt payments are made directly and simultaneously to a lead contractor and members of the supply chain. PBA's improve subcontractors' cashflow and ring-fence it from upstream insolvency.

It is the intention that the PBA will become operational during Stage 4 (construction) of the project. The documentation and contractual arrangements associated with setting up the are currently being developed in collaboration between NHS Fife and the PSCP.

5.6.2 Risk Contingency Management

A project risk register was developed at IA and this has since been developed further during OBC. It is used as an active management tool to identify and mitigate risks progressively as

the design is developed. The risk register has been priced at the OBC stage to inform contingency allowances. It will be developed further during the FBC stage and priced again at the end of that stage to reflect the residual balance of risk contingency required to complete the project. The balance or risk contingency will generally be apportioned to the party best able to manage each risk as set out and agreed in the risk register.

During the construction stage of the project risks and issues are communicated using the NEC3 Early Warning process. This process encourages the PSCP and Project Manager to alert each other to emerging issues and risks so that they can be discussed and managed collaboratively for the overall benefit of the project.

It is important to note that the risk register is primarily a tool for identifying and managing risks. It is then conveniently used as a method for assessing reasonable allocations of risk contingency in advance of construction. Once in construction however, Employer risks are defined within the NEC3 contract and administered in line with the contract provisions – i.e. the risk register has no commercial relevance.

5.6.3 Contract Variations

As noted, the project is procured under the FS2 NEC3 form of contract which manages contract variations by means of Compensation Events. The major benefit of this process is that Compensation Events are dealt with quickly within pre-defined timescales, this helps to maintain an up to date cost forecast.

The Compensation Event process enables Employer's risk items which transpire to be reflected in an adjustment to the Target/Price and/or an adjustment to the programme.

5.6.4 Disputed Payments

The FS2 NEC3 form of contract has processes to manage disputed payments. PSCP applications for payment may have disallowed costs which are monitored by the Joint Cost Advisor (JCA) at each monthly assessment to ensure that only payments due and fully accounted for are passed.

5.6.5 Payment Indexation

Payment indexation is managed centrally on FS2 and hourly staff rates for both PSCs and PSCPs are adjusted and notified annually across the Frameworks by HFS.

Construction inflation is managed by reference to Building Cost Information Services (BCIS) published cost indices. The construction inflation risk is held by the PSCP for the first two years of the programme. The risk is then passed to the NHS Client for the balance of the programme beyond two years.

5.6.6 Utilities and Service Connection Charges

As the Project is publicly funded, utilities and service connection charges are paid by NHS Fife as part of the contract.

5.6.7 Performance Incentives

The main NEC3 PSCP contract option for construction has yet to be selected. There is an opportunity to use an Option C Target Price arrangement which is an incentivised arrangement.

Once the Target Price has been agreed, the PSCP is paid their defined costs plus fee on a monthly basis. If the PSCP's defined cost at the end of the project falls below the Target Price,

then they are entitled to a share of the difference. If, however the PSCP's defined cost exceeds the Target Price then they are wholly liable for the difference. The share/pain arrangements are summarised on the table below.

Share range of Target Price	Contractor Share at Stage 4 (construction)
Less than 95%	Nil %
From 95% to 100%	50%
Greater than 100%	100%

Table 36 - NEC contract data share ranges

5.7 Contractual Arrangements

5.7.1 Contractual Overview

As previously noted under FS2 the NEC3 (ECC3) form of contract will be used to administer the contract. The NEC3 is a flexible contract allowing Client or Contractor design. It also allows for sharing of design responsibility. In addition, the contract supports six main pricing options. Under FS2, two options are offered these being:

- Option A: Price contract with activity schedule
- Option C: Target Contract with Activity schedule

In respect to design responsibility, the contract will be drafted so that 100% design responsibility is allocated to the contractor (PSCP). The contract will therefore be 100% contractor led design and build.

In terms of the main options for the PSCP, it is anticipated that Option C will be utilised for the pre-construction phases of the project (OBC and FBC). A decision on the preferred option for the construction stage together with rationale will be set out within the FBC.

The project will be procured via stages in line with Framework Scotland 2 methodology. At the end of each stage the contract documentation for consultants and the contractor will be updated and executed to allow entry into the subsequent stage. The key stages and outline dates are set out below:

Stage	Dates	In contract?
Stage 2 – OBC	May 19 to Oct. 19	Yes
Stage 3 – FBC	Nov. 19 to Sept. 20	No
Stage 4 – Construction	October 20 to Mar 22	No

Table 37 - Milestone dates

5.7.2 Roles and Responsibilities

Contractual roles and responsibilities are set out within the ECC. These roles are summarised below:

- Employer: NHS Fife
- Contractor: Graham Construction
- Project Manager: Thomson Gray
- Supervisor: To be confirmed

5.7.3 Dispute Resolution and Termination

Procedures for contract administration, dispute resolution and termination are clearly set out within the NEC3 form of contract.

5.7.4 Asset Ownership

In respect to asset ownership, the project is being procured using traditional capital funding. In this relationship the PSCP is responsible for designing and constructing the facilities. At Completion, NHS Fife will take possession of the building and will be responsible for the ongoing operation and maintenance of the facilities.

5.7.5 Personnel Implications

There are no employees who are wholly or substantially employed on services that will be transferred to the private sector under the proposals for this Project, and therefore the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) will not apply.

6 Financial Case

6.1 Introduction

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment);
- Non-recurring revenue costs associated with the project;
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline; and
- Recurring revenue costs (pay and non pay) for the preferred option.

6.2 Revisiting the Financial Case

The IA was approved by Scottish Government Health and Social Care Department (SGHSCD) in January 2018 and no specific conditions were outlined in the approval letter in relation to the Financial Case.

NHS Fife have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

6.3 Financial Model: Costs and Associated Funding for the Project

6.3.1 Capital Costs

Capital costs have been estimated by independent cost Advisors Gardiner & Theobald and have been summarised in Table 38 below. The Capital Cost Report Summary is included in appendix K and the full detailed Cost Report is available if required.

Summary of conventional capital costs						
	Funding					
Capital Costs:	IAD Submission £000's	Post IAD Agreed with SGHSCD at CIG £000's	Revised IAD Total £000's	Partner Contributions £000's	SGHSCD Funding Requirement £000's	Additional Funding required due to Movement from IAD to OBC £000's
Building & Engineering Works	22,458,640		22,458,640		21,396,989	- 1,061,651
Location Adjustment						-
Pre October 2019 Inflation					718,617	718,617
Post October 2019 Inflation					1,078,074	1,078,074
Quantified Construction Risk	250,000		250,000		614,445	364,445
Total Construction Costs	22,708,640		22,708,640		23,808,125	1,099,485
Site Acquisition						
Reprovision of Car Parking		1,138,255	1,138,255		700,788	- 437,467
Decant	100,000		100,000		108,000	8,000
Total other construction related costs	100,000	1,138,255	1,238,255		808,788	- 429,467
Furniture						
IT						
Medical Equipment	340,000		340,000		367,200	27,200
Additional itemised costs						
Total Furniture and equipment	340,000		340,000		367,200	27,200
Additional Quantified Risk					1,115,473	1,115,473
Total estimated cost before VAT and fees	23,148,640	1,138,255	24,286,895		26,099,586	1,812,692
VAT	4,629,728	227,651	4,857,379		5,219,917	362,538
Estimated Vat Recovery PSCP			-		- 318,199	- 318,199
Project Direct Labour Costs		375,727	375,727		375,727	0
Professional Fees	480,000		480,000		862,762	382,762
Estimated Vat Recovery on Fees					- 83,794	- 83,794
Total estimated cost including VAT and fees but before optimism bias	28,258,368	1,741,632	30,000,000		32,155,999	2,155,999
Allowance for optimism bias						
Total estimated cost	28,258,368	1,741,632	30,000,000		32,155,999	2,155,999

Table 38 - Summary of conventional capital costs

The total cost of the preferred option, which is to develop an Elective Orthopaedic Centre for NHS Fife is £32,155,999.

Table 39 below provides a summary of key project cost adjustments. The adjustments are described further beneath the table from a budgetary perspective.

Project Cost Adjustments

Construction Cost Details	IA £000's	OBC £000's	Increase £000's
Increased risk allowance as IAD figure was low and not suffiecient to cover identified risk register	250,000	1,729,918	1,479,918
Schedule of Accomodation reduction	22,458,640	21,396,989	- 1,061,651
Direct Labour Costs for project	375,727	375,727	0
Medical equipment allowance due to sqm increases	340,000	367,200	27,200
Inflation costs not included in IAD		1,796,691	1,796,691
Decant allowance due to sqm increase	100,000	108,000	8,000
External Works - Reprovision of car parking spaces	1,138,255	700,788	- 437,467
Professional fees increase - due to surveys , statutory consents not originally part of IAD costs	480,000	862,762	382,762
VAT adjustments due to increased costs and VAT recovery estimates applied.	4,857,379	4,817,924	- 39,455
Total	**30,000,000**	**32,155,999**	**2,155,999**

Table 39 - Project cost adjustments

Following submission of the IA to SGHSCD it was agreed at CIG that car parking re-provision and direct labour costs associated with the project should be allowed for within the budget – the IA figure rose from £28,258,368 to an agreed £30,000,000 to take account of this. The car parking re-provision amounted to £1,365,906 whilst the direct labour costs for the project were established at £375,727.

In respect to the OBC cost plan, there is a difference amounting to £2,155,999 when compared to the agreed IA allocation (£30,000,000). This difference is attributed to inflation from a budgetary perspective and has been calculated against the construction costs from IA to construction. Costs have been allocated within the adjusted budget taking account of inflation.

In the OBC cost plan the inflation assumptions have been rebased to ensure they are as current as possible, and inflation relating to the period between IA and OBC is now historical, and therefore now included in the current construction costs. There is a forecast inflation allowance built in from the period October 2019 to construction. This highlights the need when developing business cases to avoid unnecessary delay in order to alleviate inflationary pressures.

The estimates above include the following key assumptions:

Cost	Assumption
Professional Fees	Professional fees are based on tenders awarded except the supervisor fees, survey and statutory consents which are currently an estimate and yet to be awarded.
Equipment	Estimated % cost based on cost advisor allowance. Transferable equipment will be moved to the new unit.
Contingency	A priced risk register has replaced Optimism bias at OBC stage.
Inflation	Based on October 2019 Indices to construction.
VAT	VAT has been applied where applicable. Cost advisor VAT recovery estimates have been built in to the cost plan – this will to be confirmed with VAT advisors and HMRC after contract is awarded.

Table 40 – Capital key assumptions

6.3.2 Revenue costs

In order to confirm the revenue implications of the project the baseline costs (do nothing/minimum option) have been thoroughly reviewed and then compared to the projected costs of the preferred option to assess the financial implications.

A number of assumptions have been made at the OBC stage which will be further evaluated and revised throughout the process to FBC development. These assumptions are as detailed in the table below.

Cost	Assumption
Costs	Costs are calculated using 2018/19 prices and using 2018/19 budgetary information.
Workforce	Calculations include allowances for on-costs, enhancements, sick leave, public holidays and annual leave. Workforce increases are based on forecast demand growth.
Non-Pay	Non-pay costs assumed to increase in line with phased forecast demand.
Depreciation	Building – 60 years and equipment 10yrs.

Table 41 - Revenue key assumptions

The clinical and support costs for the existing Elective Orthopaedic service have been calculated as the baseline and then used as a benchmark against which any changes are considered. Estimated costs for the preferred option reflect forecast demand from 2025 (initial forecast activity increase), 2030 the second phased activity increase and then 2035 onwards showing the full impact of the increased anticipated activity.

6.3.2.1 Service model costs

The tables below summarise the total increase in costs arising from these estimates.

		Proposed Option		
	Baseline	**2025**	**2030**	**2035**
Clinical Pays	5,185,618	5,541,181	6,094,279	6,746,144
Non-pays (inc drugs)	3,142,774	3,358,242	3,693,414	4,088,438
Other Services Pays	50,829	54,409	59,979	66,543
	8,379,221	8,953,832	9,847,671	10,901,125

Table 42 - Revenue cost increases

6.3.2.2 Property costs

An outline of the changes in both running costs and depreciation is summarised below:

Property Costs

		Proposed Option		
Service	**Baseline**	**2025**	**2030**	**2035**
Maintenance	34,190	35,895	38,546	41,670
Catering	47,217	50,767	56,289	62,798
Utilities	30,359	44,194	65,714	91,078
Rates	45,246	135,738	135,738	135,738
Portering	35,347	35,347	35,347	35,347
Security	9,216	9,216	9,216	9,216
Domestics	222,634	237,275	260,049	286,890
General Service	47,379	50,975	56,570	63,163
Bedding & Linen	5,863	6,304	6,989	7,797
Total	**477,452**	**605,711**	**664,459**	**733,698**

Table 43 - Property costs

6.3.2.3 Depreciation

The depreciation for the preferred option is £572,653 based on an asset building life of 60yrs and 10yrs for equipment on an overall capital cost of £32,156,000. The overall increase in depreciation is £572,653 - which will be met from the current ring-fenced NHS Fife non-core depreciation budget. The buildings depreciation charge is pre any Valuation Office valuation being done after completion – there is an expectation that any non-value works will reduce the value held in the balance sheet once the valuation is carried out and therefore reduce the depreciation charge going forward.

6.3.2.4 Revenue cost summary

Overall Revenue Costs Summary		Proposed Option		
	Baseline	2025	2030	2035
Service Costs	8,379,221	8,953,832	9,847,671	10,901,125
Property Costs	477,452	605,711	664,459	733,698
Total	**8,856,673**	**9,559,543**	**10,512,131**	**11,634,823**

Table 44 - Revenue cost summary

The OBC identifies a phased overall recurring revenue impact by 2035 onward of £2,778,150 (excluding depreciation) for the preferred option against the baseline costs.

There are considerable staff costs associated with this development - staffing, non-pay and consumable costs will continue to be reviewed as the FBC develops.

6.3.3 Accounting Treatment

The traditional funding route for the project will impact on NHS Fife's Balance Sheet - both the capital cost of the development and the associated capital equipment will be added as non-current assets to the balance sheet and depreciated over the life of the assets in line with accounting policies.

6.4 Statement of Affordability

NHS Fife confirm that this project remains affordable in both revenue and capital terms. The capital costs of the investment will be met through a capital contribution from the Scottish Government Health and Social Care Division capital budget.

Additional recurring revenue costs for the Elective Orthopaedic Centre will be incorporated into NHS Fife's Annual Operational Plan for future years.

6.5 Stakeholder Support

As the project will be delivered by NHS Fife for Fife, written agreement of Stakeholder support from other NHSScotland / public sector organisations is not required in this instance.

6.6 Financial situation

Based on the current costs and assumptions identified, NHS Fife recognises the project will exceed what was estimated within the Local Delivery Plan 2017/18, due to various different

models that were considered. The original submission has since evolved into a standalone elective orthopaedic centre, providing future sustainability for the people of Fife.

The revenue costs are considered to be affordable within the revenue resources available.

All costs will continue to be reviewed and refined throughout the FBC process.

6.7 Resources

Both Project Board and Project Team have been established with governance arrangements in place. The Project Board will ensure appropriate governance throughout the project. The Board has insured that the following dedicated internal resources have been made available to date:

- Project Director (full time);
- Finance Accountant (part-time);
- Clinical Advisor (part-time);
- Project Administrator (full time);

Other internal stakeholders outlined at Section 7.3.1 are involved and committed to the project as noted – their project roles are over and above their core day to day roles.

6.8 Capital and revenue constraints

NHS Fife's capital funding commitments mean that the project cannot exceed the available budget. Any additional revenue costs will be met within NHS Fife's overall revenue resource envelope.

6.9 Financial contributions

Other than capital funding from the Scottish Government, there will be no financial contributions from external partners in respect to this project.

7 Management Case

7.1 Introduction

The main purpose of the Management Case is to demonstrate that NHS Fife is ready and capable of delivering the project successfully.

7.2 Revisiting the Management Case

Since IA, the management case has generally been developed in greater depth. This has been done using SCIM OBC guidance as a framework.

7.3 Reporting Structure and Governance Arrangements

7.3.1 Project Organisation

In order to deliver the project successfully, good governance is required to monitor and direct it. An understanding of the structure and mechanisms for escalation and reporting is set out on the organogram overleaf.

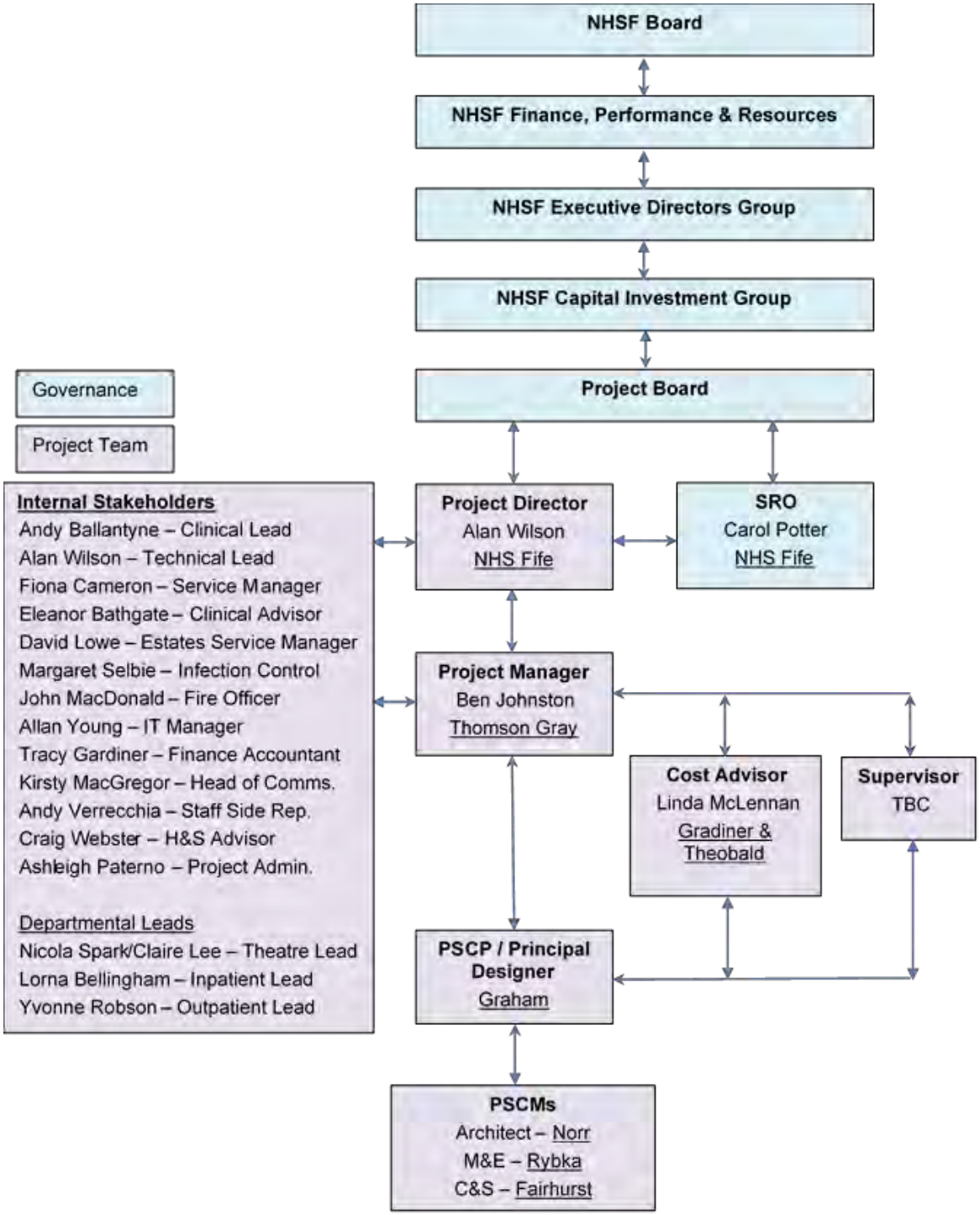


Figure 17 - Project structure

7.3.2 Project Board

A Project Board has been established to oversee the project. The Project Board was set up at commencement of the OBC and Terms of Reference have been agreed. The Project Board meets monthly where they receive a regular project update report from the Project Director. Necessary matters are escalated by the Project Director as required whilst the Project Board offers direction to the Project Team.

Project Board membership and experience is outlined in the table below:

Named Person	Project Role and Responsibilities	Experience
Carol Potter (Director of Finance)	Senior Responsible Officer – SRO with overall responsibility and accountability for the project.	Carol is a strategic finance leader with over 25 years experience across the public sector and a Chartered Public Finance Accountant. Carol has provided strong financial management support and governance to major capital investment projects within the NHS. Carol is an Executive Board Director with NHS Fife and provides a direct governance link to the NHS Board and associated Committees.
Alan Wilson (Capital Projects Director)	Project Director – Responsible for the delivery of the project from inception to completion.	Alan has worked within NHS Fife for 23 years within Estates Operations. He has over 10 years experience in the delivery of a wide range of Capital Projects within Healthcare environment. Alan is a Chartered Engineer and also an accredited NEC Project Manager.
Andy Ballantyne (Lead Consultant Orthopaedics)	Clinical Lead - Responsible for clinical governance.	Andy Ballantyne is a Consultant Orthopaedic Surgeon with NHS Fife since 2005.Andy has been the Clinical lead for Orthopaedics in NHS Fife since 2015. Andy was also a member of the core team involved in the development and submission of the IA for the Fife Elective Orthopaedic Centre delivered to CIG in Nov 2018. Andy has extensive experience in local

Named Person	Project Role and Responsibilities	Experience
		DCAQ planning and delivery. Andy is an active member of the national Scottish Committee for Orthopaedic s and Trauma for 10 years, in roles of treasurer and more recently secretary and is also Co-Chair on the East Region Acute service review – orthopaedics work stream with specific involvement in DCAQ evaluation 2016-2018.
Andrew Fairgrieve (Director of Estates, Facilities & Capital Services)	Project Board Member – Responsible for contributing towards general governance.	Andrew has vast Property and Asset management experience in the private sector and within the NHS. Andrew has a degree in IT/Electronics and a Masters Degree in building services design (mechanical and electrical). Andrew has also managed large new build and refurbishment projects.
Ellen Ryabov (Chief Operating Officer)	Project Board Member – Responsible for contributing towards general governance.	Ellen has worked in the NHS for 30 years and is both a qualified accountant ACMA and an MBA Graduate of Strathclyde Graduate Business School. Ellen has extensive Board level experience, having worked in three of the largest Acute Trusts in England. Ellen was appointed to the post of Chief Operating Officer (Acute Services) on 28 January 2019, prior to this she held the post of Chief Operating Officer with Hull and East Yorkshire Hospital before deciding to return to the NHS in Scotland.
Fiona Cameron (Service Manager Planned Care)	Service Lead – Responsible for service governance.	Fiona is Service manager Orthopaedic, theatres & anaesthetics. Fiona has 15 years experiences of Orthopaedics as an extended

Named Person	Project Role and Responsibilities	Experience
		scope physiotherapist, Orthopaedic service improvement lead and service manager. Fiona was a member of the core team involved in the development and submission of the IA for the Fife Elective Orthopaedic Centre. Fiona is also a Member of the Scottish Orthopaedic Service managers group and a member of East Region Orthopaedic service review group. Fiona has extensive experience of Orthopaedic and theatre redesign projects.
Kirsty MacGregor (Communications Manager)	Project Board Member – Responsible for communications governance.	Kirsty MacGregor brings more than 25 years of experience in public relations and marketing communications. Kirsty has a proven track record of providing expert and informed advice to senior management teams on all aspects of internal and external communications across a range of sectors including Higher Education, Local Government and the NHS. A CIPR Accredited Practitioner, Kirsty also holds two Postgraduate Diplomas from the Chartered Institute of Public Relations, and the Chartered Institute of Marketing.
Murray Cross (General Manager Planned Care)	Project Board Member - Responsible for contributing towards general governance.	Murray has worked in NHS Fife for over 30 years, having started in Finance before moving into management in 1999. Murray has held a wide range of management

Named Person	Project Role and Responsibilities	Experience
		positions across the Acute Division and has been in his current post of General Manager for Planned Care for the last 4 years.
Rona Laing (Non Executive Board Member)	Project Board Member – Responsible for contributing towards general governance.	Rona has been a Non-Executive Board member for 5 years she chaired the Audit and Risk Committee for several years and now chairs the Finance Performance and Resources Committee. Rona has contributed to the review and enhancement of the Board governance processes
Tracy Gardiner (Capital Accountant)	Capital Finance Lead – Responsible for financial governance.	Tracy has worked within NHS Fife for 25 years within the capital branch of the finance department. Tracy has a wide range of knowledge and experience in the delivery of capital projects within NHS Fife.
Wilma Brown (Employee Director)	Project Board Member – Responsible for staff governance.	Wilma has been the Employee Director for 10 years and will ensure we meet the required Staff Governance Standards through our Partnership processes. Wilma has been involved in a number of projects such as this and will ensure any aspects of the SG Standards are correctly identified and communicated between staff, staff side reps and the Project Board.

Table 45 - Project Board experience

7.3.3 Project Team

The project team sits below the Project Board and are responsible for delivering the project on a day to day basis. This includes, developing the design, managing risks, developing the costs, developing the business case, constructing the facility, commissioning the facility and successfully handing the facility over to NHS Fife at completion.

Within the Project Team, there are a range of roles with different responsibilities. The key roles and responsibilities are listed below:

Project Director – the Project Director is responsible for overseeing the delivery of the project on a day-to-day basis and for generally acting as the link between the Project Team and the Project Board. The Project Director will report to the Senior Responsible Officer and Project Board.

Clinical Lead and Service Manager – the Clinical Lead and Service Manager is responsible for clinical governance ensuring that sufficient engagement and participation is evidenced to allow the briefing and related design proposals to be robustly developed. They will also be responsible for accepting design proposals from a clinical perspective at key stages as part of the governance process and for resolving any conflict amongst Clinical Stakeholders.

Clinical Advisor – the Clinical Advisor role will involve providing support to the Clinical Lead and Service Manager. The role will also include leading on commissioning from a clinical perspective ensuring that the transfer to the new asset is managed smoothly.

Technical Lead – the Technical Lead will be responsible for ensuring that the briefing and related technical proposals align with the Board's expectations and requirements. The Technical Lead will also be responsible for accepting design proposals from a technical perspective at key stages as part of the governance process.

Technical Stakeholders – the Technical Stakeholder group consists of representation form the following areas: estates, FM, fire, ICT and infection control. They will be responsible for providing local knowledge and advice in order to refine the briefing. They will also be required to review the PSCP's proposals and attend agreed meetings so that the proposals can progressively be accepted in advance of the construction stage.

Clinical Stakeholders – the Clinical Stakeholder group are responsible for providing local knowledge and advice in order to refine the briefing. They will also be required to review the PSCP's proposals and attend agreed meetings so that the proposals can progressively be accepted in advance of the construction stage.

Project Manager – the Project Manager will be the central hub within the project responsible for delivering the project within pre-agreed time, cost and quality parameters. All project communication should flow through the Project Manager as outlined within the organogram at Section 7.3.1. The Project Manager will report to the Project Director. The Project Manager will also be responsible for managing the project in accordance with the contract option selected.

Joint Cost Advisor – the Joint Cost Advisor will primarily work alongside the Project Manager assisting with setting the budget, creating cost plans, agreeing the target/price whilst contributing towards value management, value engineering and risk management. They will also assist the Project Manager with payment assessments and compensation events. The Joint Cost Advisor will act in a "joint" capacity assisting the PSCP with preparing pricing schedules / bills of quantities and other documentation required for tender purposes.

Supervisor – the Supervisor's main duties relate to ensuring quality is provided during the construction stage. They do this through acting in accordance with the contract. The Supervisor may be appointed during the pre-construction phase to assist with developing the Works Information (testing requirements) and reviewing the PSCP's proposals.

PSCP – the PSCP is responsible for designing and constructing the project within the agreed time, cost and quality constraints. They are also responsible for working in a safe manner whilst mitigating the risk of any operational disruption caused by the works. The PSCP's full scope of duties are contained within the contract Works Information.

Principal Designer – the PSCP will be appointed as Principal Designer, in line with the CDM Regulations 2015. The role involves planning, management and coordination of health and safety in the pre-construction period, help and advice in bringing together the pre-construction information pack, working with the other designers to eliminate foreseeable health and safety risks, and ensuring the PSCP team are informed of risks requiring management in construction.

The Principal Designer is also responsible for coordinating and developing the Health and Safety File and for providing copies at the end of the project.

PSCMs – Principal Supply Chain members are designers and sub-contractors appointed directly by the PSCP to deliver and design the works.

7.3.4 External Advisors

Independent consultants who have been appointed by the Board are set out in the table below:

Project role	Organisation	Lead person(s)
Project Manager	Thomson Gray	Ben Johnston
Cost Advisor	Gardiner & Theobald	Neil Cowan Linda McLennan
Business Case Author	Thomson Gray	Ben Johnston
NEC Supervisor	TBC	TBC
Clerk of Works	TBC	TBC

Table 46 - External Advisors

7.3.5 Project Recruitment Needs

The Project Team has been developed robustly during the OBC Stage. The only remaining roles to be filled are NEC Supervisor and Clerk of Works. At this point in time, it is considered that these roles will be external appointments and will be procured towards the end of the FBC Stage. The roles may be combined into one procurement to be fulfilled by one organisation.

7.3.6 Project Plan and Key Milestones

The project plan and key milestones are set out in the table below:

Description / Activity	Date
OBC	
▪ Submit to Capital Investment Group (CIG), Scottish Government (SG)	15 Oct. 2019
▪ Finance Performance and Resources Committee (FP&R), NHS Fife	5 Nov. 2019
▪ Capital Investment Group (CIG), Scottish Government (SG) Meeting	12 Nov. 2019
▪ NHS Fife Board Meeting	27 Nov. 2019
FBC	
▪ Complete car park enabling works (to enable site to be cleared for construction)	Aug. 2020
▪ Statutory consents	Aug. 2020
▪ Submit to Capital Investment Group (CIG), Scottish Government (SG)	11 Aug. 2020
▪ Finance Performance and Resources Committee (FP&R), NHS Fife	Aug. 2020
▪ Capital Investment Group (CIG), Scottish Government (SG) Meeting	9 Sept. 2020
▪ NHS Fife Board Meeting	Sept. 2020
Construction and handover	
▪ Start	Sept. 2020
▪ Completion	March 2022
▪ Post Project Evaluation	March 2023

Table 47 - Project plan and key milestones

7.3.6.1 Car Park

As noted within the project plan, the current strategy is to complete a replacement car park as enabling works during FBC. This will allow displaced car parking to be re-provided in advance of main project works commencing.

The car park will be formed at Whyteman's Brae on land currently owned by NHS Fife. This will allow additional staff car parking at Whyteman's Brae freeing up patient/visitor car parking adjacent to the hospital.

Costs associated with the car park have been budgeted and included within the Financial Case capital cost allocation.

7.4 Change Management Arrangements

7.4.1 Operational and Service Change Plan

The Fife Elective Orthopaedic Centre will result in the following changes:

1. Increased surgical capacity by the provision of a third elective orthopaedic theatre with capacity to manage elective orthopaedic requirements for inpatient activity for the next 20 years based on ISD projections;

2. Increased ward capacity to provide a mixture of single room and day case facility to reflect the changing requirements for inpatient elective orthopaedic surgery;

3. Centralisation of NHS Fife MSK services to a single site, with resultant improved efficiency in OPD activity through developments consistent with the objectives of the Scottish Access Collaborative (SAC) in demand management within outpatients;

4. Utilisation (where appropriate) of IT strategies building consistency with local and national strategy in the delivery of the aims of the SAC in demand management.

7.4.1.1 Theatres

Theatres plan to provide increased capacity by the provision of a third elective orthopaedic theatre. This will accommodate future demand for major joint surgery within NHS Fife over the next 20 years. These calculations are based on ISD projections for hip and knee arthroplasty (2017).

Short term theatre utilisation will be attained by relocating the Hand Service to the Fife Elective Orthopaedic Centre. Future demand will be accommodated by increasing theatre time utilisation and job plan redesign (weekend working and 3 session days).

The relocation of hand service will coincide with the opening of the Fife Elective Orthopaedic Centre. Subsequent adjustment to job plans will be recognised in future consultant appointments and a review of current job plans will be undertaken with a view to increasing flexibility. This will be a progressive process over the next 20 years reflecting the demands on service.

This will be led by Clinical Leads and Service Managers working in partnership with consultants to achieve theatre efficiency and delivery of the TTG.

7.4.1.2 Wards

In respect to the increased ward capacity, the workforce planning tool will be utilised to determine future nursing needs.

It is recognised that providing a mixture of day case beds and single room inpatient beds offers patient capacity consistent to the changing requirements for inpatient bed space. An increasing number of patients, including lower limb arthroplasty, can be managed through a day case facility. This has the benefit of maximising the efficient use of staff as it is recognised that a 100% single room wards have increased nursing requirements.

7.4.1.3 Centralisation of MSK services

Currently MSK service is delivered form a number of sites across NHS Fife. Often MSK practitioners are working in isolation with limited clinical or peer support. The centralisation of MSK services to a single purpose-built facility in Fife offers a number of benefits:

- MDT MSK delivery from single site;
- Opportunity to develop MDT support – clinical staff not working in isolation;
- Development of consistently applied pathways for MSK conditions;
- Efficiency opportunities in how aspects of service delivered (fracture clinics);
- Opportunities to develop AHP staff into more advance roles (fracture clinic nurses/ANP roles); and
- Opportunities to incorporate national and local IT strategies consistent with the Scottish Access Collaborative aims in demand management within outpatient services:
  a Opt-In care
  b Patient initiated review appointments
  c Development of virtual clinics (NP and review)

This will be achieved by the service undertaking a review of current OPD activity and through a series of workshops looking at redesigning part of the service. Staff and patient engagement will be implemented within this transition. Service redesign will occur over the next three years to enable changes to be embedded prior to the transfer of services to the Fife Elective Orthopaedic Centre.

7.4.2 Facilities Change Plan

The new facility will be serviced by NHS Fife's in-house facilities team. The facility is a replacement for the current orthopaedic theatres and the associated ward currently located in Phase 2 tower block. The facility will be serviced under the existing facilities strategy through the link corridor provided in the new design that connects to the hospitals main FM corridor. Recognition has taken place that there will be a need for extra revenue costs for providing facilities services to the new building due to the increase in patient numbers projected over the next 25 years. These costs have been provided within the Financial Case (see Section 6).

7.4.3 Stakeholder Engagement and Communications Plan

A Stakeholder Engagement and Communication Plan has been developed and endorsed by the Project Board. A copy of the plan can be located at Appendix P.

Stakeholder engagement has occurred at different levels to date. From a design perspective staff and service users have been actively involved in helping to develop the design of the facility. This has occurred through the following workshops:

- Development of the project's Design Statement;
- 1:500 / 1:200 site and departmental adjacency workshops; and
- Achieving Excellence Design Evaluation Toolkit (AEDET) workshop.

At a higher level several tools have been used to communicate the project to wider staff, service users and the general public. These tools have included:

- Dedicated intranet page for staff;
- Dedicated page on NHS Fife's website for the public; and
- Project displays / notice boards within the main hospital reception at VHK.

7.5 Benefits Realisation

7.5.1 Benefits Register

The rationale for an investment needs to be reflected in the realisation of demonstrable benefits, as this will provide the evidence base that the proposal is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register and Benefit Realisation Plan for the Project. The Benefits Register is located at Appendix M.

The benefits register includes a range of benefits to be realised by the development. Each benefit includes a target that will be used to indicate the measure of success during the Post Project Evaluation (PPE).

Benefits are either assessed in a quantitative or qualitative manner.

For the quantitative benefits, the register indicates the baseline (current position) at the start of the project including the source. This will be compared with the same data source in 2023 when the PPE is completed.

For benefits that are qualitative in nature, questionnaires will be developed, and a mix of patient and staff surveys/interviews will be undertaken to outline the baseline for these benefits. The same survey tools will be used during the PPE to examine to what degree the improvements sought were achieved.

Additionally, a Red, Amber, Green (RAG) score highlighting the relative importance of each benefit is indicated using the scale outlined below in the table below.

Scale / RAG	Relative importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Table 48 - Benefits and relative importance

Whilst the benefits "measurement methods" have been identified within the OBC period, further work is required to identify the baseline and target values for each benefit – this will be undertaken within the FBC period.

Community Benefits

The Benefits Register also sets out wider sustainability opportunities associated with this Project. Notably there is potential to deliver community benefits through education, training and recruitment, whilst targeting work packages offered to Small or Medium Size Enterprises (SMEs).

Within the procurement process the requirement for community benefits was set out in the tender documentation. These requirements are referenced within the Benefits Register which the PSCP will be expected to meet and surpass.

7.5.2 Benefits Realisation Plan

A Benefits Realisation Plan has been produced to support the achievement of the benefits outlined in the Benefits Register, and it is included as Appendix N.

The benefits realisation process is a planned and systematic process consisting of four defined stages outlined below. The implementation of this plan will be reviewed regularly by the Project Board.

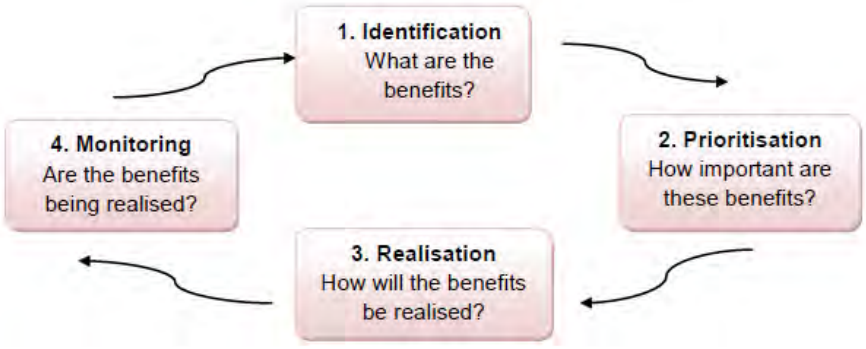


Figure 18 - Benefits realisation process

The Benefits Realisation Plan outlines:

- Which Investment Objective the benefit addresses;
- Who will receive the benefit;
- Who is responsible for delivering the benefit;
- Any dependencies that could affect delivery of the benefit; and
- Any support needed from other agencies etc. to realise the benefit.

Benefits monitoring will be ongoing over the life of the Project through the planning, procurement and implementation phases. Progress will be reported to the Project Board at regular intervals and will culminate in the Project Evaluation Report to be produced in 2023.

7.6 Risk Management

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the project lifecycle. It is a critical and continuous process throughout the planning, procurement and implementation journey of a project.

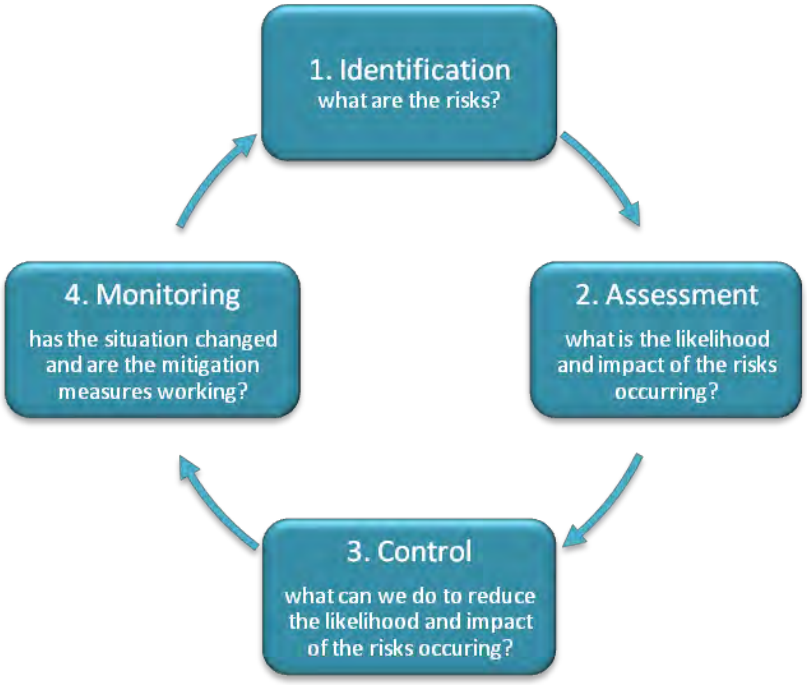


Figure 19 - Risk management process

7.6.1 Updated Risk Register

The Project Team have developed the initial Risk Register created at IA. The current risk register can be located at Appendix O. The risks are generally now more project focussed on balance and reflective of the current stage in the process. The headline items noted below, demonstrate how the risk register has been developed since IA.

- New risks have been identified and added to the register, whilst other risk have been closed;
- Probability, impact and risk ratings have been updated progressively at risk workshops;
- Mitigation measures have been agreed and updated;
- Each risk has been identified as quantifiable or unquantifiable – where the risk is identified as quantifiable it has been carried forward to allow pricing of contingency;
- Risk owners and managers have been allocated. *A risk owner has overall responsibility for the risk, whilst a manager is responsible for helping to mitigate the risk.*

7.6.2 Governance

The Project Director has overall responsibility for the project risk register. The Project Manager is however responsible for maintaining the risk register on a day to day basis and for organising regular risk workshops to review and manage the risks.

The risk register is updated and provided to the Project Board on a monthly basis as an Appendix to the Project Manager's monthly progress report. Key risks are extracted from the risk register and highlighted within the Project Manager's monthly report for ease of reference. The Project Board provide direction to the Project Director and Project Manager on risk matters as necessary.

7.7 Commissioning

The importance of the commissioning process cannot be underestimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes. The Project Board and Director are fully committed to implementing a robust commissioning process, ensuring that the facilities are safe to use and operate from the outset. With this in mind; the Project Director is actively keen to embrace and trial new commissioning and testing procedures. These will be collaboratively agreed with the PSCP, NEC Supervisor and Clerk of Works and incorporated into the contractual Woks Information as agreed obligations.

The commissioning process will be treated as a distinct workstreams, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits. Workstreams will include Technical Commissioning and Operational Commissioning and these will be supported by BIM and Soft Landing processes.

Technical Commissioning concentrates on the readiness of the facility to support operational activity. As such the mechanical and electrical systems all need to be operating satisfactorily at handover of the facility and beyond. Operational Commissioning on the other hand is involved with getting the clinical services transferred into the facility with minimal disruption to business continuity. Given these separate requirements an Operational Commissioning Manager will be appointed directly by NHS Fife (this appointment is already in place). The Technical Commissioning Manager role will be undertaken by the PSCP; however, the Project Director, Project Manager, NEC Supervisor and Clerk of Works will maintain active roles helping to facilitate a robust technical commissioning process.

The Commissioning Managers will report to the Project Manager on a day to day basis but will maintain lines of communication with the wider team to deliver against the plans.

The Commissioning Managers will be charged with developing the Commissioning Requirement Brief and Masterplan within the FBC stage of the programme. These documents will be offered as part of the FBC submission.

7.8 Post Project Evaluation

The arrangements for post implementation review and project evaluation reviews have been established in accordance with best practice. These reviews will determine whether the anticipated benefits identified at the outset have been delivered. The project will be evaluated in stages:

Stage 1 – Procurement Process Evaluation

An evaluation of the procurement process will be undertaken following the signing of the contract to assess the effectiveness of the procurement process in meeting the project objectives. This will identify any issues and lessons to be learned that will benefit future projects.

Stage 2 – Monitoring Construction

During the construction period progress will be monitored to ensure delivery of the project to time, cost, and quality to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project's intended outputs and deliver its objectives.

Stage 3 – Initial Project Evaluation of the Service Outcomes

This will be undertaken 6 to 12 months after the new facility has been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities and what lessons may be learned from the process.

Stage 4 – Follow-up Project Evaluation

This will be undertaken 2 years into the operational phase by the Evaluation Team to assess the longer-term service outcomes and ensure that the project's objectives continue to be delivered.

The following questions will be asked at each stage:

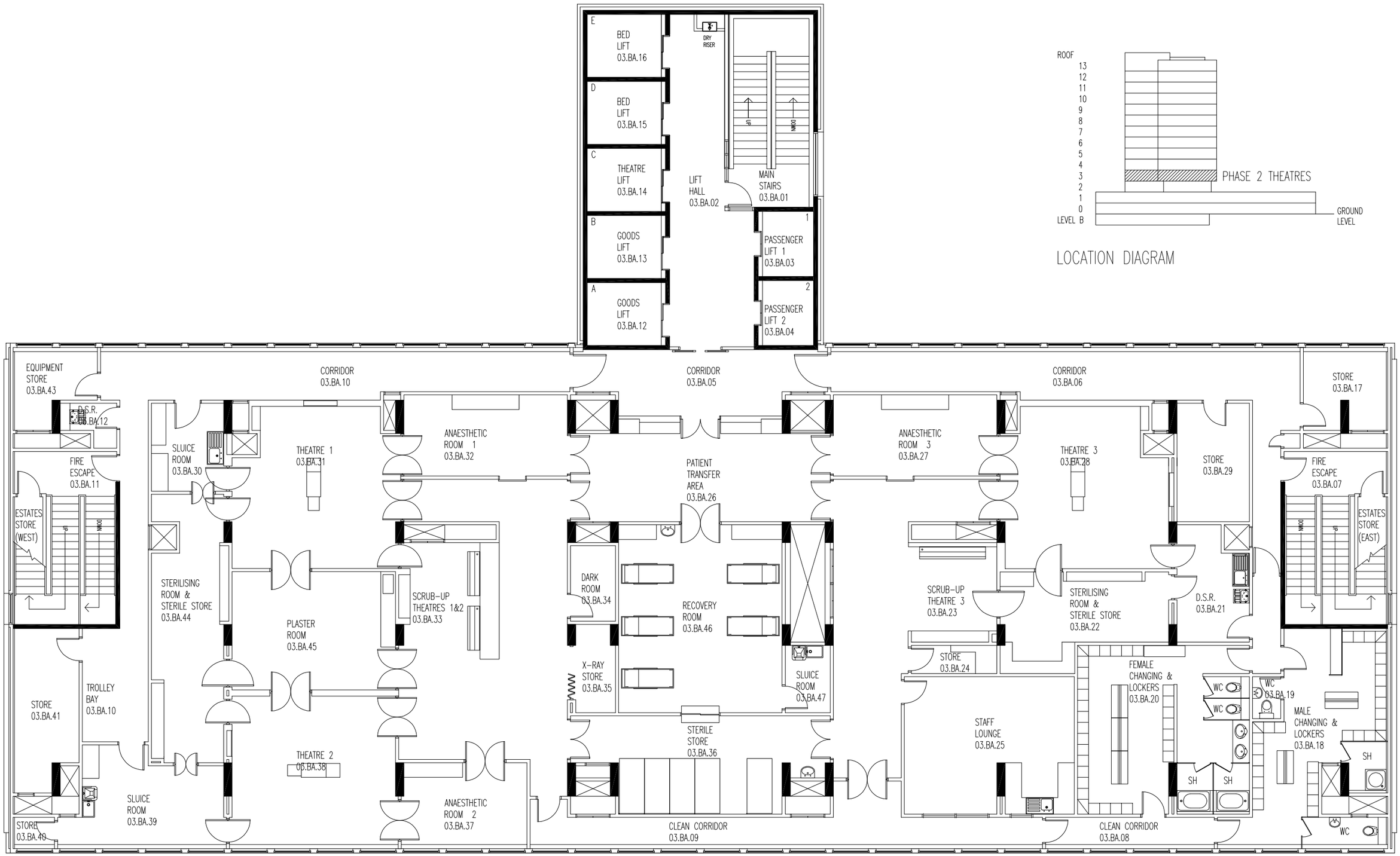
- Have relevant project objectives been achieved?
- Has the project progressed as planned?
- If the plan was not followed, why did this occur?
- If appropriate, how should plans for future projects be amended?

The process will be led by evaluators, independent of the delivery team, who will meet with representatives of the user groups and other key stakeholders. The Project Sponsor, on behalf of the Project Board, will receive reports at each stage of the evaluation process.

Strategic Assessment
Project: Fife Elective Orthopaedic Centre
13/03/2017—Rev. 3

Current Arrangements: Service is provided within Phase 2 at Victoria Hospital, Kirkcaldy serving the community of Fife. Current provision includes 2 no. orthopaedic laminar flow theatres and a supporting 24 bed ward. 22 no. sessions delivered over 6 days at capacity. Condition and flow of existing accommodation in need of improvement in order to sustain the service for the future.

What is the need for change?		What benefits will be gained from addressing these needs?		How do these benefits link to NHSScotland's Strategic Investment Priorities?	Prioritisation Score	What solution is being proposed?
1. Current ward provision does not support infection control, safety and the overarching strategy to move towards single room accommodation.	Identify Links	Positive patient experience and dignity respected.	Identify Links	Person centred	5	**Service scope/size** Orthopaedic service centre for NHS Fife
2. Current accommodation does not support effective patient pathways / flow with bottle-necks arising. Situation affects efficiency of service provision.		Maintains support to allow people to live independently together with life quality. **Overarching benefit.**		Safe	5	**Service arrangement** Co-location of 2 no. theatres and supporting ward accommodation
3. Current provision compromises patient dignity and quality of experience overall.		Improves the healthcare state (condition, quality, perception, statutory, back-log and lifecycle).		Effective quality of care	5	**Service providers** NHS Fife
4. Condition of existing facilities are below the required standard to support the service over the longer term.		Minimises readmissions and improves timely discharge.		Health of population	3	**Impact on assets** Improve existing assets
		Optimises resource usage.		Value and sustainability	5	**Value and procurement** Frameworks Scotland 2/3 (capital) - £8m
		Improves HAI and patient safety.		**TOTAL SCORE**	92	



LOCATION DIAGRAM

NHS Fife

Directorate of Estates, Facilities and Capital Services

Victoria Hospital
Hayfield Road
KIRKCALDY
Fife KY2 5AH
Tel: (01592) 643355
Fax: (01592) 648062

Project Title

VICTORIA HOSPITAL, KIRKCALDY PHASE 2 - LEVEL 3, (BLOCK BA-3) THEATRES

Drawing Title

FLOOR PLAN

		Rev
Date	SEPT 11	
Drawn	I.D.	
Scale	N.T.S.	

Drawing No
VHK \ BA-3 \ FIRE \ A3

LOCATION DIAGRAM

NHS Fife

Directorate of Estates, Facilities and Capital Services

Victoria Hospital
Hayfield Road
KIRKCALDY
Fife KY2 5AH
Tel: (01592) 643355
Fax: (01592) 648062

Project Title

VICTORIA HOSPITAL, KIRKCALDY
PHASE 2 - LEVEL 4, (BLOCK BA-4)
WARD 10

Drawing Title

FLOOR PLAN

Date	JUN 96
Drawn	ROB
Scale	N.T.S.
Rev	
Drawing No	VHK \ BA-4 \ FLOOR \ A3

Sessions required to maintain demand/capapcity balance using ISD projections for arthroplasty applied to all subspecialities[2]						
	Description of the sessional surplus/defecit of planned ortho theatre when comparing current availability with projected demand until 2035					
		Current	**2025**	**2030**	**2035**	Comments
Total sessions activity 2016-2017 and forward projections (2025,2030,2035)[1]	Total	0% 1459	18% 1722	28% 1868	33% 1940	
Total theatre (IP/DC) sessions available current (@90% utilisation)	1498	39 [4]	-224	-370	-442	
Total theatre (IP/DC) sessions available current (@85% utilisation)	1414	-45	-308	-454	-526	Reflects current utilisation 1 theatre utilised 52 week/yr = 520 sessions
Total theatre (IP/DC) sessions available current (@80% utilisation)	1331	-128	-391	-537	-609	

Notes:

[1]Total activity (planned orthopaedics) includes all the funded consultant core capapcity (as in Cons contracts), WLI and activity undertaken outwith board (GJNH). In 2016-17 demand and capapcity was balanced

[2] ISD produced projections for increased arthroplasty actvity in 2025,2030 ands 2035. It was assumed similar increases would be seen across all specialities. These projected increase in activty were applied to sessional requirements for 2016-2017 to give an estimate of future demand. These are described in sessional requirements for NHS Fife for elctive orthopaedics in 2025,2030 and 2035

[3] Theatre utilisation (as a percentage of all available sessions) was calculated at 100%, 90%, 85% and 80%. The figure calcculated reflects the total number electvie orthopaedic theatre sessions avaiulable for the described utilisation. The figures of 85% utilisation is reflective of current theatre use. NHS Fife is recognised as having some of the most efficient electvie orthopaedics theatres within Scotland.

[4] A positive number represents a surplus of theatre sessions at the defined theatre utilisation, a negative number represents a defecit of theatre sessions to meet demand compared to current sessional availability.

Fife Elective Orthopaedic Centre

Options

5 January 2018 – Rev. 2

Ref. no	Option Description		Service Size	Feasibility	Preferred, possible of discounted
Scope of Services					
1	As per current arrangements – elective orthopaedic centre		Similar to existing arrangements	Feasible. This may however include an increased schedule of accommodation compared to the existing situation in order to plan for future demand.	Preferred
2	Provide increased flexibility for trauma use		May need to increase to achieve this	Flexible use. Feasible although accommodation and resources would need to increase to accommodate this.	Possible
3	Provision for day surgery at the weekends (in/out same day)		May need to increase to achieve this	Flexible use. Feasible although accommodation and resources would need to increase to accommodate this.	Possible
4	Regional utilisation – i.e. use by other health boards		May need to increase to achieve this	Flexible use. Feasible although accommodation and resources would need to increase to accommodate this.	Possible
Service Solution					
1	Service to be delivered as per the status quo—i.e. dedicated service by NHS Fife	1a	Size to meet status quo.	Feasible.	Possible
		1b	Increase size to meet local future demand projections	Feasible, although would impact on resources/workforce and project/whole life costs.	Preferred
		1c	Increase size to meet local future demand and neighbouring Health Boards	Feasible, although would impact on resources/workforce and project/whole life costs.	Possible
2	Service to be delivered using general theatres and wards within NHS Fife (in part or whole)	1a	Size to meet status quo	Not feasible. Laminar flow theatres required and may dilute quality of service provision and efficiencies which is currently excellent.	Discount
		1b	Increase size to meet local future demand projections	Not feasible. Laminar flow theatres required and may dilute quality of service provision and efficiencies which is currently excellent.	Discount
		1c	Increase size to meet local future demand and neighbouring Health Boards	Not feasible. Laminar flow theatres required and may dilute quality of service provision and efficiencies which is currently excellent.	Discount

3	Service to be delivered by another Health Board		Not feasible – no capacity elsewhere. Potential loss of knowledge and expertise.	Discount
4	Service to be provided by a bespoke Regional Elective Centre		Not feasible. No current insight into when an elective centre might be ready or where it might be located. Centre could however eventually offer support to ease supply/demand issues in the future.	Discount
5	Private provision		Expensive solution and issues over locality.	Discount
Potential Delivery Options (based on likely scope of service and solutions as detailed above)				
1	Traditional new-build at VHK		Feasible, if finances allow. Although space to facilitate new-builds is constrained at VHK it is considered that a new-build unit could be accommodated at the site.	Possible
2	Modular new-build at VHK		Feasible, if finances allow. Although space to facilitate new-builds is constrained at VHK it is considered that a new-build unit could be accommodated at the site. Could be more affordable than a traditional new-build but design/quality constraints could be the compromise.	Possible
3	New build elsewhere within NHS Fife's estate		Not really feasible due to required adjacencies – i.e. suits service to be located at an acute site.	Discount
4	Refurbishment of existing		Not really feasible. Issues with size of existing accommodation to provide the space required and local refurbishment would not overcome inherent issues within the tower block. Furthermore service would require to be decanted to allow a refurbishment.	Discounted on the basis that any spend is considered to be a poor investment due to the inherent infrastructure issues.
5	Refurbishment/extension elsewhere at VHK		Feasible. Option would allow the Board to rationalise their existing estate proving services within suitable accommodation. Option perhaps lends itself better if replicating the existing accommodation is the preference.	Possible
6	Refurbishment/extension elsewhere within NHS Fife		Not really feasible due to required adjacencies – i.e. suits service to be located at an acute site. Could only be feasible for selected cases which would mean spitting the service across Fife which is inefficient.	Possible for selected cases but not preferred. Therefore discount.
7	Use of Vanguard facilities		Feasible although expensive and space on site is limited at the VHK to accommodate this. Perhaps more feasible for a decant option on a short-term basis.	Possible but not preferred. Therefore discount.

Summary of Options

	Option 1 - Do minimum (as existing)	Option 2 – Refurbishment of existing	Option 3 – Refurbish other estate at VHK	Option 4 – VHK modular new-build	Option 5 – VHK new-build
Service provision	Elective orthopaedic centre as per current arrangements	Elective orthopaedic centre as per current arrangements provided from its current location	Services to be provided at VHK within a refurbished area of the existing Estate Elective orthopaedic centre as per current arrangements but with added capacity to meet future local service demand projections At this stage the service has projected the need for a further theatre (3 no. in total) and a 34 no. bed ward (an increase of 6 no. beds versus the current arrangements).	Service would be provided within a dedicated new modular building on the VHK site. Elective orthopaedic centre as per current arrangements but with added capacity to meet future service demand projections At this stage the service has projected the need for a further theatre (3 no. in total) and a 34 no. bed ward (an increase of 6 no. beds versus the current arrangements).	Service would be provided within a dedicated traditional new building on the VHK site. Elective orthopaedic centre as per current arrangements but with added capacity to meet future service demand projections At this stage the service has projected the need for a further theatre (3 no. in total) and a 34 no. bed ward (an increase of 6 no. beds versus the current arrangements).
Service arrangements	As per the status quo	As per the status quo	As per the status quo but offering additional supply/capacity.	As per the status quo but offering additional supply/capacity.	As per the status quo but offering additional supply/capacity.
Service provider and workforce arrangements	As per status quo	As per status quo	Service provider as per the status quo. Workforce arrangements would need to increase in order to facilitate the extra supply offered by the service. Increase projections noted in business case.	Service provider as per the status quo. Workforce arrangements would need to increase in order to facilitate the extra supply offered by the service. Increase projections noted in business case.	Service provider as per the status quo. Workforce arrangements would need to increase in order to facilitate the extra supply offered by the service. Increase projections noted in business case.
Supporting assets	Minimal change to condition and performance of existing assets/properties	The proposal here is to refurbish the existing accommodation. Conditions would improve locally, however the inherent risks posed by the existing wider infrastructure within the VHK tower block would remain and as a result there would continue to be an ongoing risk to operations from these facilities.	Condition and performance of the existing assets/properties will be improved significantly. When the service is relocated to its new location, there will then be an opportunity to improve the condition of the accommodation where it moved from for a suitable purpose (non-clinical).	When the service is relocated to its new location, there will then be an opportunity to improve the condition of the accommodation where it moved from for a suitable purpose (non-clinical).	When the service is relocated to its new location, there will then be an opportunity to improve the condition of the accommodation where it moved from for a suitable purpose (non-clinical).
Public and service user expectations	No change to expectations or perception.	As the service will be more or less the same, expectations will be unchanged, however positive perception levels in respect to the service would increase through cosmetic improvements to the facilities. Ongoing risk that perception could be affected by a failure in the VHK tower block infrastructure causing damage to	Service user expectations should improve as the facilities, layout and accommodation on offer will contribute towards a positive patient experience. Better than options 1 and 2, similar to option 4 but perhaps not as good as option 5.	Service user expectations should improve as the facilities, layout and accommodation on offer will contribute towards a positive patient experience. Better than options 1 and 2, similar to option 3 but perhaps not as good as option 5.	Service user expectations should improve as the facilities, layout and accommodation on offer will contribute towards a positive patient experience. Considered to offer the most against all other options in this regard.

		the facilities and disruption to service provision.			
Advantages (Strengths and Opportunities)	No disruption to existing services. No capital investment required.	Improvement to the condition of the facilities which would have a positive impact on back-log costs. Limited capital investment required.	Option should realise many of the investment objectives and associated benefits but perhaps not to the same extent as option 5. Makes best use of the Boards existing assets. This option is likely to reduce back-log in the current location by the order of £1m and potentially back-log within its new location by the order of £1m (£2m back-log spend to save overall). If sufficient space can be found within the existing estate to facilitate the needs of the existing service plus future projected demand, then this option may also offer opportunities locally for dealing with trauma day surgery peaks. Dealing with future projected demand locally will also have the benefit of reducing stresses on any Regional facility.	Option should realise many of the investment objectives and associated benefits but perhaps not to the same extent as option 5. No decant strategy required (cost saving). With a new-build, more opportunity/flexibility to plan effective adjacencies and ensure suitable space provision. In addition flexibility can be built into the facility for future expansion if required. This option may offer opportunities locally for dealing with trauma day surgery peaks. Dealing with future projected demand locally will also have the benefit of reducing stresses on any Regional facility. Modular facilities tend to be able to delivered more quickly than traditional builds however this if often offset by quality.	It is considered that this option should be able to satisfy all of the investment objectives and realise all of the associated benefits. No decant strategy required (cost saving). With a new-build, more opportunity/flexibility to plan effective adjacencies and ensure suitable space provision. In addition flexibility can be built into the facility for future expansion if required. This option may offer opportunities locally for dealing with trauma day surgery peaks. Dealing with future projected demand locally will also have the benefit of reducing stresses on any Regional facility. It is considered that this option will offer the most in terms of quality over the longer term and will stand the best chance of successfully responding to the parameters set out within the Design Statement.
Disadvantages (weaknesses and threats)	As per the "need for change". Risk to service remains.	Does not successfully deal with the "need for change". Risk to service remains. Service would require to decant temporarily to facilitate this option which could be costly.	Option is likely to necessitate the need for a dependency decant project which will add additional cost. Depending on the building footprint and design, it may not be possible to achieve complete single bed accommodation. Other healthcare guidance may not be realised due to constraints. Potentially noisy/disruptive to adjacent accommodation. Option does not offer the same degree of future proofing for future demand. Furthermore opportunities to expand will be constrained.	Space for a new-build at VHK limited. Less opportunity than option 3 in respect to improving existing assets. Potential planning/public engagement implications. The building footprint required to accommodate 3 no. theatres, a 30 bed ward and supporting accommodation may not be appropriate for a modular build. Further to the point above initial cost projections are higher than option 5.	Space for a new-build at VHK limited. Less opportunity than option 3 in respect to improving existing assets. Potential planning/public engagement implications. Initial cost projections identify this option as being the second most expensive.

Does it meet the investment objectives (fully, partially, no, NA)?					
IO.1 – Reduce infection control and safety risk.	No	No – limitations	Partially – some compromise on complete "single-bed" provision may be required	Yes	Yes
IO.02 - Improve patient pathways / flows.	No	No – limitations	Partially – a refurbishment may introduce constraints and compromises	Yes	Yes
IO.03 - Improve patient perception.	No	Yes, although limitations and risk of failure in asset ongoing	Yes	Yes – but not to the same extent as option 5	Yes
IO.04 - Improve accommodation in respect to space standards and physical condition.	No	Partially – physical condition could be improved, however ability to improve space standards within existing footprint is unlikely	Partially – a refurbishment may introduce constraints and compromises	Yes	Yes
Are the indicative costs likely to be affordable (yes, maybe / unknown / no)?					
Affordability	Yes	Yes	Potentially	Potentially	Potentially
Option preferred / possible / rejected?					
Option selection	Reject	Reject	Possible	Reject	Preferred

Options	Cost updated for inflation	Cost updated for inflation and Optimism Bias
1 - As existing - do minimum	£ 63,380	£ 63,386
2 - Refurbishment of Existing	£ 11,104,993	£ 12,154,401
3 - Refurbishment of Other Asset	£ 23,185,372	£ 25,611,943
4 - Modular New Build	£ 39,841,269	£ 44,166,612
5 - Traditional New Build	£ 30,519,037	£ 33,637,272

As Existing Option 1 - Do Minimum

Minor Betterment of existing Assets; including decoration etc	1,992	m2	£	12	£	23,904	
PSCP Design					£	5,000	allowance
PSC					£	15,000	allowance
Contingency					£	5,000	allowance
Equipment					£	-	allowance
					£	48,904	
Adjustment for inflation - 8%					£	3,912.32	
					£	52,816.32	
Client Decant Costs					£	-	
VAT @ 20%					£	10,563	
					£	**63,380**	

GT GARDINER &THEOBALD

As Existing Option 1 - Do Minimum

Minor Betterment of existing Assets; including decoration etc	1,992	m2	£	12	£ 23,904	
PSCP Design					£ 5,000	allowance
PSC					£ 15,000	allowance
Contingency					£ -	See optimism bias allowance
Equipment					£ -	allowance
					£ 43,904	
Adjustment for inflation - 8%					£ 3,512	
					£ 47,416	
Client Decant Costs					£ -	
Optimism Bias at 11.40%					£ 5,405	
					£ 52,822	
VAT @ 20%					£ 10,564.36	
					£ 63,386	

Refurb Existing Asset Option 2

	Raigmore * 1Q16	Monklands * 1Q15	Royal Cornwall * 2Q12	Ward 20 St Johns * 2Q16
	£ 2,509.00	£ 3,179.00	£ 2,122.00	£ 2,298.00
Adjusted to 1Q18	5.60%	10.40%	26.10%	4.90%
	£ 140.50	£ 330.62	£ 553.84	£ 112.60
	£ 2,649.50	£ 3,509.62	£ 2,675.84	£ 2,410.60
Average	£ 2,811			
Adjustment to scope as 10% greater	£ 281			
Rate /m2	£ 3,093			

Therefore:	1,992	m2	Total Area		
Theatres and ancillary spaces	995	m2	£ 3,093	£ 3,077,067	
Recovery and wards	997	m2	£ 2,800	£ 2,791,600	
	1,992				
PSCP Design				£ 500,000	(allowance as T&T 15.12.16)
PSC				£ 250,000	(allowance as T&T 15.12.16)
Contingency				£ 150,000	(allowance as T&T 15.12.16)
Equipment				£ 200,000	(allowance as T&T 15.12.16)
				£ 6,968,667	
Client Decant Costs				£ 750,000	(allowance as T&T e-mail 10.03.17)
Upgrade existing accommodation				£ 250,000	(prior to decant)
Vanguard Theatres - 2nr				£ 600,000	(to maintain service during construction)
				£ 8,568,667	
Adjustment for inflation - 8%				£ 685,493.40	
				£ 9,254,161	
VAT @ 20%				£ 1,850,832	
				£ 11,104,993	

** Cost Data Provided by Graham Construction June 2016*

GT GARDINER &THEOBALD

Refurb Existing Asset Option 2

	Raigmore * 1Q16	Monklands * 1Q15	Royal Cornwall * 2Q12	Ward 20 St Johns * 2Q16
	£ 2,509.00	£ 3,179.00	£ 2,122.00	£ 2,298.00
Adjusted to 1Q18	5.60%	10.40%	26.10%	4.90%
	£ 140.50	£ 330.62	£ 553.84	£ 112.60
	£ 2,649.50	£ 3,509.62	£ 2,675.84	£ 2,410.60

Average	£ 2,811				
Adjustment to scope as 10% greater	£ 281				
Rate /m2	£ 3,093				
Therefore:	1,992	m2	Total Area		
Theatres and ancillary spaces	995	m2	£ 3,093	£ 3,077,067	
Recovery and wards	997	m2	£ 2,800	£ 2,791,600	
	1,992				
PSCP Design				£ 500,000	(allowance as T&T 15.12.16)
PSC				£ 250,000	(allowance as T&T 15.12.16)
Contingency				£ -	See optimism bias allowance
Equipment				£ 200,000	(allowance as T&T 15.12.16)
				£ 6,818,667	
Client Decant Costs				£ 750,000	(allowance as T&T e-mail 10.03.17)
Upgrade existing accommodation				£ 250,000	(prior to decant)
Vanguard Theatres - 2nr				£ 600,000	(to maintain service during construction)
				£ 8,418,667	
Adjustment for inflation - 8%				£ 673,493	
				£ 9,092,161	
Optimism Bias at 11.40%				£ 1,036,506	
				£ 10,128,667	
VAT @ 20%				£ 2,025,733	
				£ 12,154,401	

** Cost Data Provided by Graham Construction June 2016*

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Refurb Other Asset (with Increased Area) Option 3

	Raigmore * 1Q16	Monklands * 1Q15	Royal Cornwall * 2Q12	Ward 20 St Johns * 2Q16
	£ 2,509.00	£ 3,179.00	£ 2,122.00	£ 2,298.00
Adjusted to 1Q18	5.60%	10.40%	26.10%	4.90%
	£ 140.50	£ 330.62	£ 553.84	£ 112.60
	£ 2,649.50	£ 3,509.62	£ 2,675.84	£ 2,410.60

Average	£	2,811
Adjustment to scope as 10% greater	£	281
Rate /m2	£	3,093

Therefore:	5,920	m2	Total Area			
Theatres and ancillary spaces	1,667	m2	£ 3,093	£	5,155,248	
Recovery and wards	1,674	m2	£ 2,800	£	4,687,200	
Balance	2,579	m2	£ 2,500	£	6,447,500	
	5,920					
PSCP Design				£	500,000	(allowance as T&T 15.12.16)
PSC				£	250,000	(allowance as T&T 15.12.16)
Contingency				£	150,000	(allowance as T&T 15.12.16)
Equipment				£	200,000	(allowance as T&T 15.12.16)
				£	17,389,948	
Client Decant Costs				£	500,000	(allowance as T&T e-mail 10.03.17)
				£	17,889,948	
Adjustment for inflation - 8%				£	1,431,196	
				£	19,321,143	
VAT @ 20%				£	3,864,229	
				£	**23,185,372**	

** Cost Data Provided by Graham Construction June 2016*

GT GARDINER &THEOBALD

Refurb Other Asset (with Increased Area) Option 3

	Raigmore * 1Q16	Monklands * 1Q15	Royal Cornwall * 2Q12	Ward 20 St Johns * 2Q16
	£ 2,509.00	£ 3,179.00	£ 2,122.00	£ 2,298.00
Adjusted to 1Q18	5.60%	10.40%	26.10%	4.90%
	£ 140.50	£ 330.62	£ 553.84	£ 112.60
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Therefore:	5,920	m2	Total Area			
Theatres and ancillary spaces	1,667	m2	£	3,093	£	5,155,248
Recovery and wards	1,674	m2	£	2,800	£	4,687,200
Balance	2,579	m2	£	2,500	£	6,447,500
	5,920					
PSCP Design					£	500,000
PSC					£	250,000
Contingency					£	-
Equipment					£	200,000
					£	17,239,948
Client Decant Costs					£	500,000
					£	17,739,948
Adjustment for inflation - 8%					£	1,419,196
					£	19,159,143
Optimism Bias at 11.40%					£	2,184,142
					£	21,343,286
VAT @ 20%					£	4,268,657
					£	**25,611,943**

	(allowance as T&T 15.12.16)
	(allowance as T&T 15.12.16)
	See optimism bias allowance
	(allowance as T&T 15.12.16)
	(allowance as T&T e-mail 10.03.17)

** Cost Data Provided by Graham Construction June 2016*

Modular New Build Option 4

Modular New Build Costs as advised by Graham Construction 11.01.18 - £5,116/m2

Total Area:	***5,920***	m2	£	5,116	£	30,286,720

Additional Costs

PSCP Design		inc above	
PSC		inc above	
Contingency	£	150,000	(allowance as T&T 15.12.16)
Equipment	£	205,000	(Pro rata allowance per m2 as T&T 15.12.16)
	£	30,641,720	
Client Decant Costs; from existing to new	£	100,000	(minimal allowance)
	£	30,741,720	
Adjustment for Inflation - 8%	£	2,459,338	
	£	33,201,058	
VAT @ 20%	£	6,640,212	
	£	**39,841,269**	

Modular New Build Option 4

Modular New Build Costs as advised by Graham Construction 11.01.18 - £5,116/m2

Total Area:	***5,920***	m2	£	5,116	£ 30,286,720	
Additional Costs						
PSCP Design					inc above	
PSC					inc above	
Contingency					£ -	See optimism bias allowance
Equipment					£ 205,000	(Pro rata allowance per m2 as T&T 15.12.16)
					£ 30,491,720	
Client Decant Costs; from existing to new					£ 100,000	(minimal allowance)
					£ 30,591,720	
Adjustment for Inflation - 8%					£ 2,447,338	
					£ 33,039,058	
Optimism Bias at 11.40%					£ 3,766,453	
					£ 36,805,510	
VAT @ 20%					£ 7,361,102	
					£ 44,166,612	

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Traditional New Build Option 5

Total Area	***5,920*** m2	£ 3,667	£	21,708,640	
PSCP Design			£	750,000	allowance
PSC			£	400,000	allowance
Contingency			£	250,000	allowance
Equipment			£	340,000	(Pro rata allowance per m2 as T&T 15.12.16)
			£	23,448,640	
Client Decant Costs; from existing to new			£	100,000	(minimal allowance)
			£	23,548,640	
Adjustment for Inflation - 8%			£	1,883,891	
			£	25,432,531	
VAT @ 20%			£	5,086,506	
			£	**30,519,037**	

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Traditional New Build Option 5

Total Area	***5,920*** m2	£ 3,667	£	21,708,640	
PSCP Design			£	750,000	allowance
PSC			£	400,000	allowance
Contingency			£	-	see optimism bias
Equipment			£	340,000	(Pro rata allowance per m2 as T&T 15.12.16)
			£	23,198,640	
Client Decant Costs; from existing to new			£	100,000	(minimal allowance)
			£	23,298,640	
Adjustment for Inflation - 8%			£	1,863,891	
			£	25,162,531	
Optimism Bias @ 11.40%			£	2,868,529	
			£	28,031,060	
VAT @ 20%			£	5,606,212	
			£	**33,637,272**	

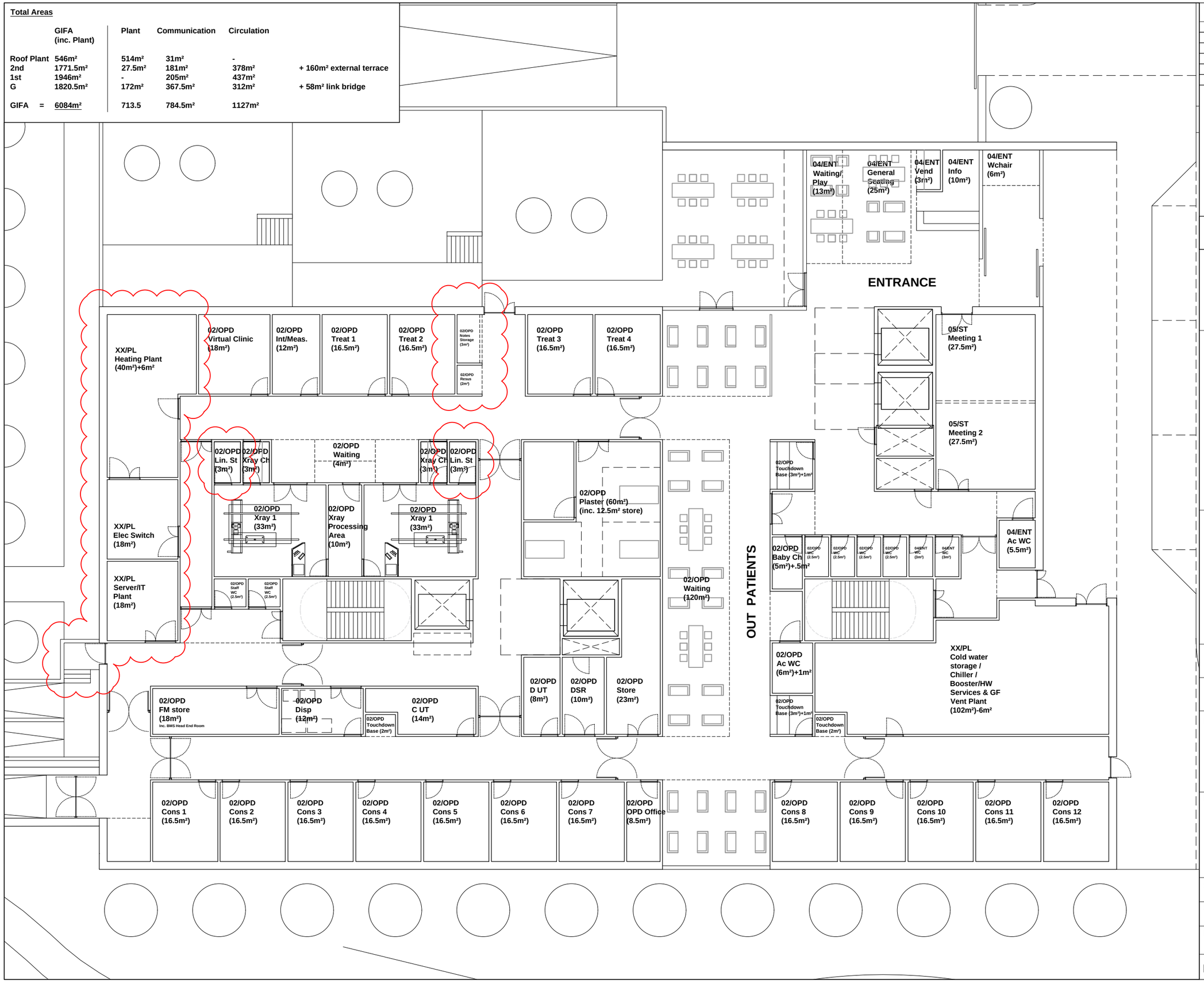
Option	Description	GIFA	Life Cycle Cost (£/m2/annum)	1yr	15 yrs	25yrs	30yrs	60yrs
1	Do minimum	1,992	£ 43.20	£ 86,054.40	£ 1,290,816.00	-	£ 2,581,632.00	£ 5,163,264.00
2	Refubish existing asset	1,992	£ 43.20	£ 86,054.40	£ 1,290,816.00	-	£ 2,581,632.00	£ 5,163,264.00
3	Refurbish other existing asset	*5,920*	£ 43.20	£ 255,744.00	£ 3,836,160.00	-	£ 7,672,320.00	£ 15,344,640.00
4	Modular New Build	*5,920*	£ 43.20	£ 255,744.00	£ 3,836,160.00	£ 44,166,612.20	£ 1,278,720.00	£ 7,672,320.00
5	Traditional New Build	5,920	£ 43.20	£ 255,744.00	£ 3,836,160.00	-	£ 7,672,320.00	£ 15,344,640.00

***Note total reinstatement cost of Modular New Build (Option 4) assumed to occur at 25yrs*

ISO A3 - 297mmx420mm

Total Areas

	GIFA (inc. Plant)	Plant	Communication	Circulation	
Roof Plant	546m²	514m²	31m²	-	
2nd	1771.5m²	27.5m²	181m²	378m²	+ 160m² external terrace
1st	1946m²	-	205m²	437m²	
G	1820.5m²	172m²	367.5m²	312m²	+ 58m² link bridge
GIFA =	6084m²	713.5	784.5m²	1127m²	



DATE	REVISION	REV	DRW	CHK
05/08/19	First Issue	P01	MW	NP
15/08/19	Revised layouts	P02	MW	NP
23/08/19	Revised layouts - usergroup comments	P03	MW	NP
29/08/19	Notes added	P04	MW	NP
30/08/19	Scale bar added	P05	MW	NP
02/09/19	Revised layouts - usergroup comments	P06	MW	NP

Scale (m) 0 1 2 3 4 5

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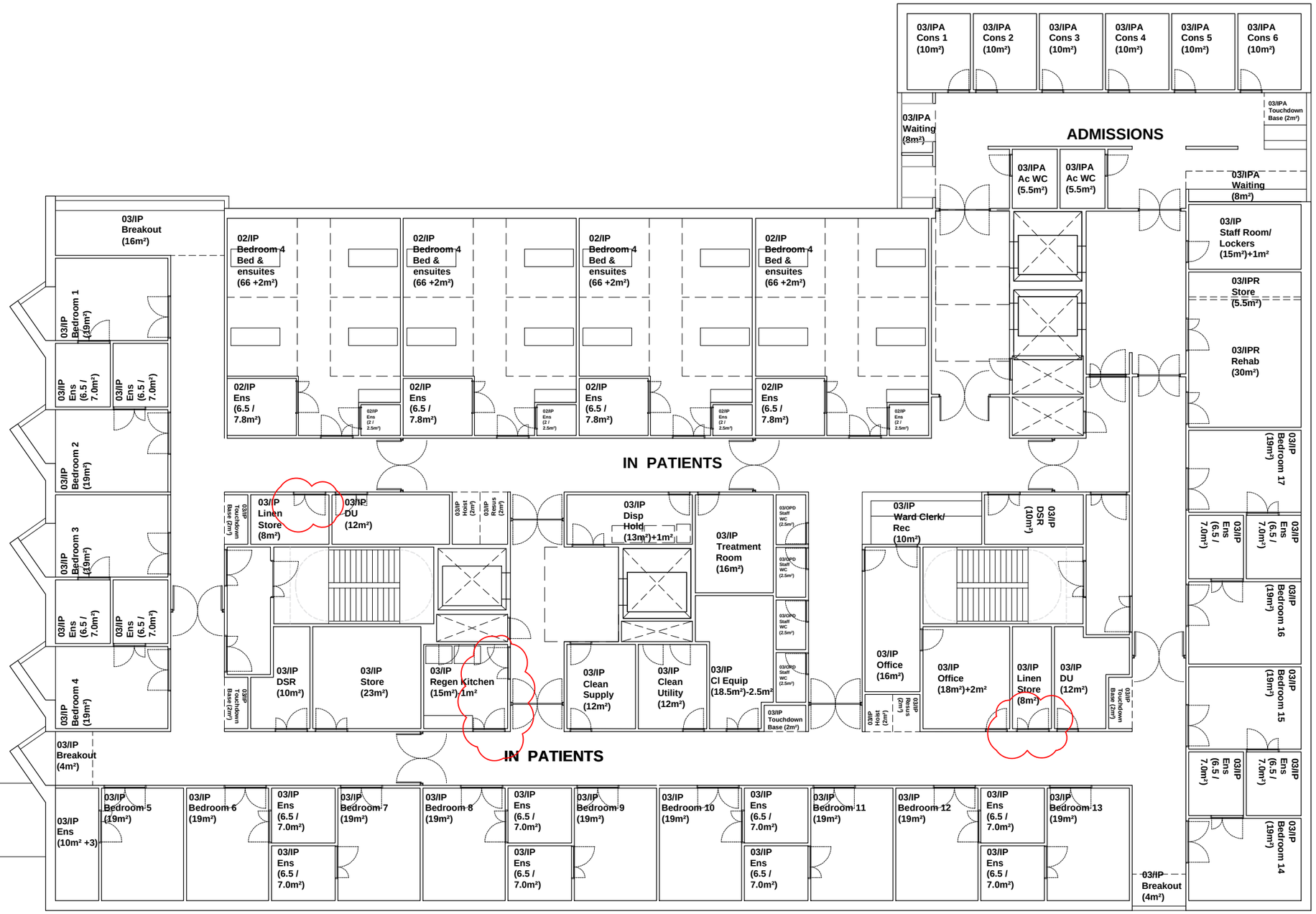
Drawn	Date
NP	05/08/19
Checked	Date
MW	05/08/19

Project Name
NHS Fife
Fife Elective Orthopaedic Center
Victoria Hospital
Kirkcaldy

Drawing Title
Ground Floor
GA Plan

Scale 1:200 @ A3
Sheet Status INFORMATION
Project No. IAGG19-0018
Drawing No. EOC-NOR-XX-00-DR-A-00001 Rev. P06

ISO A3 - 297mmx420mm



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30/08/19	Scale bar added	P05	MW	NP
02/09/19	Revised layouts - usergroup comments	P06	MW	NP

Scale (m) 0 1 2 3 4 5

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Drawn	Date
NP	05/08/19
Checked	Date
MW	05/08/19

Project Name
NHS Fife
Fife Elective Orthopaedic Center
Victoria Hospital
Kirkcaldy

Drawing Title
First Floor
GA Plan

Scale 1:200 @ A3

Sheet Status INFORMATION

Project No. IAGG19-0018

Drawing No. EOC-NOR-XX-01-DR-A-00002 Rev. P06

ISO A3 - 297mmx420mm

DATE	REVISION	REV	DRW	CHK
05/08/19	First Issue	P01	MW	NP
15/08/19	Revised layouts	P02	MW	NP
23/08/19	Revised layouts - usergroup comments	P03	MW	NP
28/08/19	Notes added	P04	MW	NP
30/08/19	Scale bar added	P05	MW	NP
02/09/19	Revised layouts - usergroup comments	P06	MW	NP

Scale (m) 0 1 2 3 4 5

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Drawn	Date
NP	05/08/19
Checked	Date
MW	05/08/19

Project Name
NHS Fife
Fife Elective Orthopaedic Center
Victoria Hospital
Kirkcaldy

Drawing Title
Second Floor
GA Plan

Scale 1:200 @ A3

Sheet Status INFORMATION

Project No. IAGG19-0018

Drawing No. EOC-NOR-XX-02-DR-A-00003 Rev. P06

Benchmark | **Fife Elective Orthopaedic Centre** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0	0	
A.02	The design facilitates the care model	1	4	
A.03	Overall the design is capable of handling the projected throughput	1	4	
A.04	Work flows and logistics are arranged optimally	1	2	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	1	
A.06	Where possible spaces are standardised and flexible in use patterns	1	1	
A.07	The design facilitates both security and supervision	1	4	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	3	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	1	
A.10	The benchmarks in the Design Statement in relation to building USE are met	0	0	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	6	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	3	
B.03	The approach and access for ambulances is appropriately provided	0	0	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	0	0	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	5	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	0	0	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	0	0	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	1	NO
C.02	The ratio of usable space to total area is good	1	1	NO
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	3	
C.04	Any necessary isolation and segregation of spaces is achieved	1	2	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	3	
C.06	There is adequate storage space	1	2	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	2	
C.08	The relationships between internal spaces and the outdoor environment work well	1	2	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0	0	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	2	
D.02	The building and grounds are easy to clean and maintain	1	1	
D.03	The building and grounds have appropriately durable finishes and components	1	1	
D.04	The building and grounds will weather and age well	0	0	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	4	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0	0	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	2	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	2	
E.03	The engineering systems are energy efficient	1	2	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	0	0	
E.06	During maintenance disruption to essential healthcare services is minimised	1	1	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	2	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	0		
F.04	The building and grounds can be readily maintained	0		
F.05	The construction is robust	0		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0		
F.09	The construction contributes to being a good neighbour	0		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	2	
G.02	The building and grounds are interesting to look at and move around in	1	3	
G.03	The building, grounds and arts design contribute to the local setting	1	2	
G.04	The design appropriately expresses the values of the NHS	1	2	
G.05	The project is likely to influence future designs	1	1	
G.06	The design provides a clear strategy for future adaptation and expansion	1	1	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	1	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0	0	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	2	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	1	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	4	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	2	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	1	
H.06	The design maximises the site opportunities and enhances a sense of place	1	1	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0	0	

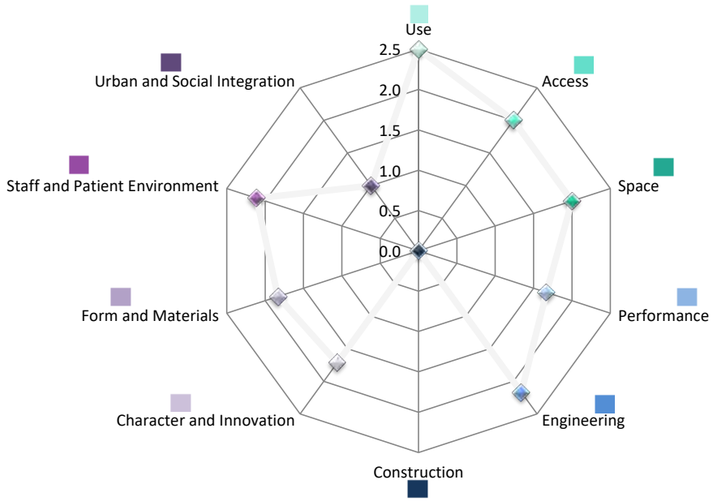
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	1	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	4	
I.03	The design maximises the opportunities for access to usable outdoor space	1	2	
I.04	There are high levels of both comfort and control of comfort	1	2	
I.05	The design is clearly understandable and wayfinding is intuitive	1	3	
I.06	The interior of the building is attractive in appearance	1	1	
I.07	There are good bath/ toilet and other facilities for patients	1	2	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	2	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	2	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0	0	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	1	
J.02	The facility contributes positively to its locality	1	1	
J.03	The hard and soft landscape contribute positively to the locality	1	1	
J.04	The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	1	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	1	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0	0	

AEDET Refresh Benchmark Summary



	Benchmark
Use	2.5
Access	2.0
Space	2.0
Performance	1.7
Engineering	2.2
Construction	0.0
Character and Innovation	1.7
Form and Materials	1.8
Staff and Patient Environment	2.1
Urban and Social Integration	1.0

Weighting	=	Target
2	= >	5 - 6
1	>	3 - 4
0	<	3

AEDET Refresh v1.1 Feb 2016

Fife Elective Orthopaedic Centre

Benchmark

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	A.10	
	B.01	
	B.02	
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	H.06	
	H.07	
	I.01	
	I.02	
	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Target | **Fife Elective Orthopaedic Centre** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	4	
A.02	The design facilitates the care model	1	4	
A.03	Overall the design is capable of handling the projected throughput	1	4	
A.04	Work flows and logistics are arranged optimally	1	4	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	4	
A.06	Where possible spaces are standardised and flexible in use patterns	1	4	
A.07	The design facilitates both security and supervision	1	4	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	4	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	6	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	3	
B.03	The approach and access for ambulances is appropriately provided	0	0	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	0	0	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	5	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	0	0	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	0	0	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0	0	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	
C.02	The ratio of usable space to total area is good	1	4	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	4	
C.04	Any necessary isolation and segregation of spaces is achieved	1	4	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	4	
C.06	There is adequate storage space	1	4	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	3	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	5	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	
D.02	The building and grounds are easy to clean and maintain	1	4	
D.03	The building and grounds have appropriately durable finishes and components	1	4	
D.04	The building and grounds will weather and age well	0	0	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	3	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	4	
D.07	The design minimises maintenance and simplifies this where it will be required	1	4	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	4	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	4	
E.03	The engineering systems are energy efficient	1	4	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	1	4	
E.06	During maintenance disruption to essential healthcare services is minimised	1	4	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	4	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	4	
F.02	Temporary construction work is minimised	1	4	
F.03	The impact of the building process on continuing healthcare provision is minimised	1	4	
F.04	The building and grounds can be readily maintained	1	4	
F.05	The construction is robust	1	4	
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	4	
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	4	
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	4	
F.09	The construction contributes to being a good neighbour	1	4	
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	4	
G.02	The building and grounds are interesting to look at and move around in	1	3	
G.03	The building, grounds and arts design contribute to the local setting	1	3	
G.04	The design appropriately expresses the values of the NHS	1	4	
G.05	The project is likely to influence future designs	1	3	
G.06	The design provides a clear strategy for future adaptation and expansion	1	3	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	3	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	4	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	4	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	3	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	4	
H.04	The external materials and detailing appear to be of high quality and are maintainable	0	0	
H.05	The external colours and textures seem appropriate and attractive for the local setting	0	0	
H.06	The design maximises the site opportunities and enhances a sense of place	0	0	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0	0	

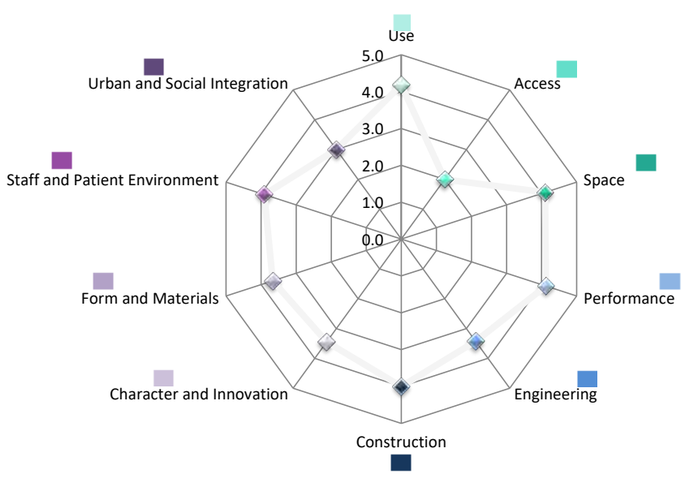
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	4	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	3	
I.03	The design maximises the opportunities for access to usable outdoor space	1	3	
I.04	There are high levels of both comfort and control of comfort	1	4	
I.05	The design is clearly understandable and wayfinding is intuitive	1	4	
I.06	The interior of the building is attractive in appearance	1	4	
I.07	There are good bath/ toilet and other facilities for patients	1	4	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	4	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	3	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	5	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The facility contributes positively to its locality	1	3	
J.03	The hard and soft landscape contribute positively to the locality	1	3	
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	3	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	3	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0	0	

AEDET Refresh Target Summary



	Target
Use	4.2
Access	2.0
Space	4.1
Performance	4.1
Engineering	3.4
Construction	4.0
Character and Innovation	3.4
Form and Materials	3.7
Staff and Patient Environment	3.9
Urban and Social Integration	3.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

AEDET Refresh v1.1 Feb 2016

Fife Elective Orthopaedic Centre

Target

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	B.01	
	B.02	
	B.03	
	B.04	
	B.05	
	B.06	
	B.07	
	B.08	
	B.09	
	C.01	
	C.02	
	C.03	
	C.04	
	C.05	
	C.06	
	C.07	
	C.08	
	C.09	
	D.01	
	D.02	
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	D.04	
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	E.01	
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	G.08	
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	H.07	
	I.01	
	I.02	
	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

OBC | **Fife Elective Orthopaedic Centre** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	5	YES
A.02	The design facilitates the care model	1	5	YES
A.03	Overall the design is capable of handling the projected throughput	1	5	YES
A.04	Work flows and logistics are arranged optimally	1	4	YES
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	5	YES
A.06	Where possible spaces are standardised and flexible in use patterns	1	5	YES
A.07	The design facilitates both security and supervision	1	4	YES
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	5	YES
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	YES
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	4	YES

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	5	Yes
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	3	YES
B.03	The approach and access for ambulances is appropriately provided	1	5	YES
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	0	0	YES
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	YES
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	3	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	YES
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	YES
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	4	YES

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	YES
C.02	The ratio of usable space to total area is good	1	5	YES
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	5	YES
C.04	Any necessary isolation and segregation of spaces is achieved	1	4	YES
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	5	YES
C.06	There is adequate storage space	1	4	YES
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	5	YES
C.08	The relationships between internal spaces and the outdoor environment work well	1	5	YES
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	4	YES

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	YES
D.02	The building and grounds are easy to clean and maintain	1	0	YES
D.03	The building and grounds have appropriately durable finishes and components	1	0	YES
D.04	The building and grounds will weather and age well	1	0	YES
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	4	YES
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	0	YES
D.07	The design minimises maintenance and simplifies this where it will be required	1	3	YES
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	4	YES

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	0	YES
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	0	YES
E.03	The engineering systems are energy efficient	1	0	YES
E.04	There are emergency backup systems that are designed to minimise disruption	1	0	YES
E.05	During construction disruption to essential services is minimised	1	0	YES
E.06	During maintenance disruption to essential healthcare services is minimised	1	0	YES
E.07	The design layout contributes to efficient zoning and energy use reduction	1	0	YES

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	0	YES
F.02	Temporary construction work is minimised	1	0	YES
F.03	The impact of the building process on continuing healthcare provision is minimised	1	0	YES
F.04	The building and grounds can be readily maintained	1	0	YES
F.05	The construction is robust	1	0	YES
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	0	YES
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	0	YES
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	0	YES
F.09	The construction contributes to being a good neighbour	1	0	YES
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	0	YES

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	5	YES
G.02	The building and grounds are interesting to look at and move around in	1	3	YES
G.03	The building, grounds and arts design contribute to the local setting	1	0	YES
G.04	The design appropriately expresses the values of the NHS	1	5	YES
G.05	The project is likely to influence future designs	1	5	YES
G.06	The design provides a clear strategy for future adaptation and expansion	1	3	YES
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	3	YES
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	3	YES

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	4	YES
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	3	YES
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	5	YES
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	0	YES
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	0	YES
H.06	The design maximises the site opportunities and enhances a sense of place	1	5	YES
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	0	YES

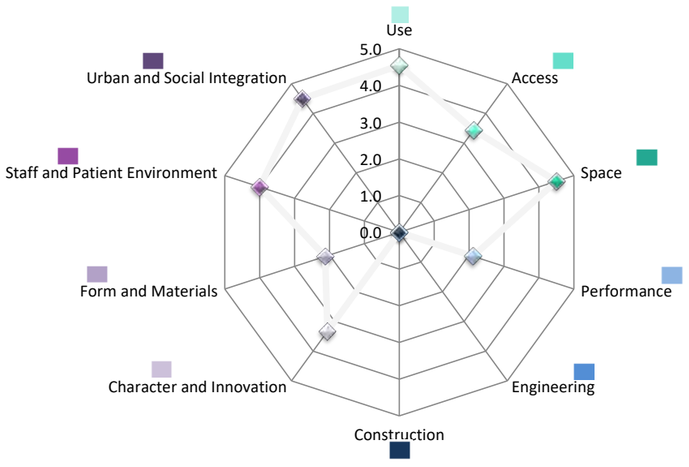
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	5	YES
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	5	YES
I.03	The design maximises the opportunities for access to usable outdoor space	1	5	YES
I.04	There are high levels of both comfort and control of comfort	1	0	YES
I.05	The design is clearly understandable and wayfinding is intuitive	1	3	YES
I.06	The interior of the building is attractive in appearance	1	3	YES
I.07	There are good bath/ toilet and other facilities for patients	1	5	YES
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	5	YES
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	5	YES
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	4	YES

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	5	YES
J.02	The facility contributes positively to its locality	1	5	YES
J.03	The hard and soft landscape contribute positively to the locality	1	4	YES
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	0		YES
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	5	YES
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	4	YES

AEDET Refresh OBC Summary



Target		Progress	
		Prev	Curr
4.2	Use	4.2	4.5
2.0	Access	2.0	3.4
4.1	Space	4.1	4.5
4.1	Performance	4.1	2.1
3.4	Engineering	3.4	0.0
4.0	Construction	4.0	0.0
3.4	Character and Innovation	3.4	3.3
3.7	Form and Materials	3.7	2.1
3.9	Staff and Patient Environment	3.9	4.0
3.0	Urban and Social Integration	3.0	4.5

Weighting	=	Target
2	= >	5 - 6
1	>	3 - 4
0	<	3

NHS National Services Scotland

Health Facilities Scotland

AEDET Refresh v1.1 Feb 2016

Fife Elective Orthopaedic Centre

OBC

Ref	Note
A.01	Some parts of the project need more discussion (I.E Outpatients work flow and radiology). Infection control are still not on board with the single bed/ 4 bed bay room split.
A.02	The new build is delivering what is intended to better the service. The plan for the new build has improved from the first draft as it now incorporates Outpatients making it a
A.03	Still some work to be done, mostly data anaylisis
A.04	Work plans and pathway designs to be changed to reflect usage in the new build
A.05	The buidling has been designed to take into consideration any elective orthopaedic service expansion within the next 20 years
A.06	Consultant, Treatment and Bedrooms will all be standardised and will follow any guidance avaliable. The usage of the rooms will be maximised.
A.07	The waiting areas will be cental areas for staff to be able to look after patients. There is a secuity strategy in place for staff and visitors accessing the unit out of hours, staff will
A.08	The design statement fits the building. Patients are not travelling between different hospital sites for appointments. Accessible for patients using public transport.
A.09	The budiling will be engergy efficient. LED Lighting will be used to save energy. Heat will be maximised by using the sun due to the location of the buidling. There is a potential
A.10	There is good seperation for patients privacy needs, as this is still at the design stage at the moment there is still more work ongoing.
B.01	There are good public transport links, there is a dedicated pathway from the bus stop and there will also be a drop/pick up point and disbaled spaces
B.02	There will be work ongoing to re - provide any other disabled spaces that will be lost during construction, these will be provided over and above the provision associated with
B.03	The drop off point will also be used for patients attending via ambulance transport (patient transport bus rather than an emergency ambulance)
B.04	There will be no service vehicles accessing the site
B.05	Work still to be done on the external design and also around floor surfaces/signage etc for patients with visual impairements and other disabilites. The building will be
B.06	Landscaping to be developed in more detail. There is only a baisc design at this stage. NHS Fife Endowment fund have said they will support any enhancements to outdoor
B.07	There will be a bike stand provided. Staff showers are also provided. However there is currently no cycle path around the Victoria site. A travel plan is to be done.
B.08	There will be enough space for 3 or 4 cars in the drop off (1 patient transport). There is also 8 blue badge spaces. Car Parking will not dominate the enterance.
B.09	There is still some work to be done but at the moment the design is meeting most of the brief.
C.01	Space within the build has not been compromised. Space standards are meeting 100% at the moment. There are no derogations, work is still to be done on the REGEN kitchen
C.02	The distance that staff have to travel in each area has been minimised
C.03	This will be a tight unit, designed for less circulation
C.04	There will be space on the ward for any patients tha require isolation with an infection for example
C.05	There will be breakout spaces on the ward. There will be courtyards outside for patient and staff to access.
C.06	All measuring has been carried out to facilitate suitable storage
C.07	There will be a Rehab Garden for patients. Meeting rooms for staff to use and Patient Information Screens will be avaliabe
C.08	Good relationship between spaces both internal and external for staff and for patients.
C.09	At this stage in the project most of the brief is being achieved
D.01	There is still some work to be done but at the moment estates are happy with the strategy in place
D.02	Too early to score
D.03	Too early to score
D.04	Too early to score
D.05	Work has started but there is still some more work that needs done
D.06	Too early to score, there will be an ecology report done
D.07	Facilities have their own access routes. There is still work to be done around sinks etc
D.08	Although there are a few areas still to early to score, the project is meeting the brief currently and is in fact set to over achieve.
E.01	To early to score
E.02	To early to score
E.03	To early to score
E.04	To early to score
E.05	To early to score
E.06	To early to score
E.07	To early to score
F.01	To early to score
F.02	To early to score
F.03	To early to score
F.04	To early to score
F.05	To early to score
F.06	To early to score
F.07	To early to score
F.08	To early to score
F.09	To early to score
F.10	To early to score
G.01	All ideas behind the build have been clear and interesting from the begining and seem to have a postive reaction with the public.
G.02	There is still work to be done. A better score can be given after there has been a more indepth look at the rehab garden
G.03	Unable to score at the moment
G.04	The design has been very well done and expresses all of the values that the NHS hold.
G.05	Hopefully once complete the buidling will influence future designs
G.06	The buidling has been designed to take into consideration any elective orthopaedic service expansion
G.07	The buidling is designed to contribute to a theraputic strategy but there will also be alternatives taken into consideration for patients who may have sensitivites to natural light (i.e blinds in waiting areas)
G.08	We have agreed to score low at the moment until there has been further design development
H.01	More work required
H.02	More work required
H.03	The building will have a clear and obvious entrance
H.04	Too early to score
H.05	Too early to score
H.06	The building will be aesthetically pleasing consdiering the space limitations
H.07	Still some work to be done, too early to score.
I.01	The design has been carried out to maximise patient dignity, privacy and respect.
I.02	Plenty of green space has been incorporated. All bedrooms will have a window and view, the north side of the building will be 18m from the nearest building and will aim to have clear views of the sky.
I.03	Plenty of green space has been incorporated. There will be a rehab garden, a garden for staff use, a garden for patients/visitors and a staff terrace
I.04	Still to be agreed, too early to comment
I.05	Still in development
I.06	There is an interior design strategy in place
I.07	Toilets are currently over provided for both staff and patients, there is also a baby change room
I.08	The new staff faciliites will be an improvement on the current conditions. Nice staff area including a terrace for socialising at breaks
I.09	Plenty of outdoor spaces to be utilised by staff and patients.
I.10	The brief is currently still under development as there are a few small items to be signed off
J.01	The current design of the building fits in with the other buildings already on the exisiting site
J.02	Once construction has finished the build should contribuite positivly to its locality.
J.03	Still work to be done
J.04	N/A
J.05	There has been a clear vision behind the design. To try and maximise patient, visitor and staff exeperience within the centre.
J.06	There is still some work to be done, we have scored a 4 for the project at the moment until FBC AEDET.

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Outline Business Case Stage

1 AEDET OBC to be recorded near end of OBC Stage and must be submitted for NDAP
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

AEDET Refresh v1.1 Feb 2016

Fife Elective Orthopaedic Centre

Summary

Category	Benchmark	Target	OBC	FBC	POE
Use	2.5	4.2	4.5	0.0	0.0
Access	2.0	2.0	3.4	0.0	0.0
Space	2.0	4.1	4.5	0.0	0.0
Performance	1.7	4.1	2.1	0.0	0.0
Engineering	2.2	3.4	0.0	0.0	0.0
Construction	0.0	4.0	0.0	0.0	0.0
Character and Innovation	1.7	3.4	3.3	0.0	0.0
Form and Materials	1.8	3.7	2.1	0.0	0.0
Staff and Patient Environment	2.1	3.9	4.0	0.0	0.0
Urban and Social Integration	1.0	3.0	4.5	0.0	0.0

NHS National Services Scotland

Health Facilities Scotland

Summary Progress

Initial brief and proposed site for development HAI – SCRIBE Sign off		
HAI-SCRIBE Name of Project	NHS Fife Elective Orthopaedic Centre	
Name of Establishment	Victoria Hospital, Kirkcaldy	National allocated number
HAI-SCRIBE Review Team	Maragret Selbie and Julia Cook	
Completed By (Print Name) Ben Johnston of Thomson Gray		Date 25.07.19
Signature(s) 		Date 25.07.19
Stage 1:		
Additional Notes: Attendess reviewed the project against information that is currently available. In some instances information was not available to confirm if there is a risk that needs to be managed and mitigated at this stage - for exampe, Ground Investigation for item 1.1. Therfore it was agreed to leave this SCRIBE open in draft meantime and review it again once the information becomes available. Items 1.1 and 1.11 remain open at 25 July 2019.		

Note: Advice may be required from specialists on issues such land engineering, etc.

Development stage 1: Initial brief and proposed site for development

Some Hazards in the surrounding areas may present a risk of pollution rather than direct infection with the control measures for the healthcare facility to keep windows and ventilation intakes closed however. However, this may increase the risk of HAI in the healthcare facility. It may be necessary to seek further information as part of the assessment of the hazard. Potential hazards from adjacent sites may include:

- the extent of the dust, noise, smell and other pollution;
- the risk of bacterial or fungal infection from existing industries in the area which may be present e.g. cooling towers and/or demolition or construction works;
- the hours of operation;
- the volume of traffic;
- the kind of materials being handled and processed;
- the volumes of materials being handled and processed;
- the time/frequency of deliveries and site traffic movement volume;
- the deliveries being in closed or open containers;
- the transfer arrangements from delivery vehicles to storage/processing facilities;
- the exhaust flues from the processing plant;
- the prevailing wind direction;
- the areas of the healthcare development most likely to be affected;
- the measures which could be designed into the proposed healthcare development to eliminate or minimise the impact of the pollution and if these measures might increase the risk of HAI;
- risk of flooding;
- asbestos in any existing buildings;
- proximity of rivers or streams;
- previous use of site, greenfield/brownfield site;
- land contamination;
- potentially polluting activities during periods of high rainfall.

Initial Brief and proposed Site for development identification of hazards, associated risks and control measures		
1.a	Brief description of the proposed development project and the planned development site.	Theatres (3 no.), inpatient accommodation (34 beds) and outpatient accommodation (12 consulting rooms). New build adjacent to ward 6.
1.b	Identify any potential hazards associated with the design and/or proposed site.	1. Adjacent to live operational buildings - dust, traffic, fumes. 2. Mainteance of fire escape routes adjacent to site. 3. Mainteance of general access routes for staff/patients. 4. Access for pharmacy deliveries may be comromised.
1.c	Identify any risk associated with the hazards above.	Dust, fumes, noise and general H&S.
1.d	Outline the control measures that require to be implemented to eliminate or mitigate the identified risks. Ensure these are entered on the project risk register.	Seperate meeting to be arranged to discuss fire, access, phrmacy and security measures.
	Control Measures.	
1.e	It has been recognised that control measures identified to address the project risk may have unintended consequences e.g. closure of windows can lead to increased temperatures in some areas. Such issues should be considered at this point, they should be noted and action to address these taken.	
	Potential Problems.	
	Control Measures.	
1.f	Actions to be addressed.	
By		Deadline

Initial Brief and proposed site for development, development stage 1: checklist to ensure all aspects have been addressed		
1.1	Is contaminated land an issue? e.g. asbestos, oils and heavy metals. (Refer to the Contaminated Land Register) Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐
Comments Not considered to be an issue based on existing site information, but can't confirm until project specific Ground Investigation is completed. OPEN		
1.2	Is there a locally recognised increased risk of contamination or infection e.g. cryptosporidium? If yes give details. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		
1.3	Are there industries or other sources in the neighbourhood which may present a risk of infection or pollution e.g. animal by-products processing plant? If yes give details. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		
1.4	If there are any industries or other sources identified in question 1.3 above, will they affect the designed operation of the healthcare system? Consider the planned function of the design as well as issues such as: Ventilation Opening of doors and windows Water systems etc. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		

Initial Brief and proposed site for development, development stage 1: checklist to ensure all aspects have been addressed continued		
1.5	Are there construction/demolition works programmed in the neighbourhood which may present a risk of pollution or infection (including fungal infection)? Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		
1.6	Are there cooling towers in the neighbourhood which may present a risk of *Legionella* infection? Consider also air handling units, water pipes etc. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		
1.7	Does the topography of the site in relation to the surrounding area and the prevailing wind direction present any HAI risk e.g. from entrainment of plumes containing *Legionella*? Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments		
1.9	Will the proposed development impact on the surrounding area in any way which may present potential for infection risk? Consider possible restrictions being applied to the operation of the proposed facility e.g. Facilities Management routes. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments The building could attract nesting birds. The design is to be considerate of this as far as possible.		

Initial Brief and proposed site for development, development stage 1: checklist to ensure all aspects have been addressed continued		
1.10	Will lack of space limit the proposed development and any future expansion or change of use of the facility? Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☒ N/A ☐ Yes ☐ No ☐ N/A ☒
Comments There will be room to expand in the future but this would be on car parking area. The briefing has built in additional space to cope with future projected demand.		
1.11	Has a demolition/refurbishment asbestos survey been carried out? Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐
Comments There will be a requirement to carry out an asbestos survey in connection to breaking into the existing building in order to form the link corrdior. OPEN		
1.12	Has consideration been given to the projected lifespan of the facility and its impact on planning and development?	Yes ☒ No ☐ N/A ☐
Comments Considered as part of the business case where refurbishment, modular and traditional buildings were appraised. Decision taken to pursue a traditional building which has the longest lifespan.		
Additional notes - Stage 1 Options for the location of the building were significantly constrained due to the briefing requirement to form a physical connection to ICU. The site adjacent to ward 6 was the only viable option.		

Development Stage 1: HAI-SCRIBE applied to the initial brief and proposed site for development			
Certification that the following documents have been accessed and the contents discussed and addressed at the Infection Control and Patient Protection Meeting held on.			
Venue	Victoria Hospital Kirkcaldy - Staff Club	Date	25.07.19
'Healthcare Associated Infection System for Controlling Risk in the Built Environment' *'HAI-SCRIBE' Implementation Strategy: Scottish Health Facilities Note (SHFN) 30: Part B*			
Declaration: We hereby certify that we have co-operated in the application of and where applicable to the aforesaid documentation.			

Present

Print name	Signature	Company	Telephone Numbers	Email address
Ben Johnston		Thomson Gray		
Alan Wilson		NHS Fife		
Ashleigh Paterno		NHS Fife		
Margaret Selbie		NHS Fife		
Julia Cook		NHS Fife		
Eleanor Bathgate		NHS Fife		
Craig Webster		NHS Fife		
Paul Moreland		Graham Construction		
Andy Ballantyne		NHS Fife		
David Lowe		NHS Fife		
Susan Grubb		NHS Fife		

Document to be signed once items 1.1 and 1.11 are updated.

Fife Elective Orthopaedic Centre

Design Statement

19 July 2019 – Rev. 5

Investment Objectives:

The investment objectives of the project are:

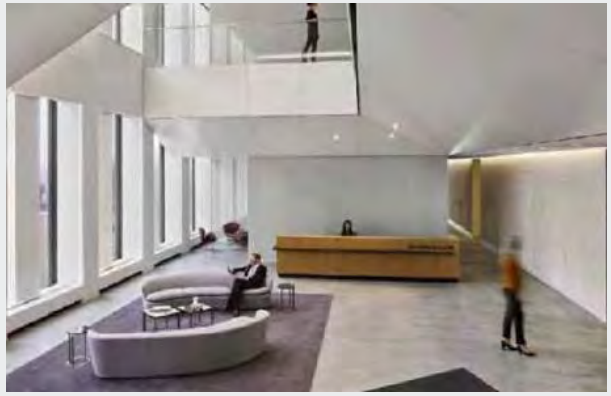
1. Improve infection control and safety risk
2. Improve patient pathways and flows
3. Improve patient perception
4. Improve accommodation in respect to space standards and physical condition

Therefore, in order to realise the above objectives through investment in facilities, the resultant facility must possess the following attributes:

1 Non-negotiables for patients

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
1.1	The appointment/pre-assessment system, staffing/support systems, and the physical environment must make access to the facility easy, calming, welcoming and enable patients to maintain their independence & dignity. The facilities must be accessible from a variety of modes of transport including cars, buses and patient drop-off points.	▪ Pre-arrival systems to prevent the need for sensitive personal information to be sought at check-in and ensure any support in movement (chairs for those with difficulty walking or people to support those with sensory or cognitive impairments) can be booked in advance so that it's there to meet patients at the car/ drop-off/bus stop or reception as agreed. ▪ Information and directions pre-appointment to be provided in accessible format tailored to patient's needs providing direction to correct site entrance and building entrance considering planned transport mode, this will communicate landmarks of identity to look out (*this requires the physical environment to have such landmarks at key points on the journey)* for as well as written signposting. ▪ Good communication in advance of arriving including pictorial images and maps. ▪ Robust wayfinding. Variety of forms to be incorporated including signage and use of colours. As per NHS Guidance on signage formats. ▪ Drop off points and car parking close to entrance. Drop off point will be within 20m of entrance. ▪ Adequate parking including ample blue badge spaces. ▪ There will be a system in place to protect	 ▪ Example of good proximity of drop-off to entrance.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
		patient parking (barrier).	
1.2	The entrance to the facilities will be welcoming and clearly visible.	▪ Entrance will be visible and clearly marked/signed. ▪ Entrance and route to the entrance will be accessible and smoothly paved to avoid tripping hazard. ▪ Floor surface on entrance to prevent tracking of water, dirt. ▪ Doors will be user friendly for all mobilities and suitable for all ages. ▪ Covered sheltered entrance. ▪ Green space/features.	 ▪ The above example draws you towards the entrance without the need for sigange. Green features also offerred. Length of path to entrance excessive however.  ▪ Entrance clearly visible and covered/sheltered entrance provided. Surfaces look flat/smooth.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
1.3	The facilities will include a distinct reception area to help with patient transition into the ward. The area will be comfortable, welcoming and convenient. On entering the building there must be immediate access to assistance, toilet facilities, refreshments and a clear onward direction. The arrival space must be open, bright, soothing, and have positive distractions for those who may wish to linger there a while before moving into the ward/treatment environment.	▪ The entrance/reception area will contain a clearly visible desk in which to greet the patient and provide a sense of security and familiarity. ▪ The reception area will contain flexible seating and will appear bright, homely and welcoming. ▪ The reception will contain natural light but will be considerate of the use of light in respect to the visually impaired. ▪ The reception will contain accessible toilets and all of the toilets provided shall be accessible. All toilets will be fitted to Doc M pack standards. Toilets will be signed for all disabilities (not just wheelchair). Doors will also be marked for left and right transfer. Toilets will be visible from the reception area and therefore the rooms shall be directly adjacent. Distance from furthest waiting seat and toilet will be no longer than 30m. ▪ This reception space will be for arrival only and a separate segregated space will be provided for discharge to reduce patient discomfort/anxiety. ▪ Floor finish to be appropriate for use and will not be too reflective. ▪ Proximity of external door to seating area / reception to be considered to avoid cold air and discomfort.	 ▪ Feeling of space, light and a prominent reception desk feature appeals. ▪ Seating will not be fixed.  ▪ Area bright and spacious. Conection to first floor appeals providing volume, space and light to reception. Connection may also assist with wayfinding.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
			 ▪ Good use of glazing to offer light and excellent connections to other floors.  ▪ Possible examples of colourful, comfortable seating.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
1.4	Admissions area: the experience of waiting prior to surgery must be calming and allow for personal choice in the level of social interaction you have (sit quietly alone, with friends/family) or interact with other patients for mutual support. There must be things to keep your mind occupied. You must feel confident that staff know that you are there, aware of any delays and able to get assistance easily.	▪ Waiting areas to have seating arranged in groups of different sizes and nature. ▪ Space to have view to attractive external space, with direct access out. ▪ Staff area within 10m and visible from waiting. ▪ Sitting area and interview rooms/pods required to deal with pre-assessment of the patient. ▪ Toilets require to be accessible to this area (i.e. directly adjacent).	  ▪ The examples above show comfortable seating that can be private or more social.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
1.5	Bedrooms to be a homely environment where you feel you and your belongings are safe, you can have private time and peace, but you are not disconnected from support in the ward and from your friends/family. This is the first environment for enablement and therapy so it must provide space and encouragement to get out of the bed and engage in everyday activities.	▪ A mix of bed space if desirable consisting of multi-beds and single beds. This will help to cater for different patient needs – some patients prefer to be accommodated in more social areas where as others prefer their own space. Multi-bed areas also help from an assistance perspective where patients sometimes feel more secure in this environment. Bed ratios will also facilitate the services requirements in respect to inpatient and day case. ▪ Activities and views must be equally available from a comfortable seat as from the bed to encourage people to get up and dressed and moving. ▪ Personal control of environment including temperature, ventilation, lighting (including task lighting and mood lighting) and blinds. ▪ Flexible spaces to be adopted to allow male/female patient segregation. ▪ En-suite facilities to be provided. Standard same as outlined in item 3. ▪ No central TV facilities desirable but infrastructure for personal entertainment is. ▪ Placement of clinical facilities at the bedhead space to be carefully considered to facilitate accessibility.	

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
			 

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
1.6	The ward, in its layout and amenities, must reduce isolation and facilitate enablement of patients, encouraging them to be up and about and engaging in normal day to day experiences as quickly as possible. A range of flexible carefully located spaces are to be provided for dining, socialising and reflecting.	▪ Flexible spaces for dining, socialising and reflecting are to be provided. ▪ Appropriate new furniture is to be provided. ▪ Outside space to facilitate rehabilitation and to act as another social/reflective space. Social areas of different types/natures to be incorporated into the wards to allow patients to sit in small groups to talk/eat/be entertained, allowing people a choice of environment and activity. Spaces must be flexible to be used for a range of purposes through the day including special events like a movie night. ▪ There will be a place to make your own refreshments to maximise independence. ▪ At least one of these spaces to be visible from every bedroom, and within 10m of that bedroom door, to encourage people out of their room. ▪ Spaces to be visible/observable from staff locations/routes, and all spaces designed to be occupied for over 30mins to have natural light and a view to greenspace.	 ▪ Covered outide space appeals.  ▪ Bright social space with good use of natural light.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
			 ▪ Quieter spaces with views to the outside.
1.7	The experience of going to, and returning from, theatre must enable patients to retain independence for as long as possible, reduce stress and defend dignity.	▪ Discrete route from ward to theatre away from public routes. Route to be max 20m to allow people to walk and reduce trolley/wheelchair transfer. ▪ Waiting close to theatre (generally 15 mins) to be in nice, calming environment with positive distractions. ▪ Routes into and out of theatres to separate patient flows so people under the influence of sedation are not viewed by other patients. ▪ The Anaesthetic room and theatres must have a calming environment (though clearly clean, professional, clinical) with positive distractions and the means for patients to see, or not see, the procedure. There must be facilities to play music and ceilings shall include interesting artwork or other features to look at when prostrate and conscious.	 ▪ Calming mood lighting in theatre ▪ Art work.

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
			 ▪ Interesting ceiling features.  ▪ Discreet transfer route ▪ Wide / colourful corridors.
1.8	Other considerations	▪ Rehab facilities/spaces will be incorporated into the design.	

Ref. no	Non-negotiables	Benchmark standards	What success might look like (note: images are not always fully reflective of what is required and therefore where appropriate supporting notes have been provided to aid understanding).
		▪ A discharge area similar in environment as the reception area shall be provided. NOTE – this should be separate/segregated from the reception area forming and "in/out" flow.	

Patient consultation workshop took place at the Victoria Hospital in Kirkcaldy on 29 June 2017. The following individuals attended the workshop.

Name	Designation	Contact details
Betty McNeil	Member of Public (Secretary Fife IA)	betty.mcneil@talktalk.net
Dave Davies	Member of Public (Former service user)	dave@stegotc.co.uk
Tina Chapman	Member of Public	tinachapman1@msn.com
Moira Nelson	Senior Charge Nurse	moiranelson@nhs.net
Ben Johnston	Senior Project Manager – Turner & Townsend	ben.johnston@turntown.co.uk
Alan Wilson	Head of Estates / Project Director	alan.wilson1@nhs.net
Pauline Hope	Clinical Nurse Manager	pauline.hope@nhs.net
Deirdre Harris	Consultant Nurse – Infection Control	deirdreharris@nhs.net

Eleanor Bathgate	Theatre Manager	eleanor.bathgate@nhs.net
Lorna Bellingham	Senior Charge Nurse	lorna.bellingham@nhs.net
Fiona Cameron	Service Manager	fiona.cameron1@nhs.net

2 Non-negotiables for staff

Ref. no	Non-negotiables	Benchmark standards	What success might look like
2.1	Sufficient designated rest areas to be provided to allow staff to replenish and unwind in an appropriate environment and carefully considered convenient location.	▪ Rest areas will include appropriate catering facilities. ▪ Rest areas will include areas for meals, snacks, informal meetings and breakout space for informal working ▪ Rest areas can be used by all Orthopaedic staff. ▪ Rest area(s) can be shared with other services so long as they have capacity and do not compromise on travel distances. Rest room(s) with facilities to store/prep food within 50m of ward and 50m of theatre suite. These must have daylight and views and provide space for staff to sit together for social interaction, or alone for a moments peace. They will be designed so that they can be used for other informal purposes (such as sitting with a laptop or coming together for special occasions).	 ▪ Interesting room with good use of light. ▪ Functional space with blend of welfare and desk/table space.  ▪ Clever use of worktops which might be appropriate for informal hotdesking.

Ref. no	Non-negotiables	Benchmark standards	What success might look like
			 ▪ Nice light space with a variety of seating options.  ▪ Possible outdoor seating area.

Ref. no	Non-negotiables	Benchmark standards	What success might look like
2.2	The facilities will include flexible spaces for meetings and multi-use purposes.	▪ The spaces will be carefully designed to accommodate a variety of uses. ▪ Office areas to be designed to bring like activities together, and provide break out spaces for 1to1 conversations, phone calls and impromptu meetings/discussions. ▪ Infrastructure shall be included to facilitate mixed forms of communication and IT. ▪ Lighting shall be appropriate for the tasks/use. ▪ Hotdesking facilities to be provided via functional efficient spaces but with a degree of privacy (screening as an example).	  ▪ Good use of screening to create some privacy in a hot desk environment.
2.3	Appropriate changing areas will be provided close to the working environments.	▪ The changing areas will allow staff to change into their uniforms prior to entering the patient areas. ▪ Changing areas can be used by all Orthopaedic staff so long as acceptable travel distances can be maintained.	
2.4	Adequate storage shall be provided to enable other spaces to function as designed and intended.		

Staff consultation workshop took place at the Victoria Hospital in Kirkcaldy on 23 June 2017. The following individuals attended the workshop.

Name	Designation	Contact details
Moira Nelson	Senior Charge Nurse	moiranelson@nhs.net
Ben Johnston	Senior Project Manager – Turner & Townsend	ben.johnston@turntown.co.uk
Alan Wilson	Head of Estates / Project Director	alan.wilson1@nhs.net
Deirdre Harris	Consultant Nurse – Infection Control	deirdreharris@nhs.net
Eleanor Bathgate	Theatre Manager	eleanor.bathgate@nhs.net
Lorna Bellingham	Senior Charge Nurse	lorna.bellingham@nhs.net
Pauline Hope	Clinical Nurse Manager	pauline.hope@nhs.net
Fiona Cameron	Service Manager	fiona.cameron1@nhs.net
Andrew Ballantyne	Consultant Orthopaedic Surgeon	andyballantyne@nhs.net
Dianne Williamson	Equality and Diversity Lead	dianne.williamson@nhs.net

3 Non-negotiables for visitors

The needs of these people will be largely met by the objectives above, only additional criteria are noted below.

Ref. no	Non-negotiables	Benchmark standards	What success might look like
3.1	Designated visitor toilet facilities will be provided.	▪ The facilities will be accessible to the standard noted earlier (refer to item 1.3).	
3.2	The facility must enable staff to support patients and family members in their understanding of the issues with treatment and provide space for them to deal with any impact on themselves away from the patient.	▪ There must be space on the ward for staff members to have quiet conversations with family members, to provide information and support to them in their role as carers and for them to sit in peace and privacy when needed. This must be in an environment that is calming and homely, with daylight and privacy.	 ▪ This space could be a room as referenced above, or provided by a flexible quiet seating area as referenced below. 

4 Alignment of investment with policy

This section is about the additional benefits (not directly related to the service to be provided) that can be delivered, so things like contributing to regeneration, health promotion, good corporate citizenship etc

Ref. no	Non-negotiables	Benchmark standards	What success might look like
4.1	Contribution towards Victoria Hospital's estate strategy.	▪ The project will contribute towards Victoria Hospital's estate strategy. This involves creating opportunities for the clinical care to be withdrawn from the tower block. ▪ Any new development will seek to rebalance any displaced car-parking. ▪ Existing bus, taxi, drop off and hospital servicing will not be negatively impacted by the project. ▪ The project will look to maintain and if possible, enhance accessibility, understanding and the visual impact of the wider site. This may include improvement around site access, wayfinding, carparking, nature and connections to relevant adjacent services. Any new facility will be planned in the context of the existing site helping to improve the visual impact of the hospital.	
4.2	Energy	The design will positively contribute to the energy and emissions criteria as described within current Scottish Government policies; i.e. evidenced measured reportable 59% emissions reduction compared with 2015 levels by 2032: per: Duties of Public Bodies: Reporting Requirements, and Energy Efficient Scotland Road Map (May 2018). The facilities shall be designed so that estimated	

Ref. no	Non-negotiables	Benchmark standards	What success might look like
		operational energy consumption does not exceed 300kWhr/m2. With respect to thermal comfort the design will evidence through the use of appropriate current and future weather data that none of the rooms within the facilities will exceed guideline temperatures as set out in CIBSE TM52 and TM59.	
4.3	Sustainability	Conduct a BREEAM assessment per Scottish Capital Investment Manual to obtain a BREEAM Healthcare or equivalent 'Excellent ' rating.	
4.3	Expansion	The design shall consider the means for departments to be used flexibly, adapted or expanded. National policy, clinical advancements and technological changes will impact on the way services are provided in the future, and the Facilities need to be sufficiently flexible to handle these advances. The design process shall demonstrate that potential change for expansion has been considered for rooms, departments and infrastructure. The structural grid, construction technique, structure, service penetrations and engineering services strategy shall demonstrate that the design proposals for expansion, adaptation and flexibility are co-ordinated. Benchmarks will include; • Maximising the use of repeatable rooms • Modular grid • Adequate infrastructure capacity to deal	

Ref. no	Non-negotiables	Benchmark standards	What success might look like
		with future change *Note: the above text does not seek to unnecessarily build a larger facility. It does however call for consideration and engagement within the Project Team to demonstrate that expansion and flexibility has been adequately considered and built into the proposals where there is clear justification for doing so.*	

Design Milestone	Authority of Decision	Additional Skills	How the Criteria will be evaluated and valued	Information needed to allow evaluation
Site Selection	NHS Fife	Architect		Design feasibility study
Selection of design team and PSCP	NHS Fife	Project Manager	As per High Level Information Pack criteria and scoring	PSCP responses
Project Brief	NHS Fife	Project Manager and PSCP	NHS Fife to develop draft brief. Project Manager and PSCP to assist NHS Fife with development.	Brief to be frozen by the end of RIBA Stage 2.
Acceptance of Concept Design	NHS Fife Project Manager	NDAP	AEDET, NDAP, Design Statement RIBA Stage 2 and Project Brief.	Information to be aligned with RIBA Stage 2 and NDAP OBC requirements.
Acceptance of technical design	NHS Fife Project Manager	NDAP	AEDET, NDAP, Design Statement RIBA Stage 4 and Project Brief.	Information to be aligned with RIBA Stage 4 and NDAP FBC requirements.
Post Project and Post Occupancy Evaluations	NHS Fife	Project Participants	Benefits outlined within the business case will be measured to ascertain if they have been realised. Post Project Evaluation to be undertaken in line with SCIM Guidance.	Data will be required circa 12 months following occupation in order to measure if the benefits have been realised. This data will be compared against the "as existing" data to measure the extent of improvement and whether the benefits have been realised.

EOC-NOR-XX-XX-RP-A-00014

NORR

NHSF Orthopaedic Elective Care Centre - Schedule of Derogations

REV P01 04/10/2019

Source - HFS complete list of publications October 2018

Schedule is a libe document that will be updated through FBC

Title	Section	Category	Reference	Date	Relevance Y/N	Derogation	Notes/Clarifications
Requirements for Compliant CDUs (GUID 5014) [PDF 387Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5014	Nov-16	N		
National Decontamination Guidance on loan devices (GUID 5002) [PDF 304Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5002	Jul-15	N		
Management of reusable surgical instruments during transportation storage and after clinical use (GUID 5010 Part B) [PDF 758Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5010 Part B	Dec-14	N		
Management of reusable surgical instruments during transportation storage and after clinical use (GUID 5010 Part A) [PDF 1017Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5010 Part A	Dec-14	N		
Requirements for Compliant Endoscope Decontamination Units (GUID 5013) [PDF 283Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5013	Nov-14	N		
Provision of Compliant Podiatry Instruments (GUID 5007) [PDF 319Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5007	Nov-14	N		
Guidance for Disposal and Recycling of Medical Devices (GUID 5008) [PDF 364Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5008	Oct-14	N		
NHSScotland Guide to the Carriage of Dangerous Goods Regulations with respect to Used Medical Devices (GUID 5006) [PDF 281Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5006	Dec-13	N		
Compliant Dental Local Decontamination Units in Scotland Primary Care (GUID 5005) [PDF 140Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID 5005	May-13	N		
Decontamination Facilities - Central Decontamination Unit (SHPN 13 Part 1) [PDF 910Kb]	Decontamination	Scottish Health Planning Note (SHPN)	SHPN 13 Part 1	Jul-11	N		
Decontamination Facilities: Endoscope Decontamination Units (SHPN 13 Part 3) [PDF 559Kb]	Decontamination	Scottish Health Planning Note (SHPN)	SHPN 13 Part 3	Sep-10	N		
Decontamination Facilities (SHPN 13 Part 2) [PDF 582Kb]	Decontamination	Scottish Health Planning Note (SHPN)	SHPN 13 Part 2	Jun-08	N		
Operational management Washer-disinfectors (SHTM 2030 Part 2) [PDF 620Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2030 Part 2	Oct-01	N		
Design considerations Washer-disinfectors (SHTM 2030 Part 1) [PDF 1Mb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2030 Part 1	Oct-01	N		
Validation and Verification Washer-disinfectors (SHTM 2030 Part 3) [PDF 581Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2030 Part 3	Oct-01	N		
Overview and management responsibilities Sterilization (SHTM 2010 Part 1) [PDF 265Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 1	Jun-01	N		
Design considerations Sterilization (SHTM 2010 Part 2) [PDF 645Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 2	Jun-01	N		
Validation and verification Sterilization (SHTM 2010 Part 3) [PDF 1Mb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 3	Jun-01	N		
Clean steam for sterilization (SHTM 2031 Part 1) [PDF 588Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2031 Part 1	Jun-01	N		
Operational management Sterilization (SHTM 2010 Part 4) [PDF 779Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 4	Jun-01	N		
Good Practice Guide Sterilization (SHTM 2010 Part 5) [PDF 1Mb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 5	Jun-01	N		
Testing and validation protocols Sterilization (SHTM 2010 Part 6) [PDF 338Kb]	Decontamination	Scottish Health Technical Memorandum (SHTM)	SHTM 2010 Part 6	Jun-01	N		
Pressure Systems: Policies and Guidance (SHTM 08-08) [PDFÂ 464Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-08	Feb-15	Y		
Confined Spaces policies procedures and guidance (SHTM 08-07) [PDFÂ 950Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-07	Feb-15	Y		
The Control of Legionella hygiene 'safe' hot water cold water and drinking water systems emerging technologies: Solar domestic hot water heating	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-02 Part A	Apr-14	N		
HAI-SCRIBE Implementation strategy and assessment process (SHFN 30 Part B) [PDFÂ 827Kb]	Engineering	Scottish Health Facilities Note (SHFN)	SHFN 30 Part B	Jan-14	Y		Staged HAI-Scribe process ongoing. Issues / Derogations tbc
Ventilation for Healthcare Premises: Design and Validation (SHTM 03-01) [PDFÂ 26Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 03-01	Dec-13	Y	Clause 2.59 - Duplicate stand-by air handling plant will not be provided in AHUs serving theatres	Clause 4.13 - No colour coding will be provided on air handling units.It is assumed that air handling units will be delivered in a standard colour from the factory. Clarification on the requirement for this derogation is required.
Healthcare engineering: Policies and Principles best practice guidance [PDFÂ 507Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 00	Dec-13	Y		

Electrical safety guidance for low voltage systems (SHTM 06-02) [PDFÂ 1Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 06-02	Feb-13	Y		
The control of Legionella hygiene â€˜safe€™ hot water cold water and drinking water systems: TVC Testing Protocol (SHTM 04-01 Part C) [PDFÂ 325	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part C	Feb-13	Y		
Lifts (SHTM 08-02) [PDFÂ 1Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-02	Feb-13	Y		
Water Safety for Healthcare Premises: Operational Procedures and exemplar Written Schemes (SHTM 04-01 Part G) [PDFÂ 2Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part G	Feb-13	Y		
Medical Gas Pipeline Systems: Design Installation Validation and Verification (SHTM 02-01 Part A) [PDFÂ 4Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 02-01 Part A	Jun-12	Y		
Medical Gas Pipeline Systems: Operational Management (SHTM 02-01 Part B) [PDFÂ 2Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 02-01 Part B	Jun-12	Y		
Building Management Systems: Operational Management (SHTM 08-05 Part D) [PDFÂ 278Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-05 Part D	Apr-12	Y		
Building Management Systems: Validation and Verification (SHTM 08-05 Part C) [PDFÂ 325Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-05 Part C	Apr-12	Y		
Building Management Systems: Design Considerations (SHTM 08-05 Part B) [PDFÂ 723Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-05 Part B	Apr-12	Y		
Building Management Systems: Overview and Management Responsbilities (SHTM 08-05 Part A) [PDFÂ 341Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-05 Part A	Apr-12	Y		
The Control of Legionella hygiene 'safe' hot water cold water and drinking water systems: Alternative materials and filtration (SHTM 04-01 Part E) [	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part E	Dec-11	Y		
The control of legionella hygiene 'safe' hot water cold water and drinking water systems: Chloramination of water supplies (SHTM 04-01 Part F) [PD	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part F	Dec-11	Y		
The Control of Legionella hygiene 'safe' hot water cold water and drinking water systems emerging technologies: Rainwater harvesting (SHTM 04-0	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-02 Part B	Dec-11	Y		
The Control of Legionella hygiene 'safe' hot water cold water and drinking water systems emerging technologies: Grey water recovery (SHTM 04-02	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-02 Part C	Dec-11	Y		
Pneumatic Tube Transport Systems: Overview and Management Responsbilities (SHTM 08-04 Part A) [PDFÂ 358Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-04 Part A	Nov-11	N		
Pneumatic Tube Transport Systems: Design Considerations and Good Practice Guide (SHTM 08-04 Part B) [PDFÂ 696Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-04 Part B	Nov-11	N		
Electrical services supply and distribution: Operational management (SHTM 06-01 Part B) [PDFÂ 638Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 06-01 Part B	Oct-11	Y		
Ventilation for Healthcare Premises - Design and Validation (SHTM 03-01 Part A) [PDFÂ 3Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 03-01 Part A	Oct-11	Y		
Ventilation for Healthcare Premises: Operational Management and Performance Verification (SHTM 03-01 Part B) [PDFÂ 319Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 03-01 Part B	Oct-11	Y		
Electrical services supply and distribution: Design considerations (SHTM 06-01 Part A) [PDFÂ 3Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 06-01 Part A	Oct-11	Y		
Electrical Safety Guidance for High Voltage Systems (SHTM 06-03) [PDFÂ 1Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 06-03	Sep-11	N		
The control of Legionella hygiene â€˜safeâ€™ hot water cold water and drinking water systems: Disinfection of domestic water service (SHTM 04-01	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part D	Aug-11	Y		
Specialist Services - Bedhead Services (SHTM 08-03) [PDFÂ 531Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-03	Jul-11	Y	From the 1:50 review meeting with NHSF the outlets required for bedhead services deregate from the SHTM-08-03 bedhead services table	
Specialist Services - Pathology Laboratory Gas Systems (SHTM 08-06) [PDFÂ 702Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-06	Jul-11	N		
Specialist Services: Acoustics (SHTM 08-01) [PDFÂ 2Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 08-01	May-11	Y		1.2 Acoustic consultant to be engaged at next stage therefore any acoustic issues are based on a series of high level assumptions.2.8 Existing site acoustic / vibration survey to be completed at next stage. External existing ambient noise levels unknown. Assumed that openable windows / vents are acceptable on all elevations. 2.50/2.66 Sound insulation for rooms - to be confirmed and design developed at next stage. 2.89 Structure bourne sound - requirements to be confirmed by Acoustic consultant in relation to floor to floor acoustic separation.2.36-2.46 / 2.122 Noise/ vibration from plant/ plantrooms to be considered at the next stage. SE to comment
Dental compressed air and vacuum systems (SHTM 2022 Supp 1) [PDFÂ 2Mb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 2022 Supp 1	Mar-04	N		
Overview and management responsibilities Mains signalling (SHTM 2035 Part 1) [PDFÂ 163Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 2035 Part 1	Jun-01	N		

Design Considerations Mains signalling (SHTM 2035 Part 2) [PDFÂ 292Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 2035 Part 2	Jun-01	N		
Validation and Verification / Operational Management Mains signalling (SHTM 2035 Part 3) [PDFÂ 266Kb]	Engineering	Scottish Health Technical Memorandum (SHTM)	SHTM 2035 Part 3	Jun-01	N		
NHSScotland waste management guidance: Compendium of regulatory requirements (SHTN 3 Part C) [PDFÂ 1Mb]	Environment	Scottish Health Technical Note (SHTN)	SHTN 3 PART C	Feb-15	N		
NHSScotland waste management guidance: Waste management policy template (SHTN 3 Part B) [PDFÂ 265Kb]	Environment	Scottish Health Technical Note (SHTN)	SHTN 3 Part B	Feb-15	N		
NHSScotland waste management guidance: Guidance and example text for waste procedures (SHTN 3 Part D) [PDFÂ 702Kb]	Environment	Scottish Health Technical Note (SHTN)	SHTN 3 Part D	Feb-15	N		
NHSScotland waste management guidance. Segregation Chart (SHTN 3) [PDFÂ 287Kb]	Environment	Scottish Health Technical Note (SHTN)	SHTN 3	Feb-15	N		
NHSScotland waste management guidance: Summary of requirements - best practice overview (SHTN 3 Part A) [PDFÂ 639Kb]	Environment	Scottish Health Technical Note (SHTN)	SHTN 3 Part A	Feb-15	N		
HAI-SCRIBE questionsets and checklists (SHFN 30 Part C) [PDFÂ 1Mb]	Environment	Scottish Health Facilities Note (SHFN)	SHFN 30 Part C	Jan-15	Y		Staged HAI-Scribe process ongoing. Issues / Derogations tbc
Water safety for healthcare premises: Operational management (SHTM 04-01 Part B) [PDFÂ 804Kb]	Environment	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part B	Jul-14	Y		
Water safety for healthcare premises: Design installation and testing (SHTM 04-01 Part A) [PDFÂ 2Mb]	Environment	Scottish Health Technical Memorandum (SHTM)	SHTM 04-01 Part A	Jul-14	Y	Section 4 Water Softening - No requirement for water softening plant. Section 5 Filtration - requirement omitted for filtration on incoming mains water from Scottish Water main. Clause 7.3 24 24 hour storage - Water Storage to be based on 180 litres per bed with a diversity of 50% as stated in CIBSE Guide G equates to storage of 12 hours per day.	
HAI-SCRIBE Manual Information for Design Teams Construction Teams Estates & Facilities and Infection Prevention & Control Teams (SHFN 30 Part	Environment	Scottish Health Facilities Note (SHFN)	SHFN 30 Part A	Jan	Y		Staged HAI-Scribe process ongoing. Issues / Derogations tbc
Implementation and Communication Plan NCSS vr 2.0 (SHFN 01-03) [PDFÂ 97Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 01-03	Dec-16	N		
NHSScotland National Cleaning Services Specification (SHFN 01-02) [PDFÂ 906Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 01-02	Jun-16	N		
National Facilities Monitoring Framework Manual (SHFN 01-01) [PDFÂ 12Mb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 01-01	Jun-16	N		
Food in Hospitals (SHFN 04-01) [PDFÂ 1Mb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 04-01	Mar-16	N		
NHSScotland Policy for Food Allergen Management (SHFN 04-04) [PDFÂ 115Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 04-04	Mar-14	N		
NHSScotland National Food Safety Assurance Manual (SHFN 04-03) [PDFÂ 584Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 04-03	Mar-14	N		
Security Services Standards for NHSScotland (SHFN 03-02) [PDFÂ 231Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 03-02	Mar-14	N		
Portering Services Standards for NHSScotland (SHFN 02-01) [PDFÂ 1Mb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 02-01	Jun-10	N		
Security Management Framework for NHS Boards in Scotland (SHFN 03-01) [PDFÂ 488Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 03-01	Dec-08	N		
Guidance on the use of Mobile Communication Devices in healthcare premises (SHFN 03-03) [PDFÂ 2Mb]	Facilities	Scottish Health Facilities Note (SHFN)	SHFN 03-03	Feb-08	N		
Transport management and car parking (SHTM 07-03) [PDFÂ 525Kb]	Facilities	Scottish Health Technical Memorandum (SHTM)	SHTM 07-03	Jan-08	N		
NHSScotland Travel Plan Guidance (SHTM 07-04) [PDFÂ 407Kb]	Facilities	Scottish Health Facilities Note (SHFN)	SHTM 07-04	Sep-07	N		
Property Appraisal Manual V.3 (SHTN 00-01) [PDFÂ 4Mb]	Property & Capital F	Scottish Health Technical Note (SHTN)	SHTN 00-01	Aug-16	N		
Dementia-friendly Health and Social Care Environments (HBN 08-02) [PDFÂ 16Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 08-02	Mar-15	Y		Design to be developed at next stage
Out-patient care: Sexual and reproductive health clinics (HBN 12-01 sup A) [PDFÂ 1Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 12-01 sup A	Oct-14	N		
Renal Care - Main renal unit (HBN 07-02) [PDFÂ 1Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 07-02	Oct-14	N		
Diagnostic imaging: PACS and specialist imaging (HBN 06 vol 2) [PDFÂ 589Kb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 06 vol 2	Oct-14	N		

Facilities for surgical procedures (HBN 26 vol 1) [PDFÂ 3Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 26 vol 1	Oct-14	Y		General - Detail on room FF&E activity spaces etc tbc at next stage. 2.28,2.31, 4.148 Provide natural light, in surgical facilities, staff rest, theatres; and recovery unit .4.8 'corridors sufficient for passage of 2 beds' this would require a width of 2960 clear) - corridors in current design this width at the theatres and theatre lifts only. Elsewhere corridors are suitable for the passage of a single bed (2150 clear) 4.106 cardiac arrest trolley should be located in a recess in the main theatre corridor. Trolley is located in recovery area. Recess could be extended to allow for additional trolley.
Hospital accommodation for children and young people (HBN 23) [PDFÂ 2Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 23	Oct-14	N		
Medicines management: Pharmacy and radiopharmacy facilities (HBN 14-01) [PDFÂ 2Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 14-01	Oct-14	Y		Detailed elements tbc at next design stage
Mental health - Adult acute units (HBN 03-01) [PDFÂ 2Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 03-01	Oct-14	N		
Core guidance - Clinical and clinical support spaces (HBN 00-03) [PDFÂ 15Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 00-03	Oct-14	Y		Typical 1:50 layouts issued for review. Spatial compliance generally followed, final derogations tbc. Detailed elements tbc at next design stage.
Core guidance - General design for healthcare buildings (HBN 00-01) [PDFÂ 4Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 00-01	Oct-14	Y		Detailed elements tbc at next design stage
Cardiac facilities (HBN 01-01) [PDFÂ 1Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 01-01	Oct-14	N		
Core guidance - Sanitary spaces (HBN 00-02) [PDFÂ 9Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 00-02	Oct-14	Y		Detailed elements, door positions, activity spaces room proportions etc tbc at next design stage
Cancer treatment facilities (HBN 02-01) [PDFÂ 1Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 02-01	Oct-14	N		
In-patient facilities for older people (HBN 37) [PDFÂ 5Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 37	Oct-14	N		
Facilities for pathology services (HBN 15) [PDFÂ 1Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 15	Oct-14	N		
Renal care: Satellite dialysis unit (HBN 07-01) [PDFÂ 2Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 07-01	Oct-14	N		
Core guidance - Planning for a resilient healthcare estate (HBN 00-07) [PDFÂ 2Mb]	Property & Capital F	DoH guidance (HBN; HTM; Other)	HBN 00-07	Oct-14	N		
Police Custody Medical Facilities (SHPN 11-10) [PDFÂ 812Kb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 11-10	Jan-14	N		
Fire safety - Risk assessment (SHTM 86) [PDFÂ 880Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 86	Jun-13	Y		Output from fire risk assessments (by others) tbc
Fire safety - Atria in healthcare premises (SHTM 81 part 3) [PDFÂ 266Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 81 part 3	Apr-13	N		
Fire safety - alarm and detection systems (SHTM 82) [PDFÂ 207Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 82	Apr-13	Y		
Property appraisal guidance for NHSScotland - Risk based methodology (SHTN 00-03) [PDFÂ 318Kb]	Property & Capital F	Scottish Health Technical Note (SHTN)	SHTN 00-03	Nov-10	N		
Strategic property and asset management guidance for NHSScotland - PAMS (SHTN 00-02) [PDFÂ 381Kb]	Property & Capital F	Scottish Health Technical Note (SHTN)	SHTN 00-02	Nov-10	N		
Adult in-patient facilities (SHPN 04-01) [PDFÂ 1Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 04-01	Oct-10	Y	*In new developments where there are clinical reasons for not making 100% single room provision they should be clearly identified and articulated in the appropriate Business Case* ' Single bed provision is over 50% 17single /16 multi-bed spaces. Refer to business case and NHSF SBAR reports for further justification	Ensuite door sizes / hoist access to be considered at next stage.
Sanitary Assemblies (SHTM 64) [PDFÂ 1Mb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 64	Dec-09	Y		To be developed at next stage
Core Guidance - Resilience Planning for the Healthcare Estate (SHPN 00-07) [PDFÂ 2Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 00-07	Sep-09	N		
Textiles and furniture (SHTM 87) [PDFÂ 422Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 87	Aug-09	N		
Building component series - Flooring (SHTM 61) [PDFÂ 256Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 61	Jul-09	Y		Flooring types to be finalised at next stage. Flooring cleaning regime tbc. Contamination and slip risk assessments to take place

Fire safety - Fire engineering of healthcare premises (SHTM 81 part 2) [PDFÂ 625Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 81 part 2	Jul-09	Y	5.8 Upper floor above 7.5m ' should comprise at least 4 compartments, each of which should have an area of at least 500m2' 3 of the compartments are below this area. Refer to separate Fire stragegy report appendix A for fire engineering solution.	In general the building is designed to meet the requirements of SHTM 81 Part 1 and the 'Non-domestic Technical Handbook'.
Fire safety - Precautions in new healthcare premises (SHTM 81 part 1) [PDFÂ 214Kb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 81 part 1	Jul-09	Y		5.11 '*Where an escape route from a room is into an unprotected open plan zone and/or passes a waiting or sub-waiting area, or any escape route passes through or involves crossing a large open plan area, the escape route must be clearly defined by a fixed screen, partition or similar means*' glass screens/ dwarf walls / fixed seating to be considered at the next stage.
Building component series - Flooring - matrix example (SHTM 61 app 1a) [XLSÂ 554Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 61 app 1a	Jul-09	Y		To be completed at the next stage
In-patient accommodation - supplement 1 - Isolation facilities in acute settings (SHPN 4 sup 1) [PDFÂ 649Kb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 4 sup 1	Sep-08	N		
Community Pharmacy Premises in Scotland Providing NHS Pharmaceuticals (SHPN 36 part 3) [PDFÂ 2Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 36 part 3	Aug-08	Y		Detailed elements tbc at next design stage
Fire safety - Precautions in existing healthcare premises (SHTM 85) [PDFÂ 1Mb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 85	Dec-07	N		
Wayfinding - effective wayfinding and signing systems guidance for healthcare facilities (SHTM 65) [PDFÂ 4Mb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 65	Oct-07	Y		Detailed elements tbc at next design stage
Access - checklist for people with dementia in healthcare premises (SHFN 03) [PDFÂ 2Mb]	Property & Capital F	Scottish Health Facilities Note (SHFN)	SHFN 03	Oct-07	Y		Detailed elements tbc at next design stage
Fire safety - Prevention and control of deliberate fire-raising in healthcare premises v3.0 (SFPN 6) [PDFÂ 153Kb]	Property & Capital F	Scottish Fire Practice Note (SFPN)	SFPN 6	Sep-07	N		
Accident and emergency facilities for adults and children (SHPN 22) [PDFÂ 1Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 22	Jan-07	N		
Building component series -Laboratory storage systems (SHTM 67) [PDFÂ 1Mb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 67	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Cubicle curtain track (SHTM 66) [PDFÂ 211Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 66	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Demountable storage systems (SHTM 62) [PDFÂ 284Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 62	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Fitted storage systems (SHTM 63) [PDFÂ 459Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 63	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Internal doorsets (SHTM 58) [PDFÂ 278Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 58	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Ironmongery (SHTM 59) [PDFÂ 253Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 59	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -User manual (SHTM 54) [PDFÂ 75Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 54	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Windows (SHTM 55) [PDFÂ 418Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 55	Dec-06	Y		Natural ventilation strategy to some rooms -Inward opening windows when fully open are guarded so that no gap in the opening exceeeds 100mm. Note projection of window into room Where natural and mechanically ventilated outward opening lights restricted to 100mm.
Building component series -Protection (SHTM 69) [PDFÂ 1Mb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 69	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Partitions (SHTM 56) [PDFÂ 270Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 56	Dec-06	Y		Detailed elements tbc at next design stage
Building component series -Internal glazing (SHTM 57) [PDFÂ 139Kb]	Property & Capital F	SHTM Building Component (SHTM)	SHTM 57	Dec-06	Y		Detailed elements tbc at next design stage
General Medical Practice Premises in Scotland (SHPN 36 part 1) [PDFÂ 3Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 36 Part 1	Jul-06	N		
NHS Dental Premises in Scotland (SHPN 36 Part 2) [PDFÂ 986Kb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 36 Part 2	Jun-06	N		
Fire safety - General fire precautions in healthcare premises (SHTM 83) [PDFÂ 3Mb]	Property & Capital F	Scottish Health Technical Memorandum (SHTM)	SHTM 83	Apr-04	N		
Facilities for diagnostic imaging and interventional radiology (SHPN 06 Part 1) [PDFÂ 5Mb]	Property & Capital F	Scottish Health Planning Note (SHPN)	SHPN 06 Part 1	Mar-04	N		

Fire safety - Risk assessment in residential care premises (SHTM 84) [PDFÂ 294Kb]	Property & Capital P	Scottish Health Technical Memorandum (SHTM)	SHTM 84	Apr-03	N		
Access - Audit survey toolkit for disabled people in healthcare premises (SHFN 02) [PDFÂ 735Kb]	Property & Capital P	Scottish Health Facilities Note (SHFN)	SHFN 02	Oct-02	Y		Detailed elements tbc at next design stage
Day care part 2 - Endoscopy unit (SHPN 52 Part 2) [PDFÂ 2Mb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN 52 Part 2	Jan-02	N		
Day care part 1 - Day surgery unit (SHPN 52 Part 1) [PDFÂ 3Mb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN Part 1	Jan-02	Y		Detailed elements tbc at next design stage
Facilities for rehabilitation services (SHPN 08) [PDFÂ 3Mb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN 08	Jan-02	N		
Day care part 3 - Medical investigation and treatment unit (SHPN 52 Part 3) [PDFÂ 2Mb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN 52 Part 3	Jan-02	N		
Facilities for Mortuary and Post-Mortem Room services (SHPN 20) [PDFÂ 2Mb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN 20	Jan-02	N		
General design guidance (SHPN 03) [PDFÂ 409Kb]	Property & Capital P	Scottish Health Planning Note (SHPN)	SHPN 03	Jan-02	Y		Internal rooms 2.59 Such rooms do not provide good working conditions and should be used only for activities of infrequent or intermittent occurrence or which demand a controlled environment. Rooms that are likely to be occupied for any length of time by staff or patients should have windows. Some internal rooms are provided - these are either specialist in nature - Xray/ Plaster room; Infrequently used - treatment room at In-Patient ward or are central to the ward function - office / desk spaces located centrally to the Theatres department / In-Patient department. Centrally located offices to have glazed screens to borrow light from adjacent spaces. Detailed elements tbc at next design stage
Access - Disability (SHFN 14) [PDFÂ 1Mb]	Property & Capital P	Scottish Health Facilities Note (SHFN)	SHFN 14	Sep-00	Y		Design to be developed at next stage
Access - audits of primary healthcare facilities (SHFN 20) [PDFÂ 2Mb]	Property & Capital P	Scottish Health Facilities Note (SHFN)	SHFN 20	Sep-00	N		
Fire Safety -Hospital main kitchens (SFPN 4) [PDFÂ 1Mb]	Property & Capital P	Scottish Fire Practice Note (SFPN)	SFPN 4	Dec-99	N		
Fire Safety -Laboratories on hospital premises (SFPN 10) [PDFÂ 1Mb]	Property & Capital P	Scottish Fire Practice Note (SFPN)	SFPN 10	Dec-99	N		
Fire safety - A model management structure (SFPN 00-01) [PDFÂ 169Kb]	Property & Capital P	Scottish Fire Practice Note (SFPN)	SFPN 00-01	Dec-99	N		
Engineering Staff Roles & Responsibilities (GUID5015) [PDF 157Kb]	Decontamination	GUIDance on Decontamination (GUID)	GUID5015	Feb-17	N		
Core elements - Sanitary Spaces (HBN 00-02)	Property & Capital P	DoH guidance (HBN; HTM; Other)	HBN 00-02	Mar-17	Y		Detailed elements tbc at next design stage
Core Guidance - Circulation and communication spaces (HBN 00+A117-04) [PDF 2Mb]	Property & Capital P	DoH guidance (HBN; HTM; Other)	HBN 00-04	Oct-14	Y		3.9 The recommended minimum clear corridor width for circulation of beds/trolleys is 2150 mm if passing spaces are provided. 3.10 Where two beds need to pass regularly, the recommended minimum clear corridor width should be 2960 mm. A clear width of 2150 is provided (between handrails) generally. At the theatres a clear width of 2960 is provided locally. At the public/staff lift and stair lobby where there is no bed transit corridors reduce to 1500min clear locally. 5.13 Stairs - minimum recommended going (top of step depth) is 280mm. 250 going (compliant with technical standards) provided for escape / access stairs. 6.20 'A protected lobby should be provided where a lift does not open of a hospital street' Lifts provided with lobby with the exception of the public lifts at ground floor. Further detailed elements tbc at next design stage
Building Component Series – Sanitary assemblies (SHTM 64) [PDF 1Mb]	Property & Capital P	SHTM Building Component (SHTM)	SHTM 64	Dec-09	Y		Detailed elements tbc at next design stage

Building Component Series - Ceilings (SHTM 60) [PDF 674Kb]	Property & Capital P	SHTM Building Component (SHTM)	SHTM 60	Oct-09	Y		Detailed elements tbc at next design stage
Fire Safety- Fire safety training (SHTM 83 Part 2) [PDF 640Kb]	Property & Capital P	SHTM Building Component (SHTM)	SHTM 83 Part 2	Jul-17	N		
Critical care units (HBN 04-02)	Property & Capital P	DoH guidance (HBN; HTM; Other)	HBN 04-02	Oct-14	N		
Wayfinding -effective wayfinding and signing for healthcare facilities (HTM 65)	Property & Capital P	DoH guidance (HBN; HTM; Other)	HTM 65	Aug-16	Y		Detailed elements tbc at next design stage
Mortuary and Post Mortem Facilities (SHPN 16-01) [PDF 4Mb]	Property & Capital P	Scottish Health Planning N	SHPN16-01	Nov-17	N		
SHTN 02-00 Sustainable Development Strategy 2012 [PDF 543Kb]	Engineering	Scottish Health Technical Note	SHTN02-00	Feb-12	N		

NHS Fife

COST REPORT SUMMARY AGAINST PROJECT BUDGET
CONSTRUCTION COST REPORT NO. 1

GT GARDINER &THEOBALD

ELECTIVE ORTHOPAEDIC CENTRE AT VHK

Works to 04 October 2019

PROJECT BUDGET
GIFA (m2) = 6,142
Car Park = 4,069

		Rate (£/m² GIFA)	Total Cost (£)	Total Cost inc VAT (£)	Total Cost TO DATE (£)	Total Cost TO DATE inc VAT (£)	Comment
ESTIMATED PSCP COSTS							
1 Construction Works							
Building Works		2,930	17,998,299	21,597,959	0	0	
Preliminaries		276	1,695,440	2,034,528	0	0	
Inflation at 5.32%		176	1,078,074	1,293,689			
PSCP Fee at 4%		135	830,873	997,047	0	0	
	Element Total	3,517	21,602,686	25,923,223	0	0	
2 Stage 2 Fees & Charges							
Statutory Fees & Charges			inc				
Design Fees Stage 2		66	407,602	489,122	0	0	
PSCP OH&P on Fees		3	16,304	19,565	0	0	
	Element Total	69	423,906	508,687	0	0	
3 Stage 3 Fees & Charges							
Statutory Fees & Charges			inc				
Design Fees Stage 3		117	718,312	861,974	0	0	
PSCP OH&P on Fees		5	28,732	34,479	0	0	
	Element Total	122	747,044	896,453	0	0	
4 Stage 4 Fees & Charges							
Statutory Fees & Charges			inc				
Design Fees Stage 4 (PSCMs)		66	403,888	484,666	0	0	
PSCP OH&P on Fees		3	16,156	19,387	0	0	
	Element Total	68	420,044	504,052	0	0	
5 PSCP Risk			-				
Risk		96	590,812	708,974	0	0	
PSCP Fee at 4%		4	23,633	28,360			
	Element Total	100	614,445	737,335	0	0	
6 Estimated VAT Recovery							
Allowance for VAT Recovery; to be confirmed by NHS Fife VAT Consultants				(318,199)			
	Element Total			(318,199)		0	
TOTAL PSCP TARGET PRICE		3,876	23,808,125	28,251,551	0	0	
7 Changes to Target Price							
Compensation Events		0	0	0			
Early Warnings		0	0	0			
	Element Total	0	0	0	0	0	
ADJUSTED PSCP TARGET PRICE		3,876	23,808,125	28,251,551	0	0	
PREVIOUSLY PAID					0		
PSCP COST IN MONTH					0		
RETENTION					0		
AMOUNT DUE					0	0	
ESTIMATED NHS FIFE COSTS							
8 NHS Fife Direct Costs							
Project Team Costs (based on 2 years)		61	375,727	375,727		0	
Allowance for Project Manager Fees		28	169,006	202,807		0	
Allowance for Cost Advisor Fees		21	129,962	155,954		0	
Allowance for CDM-C Fees		-	??	-		0	
Allowance for Supervisor's / Clerk of Works Fee		20	120,000	144,000		0	
Surveys, statutory consents etc		49	300,000	360,000			
	Element Total	178	1,094,695	1,238,488	0	0	
9 NHS Fife Risk							
Allowance		182	1,115,473	1,338,568		0	
Funding of Compensation Events		0	0	0		0	
	Element Total	182	1,115,473	1,338,568	0	0	
10 Equipment							
Group 2, 3 and 4 Equipment		60	367,200	440,640		0	
IT and Telecommunications			inc			0	
	Element Total	60	367,200	440,640	0	0	
11 Transitional Costs							
Decommissioning of existing Facilities		0	TBA	-		0	
Decant and Transition Costs		18	108,000	129,600		0	
	Element Total	18	108,000	129,600	0	0	

NHS Fife

COST REPORT SUMMARY AGAINST PROJECT BUDGET
CONSTRUCTION COST REPORT NO. 1

GT GARDINER &THEOBALD

ELECTIVE ORTHOPAEDIC CENTRE AT VHK

Works to 04 October 2019

12	Car Park					
	Building Works		432,675	519,210	0	0
	Preliminaries		40,758	48,910	0	0
	Risk at 3%		14,203	17,044	0	0
	Inflation at 5.32%		25,942	31,131		
	PSCP Fee at 4%		20,543	24,652	0	0
	Element Total		534,121	640,946	0	0
13	Car Park					
	Fees, Surveys and Statutory Consents		166,667	200,000	0	0
			166,667	200,000	0	0
13	Estimated VAT Recovery					
	Allowance for VAT Recovery; to be confirmed by NHS Fife VAT Consultants			(83,794)		As per previous Frameworks Scotland and Procure 21 projects assumed that VAT will be recoverable on Design Team Fees
	Element Total			(83,794)		0
	Total - Estimated NHS Costs		3,386,156	3,904,448	0	0
	Total Project Cost	4,428	27,194,281	32,156,000	0	0

Fife Elective Orthopaedic Centre

Benefits Register

3 October 2019 – Rev. 2

Ref. no	Benefit	Assessment	Measured?	Baseline value	Target value	Relative importance
1	Positive patient experience and dignity respected	Qualitative	Patient survey Complaints	TBC FBC	TBC FBC	5
2	Maintain support to allow people to live independently together with life quality. Overarching benefit	Quantitative	Length of stay Discharge Function scores (hips/knees) Use of ACRT, PIR and Opt-in	TBC FBC	TBC FBC	5
3	Improves the healthcare state (condition, quality, perception, statutory, back-log and lifecycle)	Quantitative	EAMS Back-log	Fabric: B/C M&E: D Theatre £1.185m Ward 10: £0.954m	A (new build) A (new build) £0 for new build initially.	4

4	Minimises readmissions (post operation complications) and optimises timely discharge	Quantitative	Length of stay BADS target – discharges T&O national admissions	TBC at FBC	TBC at FBC	3
5	Optimises resource usage (theatre and bed utilisation)	Quantitative	Clinical room utilisation Patient bed days Theatre utilisation	TBC FBC	TBC FBC	4
6	Improves HAI and patient safety	Quantitative	Infection data for ward & theatres Theatre downtime Ward falls	TBC FBC	TBC FBC	4
7	Community benefits – local employment	Quantitative	Data from PSCP	NA	Evidence of local employment through the contract.	3
8	Community benefits – skills and training (work placements and school/college interface)	Quantitative	Data from PSCP	NA	Evidence of skills and training through the contract.	3
9	Community benefits – opportunities for SME	Quantitative	Data from PSCP	NA	Evidence of SME opportunities through the contract.	3

Benefits Prioritisation

Each identified benefit needs to be prioritised so that resources can be focussed on delivery of those of greatest importance and/or highest impact. The RAG table below demonstrates how relative importance has been considered in respect to the Fife Elective Orthopaedic Centre.

Scale / RAG	Relative importance
1	Fairly insignificant
2	
3	Moderately important
4	
5	Vital

Fife Elective Orthopaedic Centre

Benefits Realisation Plan

3 October 2019 – Rev. 0

Ref. no	Benefit	Who benefits	Who is responsible	Investment objective	Dependencies	Support needed	Date of realisation
1	Positive patient experience and dignity respected	Patient and Service	Service manager Clinical lead Clinical managers	Improve patient perception. Improve accommodation in respect to space standards and physical condition.	Staffing levels / skill mix Quality of facility	Senior management to ensure staffing and skills are in place to support a quality service.	2022
2	Maintain support to allow people to live independently together with life quality. Overarching benefit	Patient and Service	Service manager Clinical lead Clinical managers	Improve patient pathways / flows.	Staffing levels / skill mix Rehabilitation unit	Senior management Social support Home / community support Health and social care	2022
3	Improves the healthcare state (condition, quality, perception, statutory, back-log and lifecycle)	Patient, Service and staff	Project Board Project Director Project Team	Improve accommodation in respect to space standards and physical condition. Improve infection control and safety risk.	Funding Project approval Quality design and construction	Scottish Government NDAP NHSF governance Project stakeholders	2022
4	Minimises readmissions (post operation complications) and optimises timely discharge	Patient and Service	Service manager Clinical lead Clinical managers	Improve infection control and safety risk. Improve patient pathways / flows.	Building / environment Support clinical services to achieve optimal outcomes (equipment, staffing, innovations)	Senior management	2022
5	Optimises resource usage (theatre, bed utilisation and consulting rooms)	Patient, Service and staff	Service manager Clinical lead Clinical managers	Improve patient pathways / flows.	Building / environment Workforce including job planning Flexibility in job roles IT support	Senior management to sign-off job plans	2022
6	Improves HAI and patient safety	Patient and Service	Clinical managers	Improve accommodation in respect to space standards and physical condition.	Building functionality Support from infection control	Infection control and health & safety	2022

				Improve infection control and safety risk.			
7	Community benefits – local employment	Local community, NHSF, PSCP, project	Project Director Project Manager PSCP	NA	None	None	2020-2022
8	Community benefits – skills and training (work placements and school/college interface)	Local community, NHSF, PSCP, project	Project Director Project Manager PSCP	NA	Safe environment	None	2020-2022
9	Community benefits – opportunities for SME	Local community, NHSF, PSCP, project	Project Director Project Manager PSCP	NA	Good quality local supply chain Market conditions	Communications team	2020-2022

Fife Elective Orthopaedic Centre

Design and Construction Risk Register

October 2019 - Rev. 3

		Risk Rating											
Ref No:	**Risk Description**	**Probability (1-5)**	**Impact (1-5)**	**Risk Rating (1-25)**	**Mitigation**	**Agreed PSCP Provision**	**Agreed NHS Provision**	**Quantifiable**	**Risk Owner**	**Risk Manager (if not Risk Owner)**	**Action Date**	**Closed Out**	**Comments**
	Pre-construction												
1	Client doesn't have the capacity or capability to deliver the project	2	3	6	Develop appropriate governance arrangements and develop a competent project team using internal and external resources.		£ 10,000	Yes	NHS F				Team has been developed with adequate internal and external resources in position
2	The clinical need for change and expected outcomes isn't clearly defined	2	4	8	Set out a plan to engage with service providers to fully understand the service based need for change and the expected outcome from investment		£ 10,000	Yes	NHS F				Need for change, investment objectives and benefits clearly set out in business case.
3	Poor stakeholder involvement results in a lack of support for the project	3	4	12	Prepare and implement an appropriate project communication plan which engages with all appropriate stakeholders at appropriate stages of the project		£ 25,000	Yes	NHS F				Stakeholder involvement in the OBC design has been strong to date. Communication plan to be implemented for external communication.
4	Adverse publicity occurs due to an issue with the project	3	4	12	Review the reputational impact of all risks in this register and take action		£ 25,000	Yes	NHS F				
5	Poor communication ignores stakeholder interests	3	4	12	Prepare and implement an appropriate project communication plan which engages with all appropriate stakeholders at appropriate stages of the project		£ 25,000	Yes	NHS F				Communication plan in place which is to be implemented.
6	Demand for the service does not match the levels planned, projected or presumed	3	4	12	Current risk relates to radiology, outpatients and pre-assessment. Work required by the service in respect to re-design. Action ongoing.		£ 25,000	No	NHS F				
7	Local community objects to the project	2	4	8	Given the proposed location, within the existing campus, objections are considered to be unlikely.		£ 15,000	Yes	NHS F				
8	Brief Inadequate/Unreliable	2	4	8	SoA and Design Statement in place which the project is working to.		£ 15,000	Yes	NHS F				
9	The design does not meet the Design Assessment expectations	2	4	8	Team have had regular dialogue with HFS and NDAP.		£ 15,000	Yes	NHS F	PSCP			
10	Failure to design in accordance with statutory requirements and appropriate healthcare guidance	2	4	8	Appoint a professional and experienced design team. Draft derogation schedule to be provided at OBC.	£ 15,000		Yes	PSCP				
~~11~~	~~New Framework may impact on time required to appoint contractor and/or professional team.~~	~~5~~	~~3~~	~~15~~	~~Early engagement with HFS~~				~~NHS F~~			~~Y~~	~~Risk can be closed as it is now behind us and we are working to an agreed programme for OBC currently.~~
12	The project cost estimate includes inaccuracies.	2	4	8	Utilise an experienced Cost Advisor throughout the project and ensure that appropriate levels of contingency are built in throughout the key stages of the project (IA, OBC, FBC and Construction)		£ 15,000	Yes	NHS F				
13	The project becomes unaffordable	3	4	12	The affordability of the project has been tested at IA stage and will be further explored as part of the OBC and FBC stages of the project.		£ 25,000	Yes	NHS F				
14	Inflation costs rise above those projected	3	4	12	Utilise an experienced Cost Advisor throughout the project and ensure that appropriate consideration for inflation is built into the project in line with projected indices.		£ 25,000	Yes	NHS F				
15	Changes to non-legislation policy affects project cost or progress	3	3	9	An external risk that cannot easily be controlled.		£ 20,000	Yes	NHS F				
16	Changes in legislation or tax rules increase project costs	3	4	12	An external risk that cannot easily be controlled. The project team's brief will be to design in line with current statutory and healthcare guidance. Changes in tax cannot be controlled.		£ 25,000	Yes	NHS F				
17	There are uncertainties over future policy	3	3	9	An external risk that cannot easily be controlled.		£ 20,000	Yes	NHS F				
18	Management of Expectations. Planned facilities do not meet expectations of public, staff, clinicians, NHS and council strategies etc. Reputation & service delivery impact	2	4	8	Stakeholder engagement to be planned out via key milestones within the programme		£ 15,000	Yes	NHS F				
19	Statutory Consents. May fail to acquire or delay in obtaining	3	4	12	Engage with planning authority. Early engagement planned in advance of an application.	£ 15,000	£ 15,000	Yes	NHS F	PSCP			
20	Change of scope; the requirement statement may be subject to uncontrolled scope creep.	2	3	6	Project Board to agree any changes if required. Maintain continuity over stakeholder groups.		£ 10,000	Yes	NHS F				
21	Budget Costs(Site Conditions) The options may fail to identify and address site constraints, environmental concerns, ground conditions etc.	3	4	12	To be considered through site investigations, surveys and design development.		£ 50,000	Yes	NHS F	PSCP			
22	Planning Costs. Costs of discharging conditions of planning consent may be greater than allowance provided for.	3	3	9	Engage with planning authority. Early engagement planned in advance of an application.		£ 20,000	Yes	NHS F	PSCP			

23	New SER implications with requirements for early contractor (sub contractor) design.	4	2	8	Could mean additional upfront expenditure as part of the FBC stage. No additional cost just an earlier commitment. Affected packages to be identified early. Value for money v early sub contractor commitment to be reviewed		£ -	No	N/A				
24	1:1250/1:500/1:200 design proposals not accepted by key project stakeholders	2	4	8	Ensure that engagement process is inclusive and well planned via agreed workshops. Deal with issues arising progressively. Manage NDAP process.		£ 15,000	Yes	NHS F				
25	Building Warrant Approval times do not align with proposed construction period. (during Construction this risk then becomes a PSCP Risk)	3	4	12	Early engagement to take place in FBC process with the intention to agree strategy for staging building warrants to de - risk.		£ 25,000	Yes	NHS F				
26	Resource levels from all team members do not prove sufficient to deliver FBC Programme (particularly 1:50 design)	2	3	6	Resource strategy to be developed with then agreement on required staffing levels from all parties		£ 10,000	Yes	NHS F				
27	Utility Costs	2	4	8	Most of the connections will be from the retained estate so risk of occurrence is low. Water connection required.		£ 15,000	Yes	NHS F	PSCP			
28	Future Change. The requirement statement may fail to keep abreast of future clinical practice.	3	3	9	Requirements to be kept under regular review. Design to be as flexible as possible without allowing for over provision/ additional cost.		£ 20,000	No	NHS F				
29	Workforce Planning. NHS Fife may fail to effectively plan future staff requirements	3	4	12	Project Board to review. Dedicated Workforce Workshop to be delivered to seek alignment on plan linked to clear service requirement		£ 25,000	No	NHS F				
30	Recruitment and Retention. NHS Fife may fail to attract sufficient appropriately skilled staff to meet the anticipated increase in demand	3	4	12	Recruitment and retention plan including succession planning. Anticipated that dedicated centre will attract/retain staff.		£ 25,000	No	NHS F				
31	Equipment. May not conduct equipment planning effectively	3	3	9	A high level equipment list is being developed and will be further developed and finalised as part of the OBC Process.		£ 15,000	Yes	NHS F				
32	Project Plan. The Project Plan does not adequately reflect required tasks and timescales	3	4	12	The OBC Programme is in place and progress is reviewed on a monthly basis. All programmes are subject to change and delay, however an experienced team in place to help manage and mitigate impacts arising.		£ 25,000	Yes	NHS F				
33	Building Size/Configuration (Clinical Pathways) New clinical pathways still not tested which may impact on schedule of accommodation	3	4	12	Possible impact. NHSF to review and progress workplans and operational policies.		£ 25,000	No	NHS F				
34	Lack of up to date existing site information	2	4	8	Surveys/investigations will inform once carried out		£ 15,000	Yes	NHS F	PSCP			
35	Client changes to Brief or design after the project has started	3	4	12	Good consultation during pre construction. Acceptances at the end of key stages. Strong governance and control structure during construction		£ 25,000	Yes	NHS F				
36	Car parking - the new car park needs to be opened before the current one closes.	3	4	12	Surveys to be completed and design to be developed in time for car parking to be delivered pre October 20.		£ 25,000	Yes	NHS F	PSCP			
37	Robustness of design for market testing (gaps).	3	3	9	Design manager and PSCP to manage design team and set quality and output expectations.	£ 20,000		Yes	PSCP				
38	The new heat station on the excising estate needs to be functional before the new build can start.	2	4	8	Engie to install new heat station in advance of October 20.	£ -	£ 15,000	Yes	NHS F				
39	Legalities with link bridge connection.	2	4	8	Design to be developed to allow NHS F to enter commercial discussions.		£ 15,000	Yes	NHS F				
40	Design development - confirmation of services routes.	3	3	9	Discussions progressing with Stakeholders to confirm connection points.		£ 20,000	Yes	NHS F				
41	Gaps in billing information	3	3	9	Robust design. Time/planning for QS to complete robust bills.	£ 30,000		Yes	PSCP				
42	Cradle project: crane lift delays affecting construction start date.	2	3	6	Project should be complete. Monitor progress.		£ 10,000	Yes	NHSF				
43	Additional roof plantroom area for MEP Services coordination	3	4	12	Further design development and rationalisation of MEP Services to minimise any required increase in area		£ 25,000	Yes	NHSF	PSCP			
	Construction												
1	Critical programme dates are unrealistic	3	3	9	A realistic project programme will be developed which will be regularly monitored and reviewed.	£ 25,000		Yes	PSCP				
2	Unforeseen conditions when working with existing assets	3	4	12	As far as possible, review existing information and carry out detailed surveys and investigations during the design stage of the project. Allow appropriate contingency for residual risk.		£ 25,000	Yes	NHS F				
3	The project disrupts day to day business operations	3	4	12	Develop plans at OBC/FBC stage prior to construction.		£ 25,000	Yes	NHS F	PSCP			
4	Adverse publicity occurs due to an issue with the project	3	4	12	Review the reputational impact of all risks in this register and take action		£ 25,000	Yes	NHS F				
5	Brexit and impact on construction supply chain.	3	4	12	Difficult risk to manage as market conditions are out with the control of the project. Status to be monitored	£ 25,000		No	PSCP				
6	Access to part of the site is delayed	2	3	6	Site access and protocols to be reviewed in further detail during the FBC stage		£ 10,000	Yes	NHS F				
7	The employer does not provide something by the date for providing it as shown on the accepted programme	2	3	6	Key Milestones to be marked on the programme. Consultation with relevant parties to gain buy-in respect to meeting the proposed dates. Review status at regular meetings		£ 10,000	Yes	NHS F				

8	Instruction given to stop/not start the work	3	3	9	Would only be given for significant issues arising - i.e. major disruption or health and safety		£ 20,000	Yes	NHS F				
9	Late response to a communication or acceptance affecting progress of work	2	3	6	PM to manage responses in line with contract timescales		£ 15,000	Yes	NHS F				
10	The PSCP encounters physical conditions which they should/could have foreseen	3	3	9	PSCP to satisfy themselves of all site conditions. No CE will be given for matters arising that could have been better understood by commissioning a survey/investigation	£ 20,000		Yes	PSCP				
11	Physical conditions that the PSCP could not have foreseen	3	3	9	On the basis that all of the relevant surveys and investigations have been completed, this risk can only be managed via NHS F time/cost contingency		£ 20,000	Yes	NHS F				
12	A weather measurement leading to a CE	3	3	9	This risk can only be managed via NHS F time/cost contingency		£ 20,000	Yes	NHS F				
13	Adverse weather that is not a CE	3	3	9	PSCP to build in provision within the programme for weather risk	£ 20,000		Yes	PSCP				
14	Issues leading to deign development	3	3	9	PSCP to manage via design/technical meetings	£ 20,000		Yes	PSCP				
15	Clashes in design coordination leading to design development	3	3	9	PSCP to manage via design/technical meetings	£ 20,000		Yes	PSCP				
16	Poor sub-contractor performance leading to poor quality and or delay	3	3	9	Sub- contractors to be selected on the basis of quality together with cost. Strong local supply chain to be assembled	£ 20,000		Yes	PSCP				
17	Delay in handover due to number of defects	3	4	12	Programme to be challenging but realistic offering time provision for correcting defects and carrying out commissioning in advance of handover	£ 25,000		Yes	PSCP				
18	Delay in delivery of Groups 2,3 and 4 equipment leading to delays in commissioning and opening unit	3	3	9	Key Milestones to be marked on the programme. Consultation with relevant parties to gain buy-in respect to meeting the proposed dates. Review status at regular meetings, consider setting up an equipment sub-group		£ 20,000	Yes	NHS F				
19	Inflation beyond target/price agreement	3	3	9	Difficult to manage. PSCP to accept risk and manage within agreed contingency allowances.	£ 20,000		Yes	PSCP				
20	Poor Project/Design Management leading to delays	3	3	9	PSCP to offer a strong team with sufficient resource allocation to manage project diligently	£ 20,000		Yes	PSCP				
21	Traffic issues including public safety/interface	3	3	9	Plans to be agreed in advance of construction. To be reflected within the construction phase plan	£ 25,000	£ 20,000	No	NHS F	PSCP			
22	Problems with contractors access to site	2	3	6	Construction phase plan to be developed.	£ 20,000		Yes	PSCP				
23	Next stage(s) of building warrant delayed affecting progress of works	2	4	8	Procure contractors to assist with contractor design	£ 15,000		Yes	PSCP				
24	Measurement risk with bills	3	3	9	Mitigation is that the contractor price, the drawings and specs - not the bills- contracts should refer	£ 20,000		Yes	PSCP				
25	Access for deliveries. Agreement required on what can be delivered and when. Once agreement is in place there is a risk that this could constrain or delay the PSCPS work	3	3	9	Construction phasing and plans for cabin, scaffolding and deliveries all agreed and confirmed	£ 25,000		Yes	PSCP				
26	HAI Scribe issues	3	4	12	Carry out stage 3 HAI in detail	£ 25,000		Yes	PSCP				
27	HAI Scribe issues affecting staff/patients	3	4	12	Carry out stage 3 HAI in detail		£ 25,000	No	NHS F	PSCP			
28	Supply chain bankruptcy/insolvency	2	4	8	PSCP to select robust supply chain and ensure that quality is a factor in selection	£ 20,000		Yes	PSCP				
29	Long lead in periods for materials	2	3	6	To be reflected within the construction programme. Noted that this should be low risk given the scope of the project	£ 15,000		Yes	PSCP				
30	Health and safety issues leading to delays	3	3	9	Robust construction phase plan, good site manager and regular H&S audits.	£ 20,000		Yes	PSCP				
31	Business continuity risk through cut/damaged services	3	4	12	Isolation protocol to be established between NHS F and PSCP		£ 25,000	No	NHS F	PSCP			
32	NHS F staff not available to isolate services to meet programme	3	3	9	Procedure and notice periods to be confirmed and established		£ 20,000	Yes	NHS F				
33	Damage/delaps caused through work	3	3	9	PSCP to undertake delaps survey and make good as required	£ 30,000		Yes	PSCP				
34	Business continuity risk caused through security issues - i.e. Unauthorised people accessing plant rooms	3	3	9	Access protocol to be established		£ 20,000	No	NHS F	PSCP			
35	Logistics of working adjacent to live areas and fire escapes	3	4	12	Construction phase plan to consider and resolve	£ 25,000		No	PSCP				
36	Other on site construction constraints i.e. cars parked in the way of access routes causing disruption/delay.	3	2	6		£ 15,000		Yes	PSCP				
37	Insufficient timescales for testing and commissioning	3	4	12	Setting realistic timescales to meet the deadline for the build being operational. Robust commissioning plan.	£ 25,000		Yes	PSCP				
38	Security of people accessing the construction site and causing damage/disruption/delay.	3	2	6	Precautions must be taken to ensure no unauthorised access. Robust fencing / access controls etc.	£ 15,000		Yes	PSCP				

	Post-construction												
1	Risk that when in operation the project cannot be easily maintained from an operation and/or cost perspective.	3	4	12	Set up an effective project team where the designers engage with Estates and FM.		£ 30,000		NHS F				
2	Soft landings process not correctly implemented resulting in project not having maximum impact	3	4	12	Agree soft landings strategy during FBC. Agree FM strategy with NHS F estates team. Identify suitable opportunities to embed maintenance provisions within the PSCP supply chain appointments to cover systems maintenance for agreed periods beyond PC - note this will add to capital costs but may reduce revenue cost		£ 30,000		NHS F				
						£ 590,000	**£ 1,115,000**						
						PSCP	**NHSF**						
						Total	**£ 1,705,000**						

Elective Orthopaedic Centre Communications Plan – Draft V2

1. Elective Orthopaedic Centre Project Communications overview

The Elective Orthopaedic Centre Project team have asked communications to develop a communications plan to identify the communications collateral required to ensure targeted and timely engagement with key stakeholders including staff, patients, visitors to the Victoria Hospital as well as partner organisations and contractors leading up to and throughout the period of the Orthopaedic Centre works.

2. Elective Orthopaedic Centre Stakeholder communications

The following key stakeholder groups have been identified:

- Internal communications (Staff, Patients, Hospital Visitors and Hospital suppliers)
- External communications (Press and Media, Social Media)
- Partner Communication (Scottish Government, Fife Council, Contractors)

3. Communications tools required:

The following communications tools and resources were identified to support stakeholder communications around the work:

- Dedicated NHS Fife web and Intranet Pages
- Project name (EOC), ”Branding” and logos to be designed and used across all communications material, along with the individual partners logos where appropriate
- Social media # to be created - #NHSFifeEOC
- FAQ’s to be developed and evolved throughout the works period to directly address feedback or specific issues raised by service users
- Maps and architects drawings for designs and areas likely to be impacted (including car parking)
- Calendar of activity (Key mile stones)
- Project team – who’s who
- Agreed spokesperson and media release / update sign off process, who issues
- Communication leads / contacts for the partner organisations / contractors to ensure coordinated and consistent messages
- Video and photo updates – time-lapse video opportunity, talking heads / project team interviews
- Victoria Hospital Main Reception display / Ward 10 pre-assessment poster – outlining works and progress
- Onelan TV Screen updates
- E-update / Newsletter for staff – issued every 4-6 months during the 18 month construction
- Media presentation prior to works starting
- Governance – working groups and reporting structure to be confirmed
- Temporary directional signage
- Accessibility and alternative formats for all communications material produced

4. Official Spokespersons and Communications leads for the project

A range of spokespersons and communications leads / contacts should be agreed in advance as part of communications planning. Once this group of individuals have been identified a media statement development and sign off process will need to be agreed.

Organisation	Communications Lead	Official Spokesperson/s
NHS Fife	Kirsty MacGregor, Head of Communications	Alan Wilson, Capital Project Director, Finance, NHS Fife Carol Potter, Finance Director, NHS Fife
Scottish Government?		
Principal Supply Chain Partner (PSCP), Graham Construction	Pre-construction: Chris McLeod, Framework Director Construction: Pat O'Hare, Contracts Director	Pre-construction: Chris McLeod, Framework Director Construction: Pat O'Hare, Contracts Director
Thomson Gray, Project Manager	Ben Johnston, Associate Project Manager	Ken Fraser, Regional Director
Gardiner & Theobald, Cost Advisor	Linda McLennan, Senior Associate	Mark Findlay, Partner

5. Develop Standard Media Lines:

Some standard statements should be developed with the project team. These will develop and evolve throughout the length of the project, however it is important that we 'set the scene' for the works starting, "sell" the ambition and positive impact of the project and concisely outline the work involved and offer reassurance to service users and staff that steps will be taken to minimise impact on the day to day working of the hospital.

6. Frequently Asked Questions:

The following FAQ's have been drafted as a starting point for the communications around the Elective Orthopaedic Centre works. These will be developed as the project evolves.

What are the timescales of the project?
Work will commence on October 2020 and it is anticipated that the work will last for 18 months... During this period we will provide staff and service users with regular updates on the programme of works and any localised changes to current arrangements.

What will the works involve?
The work will involve the construction of an Elective Orthopaedic Centre, consisting of 3 in number theatres, 34 bed supporting Ward and Outpatients department.

Who will oversee the project?
Agreement and sign off of the design proposals will ultimately sit with the Board of NHS Fife.

The project will be managed by Alan Wilson Capital Project Director directly reporting to Carol Potter Senior Responsible Officer.

A project team will also be established to ensure staff and service users are informed and consulted in regard to the progress of the project.

Throughout the programme of works we will continue to work closely with clinical colleagues, meeting on a regular basis to ensure active engagement in the project and minimise any impact on the day to day provision of services.

How much will these works cost?
The works will be funded from the Scottish Governments £30 million.

Will car parking be impacted by this work?
We hope to minimise the impact on car parking, however at certain points in the project we may be required to close off some car parking spaces for works access. These planned closures will be communicated in advance to allow visitors and staff to make alternative arrangements.

How can I find out more?
A dedicated area on the NHS Fife Intranet and website has been created that outlines the schedule of works and illustrations of the areas of work.

7. Crisis Communications response

Given heightened public and political interest in publically funded builds across the NHS in Scotland, it is important that we address any potential 'Crisis' and how we would manage the communication response to this. In terms of crisis, this could be associated with any deadline delays, contractor issues, planning or health and safety issues.
In-line with any media statement being issued, we would need to agree a clear process of sign off, attributed spokesperson and a briefing for the Scottish Government that would sit with any media release or statement

8. Next steps

It is proposed that a Communications Working group be established to support the enhancement works and develop the communications tools identified.

This group would report into the main project management group.

Membership of this group would be the communication leads identified by each of the partners, along with staff representation from the acute hospital and member of the project management team.

Fife Integrated Performance & Quality Report

Produced in October 2019

NHS Fife

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Assessment

II. Performance Assessment Reports

Clinical Governance

Finance, Performance & Resources
- Operational Performance
- Finance

Staff Governance

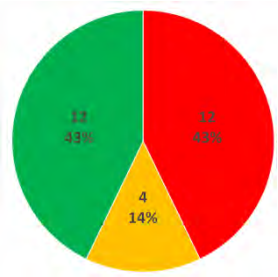
Section II provides further detail for indicators of continual focus or those that are currently underperforming. Each report contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions. The latter, along with trajectories, are taken as far as possible from the 2019/20 Annual Operational Plan (AOP). For indicators outwith the scope of the AOP, improvement actions and trajectories were agreed locally following discussion with related services.

A summary report of the IPQR, the Executive Summary IPQR (ESIPR), is presented at each NHS Fife Board Meeting.

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other NHS Boards.

a. LDP Standards & Key Performance Indicators

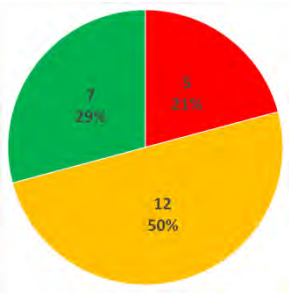


The current performance status of the 28 indicators within this report is 12 (43%) classified as **GREEN**, 4 (14%) **AMBER** and 12 (43%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits or considerably below standard/trajectory.

There are four indicators that consistently exceed the Standard performance; C Diff infection rate, IVF Treatment Waiting Times (regional service), Antenatal Access and Drugs & Alcohol Waiting Times. Other areas of success should also be noted…

- Inpatients Falls with Harm, remaining significantly below the target level, at 1.53 per 1,000 Occupied Bed Days
- New Outpatient Waiting Times achieved above Standard performance for the fifth month in succession
- Patient TTG (Patients Waiting at Month End), continuing to be above the Improvement Trajectory for 2019/20
- Cancer 31-Day DTT achieving the Standard for the third successive month
- The number of smoking quits recorded after 2 months of the FY was in line with the trajectory
- Performance in responding to FoI Requests continued to improve

b. National Benchmarking



National Benchmarking is based on whether indicator is in upper quartile (▲), lower quartile (▼) or mid-range (◄►); based on 11 mainland NHS Boards. The current benchmarking status of the 24 indicators within this report has 7 (29%) within upper quartile, 12 (50%) in mid-range and 5 (21%) in lower quartile. There are indicators where national comparison is not available or not directly comparable.

Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
▲	Upper Quartile
◀ ▶	Mid Range
▼	Lower Quartile

Section	LDP Standard	Standard	Target 2019/20	Reporting Period	Year Previous		Previous		Current			Reporting Period	Fife		Scotland
Clinical Governance	N/A	Major & Extreme Adverse Events	N/A	Month	Aug-18	52	Jul-19	63	Aug-19	47	↑	N/A			
	N/A	HSMR	N/A	Year Ending	Mar-18	N/A	Dec-18	N/A	Mar-19	1.01		2018/19	1.01	◀ ▶	1.00
	N/A	Inpatient Falls	5.97	Month	Aug-18	7.92	Jul-19	7.04	Aug-19	6.72	↑	N/A			
	N/A	Inpatient Falls with Harm	2.16	Month	Aug-18	1.69	Jul-19	1.31	Aug-19	1.53	↓	N/A			
	N/A	Pressure Ulcers	0.42	Month	Aug-18	0.63	Jul-19	1.10	Aug-19	0.61	↑	N/A			
	N/A	Caesarean Section SSI	2.5%	Quarter Ending	Jun-18	3.1%	Mar-19	6.5%	Jun-19	2.0%	↑	QE Jun-19	2.0%	▼	1.0%
	0.32	HAI - C Diff	0.32	Quarter Ending	Aug-18	0.16	Jul-19	0.18	Aug-19	0.18	↔	2018	0.19	▲	0.27
	0.24	HAI - SABs	0.34	Quarter Ending	Aug-18	0.50	Jul-19	0.36	Aug-19	0.33	↑	2018	0.43	▼	0.33
	N/A	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Aug-18	73.7%	Jul-19	68.6%	Aug-19	75.3%	↑	2017/18	77.5%	◀ ▶	74.4%
	N/A	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Aug-18	34.4%	Jul-19	57.7%	Aug-19	57.8%	↑	2017/18	49.7%	◀ ▶	52.8%
Operational Performance	90%	IVF Treatment Waiting Times	90%	Month	Aug-18	100.0%	Jul-19	100.0%	Aug-19	100.0%	↔	N/A			
	95%	4-Hour Emergency Access	96%	Month	Aug-18	97.3%	Jul-19	95.1%	Aug-19	93.6%	↓	Aug-19	93.6%	◀ ▶	90.6%
	N/A	Delayed Discharge (% Bed Days Lost)	5%	Month	Aug-18	4.3%	Jul-19	7.2%	Aug-19	8.0%	↓	QE Dec-18	7.5%	◀ ▶	7.1%
	95%	New Outpatients Waiting Times	95%	Month	Aug-18	91.2%	Jul-19	96.2%	Aug-19	95.0%	↓	Jun-19	95.8%	▲	73.5%
	100%	Diagnostics Waiting Times	100%	Month	Aug-18	97.7%	Jul-19	98.3%	Aug-19	97.6%	↓	Jun-19	99.5%	▲	81.6%
	100%	Patient TTG (Ongoing Waits)	80%	Month	Aug-18	83.3%	Jul-19	90.1%	Aug-19	89.9%	↓	QE Jun-19	90.6%	▲	67.8%
	90%	18 Weeks RTT	84%	Month	Aug-18	80.9%	Jul-19	82.9%	Aug-19	82.0%	↓	Jun-19	83.4%	▲	79.2%
	95%	Cancer 31-Day DTT	95%	Month	Aug-18	97.5%	Jul-19	95.0%	Aug-19	97.0%	↑	QE Jun-19	93.0%	▼	94.7%
	95%	Cancer 62-Day RTT	94%	Month	Aug-18	80.2%	Jul-19	87.5%	Aug-19	84.0%	↓	QE Jun-19	85.4%	◀ ▶	82.4%
	29%	Detect Cancer Early	27%	Year Ending	Mar-18	24.5%	Dec-18	27.6%	Mar-19	24.8%	↓	2017, 2018	25.1%	◀ ▶	25.5%
	80%	Antenatal Access	80%	Month	Jun-18	88.0%	May-19	90.0%	Jun-19	88.2%	↓	QE Dec-18	90.2%	◀ ▶	88.0%
	473	Smoking Cessation	473	YTD	May-18	N/A	Apr-19	100.0%	May-19	100.0%	↔	2018/19	88.6%	◀ ▶	95.2%
	90%	CAMHS Waiting Times	88%	Month	Aug-18	78.4%	Jul-19	73.2%	Aug-19	74.8%	↑	QE Jun-19	71.0%	◀ ▶	69.7%
	90%	Psychological Therapies Waiting Times	82%	Month	Aug-18	68.7%	Jul-19	65.5%	Aug-19	65.2%	↓	QE Jun-19	66.2%	▼	78.7%
	80%	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Jun-18	N/A	Mar-19	66.1%	Jun-19	75.0%	↑	2018/19	66.1%	◀ ▶	85.6%
	90%	Drugs & Alcohol Treatment Waiting Times	90%	Month	Jun-18	99.1%	May-19	95.8%	Jun-19	95.5%	↓	QE Jun-19	95.5%	◀ ▶	93.2%
	N/A	Dementia Post-Diagnostic Support	TBD	Annual	2017/18	87.2%	2017/18	87.2%	2018/19	94.5%	↓	2018/19	94.5%	▲	63.9%
	N/A	Dementia Referrals	TBD	YTD	Mar-18	N/A	Dec-18	61.0%	Mar-19	57.4%	↓	2018/19	57.4%	▲	39.2%
	N/A	Freedom of Information Requests	85%	Quarter Ending	Aug-18	N/A	Jul-19	68.3%	Aug-19	71.1%	↑	N/A			
Finance	N/A	Revenue Expenditure	£0	Month	Sep-18	N/A	Aug-19	£6.281m	Sep-19	£7.583m	↓	N/A			
	N/A	Capital Expenditure	£7.394m	Month	Sep-18	N/A	Aug-19	£1.280m	Sep-19	£1.585m	↑	N/A			
Staff Governance	4.00%	Sickness Absence	4.89%	Month	Aug-18	5.46%	Jul-19	5.78%	Aug-19	5.44%	↑	YE Jun-19	5.55%	▼	5.32%

d. Assessment

Clinical Governance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Inpatient Falls Reduce falls with harm by 20%	2.16	Aug-19	2.16	Aug-19	1.53	N/A	N/A
While the Falls with Harm Rate has been static overall, the data highlights an increase in a few areas within the ASD. Work is underway to explore the reasons for this including appropriate completion of the falls prevention and management bundle through audit, local environment assessment and patient profile, including those patients who have boarded in other wards. New work around Care & Comfort Rounds is also intended to support overall improvement in performance.							
Pressure Ulcers 50% reduction by December 2019	0.42	Never Met	0.42	Aug-19	0.61	N/A	N/A
The number of pressure ulcers recorded each month continues to vary, although there has been a general improvement trend since the start of 2019. Improvement activity focusing particularly on comfort rounds continues across Fife, supported by refresher sessions on the use of comfort rounds within the Partnership.							
Caesarean Section SSI We will reduce the % of post-operation surgical site infections to 2.5%	2.5%	Jun-19	2.5%	Jun-19	2.0%	QE Jun-19	▼
As part of the ongoing quality improvement work, the IPC and Maternity Services have worked collaboratively to review the surveillance methodology case ascertainment process for SSI diagnosis, and a new process will launch at the start of October. Quarter 2 has seen a reduction in cases from the elevated rate of 6.5% in Quarter 1, and it is hoped that this improvement will be improved and sustained during the rest of the year.							
SAB (MRSA/MSSA) Rate of SAB (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days	0.24	Never Met	0.34	QE Aug-19	0.33	2018	▼
There were only 3 SAB in August, one of which was a Hospital Onset VAD (PVC)-related infection. The overall number was a significant fall compared to the July figure of 15. Provisional data indicates that there were 6 SAB in September, one of which has been confirmed as a Hospital Onset VAD (PVC) SAB. There has not been a PWID-related SAB since July.							
Complaints - Stage 2 At least 75% of Stage 2 complaints are completed within 20 working days	75.0%	Never Met	65%	QE Aug-19	57.8%	FY 2017/18	◀ ▶
Regular meetings are continuing with ASD colleagues to review issues and style of draft responses. Patient Relations are also in discussion with the Interim Director of Health & Social Care with an aim to support the improvement of complaint performance within the Partnership. This includes a review of the complaints process to make this consistent across the Partnership and Acute Services, along with the current approval process of Stage 2 complaints for the Partnership.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Delayed Discharge The % of Bed Days 'lost' due to Patients in Delay is to reduce	N/A	Aug-18	5%	Aug-19	8.0%	Dec-18	◀ ▶
Following performance guidance from the Scottish Government in relation to Winter Planning, the March 2020 target for bed days lost due to patients in delay has been reduced to 5%. We are currently around 3% higher than that level, and the challenge is for this position to improve during the winter months, when pressure on the system is most acute.							
4-Hour Emergency Access 95% of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment	95%	Jul-19	95%	Aug-19	93.6%	Aug-19	◀ ▶
Performance has remained static, but remains amongst the highest in Scotland., although we are continuing to see an upward trend in attendance. The PerformED Group continues to focus on improvement actions to address variability in performance and reduce 4-hour breaches as we move towards the challenging winter period. The improvement work is underpinned by the 6 Essential Actions (6EA) to Improve Unscheduled Care.							
Patient TTG (Ongoing Waits) All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat	100%	Never Met	80%	Aug-19	89.8%	QE Jun-19	▲
Performance deteriorated slightly in August but remained better than the agreed improvement trajectory. Additional independent sector capacity has been commissioned due to challenges of medical staff conducting in house waiting list initiatives as a result of pension impact.							
Cancer 62-Day RTT 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral	95%	Oct-17	94%	Aug-19	84.0%	QE Jun-19	◀ ▶
Performance deteriorated in August with 7 of the 12 breaches seen in Urology. Delays occurred requesting tests, post MDT OPA, biopsy and histopathology turnaround times. Delays to surgery impacted on breast and renal patients. Reasons for breach in lung were primarily due to issues with PET contrast and SABR. Breach durations ranged from 3 to 94 days, with an average of 39 days.							
Smoking Cessation Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas	100%	May-19	100%	May-19	100.0%	2018/19	◀ ▶
The Mobile Unit has been repaired after a 4-month delay, and an additional session is being planned for a Wednesday. Two new clinics are to commence in Methil and Lochgelly, while Better Beginnings classes have been running on the first Saturday in the month since May. We had some initial problems with the booking system when clients tried to book on the Eventbrite site, but this has now been resolved and feedback from women attending the classes has been very positive.							
CAMHS Waiting Times 90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral	90%	Sep-16	88%	Aug-19	74.8%	QE Jun-19	◀ ▶
The Group Therapy programme is underway, and evening clinics have started. These additional sessions are being provided by 9 senior CAMHS Clinicians, with a specific focus on the longest waits (over 52 weeks). Despite the level of clinical activity rising significantly, the focus on children and young people who have waited more than 18 weeks will have an adverse impact on the 18 week RTT. The delay in recruiting to PMHW posts has also impacted on performance, with increasing referrals placing additional pressure on Tier 3 CAMHS.							
Psychological Therapies 90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral	90%	Never Met	82%	Aug-19	65.2%	QE Jun-19	▼
We continue to meet the RTT for patients with less complex needs but performance in relation to people with the most complex needs remains especially challenging. This issue is being addressed through service redesign, with support from ISD/HIS Mental Health Access Improvement Support team. The establishment of Community Mental Health Teams across Fife continues to progress well, but the delay in both implementation of service redesign in the Day Hospitals and the setbacks in sourcing funding for a programme of staff training in a new clinical approach is impacting on the anticipated reduction in waiting times.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
FoI Requests At least 85% of Freedom of Information Requests are completed within 20 working days	N/A	N/A	85%	QE Aug-19	71.1%	N/A	N/A

There has been a small improvement in performance in August and the positive trajectory would indicate the initial effectiveness of the actions put in place to address overall timeliness of response. From mid-September, management of the FOI inbox has been assigned to the Information Governance & Security team, to enhance expertise and resilience in managing information requests. New processes are presently under development to ensure final sign-off of responses at Director level is done in a timely manner.

Finance, Performance & Resources Finance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Revenue Expenditure Work within the revenue resource limits set by the SG Health & Social Care Directorates	Breakeven	N/A	Breakeven	Sep-19	+ £7.583m	N/A	N/A

The revenue position for the 6 months to 30 September reflects an over spend of £7.583m. This is significantly higher than the position reported for the same period in each of the four previous financial years.
Based on this year to date position, and a number of high level planning assumptions as agreed by delegated budget holders, the year end forecast ranges from a potential optimistic forecast of £7m overspend to a potential worst case of £15.8m overspend.
The key challenges are the overspend on Acute Services (largely driven by non delivery of savings and a number of specific cost pressures) and the risk share impact of the Integration Joint Board position (entirely driven by social care costs). In addition, there is a growing cost pressure in relation to activity outside Fife and in particular, the number of specialist high cost, low volume procedures undertaken in Edinburgh. On a positive note, the forecast position reported does not take into account the ongoing work to review potential offsetting benefits such as increased financial flexibility from financial plan commitments (including unplanned slippage on allocations), review of balance sheet accruals, and non recurring ADEL (Additional Departmental Expenditure Limit) funding. An early estimate of these additional offsetting benefits provides a degree of assurance that the net (optimistic) forecast overspend on the Health Board retained services might be mitigated to an extent.
However, as highlighted in the Integrated Performance & Quality Report last month, there is limited assurance that NHS Fife can remain within the overall revenue resource limit if we are required to cover the impact of the IJB position (capped at 72% of the initial £6.5m budget gap) ie £4.6m. This would become even more challenging, if we are required to cover the impact of the forecast outturn position for the IJB (currently in excess of £11m). This therefore raises a concern that the Board cannot deliver on its statutory requirement to break even.
For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR) we have included a funding assumption to the value of the risk share impact and a continued commitment to cover the net overspend on the Health Board budgets through increased financial flexibility.

Capital Expenditure Work within the capital resource limits set by the SG Health & Social Care Directorates	£7.394m	N/A	£7.394m	Sep-19	£1.280m	N/A	N/A

The total Capital Resource Limit for 2019/20 is £7.394m. The capital position for the 6 months to September shows investment of £1.585m, equivalent to 21.43% of the total allocation. Plans are in place to ensure the Capital Resource Limit is utilised in full.

Staff Governance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Sickness Absence To achieve a sickness absence rate of 4% or less	4.00%	Never Met	4.89%	Aug-19	5.44%	YE Jun-19	▼

The sickness absence rate for August was 5.44%, a reduction of 0.34% compared to July. The improvement in August means that we are closer to the 5.18% trajectory set at the start of the FY.
Improvement actions continue to take place within each operational unit to work towards achieving the trajectories set for the Board.

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources – Operational Performance

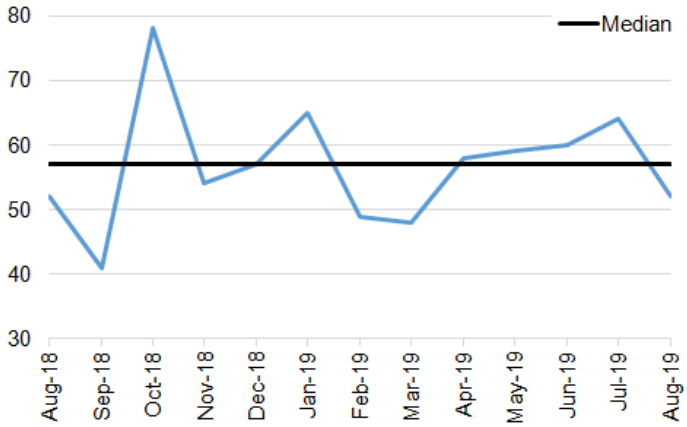
Finance, Performance & Resources – Finance

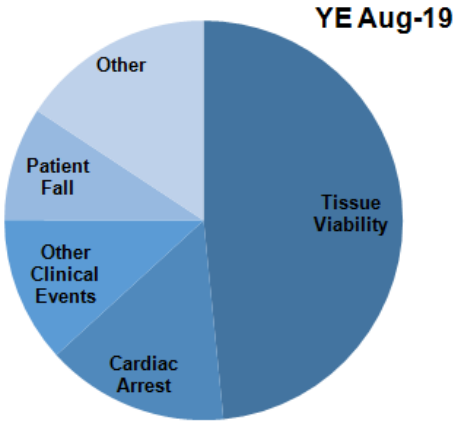
Staff Governance

Clinical Governance

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2018					2019							
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
ALL	NHS Fife	1401	1202	1468	1287	1239	1348	1264	1281	1235	1291	1237	1400	1290
	Acute Services	596	523	615	614	577	629	585	574	538	594	564	560	572
	HSCP	737	634	772	631	619	668	627	663	645	625	627	798	665
	Corporate	68	45	81	42	43	51	52	44	52	72	46	42	53
CLINICAL	NHS Fife	932	810	967	925	869	973	874	896	854	934	830	912	830
	Acute Services	532	470	571	566	518	567	523	524	486	551	514	518	519
	HSCP	380	321	373	348	340	390	338	356	356	346	297	380	282
	Corporate	20	19	23	11	11	16	13	16	12	37	19	14	29

Commentary

The Medical Director and Director of Nursing are currently reviewing the Adverse Events policy in light of the HIS national Adverse Event report. It is clear that NHS Fife is an outlier in terms of reporting of major and extreme events, however this is attributable to our policy on recording tissue viability and cardiac arrests.

Clinical Governance

HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of is more than predicted.

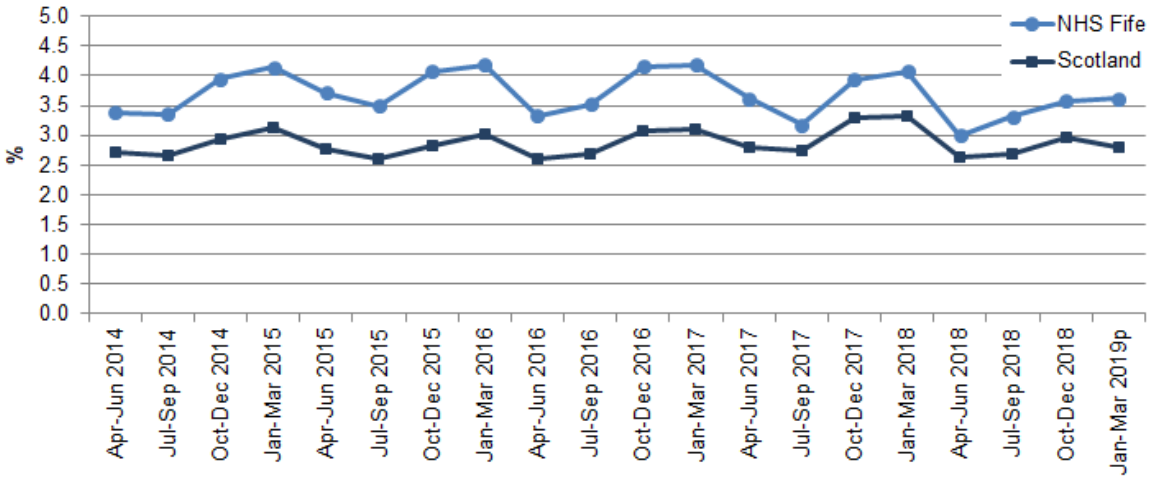
Reporting Period; April 2018 to March 2019p

Please note that as of August 2019, HSMR is presented using a 12 month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

Crude mortality values presented here are reflective of the latest 12 month HSMR reporting period. For crude mortality trends by individual quarter please refer to **Crude Trends (Overall)**.

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR
Scotland	**25,362**	**25,362**	**702,449**	**3.6%**	**1.00**
NHS Fife	1,669	1,655	38,011	4.4%	1.01
Queen Margaret Hospital	49	40	7,426	0.7%	1.24
Victoria Hospital	1,545	1,545	30,328	5.1%	1.00

Crude Mortality Rate



Commentary

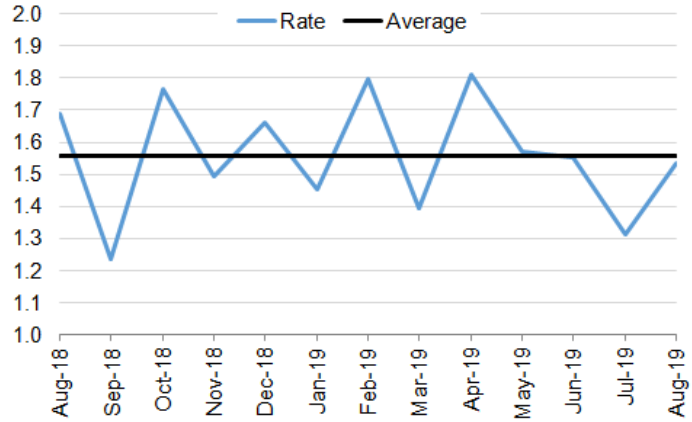
The HSMR for NHS Fife is on track with the national average. The figures for QMH almost certainly represent the cohort of patients cared for in those inpatient beds (care of the elderly and hospice). Recent crude mortality (unadjusted) shows a reassuring downward trend.

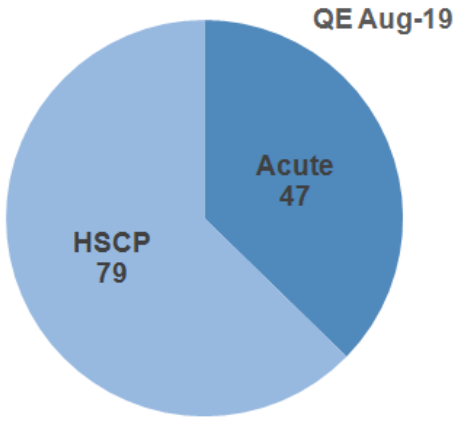
Clinical Governance

Inpatient Falls with Harm

Reduce Inpatient Falls With Harm rate per 100,000 Occupied Bed Days (OBD)
Improvement Target rate (by end December 2019) = ***2.16 per 100,000 OBD***

Local Performance





Service Performance

Month	2018					2019							
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	1.69	1.24	1.77	1.49	1.66	1.45	1.80	1.40	1.81	1.57	1.55	1.31	1.53
Acute Services	1.32	0.63	1.21	1.22	1.49	1.19	1.62	0.84	1.17	0.89	1.73	0.54	1.34
HSCP	1.99	1.73	2.22	1.72	1.80	1.69	1.95	1.85	2.34	2.15	1.40	1.95	1.70

Commentary

While the Falls with Harm Rate has been static overall, the data highlights an increase in a few areas within the ASD. Work is underway to explore the reasons for this including appropriate completion of the falls prevention and management bundle through audit, local environment assessment and patient profile, including those patients who have boarded in other wards. New work around Care & Comfort Rounds is also intended to support overall improvement in performance.

Current Challenges	Need to continue to review the performance with increased demands in in-patient settings and bed modelling within the acute setting. Bed Modelling is continuing. – ***Actions 1, 2, 3 and 4***

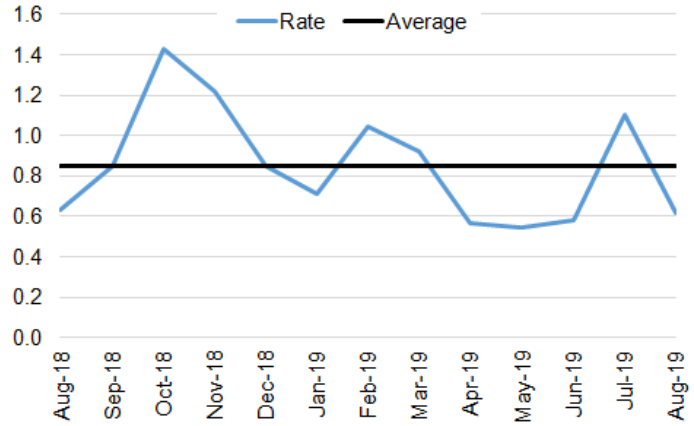
Improvement Actions	Progress	Timescale/ Status
1. Review the Falls Toolkit and Falls Flowchart	The updated falls toolkit was launched on 10th September, and the target for transition over to the new documentation is 1st October. A designated (In-patient) folder focused on falls has been created on the intranet for all documentation and resources.	Complete
2. Develop Older People's Knowledge and Skills Framework	Framework (relevant to all clinical areas that care for older people across our acute and community hospitals) has been piloted with a number of health professionals within the acute hospital and the feedback is extremely positive.	Complete
3. Falls Audit	The audit was completed over a 5 week period, focused on 5 acute wards and showed that falls intervention reviews are poorly completed. Improvement is anticipated following the launch of the revised toolkit, and a further compliance audit is planned for January 2020. **The action timescale has been adjusted accordingly.**	~~Aug 2019~~ Delayed to Jan 2020
4. Care and Comfort Rounding	Work on the approach to comfort rounds is in final stage of testing, with a Care and Comfort clock being designed to be a person centred document	Nov 2019 On Track

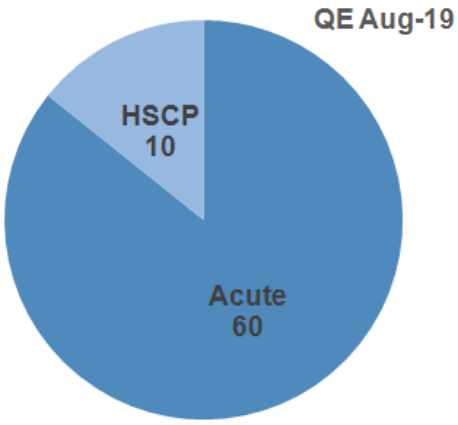
Clinical Governance

Pressure Ulcers

Achieve 50% reduction in pressure ulcers (grades 2 to 4) developed in a healthcare setting
Improvement Target rate (by end December 2019) = ***0.42 per 1,000 Occupied Bed Days***

Local Performance





Service Performance

Month	2018					2019								Sep-19
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	0.63	0.85	1.43	1.22	0.85	0.71	1.04	0.92	0.57	0.55	0.58	1.10	0.61	**0.52**
Acute Services	1.01	1.73	2.49	1.99	1.57	1.12	1.54	0.91	0.70	0.89	1.25	2.15	1.19	**0.64**
HSCP	0.32	0.13	0.56	0.57	0.25	0.36	0.61	0.92	0.45	0.25	0.27	0.25	0.13	**0.37**

Commentary

The number of pressure ulcers recorded each month continues to vary, although there has been a general improvement trend since the start of 2019.

Improvement activity focusing particularly on comfort rounds continues across Fife, supported by refresher sessions on the use of comfort rounds within the Partnership.

Current Challenges	Reducing number of pressure ulcers across all NHS Fife Wards – ***Actions 1 and 3***
	Reducing the random monthly variation in HSCP wards – ***Actions 2 and 3***

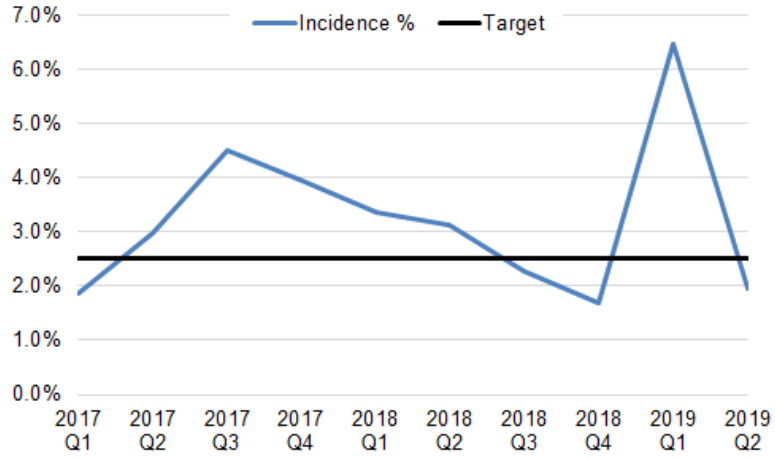
Improvement Actions	Progress	Timescale/ Status
1. All identified wards will undertake a weekly audit of compliance with SSKIN bundle	All wards are completing SSKIN bundle on a weekly basis, continued support to ensure consistent compliance is ongoing	Dec 2019 On Track
2. Fife-wide task group commissioned to review SBAR/LAER reporting	The task group have completed the recommendation of SBAR/LAER reporting and will now follow the governance structure for approval	Oct 2019 On Track
3. Improvement collaborative project extended to December 2019 across identified wards	All 10 wards continue to work within the QI programme	Dec 2019 On Track

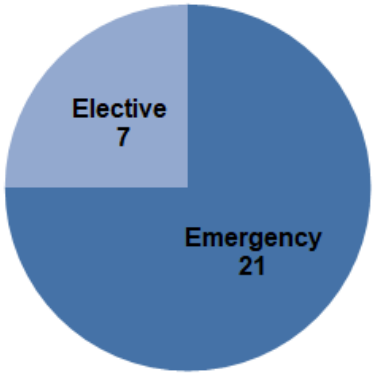
Clinical Governance

SSI Caesarean Section

To reduce C Section SSI incidence (per 100 procedures) for inpatients and post discharge surveillance to day 10 by 4% by March 2020.

Local Performance





Service Performance

	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2
NHS Fife	1.9%	3.0%	4.5%	4.0%	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%
Scotland	1.4%	1.2%	1.3%	1.6%	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%

Current Challenges	NHS Fife SSI Caesarean Section incidence rate still remains higher than the Scottish incidence rate – ***Action 1***
	NHS Fife BMI rates are higher than the national rate – ***Action 2***

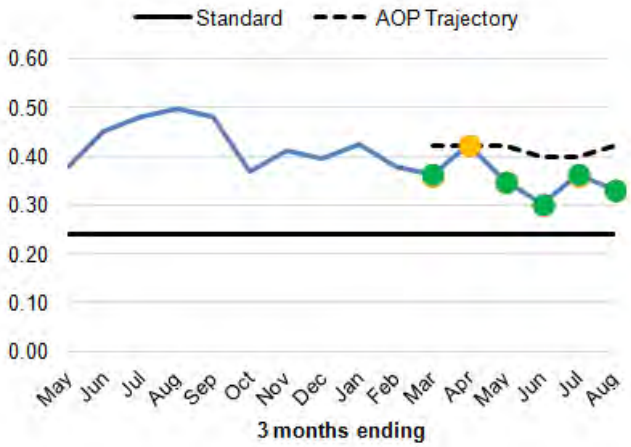
Improvement Actions	Progress	Timescale/ Status
1. Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	Improvement Plan updated in light of exception report received for Q1 2019 New case ascertainment methodology to be adopted from October	Mar 2020 On Track
2. Support an Obesity Prevention and Management Strategy for pregnant women in Fife, which will support lifestyle interventions during pregnancy and beyond	A number of strategies are in place: • Family Health Team • Winning By Losing • Smoking Cessation Analysis of data currently ongoing to determine what impact these initiatives are having on pregnant women in Fife with a high BMI	Mar 2020 On Track

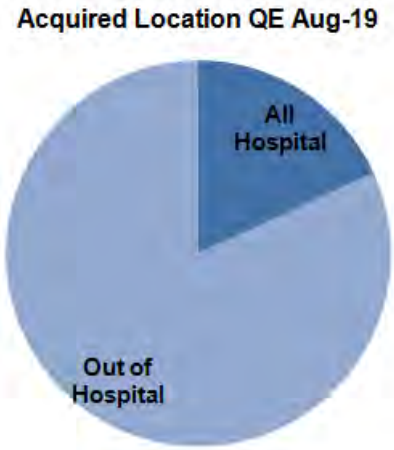
Clinical Governance

HAI SAB (including MRSA)

Rate of 0.24 cases or less per 1,000 Acute Occupied Bed Days (AOBD)
*Improvement Target for 2019/20 = **0.34***

Local Performance | Quarter Ending





National Benchmarking | Year Ending

	2018					2019								Sep-19
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	0.41	0.42	0.42	0.44	0.43	0.42	0.42	0.42	0.42	0.41	0.38	0.40	0.37	0.38
Scotland		0.33			0.33									

Current Challenges	Increase in number of VAD-related infections – ***Action 1***
	Number of SAB in diabetic patients – ***Action 2***
	Increase in number of SAB in People Who Inject Drugs (PWID) – ***Action 3***

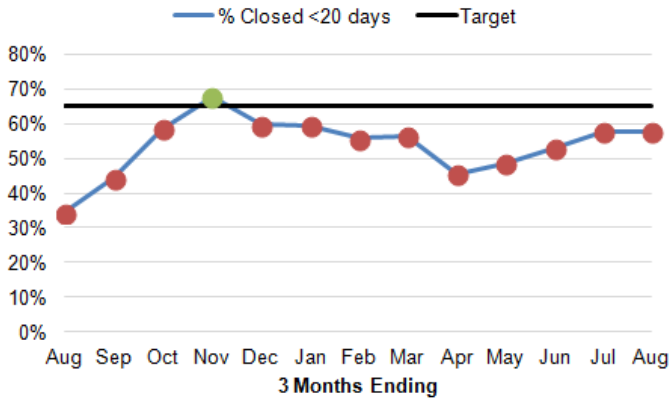
Improvement Actions	Progress	Timescale/ Status
1. Complete work mandated by Vascular Access Strategy Group	The Vascular Access Strategy Group agreed the group had fulfilled its original purpose and the ongoing actions would now be subsumed within Clinical and Operational management structures	Mar 2020 On Track
2. Explore a new programme of work focusing on reducing the risk of SAB in diabetic patients	An initial meeting with surveillance to review and analyse the last 2 years worth of data relating to SAB with Diabetes as a risk factor has taken place. This covered Hospital Onset, Healthcare Associated and Community Onset SAB. The Vascular Access Strategy and Urinary Catheter Improvement Group are developing appropriate improvement work, and further discussions are planned for October.	Mar 2021 On Track
3. Reduce the number of SAB in PWIDs	First meeting with key stakeholders to discuss SAB prevention in the PWID completed: • ADN for HSCP engaged • Head of Quality and Clinical & Care Governance investigating and reviewing the issues • Addictions Services keen to get initiatives up and running to prevent infection and early diagnosis of wound infection • incidence charts are being used to support in QI	Mar 2021 On Track

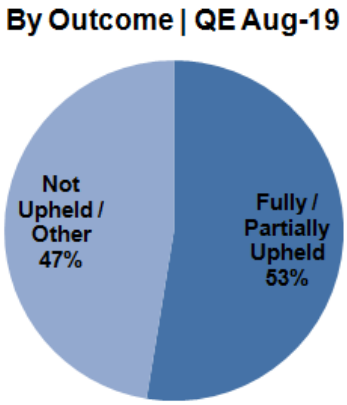
Clinical Governance

Complaints | Stage 2

At least 75% of Stage 2 complaints are completed within 20 working days
*Improvement Target for 2019/20 = **65%***

Local Performance





Local Performance by Directorate/Division

3-Month Ending	2018/19					2019/20							
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	34.4%	44.5%	58.7%	67.5%	59.8%	59.6%	55.8%	56.5%	45.5%	48.7%	52.9%	57.7%	57.8%
Acknowledged <= 3 Days	72.1%	79.6%	88.9%	94.0%	95.7%	92.7%	95.2%	93.5%	97.4%	97.4%	96.6%	96.2%	94.8%
ASD	40.9%	50.5%	67.1%	75.6%	70.7%	69.0%	62.7%	60.3%	52.6%	60.3%	68.3%	71.8%	66.7%
HSCP	16.1%	27.8%	37.5%	38.7%	26.5%	35.3%	38.2%	44.4%	21.1%	11.1%	8.7%	22.6%	32.4%

Current Challenges	To improve quality of draft responses – ***Action 1***
	To improve quality of investigation statements – ***Action 2***
	Inconsistent management of medical statements and inconsistent style of responses within ASD – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Patient Relations Officers to undertake peer review	This continues and learning is being shared directly with individual Officers. Monthly meetings with ASD to discuss complaint issues and style of drafts are in place. Joint education session to be arranged to agree draft styles.	Mar 2020 On Track
2. Deliver education to service to improve quality of investigation statements	Yearly education delivered to FY2 doctors and student nurses. *Ad Hoc* training sessions are also delivered when required.	Mar 2020 On Track
3. Agree a process for managing medical statements, and a consistent style for responses	ASD to discuss with Clinical Leads PRD raise issues at monthly meeting	Oct 2019 On Track

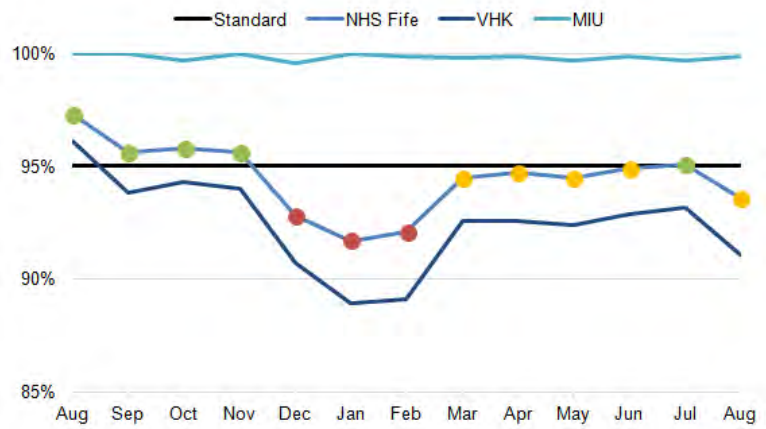
Finance, Performance & Resources – Operational Performance

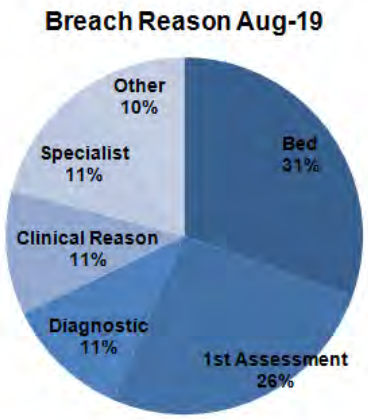
4-Hour Emergency Access

At least 95% of patients (stretch target of 98%) will wait less than 4 hours from arrival to admission, discharge or transfer for Accident and Emergency treatment

*Improvement Target for 2019/20 = **96%***

Local Performance





National Benchmarking

Month	2018/19								2019/20				
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	97.3%	95.6%	95.8%	95.6%	92.8%	91.7%	92.1%	94.5%	94.7%	94.5%	94.9%	95.1%	93.6%
Scotland	92.0%	90.9%	92.2%	91.3%	89.6%	88.8%	89.3%	91.3%	89.9%	90.7%	90.3%	91.2%	90.6%

Current Challenges	Variation in 4-Hour Emergency Access Performance - ***Action 1***
	Patient Flow – ***Action 2***
	ECAS and OPAT Services and Capacity – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Formation of PerformED group to analyse performance trends	Nursing staff models have been reviewed and identified where support is required to reduce length of stay in the department with proactive triage loading. Particular focus on breaches where patients exit ED between hours 4 and 5.	Jan 2020 On Track
2. Review of AU1 Assessment Pathway	The new flow model continues to assist with control of occupancy, and a test of change is in place for October to assess the impact of consultant handling GP referrals and advice calls with view to reducing attendances. The year-on-year increase in attendances is 18.5%.	Oct 2019 On Track
3. Development of services for ECAS and implementation of OPAT	A review of the ECAS model within Fife compared to other boards is to be implemented, with support from SG review of front door flow. Microbiology support to OPAT is starting in October.	Oct 2019 On Track

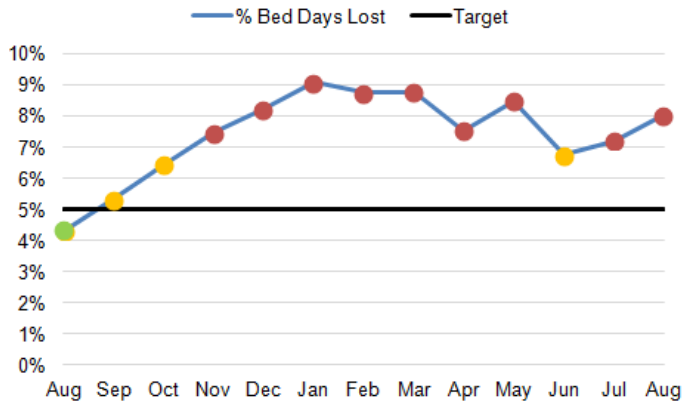
Finance, Performance & Resources – Operational Performance

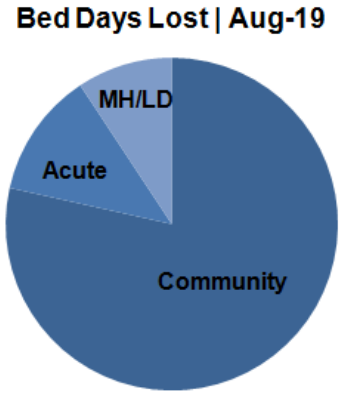
Delayed Discharges

We will reduce the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

*Improvement Target for 2019/20 = **5%***

Local Performance





National Benchmarking

Quarter Ending	2017/18				2018/19		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	5.5%	6.5%	5.0%	4.1%	4.2%	4.8%	7.5%
Scotland	5.7%	6.1%	6.4%	6.0%	6.6%	7.0%	7.1%

Current Challenges	To reduce the number of hospital bed days lost due to patients in delay – ***Actions 1 and 3***
	To improve the time taken to complete social work assessments – ***Action 2***

Improvement Actions	Progress	Timescale/ Status
1. Test a trusted assessors model within VHK for patients transferring to STAR/assessment beds	Framework developed. Training and shadowing sessions for staff to be progressed.	Oct 2019 On Track
2. Review timescales of social work assessments	Meeting to review process and timescales has taken place. Patients discharged from VHK who require single carer are being assessed at home provided they go home with ICASS. This is the case for the majority of VHK discharges. **As the implementation is still to be agreed, the action timescale has been adjusted.**	~~Sep 2019~~ Delayed to Nov 2019
3. Moving On Policy to be implemented to support staff where families are refusing choices and/ or where there is no availability of the assessed resource	Policy to be signed off and implemented by winter	Nov 2019 On Track

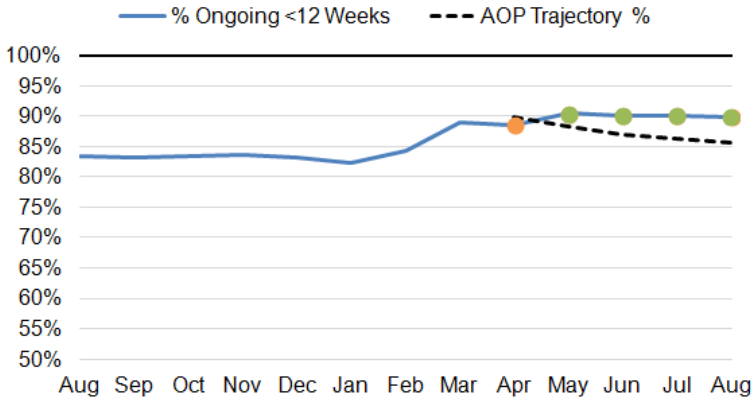
Finance, Performance & Resources – Operational Performance

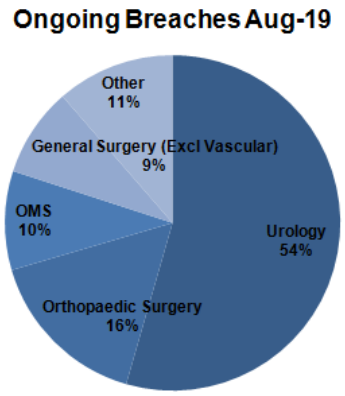
Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

*Improvement Target for 2019/20 = **80%** (Patients Waiting <= 12 Weeks at month end, as per Scottish Government Waiting Times Plan)*

Local Performance





National Benchmarking

	2018/19								2019/20					Sep-19
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	83.3%	83.3%	83.4%	83.5%	83.3%	82.4%	84.4%	89.0%	88.5%	90.4%	90.1%	90.1%	89.9%	**84.8%**
Scotland		68.1%			67.5%	66.6%	66.8%	70.1%	68.9%	68.4%	67.8%			

Current Challenges	Recurring gap in IP/DC capacity – ***Actions 1, 2 and 3***
	Difficulty in recruiting to Specialist Consultant posts – ***Actions 1 and 2***
	Difficulty in staffing additional in-house activity - ***Actions 1, 2 and 3***
	Cancellation of IP/DC activity due to unscheduled care pressures - ***Action 2***

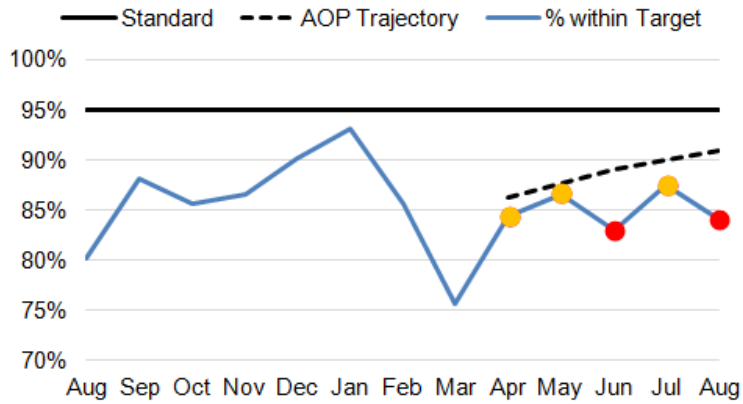
Improvement Actions	Progress	Timescale/ Status
1. Secure resources in order to deliver waiting times improvement plan for 19/20	Letter confirming first allocation of funding received; plan being delivered	Complete
2. Develop and deliver Clinical Space redesign Improvement programme	Meetings continue, report from Bed Modelling exercise awaited	Mar 2020 On Track
3. Theatre Action Group develop and deliver plan	Monthly meetings continue, action plan in place. Day Surgery event planned to explore options for delivery of the new BADS targets and to maximise the use of day surgery capacity at QMH.	Mar 2020 On Track

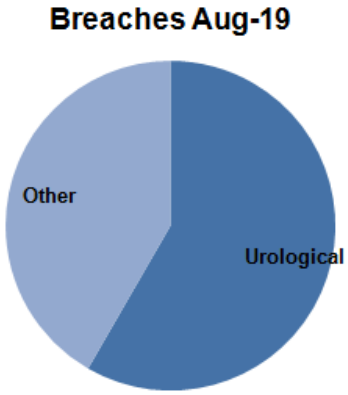
Finance, Performance & Resources – Operational Performance

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days
*Improvement Target for 2019/20 = **94%***

Local Performance





National Benchmarking

	2018/19								2019/20					Sep-19
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	80.2%	88.2%	85.6%	86.6%	90.2%	93.1%	85.6%	75.6%	84.4%	86.6%	82.9%	87.5%	84.0%	**92.0%**
Scotland	79.7%	80.2%	81.6%	81.0%	83.4%	79.9%	79.9%	81.6%	80.4%	81.1%	82.6%	81.8%	82.1%	

Current Challenges	Urology 62 day performance (Prostate) – ***Actions 1 and 2***
	Cancer Waiting Times 'education' – ***Action 2***
	Delays to steps in pathways for 1st OPA, diagnostic investigations and reporting – ***Action 2***
	Number of breaches in various specialties – ***Action 3***

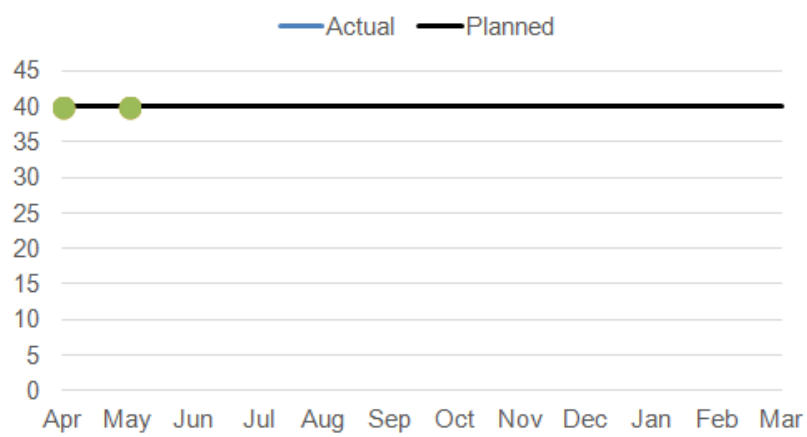
Improvement Actions	Progress	Timescale/ Status
1. Urology Improvement Group review prostate pathway to minimise wait between each step	Improvements implemented have delivered a reduction in waits to 1st OPA, MRI, TRUS biopsy, and histopathology turnaround times. Pathway reviewed and revised in collaboration with clinical team. Clinical team are now working towards implementation of "bundle booking" whereby all diagnostics and appointments required are booked at the point of vetting. The backlog of patients breached and not treated has reduced.	Jan 2020 On Track
2. Improvement in cancer governance structure and redesign of weekly PTL meeting together with organisation-wide education sessions to ensure clear focus on escalation processes	• Governance structure agreed • Meetings to be arranged and ToRs finalised • CWT education package under development • SOP to be reviewed Further metrics introduced into the PTL meeting to allow services to manage cancer referral demand and capacity. **The action completion date has been adjusted to reflect that work in this area is continuing.**	~~Oct 2019~~ Delayed to Dec 2019
3. Robust review of timed cancer pathways to ensure up to date and with clear escalation points	Current pathways distributed to teams for review Escalation protocols being developed by each service to avoid any "communication delays in pathway".	Jan 2020 On Track

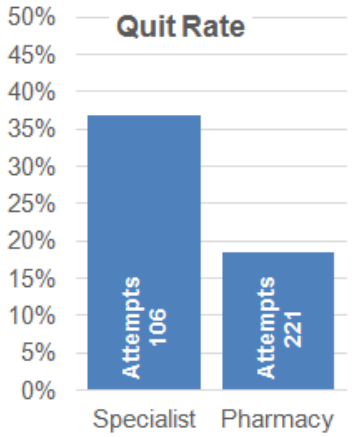
Finance, Performance & Resources – Operational Performance

Smoking Cessation

In 2019/20, we will deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance





National Benchmarking

Quits (Number and % Achieved against		2019/20											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS Fife	Actual	40	40										
	Actual Cumul	40	80										
	Achieved	100%	100%										
Scotland	Achieved												

Current Challenges	To improve uptake in deprived communities – ***Action 1***
	To increase uptake of Champix – ***Action 2***
	To increase smoking cessation in Antenatal Setting – ***Action 3***

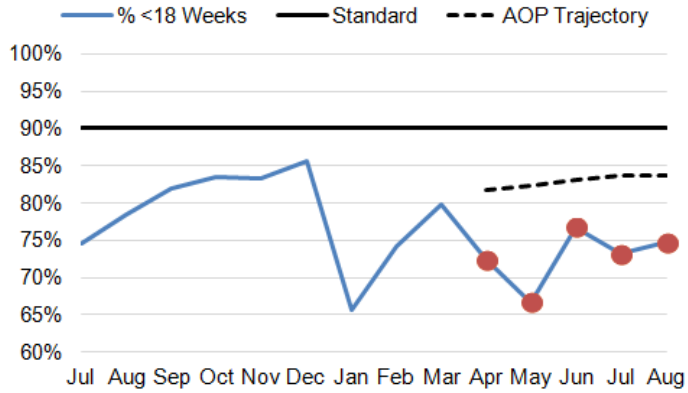
Improvement Actions	Progress	Timescale/ Status
1. Outreach development with Gypsy Travellers in Thornton	We have had no further stop smoking engagement with the Gypsy Travellers in Thornton. However, we have supplied relevant information to be displayed on site and will attend a lifestyle awareness session in October.	Complete
2. Test effectiveness and efficiency of Champix prescribing at point of contact within hospital respiratory clinic	Plans in progress, monthly meetings with Respiratory Consultant to organise paperwork and process/pathways	Mar 2020 On Track
3. 'Better Beginnings' class for pregnant women on Saturday mornings	Plans have progressed and Saturday provision has started - ongoing monitoring in place	Mar 2020 On Track

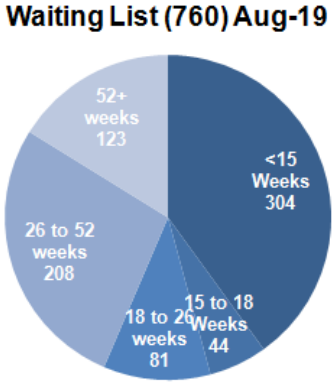
Finance, Performance & Resources – Operational Performance

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment
*Improvement Target for 2019/20 = **88%***

Local Performance





National Benchmarking

Month		2018/19								2019/20					Sep-19
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	% <18 Weeks	78.4%	82.0%	83.5%	83.3%	85.5%	65.7%	74.3%	79.8%	72.3%	66.7%	76.7%	73.2%	74.8%	**85.0%**
Scotland		66.3%	70.7%	72.9%	68.3%	78.6%	72.1%	73.4%	75.6%	69.2%	69.1%	70.9%			

Current Challenges	Increased referrals to service – ***Action 1***
	Pressure on existing staff – ***Action 2***
	Improving efficiency of workload allocation – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Introduction of Primary Mental Health Worker (PMHW) First Contact Appointments System and Group Therapy Programme	Started in April 2019 following SG Action 15 funding. Four additional staff were recruited on 1-year contracts. Impact has been extremely positive with significant amount of C&YP signposted following assessment to alternative service providers. New staff have since moved on to permanent posts, and recruitment has restarted. This is experiencing significant delay.	Mar 2020 On Track
2. Waiting List Additional Staffing Resource	Additional evening clinics now in operation. It is anticipated that 80-100 additional C&YP will be allocated individual therapy depending on uptake and attendance. Group programme underway, resulting in 158 C&YP being allocated group places up until Jan 2020.	Sep 2019 to Feb 2020 On Track
3. Introduction of Substantive Team Leader Role	Posts in place. Active allocation of appointments underway. Team Leaders identifying patients for prioritisation and for evening clinics.	Mar 2020 On Track

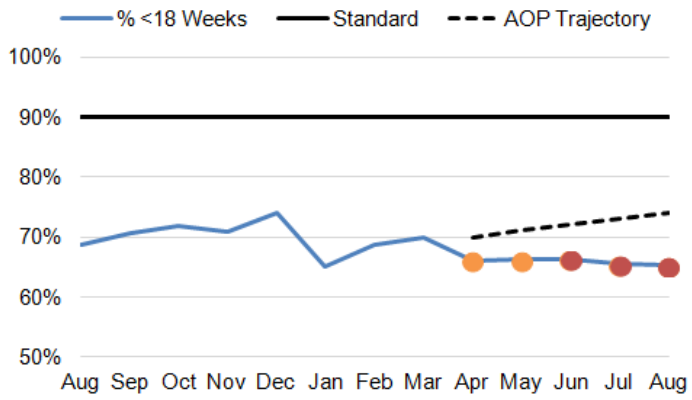
Finance, Performance & Resources – Operational Performance

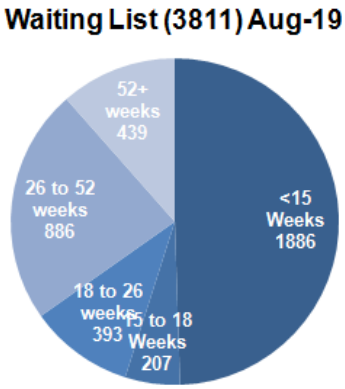
Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment for Psychological Therapies

Improvement Target for 2019/20 = ***82%***

Local Performance





National Benchmarking

Month	2018/19									2019/20					Sep-19
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Target
NHS Fife	62.9%	68.7%	70.7%	71.9%	70.8%	73.9%	65.0%	68.7%	69.8%	66.1%	66.2%	66.3%	65.5%	65.2%	**75.0%**
Scotland	75.9%	74.8%	75.8%	75.6%	74.6%	77.5%	75.3%	77.7%	79.6%	76.7%	79.3%	80.0%			

Current Challenges	To reduce delays for patients with complex needs requiring PTs within care programme approach – ***Action 1***
	To provide sufficient low-intensity PTs for mild-moderate mental health problems – ***Action 2***
	To increase capacity in services offering PTs for secondary care patients – ***Action 3***
	To improve triage in Primary Care to improve access to appropriate PTs – ***Action 4***

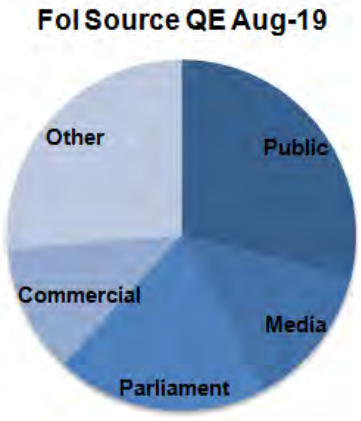
Improvement Actions	Progress	Timescale/ Status
1. Introduction of single point of access for secondary care patients via CMHT	Underway in 4 of 6 CMHTs; working with e-health to develop SCI gateway option to facilitate	Dec 2019 On Track
2. Introduction of Extended Group Programme in primary care, accessible by self-referral	Monitoring of referral rates from GPs to relevant tier of AMH service suggests positive impact on capacity for more highly specialist work within this tier. Further data is required to determine if this is a trend. **Target date December 2019.** Plans underway to expand self referral via website for low intensity PTs within Child and Family Psychology service and monitor impact on access and capacity.	Mar 2020 On Track (scope extended)
3. Redesign of Day Hospital provision to support CMHTs	Implementation of full re-design delayed due to revised timetable for staff engagement work. Further progress required to impact on capacity for delivery of PTs.	Mar 2020 On Track
4. Implementation of mental health triage nurse pilot programme in Primary Care	Staff in post in selected GP Cluster areas; service being well-utilised; evaluation underway (interim report due in September)	Oct 2019 On Track

Finance, Performance & Resources – Operational Performance

Freedom of Information Requests

In 2019/20, we will respond to a minimum of 85% of FoI Requests within 20 working days

Local Performance



Service Performance

Monthly	2018/19					2019/20							
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Health Board	53.1%	48.4%	55.6%	55.4%	76.0%	83.7%	80.4%	76.2%	52.2%	56.8%	64.4%	68.9%	73.0%
IJB						100.0%	100.0%	55.6%	100.0%	86.7%	71.4%	86.7%	100.0%

Current Challenges	Performance variable due to delays in the return of responses from services and pressure on corporate support for finalising responses – ***Actions 1, 2, 3 and 4***

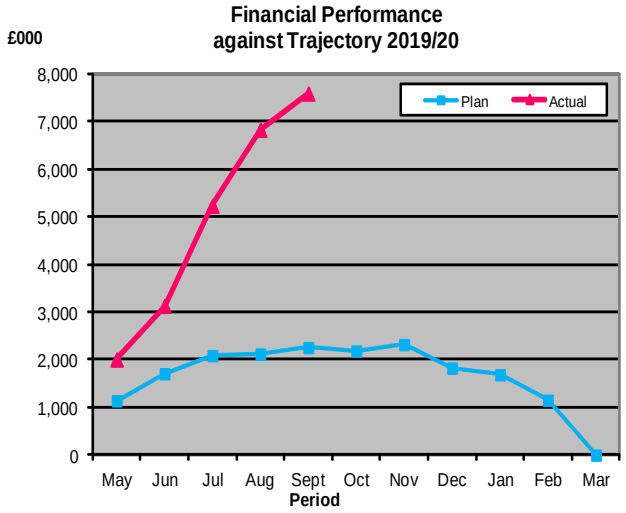
Improvement Actions	Progress	Timescale/ Status
1. Map pathway out and identify areas that have recurring issues with delayed responses	New spreadsheet created to improve ongoing tracking of enquiries and identify stages of delay. Revised spreadsheet continues to be tested and refined.	Aug 2019 Complete
2. Improve FoI case recording and monitoring of timeliness of responses	Revised spreadsheet now in use and timeliness of response has improved over this short-term period. Further capturing of data will indicate any ongoing problem areas where timeliness is a repeat issue.	Sep 2019 Complete
3. Review enhanced cover arrangements for corporate administration of requests, to improve resilience	Training session has taken place in September for corporate staff. Day-to-day management of FOI inbox has now been transferred to staff within Information Governance & Security Team, which has greatly improved overall resilience.	Sep 2019 Complete
4. Update of FOI processes to reflect involvement of Information Governance & Security Team	Meetings arranged for October to review and update administrative pathways, processes and existing paperwork / templates.	Dec 2019 On Track

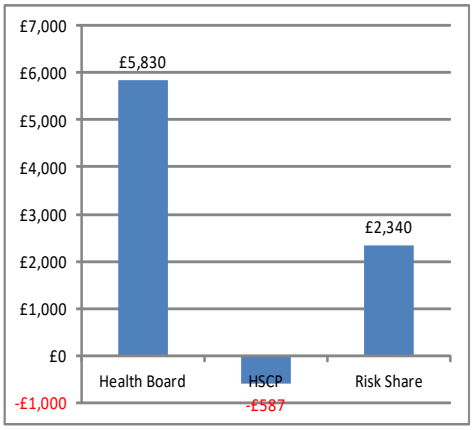
Finance, Performance & Resources – Finance

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD).

Local Performance





Expenditure by Health Board/IJB

Memorandum	Budget			Expenditure			*Variance split by*	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	*Run Rate £'000*	*Savings £'000*
Health Board	416,309	418,039	200,601	206,431	5,830	2.91%	1,397	4,433
Integration Joint Board	349,458	351,763	174,208	173,621	-587	-0.34%	*-772*	*185*
Risk Share				2,340	2,340	0.00%	2,340	
Total	**765,767**	**769,802**	**374,809**	**382,392**	**7,583**	**2.02%**	***2,965***	***4,618***

Commentary

The revenue position for the 6 months to 30 September reflects an over spend of £7.583m. This is significantly higher than the position reported for the same period in each of the four previous financial years.

Based on this year to date position, and a number of high level planning assumptions as agreed by delegated budget holders, the year end forecast ranges from a potential optimistic forecast of £7m overspend to a potential worst case of £15.8m overspend.

The key challenges are the overspend on Acute Services (largely driven by non delivery of savings and a number of specific cost pressures) and the risk share impact of the Integration Joint Board position (entirely driven by social care costs). In addition, there is a growing cost pressure in relation to activity outside Fife and in particular, the number of specialist high cost, low volume procedures undertaken in Edinburgh. On a positive note, the forecast position reported does not take into account the ongoing work to review potential offsetting benefits such as increased financial flexibility from financial plan commitments (including unplanned slippage on allocations), review of balance sheet accruals, and non recurring ADEL (Additional Departmental Expenditure Limit) funding. An early estimate of these additional offsetting benefits provides a *degree* of assurance that the net (optimistic) forecast overspend on the Health Board retained services might be mitigated to an extent.

However, as highlighted in the Integrated Performance & Quality Report last month, there is limited assurance that NHS Fife can remain within the overall revenue resource limit if we are required to cover the impact of the IJB position (capped at 72% of the initial £6.5m budget gap) ie £4.6m. This would become even more challenging, if we are required to cover the impact of the forecast outturn position for the IJB (currently in excess of £11m). This therefore raises a concern that the Board cannot deliver on its statutory requirement to break even.

For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR) we have included a funding assumption to the value of the risk share impact and a continued commitment to cover the net overspend on the Health Board budgets through increased financial

flexibility	
Current Challenges	Acute Services Division: overspend of £7.363m, the key driver being the shortfall on savings – ***Action 1 and 3***
	IJB: extent of social care overspend and resultant impact of risk share arrangement – ***Actions 2 and 3***
	Non recurring financial flexibility: under review but currently not sufficient to offset full extent of overspend, including IJB risk share – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Savings	External review completed Detailed action plan required from ASD **This will be an ongoing activity throughout 2019/20 and 2020/21**	~~Sep 2019~~ Delayed to Mar 2021
2. Discussions with Scottish Government to support financial position	Meeting held in early October Further discussion required with SG in November **Action completion date adjusted accordingly**	~~Oct 2019~~ Delayed to Nov 2019
3. Ongoing grip and control measures across all services	All Directors required to confirm measures in place within delegated areas of responsibilities. Oversight undertaken through EDG. Proactive communication required with all staff via Directors **Action completion date adjusted accordingly**	~~Oct 2019~~ Delayed to Nov 2019

1. Annual Operational Plan

1.1 The Financial Plan for 2019/20 was approved by the Board on 27 March 2019, with the related Annual Operational Plan approved on 29 May 2019.

2. Financial Allocations

Revenue Resource Limit (RRL)

2.1 On 1 October 2019 NHS Fife received confirmation of September core revenue and core capital allocation amounts. The revised core revenue resource limit (RRL) has been confirmed at £753.554m. A breakdown of the additional funding received in month is shown in Appendix 1 and Appendix 2 shows details of anticipated allocations expected to be received.

Non Core Revenue Resource Limit

2.2 NHS Fife also receives 'non core' revenue resource limit funding for technical accounting entries which do not trigger a cash payment. This includes, for example, depreciation or impairment of assets. The anticipated non core RRL funding of £24.367m is detailed in Appendix 3

Total RRL

2.3 The total current year budget at 30 September is therefore £769.802m

3. Summary Position

3.1 At the end of September, NHS Fife is reporting an overspend of £7.583m against the revenue resource limit. Table 1 below provides a summary of the position across the constituent parts of the system: an overspend of £5.830m is attributable to Health Board retained budgets; an underspend of £0.578m is attributable to the health budgets delegated to the Integration Joint Board and an overspend shown of £2.340m relating to the IJB risk share (capped at the opening budget deficit of £6.5m).

3.2 Key points to note from Table 1 are:

3.2.1 Acute Division overspend of £7.363m, driven largely as a result of non delivery of savings (£4.316m);

3.2.2 The aforementioned Acute Division overspend includes £3.011m overspend relating to a number of Acute services budgets that are 'set aside' for inclusion in the strategic planning of the IJB, but which remain managed by the NHS Board;

3.2.3 Underspend across Estates & Facilities;

3.2.4 Underspend of £0.578m against the Health budgets delegated to the IJB; and.

3.2.5 Risk share impact of the overall IJB position (budget deficit) of £2.340m.

Table 1: Summary Financial Position for the period ended September 2019

Memorandum	Budget			Expenditure			*Variance split by*	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	*Run Rate £'000*	*Savings £'000*
Health Board	416,309	418,039	200,601	206,431	5,830	2.91%	*1,397*	*4,433*
Integration Joint Board - Health	349,458	351,763	174,208	175,961	1,753	1.01%	*1,568*	*185*
Total	**765,767**	**769,802**	**374,809**	**382,392**	**7,583**	**2.02%**	***2,965***	***4,618***

	Budget			Expenditure			*Variance split by*	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	*Run Rate £'000*	*Savings £'000*
Acute Services Division	198,462	203,644	102,903	110,266	7,363	7.16%	*3,047*	*4,316*
IJB Non-delegated	8,189	8,204	4,132	4,122	-10	-0.24%	*-37*	*27*
Estates & Facilities	72,837	73,009	35,980	35,734	-246	-0.68%	*-292*	*46*
Board Admin & Other Services	53,251	69,740	39,250	39,224	-26	-0.07%	*-70*	*44*
Non Fife & Other Healthcare Providers	85,946	85,946	42,941	43,633	692	1.61%	*692*	*0*
Financial Flexibility & Allocations	22,822	17,582	1,663	0	-1,663	-100.00%	*-1,663*	*0*
Health Board	**441,507**	**458,125**	**226,869**	**232,979**	**6,110**	**2.69%**	***1,677***	***4,433***
Integration Joint Board - Core	374,019	398,885	199,486	198,908	-578	-0.29%	*-763*	*185*
Integration Fund & Other Allocations	13,880	2,326	0	0	0	0.00%	*0*	*0*
Sub total Integration Joint Board Core	**387,899**	**401,211**	**199,486**	**198,908**	**-578**	**-0.29%**	***-763***	***185***
IJB Risk Share Arrangement	0	0	0	2,340	2,340	0.00%	*2,340*	*0*
Total Integration Joint Board - Health	**387,899**	**401,211**	**199,486**	**201,248**	**1,762**	**0.88%**	***1,577***	***185***
Total Expenditure	**829,406**	**859,336**	**426,355**	**434,227**	**7,872**	**1.85%**	***3,254***	***4,618***
IJB - Health	-38,441	-49,448	-25,278	-25,287	-9	**0.04%**	*-9*	*0*
Health Board	-25,198	-40,086	-26,268	-26,548	-280	**1.07%**	*-280*	*0*
Miscellaneous Income	**-63,639**	**-89,534**	**-51,546**	**-51,835**	**-289**	**0.56%**	***-289***	***0***
Net position including income	**765,767**	**769,802**	**374,809**	**382,392**	**7,583**	**2.02%**	***2,965***	***4,618***

4. Operational Financial Performance for the year

Acute Services

4.1 The Acute Services Division reports a **net overspend of £7.363m for the year to date**. This reflects an overspend in operational run rate performance of £3.047m, and unmet savings of £4.316m. Within the run rate performance, pay is overspent by £2.908m. The overall position has been driven by a combination of unidentified savings and continued pressure from the use of agency locums, junior doctor banding supplements, incremental progression and nursing recruitment in line with workforce planning tool as well as supplementary staffing to support surge capacity. As the operational performance section of the IPQR highlights, there is increasing pressure across unscheduled care in terms of demand; the financial position demonstrates the cost impact of the additional capacity required.

4.2 As previously reported, external expertise provided through Deloitte LLP has been positive in robustly supporting and challenging the Acute Services team to design and implement an effective savings programme. This work now needs to progress with pace and whilst it may result in some benefit in the current year it specifically provides a focus on the longer term financial challenge facing our acute services. This includes: transformational change in relation to outpatients, theatres and A&E attendances; Directorate schemes already identified as opportunities but not yet progressed; and underlying grip and control measures particularly in relation to supplementary staffing.

Table 2: Acute Division Financial Position for the period ended September 2019

	Budget			Expenditure			*Variance split by*	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	*Run Rate £'000*	*Savings £'000*
Acute Services Division								
- Planned Care & Surgery	67,710	69,767	35,499	37,560	2,061	**5.81%**	*415*	*1,646*
- Emergency Care & Medicine	73,085	75,430	38,178	41,746	3,568	**9.35%**	*2,484*	*1,084*
- Women, Children & Clinical Services	54,022	54,741	27,307	29,608	2,301	**8.43%**	*715*	*1,586*
- Acute Nursing	596	616	279	244	-35	**-12.54%**	*-35*	
- Other	3,049	3,090	1,640	1,108	-532	-32.44%	*-532*	
Total	**198,462**	**203,644**	**102,903**	**110,266**	**7,363**	**7.16%**	***3,047***	***4,316***

Estates & Facilities

4.3 The Estates and Facilities budgets report an **under spend of £0.246m** which is generally attributable to vacancies, energy and water and property rates, and partially offset by an overspend on property maintenance.

Corporate Services

4.4 Within the Board's corporate services there is **an underspend of £0.026m**. Further analysis of Corporate Directorates is detailed per Appendix 4.

Non Fife and Other Healthcare Providers

4.5 The budget for healthcare services provided out with NHS Fife is **overspent by £0.692m.** This remains an area of increasing challenge particularly given the relative higher costs of some other Boards. Included in the position this month is the impact of holding back funding for the new Royal Hospital for Children & Young People / Department of Clinical Neurosciences in Edinburgh. This can be seen in the underspend reported against NHS Lothian in Appendix 5.

Financial Plan Reserves & Allocations

4.6 Financial plan expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year, and therefore form part of devolved budgets. A number of residual uplifts and new in year allocations are held in a central budget and are subject to robust scrutiny and review each month. The detailed review of the financial plan reserves at Appendix 6 allows an assessment of financial flexibility for the year to date. Whilst no specific decisions are made to hold back new allocations, there are often unplanned underspends which emerge as the year progresses.

4.7 As in every financial year, this 'financial flexibility' allows mitigation of slippage in savings delivery, and is a crucial element of the Board's ability to deliver against the statutory financial target of a break even position against the revenue resource limit.

Integration Services

4.8 The health budgets delegated to the Integration Joint Board report an **underspend of £0.578m for the year to date**. This position comprises an under spend in the run rate

performance of £0.763m; together with unmet savings of £0.185m. The underlying drivers for the run rate under spend are vacancies in community nursing, health visiting, school nursing, community and general dental services across Fife Wide Division. The aforementioned under spend is partly offset by locum costs within mental health services and inpatient service costs within East and West Fife. The IJB risk share is included within the position month and is shown separately in the Table 1 above. The position shown for the first 6 months of 2019/20 is **£2.340m**, representing a share of the overall initial budget gap of £6.5m. The key financial risk in relation to the Health & Social Care Partnership is this overall gap (comprising an under delivery of £7.2m on social care and over delivery of £0.7m on delegated health budgets) and the increasing actual overspend on social care budgets seen in the first quarter of the year. In parallel with the increasing pressure across unscheduled care within the Acute Services Division, as reported in 4.1 above, there is increasing demand within social care and this is manifesting in additional packages which are outwith the budget available.

4.9 The Integration Scheme for the IJB describes the steps required to manage any overspend:

"Process for resolving budget variances in year - Overspend

8.2.1 The Director of Health & Social Care will strive to deliver the outcomes within the total delegated resources. Where there is a forecast overspend against an element of the operational budget, the Director of Health & Social Care, the Chief Finance Officer of the Integration Joint Board, Fife Council's Section 95 Officer and NHS Fife's Director of Finance must agree a recovery plan to balance the total budget. The recovery plan shall be subject to the approval of the Integration Joint Board.

8.2.2 The Integration Joint Board may increase the payment to the affected body, by either:

- *utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or*
- *utilising the balance on the integrated general fund, if available, of the Integration Joint Board in line with the reserves policy.*

8.2.3 If the recovery plan is unsuccessful and there are insufficient integrated general fund reserves to fund a year-end overspend, then the Parties with agreement of the Integration Joint Board shall have the option to:

- *Make additional one-off payments to the Integration Joint Board; or*
- *Provide additional resources to the Integration Joint Board which are then recovered in future years, subject to scrutiny of the reasons for the overspend and evidence that there is a plan in place to resolve this.*

8.2.4 Any remaining overspend will be funded by the Parties based on the proportion of their current year contributions to the Integration Joint Board.

4.10 In previous years, and in agreement with Fife Council colleagues, we have managed the overspend on the IJB through the risk share arrangement described at 8.2.4 of the Integration Scheme. However, as discussed and agreed through the Finance, Performance & Resources Committee in February 2019, the Annual Operational Plan for 2019/20 was predicated on the assumption that the Chief Executive and Director of Finance would actively pursue discussions with the Director of Health & Social Care and Fife Council colleagues that the risk share approach would not be the immediate option. Instead, the application of an earlier clause (ie a further recovery plan per 8.2.1,

or each party to cover their own position per 8.2.3) was preferable. This discussion was paused following various meetings with representatives of Scottish Government over recent months, with a clear expectation from SG that all partners would agree an in year recovery plan for the IJB.

Income

4.11 A small over recovery in income of £0.289m is shown for the year to date.

5. Pan Fife Analysis

5.1 Analysis of the pan NHS Fife financial position by subjective heading is summarised in Table 3 below.

Table 3: Subjective Analysis for the Period ended September 2019

	Annual Budget	Budget	Actual	Net over/ (under) spend
Pan-Fife Analysis	**£'000**	**£'000**	**£'000**	**£'000**
Pay	371,855	185,202	186,125	923
GP Prescribing	72,726	36,251	36,254	3
Drugs	29,903	15,420	14,855	-565
Other Non Pay	373,974	192,438	194,653	2,215
IJB Risk Share	0	0	2,340	2,340
Efficiency Savings	-9,030	-4,619	0	4,619
Commitments	19,908	1,663	0	-1,663
Income	-89,534	-51,546	-51,835	-289
Net underspend	**769,802**	**374,809**	**382,392**	**7,583**

Pay

5.2 The overall pay budget reflects an overspend of £0.923m. There are under spends across a number of staff groups which partly offset the overspend position within medical and dental staff; the latter being largely driven by the additional cost of supplementary staffing to cover vacancies and also nursing.

5.3 Against a total funded establishment of 7,748 wte across all staff groups, there was 7,737 wte staff in post in September.

Drugs & Prescribing

5.4 Across the system, there is a net under spend of £0.562m on medicines largely due to an under spend of £0.565m on sexual health and rheumatology drugs. The GP prescribing position is based on 2018/19 trend analysis and June and July 2019 actual information. Whilst it is difficult to predict, there are emerging concerns related to the potential increase in prices over coming months.

Other Non Pay

5.5 Other non pay budgets across NHS Fife are collectively overspent by £2.215m. The overspends are in purchase of healthcare from other Health Boards and independent providers, other supplies, property & hotel expenses and surgical sundries. These are offset by under spends across a number of areas including energy and diagniostic supplies.

6 Financial Sustainability

6.1 The Financial Plan presented to the Board in March highlighted the requirement for £17.333m cash efficiency savings to support financial balance in 2019/20. The Plan was approved with a degree of cautious optimism and confidence that the gap would be managed in order to deliver a break even position in year 1 of the 3 year planning cycle. As reported to the Board in March, this view was entirely predicated on a robust and ambitious savings programme across Acute Services and the Health & Social Care Partnership; supported by ongoing effective grip and control on day to day expenditure and existing cost pressures; and early identification and control of non recurring financial flexibility.

6.2 The extent of the recurring / non recurring savings delivery for the year is illustrated in Table 4 below.

Table 4: Savings 2019/20

Savings 2019/20	Target £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Total Identified & Achieved to date £'000	*Outstanding £'000*
Health Board	10,873	1,019	1,248	2,267	8,606
Integration Joint Board	6,460	3,431	2,605	6,036	424
Total Savings	**17,333**	**4,450**	**3,853**	**8,303**	**9,030**

7 Key Messages / Risks

7.1 The key challenges are the overspend on Acute Services (largely driven by non delivery of savings and a number of specific cost pressures) and the risk share impact of the IJB position (entirely driven by social care costs). In addition, there is a growing cost pressure in relation to activity outside Fife and in particular, the number of specialist high cost, low volume procedures undertaken in Edinburgh, as well as the cost of outflow activity in NHS Tayside.

7.2 Based on the year to date position and high level planning assumptions, estimates and information available at this time, and as agreed by delegated budget holders, the year end forecast ranges from a potential optimistic forecast of £7m overspend to a potential worst case of £15.8m overspend as detailed in table 5 below:

Table 5 – Financial Outturn (modelling based on actual position at 30 September 2019)

Forecast Outturn	Pessimistic	Mid range	Optimistic
	£'000	£'000	£'000
Acute Services Division	8,561	7,251	5,943
Acute Services Division (Acute Set Aside)	4,864	4,585	4,339
IJB Non-delegated	84	29	(4)
Estates & Facilities	87	(600)	(1,894)
Board Admin & other services	(330)	(888)	(1,076)
Non Fife & other Healthcare Providers	1,126	1,126	1,126
Financial Flexibility	(3,327)	(3,327)	(3,327)
Misc Income	(350)	(350)	(350)
Health Board Retained Budgets	**10,715**	**7,826**	**4,757**
IJB Delegated Health Budgets	397	(1,047)	(2,406)
Integration Fund & Other Allocations	0	0	0
Sub Total IJB Delegated Health Budgets	**397**	**(1,047)**	**(2,406)**
Risk Share	4,680	4,680	4,680
Net IJB Health Position	**5,077**	**3,633**	**2,274**
Total Forecast Outturn	**15,792**	**11,459**	**7,031**

7.3 On a positive note, the forecast position reported does not take into account the ongoing work to review potential offsetting benefits such as increased financial flexibility from financial plan commitments (including unplanned slippage on allocations), review of balance sheet accruals, and non recurring ADEL (Additional Departmental Expenditure Limit) funding. An early estimate of these additional offsetting benefits provides a degree of assurance that the net (optimistic) forecast overspend on the Health Board retained services might be mitigated to an extent, although this remains an area of high risk.

7.4 However, as already highlighted in the Integrated Performance & Quality Report produced in September, there is limited assurance that NHS Fife can remain within the overall revenue resource limit if we are required to cover the impact of the IJB position (capped at 72% of the initial £6.5m budget gap) ie £4.6m. This would become even more challenging if we are required to cover the impact of the forecast outturn position for the IJB (currently in excess of £11m). This therefore raises a concern that the Board cannot deliver on its statutory requirement to break even without additional funding.

7.5 For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR) we have included a funding assumption to the value of the risk share impact and a continued commitment to cover the net overspend on the Health Board budgets through increased financial flexibility.

7.6 Whilst every effort has been made to quantify the possible financial risks and benefits, there remains an element of uncertainty on the additional costs which may be incurred through: actions to achieve the winter plan; and recent decisions on the use of specific high cost medicines, as instructed by Scottish Government.

8 Recommendation

8.1 Members are invited to approach the Director of Finance or Chief Executive for any points of clarity on the position reported and are asked to:

- **Note** the reported overspend of £7.583m for the year to 30 September 2019;

and

- **Note** the current *potential* outturn position of break even; with the heavy caveat that this is entirely predicated on additional funding from SGHSCD to support any impact of the IJB risk share.

Core Revenue Resource Limit **Appendix 1**

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
May-19	Opening	662,752			662,752	
	May Adjustments	-696		-229	-925	
Jun-19	June Adjustments	16,293	3,774	6,265	26,332	
Jul-19	July Adjustments		2,863	1,678	4,541	
Aug-19	August Adjustments	280	3,268	-181	3,367	
Sept-19	£20m(2018-19) tariff reduction to global sum		-1,380	1,380	0	Change to nature of adjustment
	£20m(2019-20) tariff reduction to global sum		-1,142	1,142	0	Change to nature of adjustment
	Top slice Stereotactic Radiosurgery	-16			-16	National Adjustment
	Top slice Mitral Valve	-13			-13	National Adjustment
	Elective activity as per AOPs			100	100	Relates to Aberdeen Clinic
	CSO- support for research infrastructure			5	5	
	Flow Variability programme			70	70	Annual Allocation
	PFG - Enhancing School Nursing service			46	46	Additional School Nurses
	Veterans First Point			115	115	Annual Allocation
	Supporting improvements in primary care digital technology			209	209	Support IT used by primary care
	Primary Medical Services - provision and support		55,281		55,281	Annual Allocation
	Projects in support of primary care fund			3	3	Support dispensing staff training & implementation of falsified medicines directive
	GP Out of Hours Fund			20	20	GP Fellow
	Supporting improvements to GP premises			204	204	To Look at digitisation of GP paper records to release space and GP improvement grants
	TEC funding to support local scale up			113	113	
	Neonatal Expenses Fund			25	25	Annual Allocation
	Supporting better value healthcare in boards			6	6	
	Paid as if at work			257	257	Relates to payments for 2017/18
	National Cancer Strategy			141	141	Annual Allocation
	Shingles Rotavirus Seasonal Flu and Childhood Flu			935	935	Annual Allocation
	Men C vaccine costs			-14	-14	Annual Allocation
	Total Core Revenue Allocation	**678,600**	**62,664**	**12,290**	**753,554**	

Anticipated Core Revenue Resource Limit **Appendix 2**

	£'000
CAMHS Regional post	35
Distinction Awards	228
Community Pharmacy Pre-Reg Training	-44
New Medicine Fund	3,005
Golden Jubilee SLA	-24
Waiting List	1,675
NSD risk share	-2,566
Scotstar	-321
PET scan	-477
Depreciation to Non-core	-12,386
Mental Health Bundle	620
Capacity Building CAMHS & PT	456
Mental health innovation fund	288
Primary Care Fund GP sub Committee	34
Primary Care Improvement Fund	1,124
Capital to revenue	234
Total	-8,119

Appendix 3 - Anticipated Non Core Revenue Resource Limit Allocations

	£'000
PFI Adjustment	3,374
Donated Asset Depreciation	117
Impairment	1,000
AME Provision	-843
IFRS Adjustment	4,833
Non-core Del	3,500
Depreciation from Core allocation	12,386
Total	**24,367**

Appendix 4 - Corporate Directorates

Cost Centre	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
E Health Directorate	12,722	5,732	5,767	35
Nhs Fife Chief Executive	207	105	110	5
Nhs Fife Finance Director	5,266	2,617	2,379	-238
Nhs Fife Hr Director	3,042	1,535	1,490	-45
Nhs Fife Medical Director	6,356	2,732	2,658	-74
Nhs Fife Nurse Director	3,471	1,701	2,001	300
Nhs Fife Planning Director	1,971	960	875	-85
Legal Liabilities	15,719	13,702	13,874	172
Public Health	2,192	1,095	1,032	-63
Early Retirements & Injury Benefits	629	226	192	-34
Regional Funding	228	150	151	1
Depreciation	17,937	8,695	8,695	0
Total	**69,740**	**39,250**	**39,224**	**-26**

Finance, Performance & Resources – Finance

Service Agreements **Appendix 5**

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	95	47	29	-18
Borders	43	21	25	4
Dumfries & Galloway	24	12	30	18
Forth Valley	3,089	1,543	1,668	125
Grampian	349	174	157	-17
Highland	131	66	109	43
Lanarkshire	111	56	76	20
Scottish Ambulance Service	98	49	53	4
Lothian	30,600	15,302	14,143	-1,159
Greater Glasgow	1,607	804	509	-295
Tayside	39,772	19,886	20,385	499
	75,919	37,960	37,184	-776
UNPACS				
Health Boards	8,063	4,031	5,323	1,292
Private Sector	1,209	605	773	168
	9,272	4,636	6,096	1,460
OATS	690	345	353	8
Grants	65	0	0	0
Total	**85,946**	**42,941**	**43,633**	**692**

Financial Flexibility & Allocations

Ap

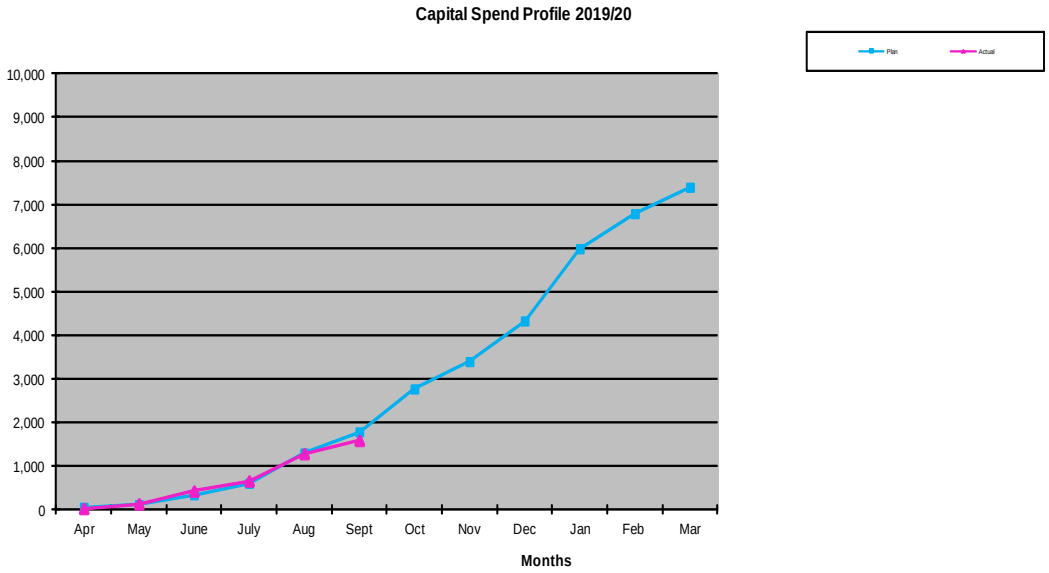
	CY Budget £'000	Flexibility Released to Sept-19 £'000
Financial Plan		
Drugs	3,599	0
Complex Weight Management	50	0
Adult Healthy Weight	104	0
National Specialist Services	166	0
Band 1's	307	154
Unitary Charge	213	57
Junior Doctor Travel	112	25
Consultant Increments	50	25
Discretionary Points	231	0
Cost pressures	4,034	1,097
Financial Flexibility	594	85
Subtotal Financial Plan	**9,460**	**1,443**
Allocations		
Health Improvement	93	0
AME Impairments	991	0
AME Provisions	-350	0
Pay Awards	251	0
Distinction Awards	37	0
Waiting List	4,524	0
CAMHS Post	35	0
Best Start	345	0
Advanced Breast Practitioner Radiology	36	0
Insulin Pumps & CGM	125	0
Superannuation	280	90
Carry Forward 18-19	260	130
Urolift	26	0
Flow Variability	70	0
Neonatal Expenses	18	0
Supporting better value	6	0
Capital to revenue	234	0
ADEL	1,000	0
National Cancer Strategy	141	0
Subtotal Allocations	**8,122**	**220**
Total	**17,582**	**1,663**

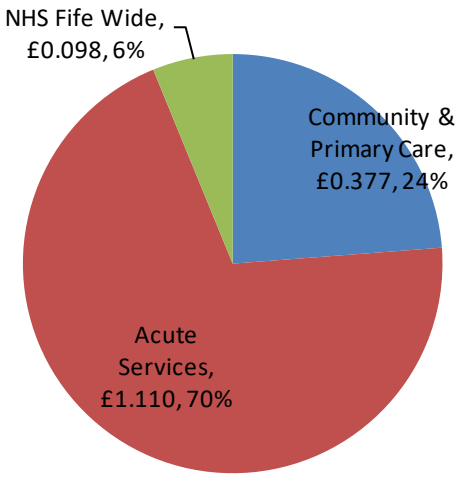
Finance, Performance & Resources – Finance

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance





Capital Programme Expenditure

Finance, Performance & Resources – Finance

Capital Expenditure Breakdown

Project	CRL New Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2019/20 £'000
COMMUNITY & PRIMARY CARE			
Statutory Compliance	947	316	947
Capital Minor Works	307	26	307
Capital Equipment	86	34	86
Condemned Equipment			
Total Community & Primary Care	**1,340**	**377**	**1,340**
ACUTE SERVICES DIVISION			
Capital Equipment	1,945	331	1,945
Statutory Compliance	2,307	393	2,307
Minor Works	168	74	168
Condemned Equipment	95	95	95
Elective Orthopaedic Centre	218	218	218
Total Acute Services Division	**4,733**	**1,110**	**4,733**
NHS FIFE WIDE SCHEMES			
Condemned Equipment			
Information Technology	1,041	95	1,041
Equipment Balance	0		0
Scheme Development	60		60
Contingency	100	1	100
Statutory Compliance - Fire Compartmentation	102	2	102
Minor Works	18		18
Total NHS Fife Wide	**1,321**	**98**	**1,321**
TOTAL ALLOCATION FOR 2019/20	**7,394**	**1,585**	**7,394**

Commentary

The total Capital Resource Limit for 2019/20 is £7.394m. The capital position for the 6 months to September shows investment of £1.585m, equivalent to 21.43% of the total allocation. Plans are in place to ensure the Capital Resource Limit is utilised in full.

Current Challenges	Overall programme of work to address all aspects of backlog maintenance, statutory compliance, equipment replacement, and investment in technology considerably outstrips capital resource limit available

Improvement Actions	Progress	Timescale/ Status
1. Managing expenditure programme within resources available	Risk management approach adopted across all categories of spend	Mar 2020 On Track

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 The Capital Plan 2019/20 was approved by the NHS Board on 27 March 2019. For information, changes to the plan since its initial approval in March are reflected in Appendix 1. On 3 June 2019 NHS Fife received confirmation of initial core capital allocation amounts of £7.394m gross. NHS Fife is anticipating an additional £2m allocation for the new Elective Orthopaedic Centre and an expected adjustment for the transfer to revenue schemes that will be actioned during the year (£0.234m).

2. Capital Receipts

2.1 The Board's capital programme is partly funded through capital receipts which, once received, will be netted off against the gross allocation highlighted in 1.1 above. Work continues on asset sales with several disposals planned:

- Lynebank Hospital Land (Plot 1) (North) – Under offer;
- Forth Park Maternity Hospital – Sold;
- Fair Isle Clinic – Sold;
- Skeith Land – preparing to market; and
- ADC – Sale due to complete October 2019.

3. Expenditure To Date / Major Scheme Progress

3.1 Details of the expenditure position across all projects are set out in the dashboard summary above. Project Leads have provided an estimated spend profile against which actual expenditure is being monitored. This is based on current commitments and historic spending patterns. The expenditure to date amounts to £1.585m or 21.43% of the total allocation, in line with the plan, and as illustrated in the spend profile graph above.

3.2 The main areas of investment to date include:

Statutory Compliance	£0.711m
Minor Works	£0.100m
Equipment	£0.460m
E-health	£0.095m
Elective Orthopaedic Centre	£0.218m

4. Capital Expenditure Outturn

4.1 At this stage of the financial year it is currently estimated that the Board will spend the Capital Resource Limit in full.

5. Recommendation

5.1 Members are invited to approach the Director of Finance or Chief Executive for any points of clarity on the position reported and are asked to:

- **note** the capital expenditure position to 30 September 2019 of £1.585m and the forecast year end spend of the capital resource allocation of £7.394m

Finance, Performance & Resources – Finance

Appendix 1: Capital Plan - Changes to Planned Expenditure

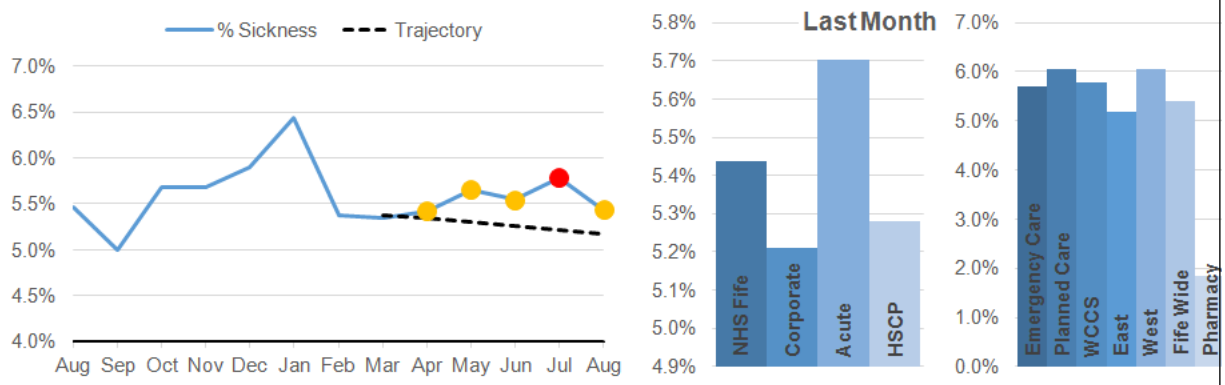
Capital Expenditure Proposals 2019/20	Board Approved 27/03/2019 £'000	Cumulative Adj to Aug £'000	Sept Adj £'000	Sept Total £'000
Routine Expenditure				
Community & Primary Care				
Minor Capital		325	(18)	307
Capital Equipment		81	6	86
Statutory Compliance		1,222	(275)	947
Condemned Equipment				
Total Community & Primary Care	**0**	**1,628**	**(287)**	**1,340**
Acute Services Division				
Capital Equipment		1,948	(3)	1,945
Minor Capital		168		168
Statutory Compliance		2,066	241	2,307
Condemned Equipment		94		94
Elective Orthopaedic Centre		186	32	218
Total Acute Service Division	**0**	**4,463**	**270**	**4,732**
Fife Wide				
Minor Work	498	(498)	18	18
Information Technology	1,041			1,041
Backlog Maintenance/Statutory Compliance	3,569	(3,469)	2	102
Condemned Equipment	90	(90)		
Scheme Development	60			60
Fife Wide Equipment	2,036	(2,033)	(3)	0
Fife Wide Contingency Balance	100			100
Total Fife Wide	**7,394**	**(6,090)**	**17**	**1,321**
Total NHS Fife	**7,394**	**0**	**0**	**7,394**

Staff Governance

Sickness Absence

To achieve a sickness absence rate of 4% or less
Improvement Target for 2019/20 = ***4.89%***

Local Performance



National Benchmarking

Month	2018/19								2019/20				
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	5.46%	5.00%	5.69%	5.68%	5.89%	6.43%	5.38%	5.34%	5.42%	5.66%	5.55%	5.78%	5.44%
Scotland	5.36%	5.02%	5.53%	5.47%	5.54%	6.17%	5.23%	5.10%	5.04%	5.23%	4.98%	5.22%	5.18%

Current Challenges	Sickness Absence Rate Significantly Above Standard – ***Action 1***
	High Level of Sickness Absence Related to Mental Health – ***Action 2***

Improvement Actions	Progress	Timescale/ Status
1. Targeted Managerial, HR, OH and Well@Work input to support management of sickness absence	This is being progressed through Attendance Management Leads within their respective areas, HR Officers / Advisors, and through the trajectory reporting for each business unit and use of the RAG status reports. A plan for additional OH support is being developed, including OH Drop-in Sessions scheduled throughout September and October. **Overall activity will continue throughout the remainder of the FY, and the action completion date has been adjusted accordingly.**	~~Sep 2019~~ Delayed to Mar 2020
2. Early OH intervention for staff absent from work due to a Mental Health related reason	This has been in place since March 2019 and will be reviewed in six months.	Oct 2019 On Track

PAUL HAWKINS
Chief Executive
23rd October 2019

Prepared by:
CAROL POTTER
Director of Finance and Performance

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Winter Plan 2019/20
EXECUTIVE LEAD:	Nicky Connor, Director of Health and Social care Ellen Ryabov, chief Operating Officer, Acute
REPORTING OFFICER:	Nicky Connor, Director of Health and Social care

Purpose of the Report (delete as appropriate)		
For Decision **reach a conclusion**	**For Discussion** **consider the options and any impact**	**For Information** **for noting** √

SBAR REPORT

Situation

This paper provides the Clinical Governance Committee with the draft Winter Plan 2019/20.

The plan has taken account of lessons learnt from 2018/19 performance and from outcomes contained within the Winter Review Event held on 2nd May 2019.

Background

The winter plan has been developed collaboratively with NHS Fife and Fife Health and Social Care Partnership focussing on priorities to manage the increased demands of the whole system.

The plan :

- Describes the arrangements in place to cope with increased demand on services over the winter period.
- Describes a shared responsibility to undertake joint effective planning of capacity.
- Ensures that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand.
- Supports a discharge model that has performance measures, a risk matrix and an escalation process.
- Ensures staff and patients are well informed about winter arrangements through a robust communications plan.
- Builds on existing strong partnership working to deliver the plan that will be tested at times of real pressure.

Assessment

The draft Winter Plan 2019/20 has been agreed following a winter planning event on 22 August 2019 with H&SCP and Resilience colleagues with a joint follow up meeting on 23 August. Detailed demand and capacity projections informed the planning assumptions to ensure capacity and priorities within the plan are allocated appropriately to meet demand.

The top 5 planning priorities for winter 2019/2020 identified are:

1. Review of the integrated escalation plan including developing a fuller understanding of the requirements of demands into social care.

2. Acute bed modelling exercise to take place and review of 18/19 bed reconfiguration.

3. Proactive recruitment including consideration of Hospital Ambulance Liaison Officer (HALO) to facilitate efficient discharges.

4. Establish appropriate point of care testing at the front door.

5. Focus on prevention of admission with further developments of High Health Gain programme, management of patients in locality huddles and identifying alternatives to GP admissions and planning timely discharges to Community Hospitals. This forms part of the Joining Up Care transformation programme.

The self-assessment guidance from the Scottish Government (Appendix 6) ensures all 7 priority areas have been addressed.

To ensure we continue to deliver safe and effective care for people throughout winter performance measures will be collected and reported on daily/weekly basis both at a local level and through System Watch.

The performance measures are:

- Emergency Access Standard
- Local and National Waiting Times Targets
- Delayed Discharges over 72 hours
- Weekly flow from Victoria Hospital
- Hospital Occupancy levels (Acute and Community Hospitals)
- Boarding numbers

The weekly winter monitoring reports will commence at the beginning of October 2019 when General managers from NHS Fife and Health and Social Care Partnership will meet to review the report and take action when necessary.

Recommendation

The Clinical Governance Committee is invited to :

- **Note and discuss the winter plan for 2019/20**

Objectives: (must be completed)	
Healthcare Standard(s):	Safe, Effective, Person centred, Quality
HB Strategic Objectives:	Priority 5 – Managing resources effectively while delivering quality outcomes Priority 4 - Living Well with long term conditions Priority 2 – Promoting mental health and wellbeing

Further Information:	
Evidence Base:	Winter Plan circular 4/9/19
Glossary of Terms:	Hospital Ambulance Liaison Officer (HALO)
Parties / Committees consulted prior to Health Board Meeting:	EDG, IJB

Impact: (must be completed)	
Financial / Value For Money	Promotes safe management of financial resources
Risk / Legal:	Low legal risk – all governance complied with
Quality / Patient Care:	Risk management system in place to support safe and person centred care
Workforce:	Workforce is critical to the safe delivery of the plan. System in place to manage risks.
Equality:	An EqIA part 1 has been completed on the winter plan. This demonstrated no negative impacts were identified for individuals or groups.

Fife Winter Plan 2019/20

NHS Fife

Fife Health & Social Care Partnership

CONTENTS

1 Introduction

Health and Social Care providers have a key responsibility to undertake effective planning of capacity to ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand on services or a mismatch between demand and supply of services. This can happen at any time of the year but commonly in winter activity rises, there is increased risk of infection (Norovirus in particular), the weather conditions can be adverse and influenza is more likely than at other times of the year.

NHS Fife, Fife Council and the Health and Social Care Partnership (HSCP) share the challenges of managing service delivery in the context of demographic change across primary, secondary and social care. The organisations are collectively responsible for managing the local health and social care system. This includes managing information and intelligence; assessing needs and working with community partners to ensure that services are fit for purpose; they meet the needs of patients; and are cost effective despite the pressures described above. The purpose of this document is to describe the arrangements put in place by NHS Fife, Fife Council, the Health and Social Care Partnership and partner organisations throughout the year, but particularly over the winter (including the Christmas and New Year holiday).

This plan is supported by:

- NHS Fife Pandemic Flu Plan
- NHS Fife Major Incident Plan
- NHS Fife Business Continuity Plan
- H&SCP Response and Recovery Plan

NHS Fife, Fife Council and the Health and Social Care Partnership have completed the self assessment checklist which helps to measure our readiness for winter across several domains. The checklist will be utilised as a local guide to assess the quality of winter preparations.

A detailed review of plans in these areas will apply a Red, Amber, or Green status. The self assessment checklist will be reviewed over winter to ensure that plans are in place to cope with system pressures and ensure continued delivery of care.

NHS Fife, Fife Council and the HSCP are confident that systems and processes will be in place to support demand.

2 Key Deliverables

The Fife Integrated Winter Plan takes on a whole system approach, to offer seamless transition between the Acute Hospital, Outpatient Services, Community Hospital and Community Social Care Services throughout Fife.

The Winter Plan aims to:

- Describe the arrangements in place to cope with increased demand on services over the winter period.

- Describe a shared responsibility to undertake joint effective planning of capacity.

- Ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand.

- Support a discharge model that has performance measures, a risk matrix and an escalation process.

- Ensure staff and patients are well informed about winter arrangements through a robust communications plan.

- Build on existing strong partnership working to deliver the plan that will be tested at times of real pressure.

Key principles to the winter plan are:

- Our workforce are key to the successful delivery of the winter plan.
- Engagement with staff across key stakeholders through winter plan workshops.
- Completion of the self assessment checklist indicates that arrangements are in progress to support the delivery of the winter plan.
- Resilience, severe weather, Norovirus and Flu plans are re-visited and are in place.

We will focus primarily on the winter period covering October 2019 to March 2020, but pressure due to capacity is present all year round.

There are a number of key pressures that are prevalent over the winter period which affect our ability to optimally manage flow and capacity. History and current intelligence tells us that these include:

- Increased clinical acuity/complexity/dependency and increased conversion rate from Emergency Department (ED) attendance to admission.
- Increased attendances to the ED.
- Increase in (medically-fit-for-discharge) patients in delay.
- Decreased resilience within the workforce (school holidays, bank holidays and sickness/absence).
- An inability to scale-down scheduled care activity due to waiting time obligations.
- Having appropriate levels of community capacity to accommodate demand from across the health and social care system.
- Increasing activity and demand in primary care against a background of issues with General Practice sustainability.

3 Planning Priorities Winter 2019/20

The review of winter 2018/19 considered performance, what went well, what went less well and helped to identify the 2019/20 planning priorities for the Acute Services Division and the HSCP.

The top 5 planning priorities for winter 2019/2020 identified at the Winter Review workshop 18/19 are:

1. Review of the integrated escalation plan including developing a fuller understanding of the requirements of demands into social care.

2. Acute bed modelling exercise to take place and review of 18/19 bed reconfiguration.

3. Proactive recruitment including consideration of Hospital Ambulance Liaison Officer (HALO) to facilitate efficient discharges.

4. Establish appropriate point of care testing at the front door.

5. Focus on prevention of admission with further developments of High Health Gain programme, management of patients in locality huddles and identifying alternatives to GP admissions and planning timely discharges to Community Hospitals. This forms part of the Joining Up Care transformation programme.

Additionally, the following actions were also identified:

- Community Hospital re-design should provide community beds at the right level and in the right place.
- Review capacity planning ICASS, Homecare and Social Care resources throughout winter.
- Multidisciplinary short life working groups to take actions forward across Acute and HSCP.
- Estimated Discharge Date process to be further developed and clear instructions in place.
- Have a discharge lead to enhance Criteria Led Discharges and get earlier discharges and plans in place.
- Enhance weekend discharge planning with further development of the weekend discharge team and enhanced clinical support.
- Consider the introduction of planned outpatient appointments for medically fit in-patients awaiting diagnostic tests.
- Explore a sustainable model for discharge lounge.
- Proactive and dynamic planning that follows predicted problems with use of system watch and better use of data.
- Full review of how and when surge capacity is used.
- Consideration of impact of individual decisions made which will affect the whole system.

- Produce a winter surgical program plan that includes use of the short stay surgical unit, and distribute the surgical programme, taking into account the periods of higher demand from emergency patients.
- Consider an enhanced ambulatory model for surgical and medical patients.
- Proactive infection control and learning for Fife Care homes.
- Continue the success of the staff flu campaign into its 3rd year.
- Urgent Care model will be up and running by winter 2019 and implemented in a staged approach.

The planning priorities identified for 2019/20 align with a range of transformation programmes across the Acute Services Division and the HSCP. These key programmes are the Joining Up Care programme (HSCP) and Acute Services Transformation Programme although it should be noted that the Redesign of Community Hospitals will not take place this winter.

During the review stage, it was agreed to proactively plan for winter by establishing a short life working group (SLWG) to take forward the development of the Winter Plan and Escalation Plan.

4 Winter Planning Process

4.1 Clear alignment between hospital, primary and social care

a) Winter Review 18/19 – What happened last year

- An EDD process was developed and is was in the early stages of being introduced with Acute directorate. This is currently reviewed within our daily safety huddle.

- To provide intermediate care capacity in West Fife, GP cover was secured. The care home capacity to provide a single intermediate care unit is a challenge with interim placements being commissioned as required.

- Over 300 High Health Gain Individuals have been assessed across HSCP and these have a care plan and care coordination in place. The rollout of this model continues.

- Testing and development of pathways into a trusted assessor model for assessment beds within VHK is ongoing.

- Urgent Care service delivery was agreed in line with the contingency arrangements in place for the Primary Care Emergency Service. Festive rotas and staffing were in place before during and after the festive period.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			NHS Fife	HSCP	
1	Ensure adequate Community Hospital capacity is available supported by community hospital and intermediate care redesign	October 2019		DGM East and West	
2	Review capacity planning ICASS, Homecare and Social Care resources throughout winter	August 2019		DGM West	
3	Focus on prevention of admission with further developments into High Health Gain, locality huddles to look at alternatives to GP admissions	March 2020		DGM West	
4	Reduce length of stay as a winter planning group and being progressed through BAU	September 2019	GMs, DCOO, Ass Dir PP	DGM West	
5	Test of Change for use of the community hub during Winter.	November 2019		DGM West	
6	Test of change to reconfigure STAR bed pathway.	November 2019		DGM West	
7	Urgent Care ED enhanced direction model	November 2019		DGM West	
8	Implementation of model for discharge lounge through tests of change	November 2019	GMs, DCOO		
9	Explore third sector transport over winter months	October 2019	GMs, DCOO		
10	Weekly senior winter monitoring meeting to review winter planning metrics and take corrective action.	October 2019	GMs, DCOO, Ass Dir PP	DGM West	

4.2 Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods

a) Winter Review 18/19 – What happened last year

- There are currently informal arrangements in place to provide 7-day pharmacy service in acute with recruitment to substantive posts continuing.
- Secure Social Work staffing in the Discharge Hub and community hospitals over the festive period.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	Secure Social Work staffing in the Discharge Hub and community hospitals over the festive period.	October 2019		DGM West	
2	Test of change of a rota of senior decision-making capacity in OOH/ weekends to promote 7-day discharges	November 2019	GM EC		
3	Agree Urgent Care workforce levels and secure staffing as early as possible.	October 2019		DGM West	
4	Enhance Clinical Co-ordinator role within the Urgent Care service.	November 2019		DGM West	
5	Consideration of a Hospital Ambulance Liaison Officer (HALO) role to further plan and arrange efficient discharges	October 2019	GMs DCOO		
6	Enhance weekend discharge planning with further development of the weekend discharge team	October 2019	GMs DCOO		
7	Explore augmenting IAT/MSK resource at front door with a view to reducing admission rate	October 2019	GM WC		
8	Proactive recruitment and a joined-up workforce plan to utilise staff intelligently across the year as well as winter	October 2019	GMs, DCOO	DGM West	

4.3 Local systems to have detailed demand and capacity projections to inform their planning assumptions

a) Winter Review 18/19 – What happened last year

- A communication plan was put in place for the public and staff.
- Advanced Nurse Practitioners are in place to focus on nurse led/criteria led discharges within GI and Respiratory.
- A flexible bed base was utilised within community hospitals with an additional 20 beds in use and locum cover secured for QMH hospital.

- A winter placement and activity tracker for HSCP was created and monitored throughout winter.
- A review of discharge transport options has taken place.
- An assessment of delayed discharges due to medicines has been completed. A focus on discharge medicines being available within 2 hours to aid discharges has been implemented.
- A winter ready section of the website and intranet was developed and completed.
- Weekly meetings between Corporate, Acute and HSCP management teams.
- A reconfiguration of beds was complete by December 2018.
- A revised weekly winter planning report was devised, as well as winter plan rag status reporting.
- An escalation plan for surge capacity was agreed.
- An acute site management structure was agreed and put in place.
- Daily community service huddles took place to flexibly manage demand and capacity across community services.
- "Black Box" testing has been invested in for front door staff.
-

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	Proactive and dynamic planning that follows predicted problems with use of system watch and better use of data including Urgent Care in collaboration with NHS 24	October 2019	GMs DCOO	DGM West	
2	Estimated Discharge Date process to be further developed and clear instructions in place	October 2019	GMs DCOO	DGM West	
3	Full review of how and when surge capacity is used against the escalation plan	September 2019	GMs DCOO	DGM West	
4	Banish boarding event to take place to reduce pressure in hospital with patients boarding in non-patient wards.	September 2019	MD COO		
5	Comprehensive review of board and ward round process across Acute inpatient wards to identify and implement consistent best practice	Observation exercise Aug 2019 December 2019	DCOO AMD		
6	Identify location for surge capacity (likely ward 4 & 13, but awaiting confirmation of roof repair for ward 4)	Oct 2019	DCOO GMs		
7	Have a discharge lead to enhance Criteria Led Discharges and get earlier discharges and plans in place	November 2019	GMs HoN		
8	Bed modelling exercise supported by SG to optimise Acute bed configuration for 19/20 including the relocation of Ward 9 to	November 2019	GM PC		

	Phase 3, beside Ward 24				
9	Intention to increase N:R ratio in AHP caseload to reduce de-conditioning in acute medical wards to reduce LoS and reduce level of support required by patients at point of discharge.	October 2019	GM WCCS		

4.4 Maximise elective activity over winter – including protecting same day surgery capacity

a) Winter Review 18/19 – What happened last year

- A review of known peaks took place and a reduction in capacity took place for the festive period and January.
- The surgical programme was reviewed weekly with a surgical short stay unit open from January.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	Produce a winter surgical programme plan that includes use of the short stay surgical unit, and distribute the surgical programme, taking into account the periods of higher demand from emergency patients	October 2019	GM PC		
2	Review the ambulatory model for surgical and medical patients and implement any enhancements	October 2019	GM EC GM PC		
3	Test the introduction of planned outpatient appointments for medically fit in-patients awaiting diagnostic tests	October 2019	GM WCCS		
4	Review theatre requirements for SHDU cases to smooth activity over the week	November 2019	GM EC GM PC		

4.5 Escalation plans tested with partners

a) Winter Review 19/20 – What happened last year

- Business continuity plans are under constant review however additional work has been carried out in respect of winter planning.
- Tabletop exercises are regularly carried out with departments to ensure the efficacy of contingency plans.
- A corporate Business Continuity Plan has been formed.
- An East of Scotland Winter Preparedness review has been held and attended by Public Health, Acute and HSCP representatives.
- An escalation plan was agreed and triggers created. Staffing issues were also incorporated into this plan.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	A review of the integrated escalation plan with action cards including training and testing, and agreement of the surge capacity model over winter, including opening and closing of surge beds	August 2019	GMs DCOO Ass Dir PP	DGM West	
2	Review and improve business continuity plans for services	September 2019	GMs DCOO	DGM West	
3	Tabletop exercise to be arranged to test Major Incident plans	November 2019	Ass Dir PP		
4	Multi Agency meeting to discuss winter arrangements across Fife	November 2019	Ass Dir PP		
5	Update Corporate Business Continuity Plan and Response and Recovery Plan	November 2019	Ass Dir PP		
6	Ensure that community services have access to 4x4 vehicles in the event of severe weather and that staff have received an appropriate level of training to drive such vehicles.	September 2019		DGM West	
7	Review the full capacity protocol	September 2019	GMs DCOO Ass Dir PP	DGM West	

The draft Integrated Escalation Plan can be found in Appendix 1.

4.6 <u>Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings</u>

a) Winter Review 19/20 – What happened last year

- A weekly winter planning meeting took place to address issues and implement improvements in a timely manner with an escalation and reporting process. This was supported by an agreed weekly winter monitoring report that allowed decisions to be.
- 26 Norovirus education sessions were delivered with a study day “winter is coming” with attendees from all disciplines.
- A tabletop exercise on the management of Norovirus outbreaks took place.
- A review of Norovirus preparedness planning took place through the NHS Fife Infection Control Committee.
- A series of Winter 2017/18 debrief sessions have taken place.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	Point of Care Testing (POCT) for flu will be implemented early this year in preparation for the challenges expected from increased numbers of patients presenting with flu	October 2019	GM WCCS		
2	Proactive infection control and learning for Fife Care homes	October 2019		DGM West	
3	POCT will also be implemented in paediatrics for RSV which will support early diagnosis (supporting winter bed pressures) and reduce requirement for unnecessary molecular testing.	October 2019	GM WCCS		
4	Weekly Winter Planning Meetings to continue to monitor hospital position	October 2019	GMs Ass Dir PP	DGM West	

4.7 Delivering seasonal flu vaccination to public and staff

a) Winter Review 18/19 – What happened last year

- A monthly review of the seasonal flu action plan took place all winter.
- An information pack was developed and distributed to the independent care sector in Fife.
- Redesign of the staff vaccination consent form has enabled more detailed and timely data collection against targets for monitoring.
- Promotion of under 65 at risk health groups for vaccination has taken place in community networks and workplace teams.
- Flu/Respiratory testing at the front door as in 2017/18.

b) Winter Planning 19/20 – Actions we are going to take this year

Ref	Action	Timescales	Lead/s		Status
			Acute	HSCP	
1	Deliver the staff vaccination programme to NHS and Fife HSCP staff through drop-in clinics and peer vaccinator programme in order to achieve 60% national target and 65% local target for uptake among healthcare workers.	October – December 2019	ADoN Public Health	ADoN Public Health	
2	Monthly review of progress against seasonal flu action plan	October – January 2019	Public Health	Public Health	
3	Deliver staff communications campaign across Acute & HSCP.	October – November 2019	Comms Manager		
4	Develop & distribute Information pack to independent care sector in Fife, covering staff vaccination, winter preparedness and outbreak control measures	October 2019	Public Health		
5	Redesign consent form and data collection methods to enable more detailed & timely monitoring of staff vaccination against targets	October 2019	Public Health	DGM West	
6	Insert flu vaccination messaging for at-risk groups in out-patient letter template	October 2019	Public Health		

5 Summary

The winter plan describes the arrangements in place to cope with increased demand on services over the winter period. In partnership NHS Fife, Fife Council and the HSCP have a shared responsibility to undertake effective planning of capacity.

The priority is to ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand. Our workforce are key to the successful delivery of the winter plan.

Resilience, severe weather, Norovirus and Flu plans have been re-visited and are in place.

The plan is supported by a discharge model, performance measures, a risk matrix and an escalation process.

Winter communications planning is well under way. The communication planned is both staff and public facing using recognised communications mechanisms (including social media).

The self assessment checklist when completed will indicate that arrangements are in progress to support the delivery of the winter plan.

Partnership working is essential in order to deliver the plan and will be tested at times of real pressure.

Appendices

Appendix 1: Fife Integrated Escalation Plan
Appendix 2: Fife Integrated Escalation Plan: Action Cards
Appendix 3: Local Procedure for Escalation Plan Level
Appendix 4: Winter Plan Financial Table
Appendix 5: Weekly Winter Monitoring Report
Appendix 6: Preparing for Winter 2018-19 Supplementary Checklist

Appendix 1: Fife Integrated Escalation Plan

Integrated NHS Fife and HSCP Escalation Plan 2019/2020 v0.7

Code	Escalation at:	Acute Actions	H&SCP Actions	Total Capacity
Extreme Pressure	EC: >=100% occupancy with 324 beds open >10 patients awaiting admission in A&E or AU1au/AU2au for admission No intensive care capacity available PC: 100% occupancy with 167 beds open H&SC: >100% Occupancy >30 patients clinically fit for next stage of care from VHK >20 EC patients boarding into PC Wards & front door boarding	**NHS Fife and Fife Council CEO to agree actions** Instigate Full Capacity Protocol as follows: • All acute beds available for any patient • Organisational business continuity plans invoked • Move all delayed patients to other locations in Fife • Surgery proceeds on a case by case basis prioritising emergency procedures and cancers in discussion with clinical team. • In the event of surgery cancellation redirect available theatre staff to support inpatient activity. • 10 Emergency Care Placements (HSCP)		**773 Adult Acute beds** EC: 312 core beds + 24 surge beds PC: 167 core HSCP: 254 core beds + 16 surge beds 10 Emergency Care Placements
Severe Pressure	EC: >=100% occupancy with 312 beds open >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds Intensive care capacity available PC: > 95% occupancy with 167 beds open H&SC: >100% Occupancy >20 patients clinically fit for next stage of care from VHK >10 EC patients boarding in PC Wards & front door boarding required	**COO and Director of H&SCP to agree sequence of actions daily** **Emergency Care** GM Huddle at lunchtime to agree plan, to increase medical staffing at ward level to focus on discharge. <u>Surge Capacity</u> (See Staffing Plan) Stage 1: Increase Ward 13 to 20 beds (6 beds) Stage 2: Increase Ward 13 to 26 beds (6 more beds) Stage 3: Surge Ward 4 open (12 beds) Weekend plan to include 3rd on call consultant with junior doctor/ANP and AHP support. Cancel outpatient clinics where medical staffing can support inpatient management based on speciality requirement. **Planned Care** Maximise use of SSSU so that inpatient surgery has no impact on hospital capacity. Assess QMH capacity and spread of activity across the two sites. Implement staffing moves. Surgical consultants are contacted by the PC management team to support with timely discharges and creation of flow. **HSCP** <u>Surge Capacity</u> (See Staffing Plan) Stage 1: Increase Cameron Hospital wards to 25 rehab and to 14 Stroke (8 beds) Stage 2: Increase Glenrothes ward to 14 beds (4 beds) Stage 3: Increase QMH ward to 24 (4 beds) Increase ICASS capacity • Offering support workers additional shifts • By escalating all care at home waits Implement community capacity calls Review requirement for delivery of non critical services with a view to deploy staff into clinical areas Critical review of planned activities across all staff groups to focus on patient care and flow	**773 Adult Acute beds** EC: 312 core beds + 24 surge beds PC: 167 core HSCP: 254 core beds + 16 surge beds
Moderate Pressure	EC: >95% occupancy with 312 beds open < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds Intensive care capacity available PC: >90% occupancy with 167 beds open H&SC: >90% Occupancy >10 patients clinically fit for next stage of care from VHK < 10 EC patients boarding in PC Wards	**Deputy COO and DGM West to agree sequence of actions daily** **Emergency Care** Every patient to be reviewed by a consultant Expedite medically fit for discharge patients. Activate additional support to frailty. All wards to identify at least 1 patient for discharge pre 10:30am Assess AHP caseload and implement staffing moves as required. Specialty ward rounds to take place every day. **Planned Care** Identification of surgical patients in surgical wards and in AU2 who are near discharge and suitable for a move to SSSU. Appropriate patients would be approved by the on call consultant general surgeon. Review boarding patients in all planned care wards to ensure plans are in place. Urology patients admitted to the surgical assessment unit (AU2) are redirected to UDTC. Specialty ward rounds to take place every day. **HSCP** Prioritise ICASS discharges from VHK & QMH - Review caseloads / increase flow to homecare outwith normal commissioning to meet increased demand. Prioritise discharges from VHK to STAR/ Assessment beds/home with homecare above normal commissioning levels	**733 Adult Acute beds** EC: 312 core beds PC: 167 core beds HSCP: 254 core beds
Planned Operational Working	EC: 85-95% occupancy with 312 beds open No patients awaiting admission in A&E or AU1au & AU2au Intensive care capacity available PC: 85-90% Occupancy with 167 beds open H&SC: <90% Occupancy <10 patients clinically fit for next stage of care from VHK No boarding patients	Management plan put in place • Huddle discussion and predictor indicates that hospital is able to accommodate both elective and emergency patients for the day • There are no patients in A&E or Admission Units awaiting admission without allocated beds	The normal flow to HSCP services is expected - 10/12 patients to exit each day	**733 Adult beds** EC: 312 core beds PC: 167 core beds HSCP: 254 core beds

Appendix 2: Fife Integrated Escalation Plan: Action Cards

Emergency Care Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	Instigate Full Capacity Protocol as follows: • All acute beds available for any patient • Organisational business continuity plans invoked • Move all delayed patients to other locations in Fife • Surgery proceeds on a case by case basis prioritising emergency procedures and cancers in discussion with clinical team. • In the event of surgery cancellation redirect available theatre staff to support inpatient activity. • 10 Emergency Care Placements (HSCP)

Severe Pressure

Triggers	Actions

• EC: >=100% occupancy with 312 beds open
• >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds
• Intensive care capacity available
• PC: > 95% occupancy with 167 beds open
• H&SC: >100% Occupancy
• >20 patients clinically fit for next stage of care from VHK
• >10 EC patients boarding in PC Wards & front door boarding required
	• GM Huddle at lunchtime to agree plan, to increase medical staffing at ward level to focus on discharge.
	• Surge Capacity (See Staffing Plan)
	  o Stage 1: Increase Ward 13 to 20 beds (6 beds)
	  o Stage 2: Increase Ward 13 to 26 beds (6 more beds)
	  o Stage 3: Surge Ward 4 open (12 beds)
	• Weekend plan to include 3rd on call consultant with junior doctor/ANP and AHP support.
	• Cancel outpatient clinics where medical staffing can support inpatient management based on specialty requirement.
	• Review requirement for delivery of non critical services with a view to deploy staff into clinical areas
	• Critical review of planned activities across all staff groups to focus on patient care and flow

Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for • next stage of care from VHK • < 10 EC patients boarding in PC Wards	• Every patient to be reviewed by a consultant • Expedite medically fit for discharge patients. • Activate additional support to frailty. • All wards to identify at least 1 patient for discharge pre 10:30am • Assess AHP caseload and implement staffing moves as required. • Specialty ward rounds to take place every day.

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	Management plan put in place • Huddle discussion and predictor indicates that hospital is able to accommodate both elective and emergency patients for the day • There are no patients in A&E or Admission Units awaiting admission without allocated beds

Planned Care Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	Instigate Full Capacity Protocol as follows: • All acute beds available for any patient • Organisational business continuity plans invoked • Move all delayed patients to other locations in Fife • Surgery proceeds on a case by case basis prioritising emergency procedures and cancers in discussion with clinical team. • In the event of surgery cancellation redirect available theatre staff to support inpatient activity. • 10 Emergency Care Placements (HSCP)

Severe Pressure

Triggers	Actions
• EC: >=100% occupancy with 312 beds open • >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: > 95% occupancy with 167 beds open • H&SC: >100% Occupancy • >20 patients clinically fit for next stage of care from VHK • >10 EC patients boarding in PC Wards & front door boarding required	• Maximise use of SSSU so that inpatient surgery has no impact on hospital capacity. • Assess QMH capacity and spread of activity across the two sites. Implement staffing moves. • Surgical consultants are contacted by the PC management team to support with timely discharges and creation of flow. • Review requirement for delivery of non critical services with a view to deploy staff into clinical areas • Critical review of planned activities across all staff groups to focus on patient care and flow

Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for • next stage of care from VHK • < 10 EC patients boarding in PC Wards	• Identification of surgical patients in surgical wards and in AU2 who are near discharge and suitable for a move to SSSU. Appropriate patients would be approved by the on call consultant general surgeon. • Review boarding patients in all planned care wards to ensure plans are in place. • Urology patients admitted to the surgical assessment unit (AU2) are redirected to UDTC. • Specialty ward rounds to take place every day.

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	Management plan put in place • Huddle discussion and predictor indicates that hospital is able to accommodate both elective and emergency patients for the day • There are no patients in A&E or Admission Units awaiting admission without allocated beds

HSCP Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with • 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	Instigate Full Capacity Protocol as follows: • All acute beds available for any patient • Organisational business continuity plans invoked • Move all delayed patients to other locations in Fife • Surgery proceeds on a case by case basis prioritising emergency procedures and cancers in discussion with clinical team. • In the event of surgery cancellation redirect available theatre staff to support inpatient activity. • 10 Emergency Care Placements (HSCP)

Severe Pressure

Triggers	Actions
• EC: >=100% occupancy with • 312 beds open • >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: > 95% occupancy with 167 beds open • H&SC: >100% Occupancy • >20 patients clinically fit for next stage of care from VHK • >10 EC patients boarding in PC Wards & front door boarding required	• Surge Capacity (See Staffing Plan) o Stage 1: Increase Cameron Hospital wards to 25 rehab and to 14 Stroke (8 beds) o Stage 2: Increase Glenrothes ward to 14 beds (4 beds) o Stage 3: Increase QMH ward to 24 (4 beds) • Increase ICASS capacity o Offering support workers additional shifts o By escalating all care at home waits • Implement community capacity calls

Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with • 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for • next stage of care from VHK • < 10 EC patients boarding in PC Wards	• Prioritise ICASS discharges from VHK & QMH - Review caseloads / increase flow to homecare outwith normal commissioning to meet increased demand. • Prioritise discharges from VHK to STAR/ Assessment beds/home with homecare above normal commissioning levels.

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	The normal flow to HSCP services is expected - 10/12 patients to exit each day

Occupational Therapy and Physiotherapy Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with • 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	• Implement staffing over establishment • Cancel non-essential clinical activity and redeploy staff accordingly

Severe Pressure

Triggers	Actions
• EC: >=100% occupancy with • 312 beds open • >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: > 95% occupancy with 167 beds open • H&SC: >100% Occupancy • >20 patients clinically fit for next stage of care from VHK • >10 EC patients boarding in PC Wards & front door boarding required	• Cancel non-clinical activities • OT/PT Managers collaborate to maximise AHP resource and share appropriate caseload. • Occupational Therapy and Physiotherapy (OT/PT) managers will engage with SMT throughout the day to optimise discharge pathways across the hospital • Optimise staffing levels within resource to increase clinical time utilising bank / voluntary uplift in hours • Seek authorisation to uplift staffing beyond resource including overtime and consideration of locum.

Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with • 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for • next stage of care from VHK • < 10 EC patients boarding in PC Wards	• OT/PT Managers review boarders lists and capacity amongst teams in preparation for step up to level 2 • Physiotherapy will activate prioritisation guidelines; respiratory acuity, prevention of deterioration, discharges, reviews. • Occupational Therapy will prioritise patients for a discharge pathway, deferring reviews • Deploy staff across specialties to meet demand

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	• Perform all inpatient activity in relation to clinical urgency, discharge, prevention of admission and rehabilitation,. Urgency determined by clinical presentation • Attendance at safety huddles and board rounds • Pursue bid to augment staffing to increase rehab capacity in Acute and MOE medical wards to reduce LoS and reduce level of support required by patients at point of discharge

Radiology and Diagnostic Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	• Continue with previous actions • Continue to review inpatient demand and accommodate activity expect to cancel non urgent outpatient examinations.

Severe Pressure

Triggers	Actions
• EC: >=100% occupancy with 312 beds open • >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: > 95% occupancy with 167 beds open • H&SC: >100% Occupancy • >20 patients clinically fit for next stage of care from VHK • >10 EC patients boarding in PC Wards & front door boarding required	• Consultant discussion to prioritise inpatients to facilitate flow and discharge. • Review requirement for routine CT inpatient activity out of hours/weekend. • Inform Everlight of expected activity increase. • Expect increase in QMH inpatient requests. • Review outpatient appointments to increase inpatient capacity • Review outpatient appointments to increase inpatient activity.

Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for next stage of care from VHK • < 10 EC patients boarding in PC Wards	• Monitor waits for inpatient examinations • Inform Clinical Services Manager when waits breach longer than 72 hours for routine request • Expect urgent outpatient requests to increase as patients discharged. • Monitor requirement to increase service provision • Continue to monitor inpatient waits • Consultant discussion to prioritise inpatients to facilitate flow and discharge

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	Perform all inpatient activity in relation to clinical urgency, urgency determined by clinical history on order comm request.

Pharmacy Action Card

Extreme Pressure

Triggers	Actions
• EC: >=100% occupancy with 324 beds open • >10 patients awaiting admission in A&E or AU1au/AU2au for admission • No intensive care capacity available • PC: 100% occupancy with 167 beds open • H&SC: >100% Occupancy • >30 patients clinically fit for next stage of care from VHK • >20 EC patients boarding into PC Wards & front door boarding	• Activate BCP and Major Incident plan to move pharmacy staff from the H&SCP to Acute services to maximise service delivery. • Pharmacist Prescribers to consider use of HBPs for dispensing in community pharmacy

Severe Pressure

Triggers	Actions
• EC: >=100% occupancy with 312 beds open • >5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: > 95% occupancy with 167 beds open • H&SC: >100% Occupancy • >20 patients clinically fit for next stage of care from VHK • >10 EC patients boarding in PC Wards & front door boarding required	• Optimise staffing levels by moving all available non-patient facing acute pharmacy staff into direct clinical care roles • Provide pharmacy and medicines management nursing support to ward 13 • Pharmacist prescribers to support increased focus on discharge

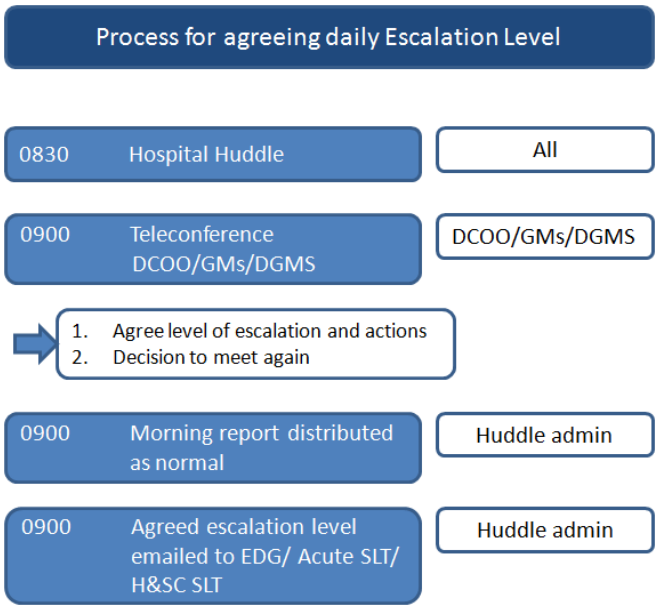
Moderate Pressure

Triggers	Actions
• EC: >98% occupancy with 312 beds open • < 5 patients awaiting admission in A&E or AU1au/AU2au without allocated beds • Intensive care capacity available • PC: >90% occupancy with 167 beds open • H&SC: >90% Occupancy • >10 patients clinically fit for next stage of care from VHK • < 10 EC patients boarding in PC Wards	• Front door pharmacy team to link with frailty team to support increased activity • Medicines Management Nurse to support discharge lounge • Review boarding patients in planned care wards to ensure medicines availability • Expedite Medically fit for discharge patients, use EDD to target pharmacy technician support to ensure medicines availability at the bedside and prioritise pharmacist review of patients that have not been seen

Planned Operational Working

Triggers	Actions
• EC: 95-98% occupancy • with 312 beds open • No patients awaiting admission in A&E or AU1au & AU2au • Intensive care capacity available • PC: 85-90% Occupancy with 167 beds open • H&SC: <90%% Occupancy • <10 patients clinically fit for next stage of care from VHK • No boarding patients	Core service delivery: • Maximise dispensary discharge prescription turnaround performance; • Clinical pharmacy service, focus on screening new admissions within AU1 & AU2 and direct admission areas; follow up of high risk patients and pharmacy technician referrals; clinical pharmacist check of all compliance aid discharges; provide medicine related advice and support through clinical coordinator • Pharmacy Distribution, ward medicines top up to maintain availability of over-labelled packs

Appendix 3: Local Procedure for Escalation Plan Level



Appendix 4: Winter Plan Financial Table

Winter Plan 2019/20 Financial Impact					
Ref	**Description**	**Area**	**Timescale**	**Cost (CYE)**	**Implementation RAG Status**
4.1 Action 1	Opening 16 additional Community Hospital Beds to support flow (c.10 WTE – mix of medical, nursing, AHP)	HSCP	October 2019 to March 2020	£500,000	Implement using AFC, avoiding agency, over recruitment and extra hours.
4.1 Action 2	Provide additional ICASS capacity to support timely discharges from and prevent admissions to hospital (5.33 WTE)	HSCP	October 2019 to March 2020	£86,424	Implement using AFC, avoiding agency, over recruitment and extra hours.
4.1 Action 2	Provide additional homecare capacity to support timely discharges from and prevent admissions to hospital	HSCP	October 2019 to March 2020	£427,557	Need to identify a care provider that could work alongside HSCP, challenging but required to meet plan.
4.1 Action 2	Provide additional Long-Term Care placements to meet demand	HSCP	October 2019 to March 2020	£602,219	**Placements are available across Fife would need GP engagement**
4.1 Action 2	Commission additional Social Care Assessment Unit beds to meet demand and support hospital discharges	HSCP	October 2019 to March 2020	£61,686	A provider is lined up and ready – we just need to inform them of our intention to commission
4.1 Action 3	Recruit an additional 1.0 WTE band 5 Nurse to support high health gain assessments	HSCP	October 2019 to March 2020	£20,000	Recruit through a 6-month secondment
4.2 Action 4	Recruit an additional 1.0 WTE band 6 Patient Flow Co-ordinator to ensure timely assessments and discharges from hospital settings	HSCP	October 2019 to March 2020	£25,000	Recruit through a 6-month secondment
4.2 Action 6	Support additional PCES activity over the festive period, public holidays, weekends and over January 2020	HSCP	November 2019 to January 2020	£115,000	Rotas already in planning
4.5 Action 6	Ensure that community services have access to 4x4 vehicles in the event of severe weather	HSCP	October 2019 to March 2020	£16,152.50	Model costed and ready to action, staff register of 4x4s and drivers able to support also underway.
4.7 Action 1	Point of Care flu testing	Public Health/Acute labs	October 2019 to March 2020	£77,000	Plan in place with public health for delivery
4.3 Action 6	Ward 13 Surge capacity (12 beds, 12.71 WTE)	Acute	October 2019 to March 2020	£222,665	Vacancy Management Forms signed off – recruitment underway

4.3 Action 6	Additional surge ward (12 beds, 24.72 WTE)	Acute	October 2019 to March 2020	£431,212	Planning on hold whilst finances are discussed.
4.3 Action 7	Pharmacy support to facilitate expedited discharges	Acute	October 2019 to March 2020	£56,000	
4.1 Action 8	Discharge support team and discharge lounge (15.19 WTE)	Acute	October 2019 to March 2020	£192,428	Test of change in process. Secondment requests for staffing underway.
			Total Required	**£2,833,344**	
			SG Winter Funding	**£320,136**	
			Funding gap	**£2,513,208**	

* Costs based on 18 week winter period

Appendix 5: Weekly Winter Monitoring Report

Weekly Winter Monitoring Scorecard

Area	Indicator	RAG Criteria	17-Mar	24-Mar	31-Mar	07-Apr	14-Apr	21-Apr	28-Apr	05-May	12-May	19-May	26-May	02-Jun	09-Jun	16-Jun	23-Jun	30-Jun	07-Jul	14-Jul	21-Jul	28-Jul	04-Aug
OOH	Contacts		1904	1945	1774	1796	1869	2016	2218	2990	2948	2002	1944	1824	1851	1949	1978	1987	1851	1952	1860	1751	1877
	OoT Home Visits		26	21	8	0	19	25	24	46	22	37	32	25	13	18	24	11	15	15	9	7	16
Emergency Department	Attendances		1304	1347	1285	1292	1286	1381	1425	1372	1386	1410	1405	1346	1273	1286	1381	1356	1288	1335	1335	1398	1413
	Av LoA		168	181	163	177	172	172	167	156	170	165	165	173	159	154	175	165	163	191	149	164	172
	Performance		93.4%	91.1%	94.9%	91.5%	93.2%	92.3%	93.0%	94.6%	91.3%	91.7%	92.5%	91.5%	94.7%	95.3%	88.9%	94.1%	95.0%	88.3%	96.4%	94.5%	92.9%
	> 8 hours		0	10	1	0	0	5	0	1	1	0	3	3	2	0	2	0	0	0	0	0	2
	>12 hours		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	% Admitted		31.9%	30.0%	31.5%	32.3%	31.3%	30.9%	28.1%	27.0%	31.7%	28.5%	27.9%	29.0%	32.1%	29.5%	28.8%	29.7%	30.0%	29.6%	27.3%	29.8%	27.7%
VHK Admissions	Total		866	928	882	896	849	874	890	868	909	901	892	851	855	848	874	858	831	847	834	876	889
	Emergency		425	468	424	450	459	456	453	441	452	468	436	432	446	450	453	413	414	440	437	445	443
	Elective		441	460	458	446	390	418	437	427	457	433	456	419	409	398	421	445	417	407	397	431	446
AU1ax	Admissions		173	202	178	191	203	221	198	196	203	221	191	196	190	237	186	177	187	192	203	194	204
	%transferred		77.5%	69.8%	63.5%	71.2%	67.5%	64.7%	67.2%	74.5%	68.0%	70.6%	66.0%	63.3%	68.4%	65.8%	69.4%	70.6%	66.8%	67.7%	66.0%	68.6%	70.1%
	% to AU1		67.1%	62.4%	53.4%	61.8%	54.2%	52.0%	60.1%	62.8%	58.1%	55.7%	58.6%	56.6%	58.4%	55.7%	60.8%	62.1%	60.4%	61.5%	55.2%	58.8%	60.8%
	LoS		04:32	06:17	05:29	04:52	05:18	05:09	04:56	04:52	06:50	06:52	05:46	06:18	05:24	06:27	07:40	06:21	04:00	04:46	04:38	06:08	04:26
AU1	Admissions		318	339	287	328	318	298	324	313	323	317	302	298	323	300	306	293	288	296	286	297	301
	%transferred		65.4%	63.4%	66.2%	64.9%	63.5%	64.1%	63.6%	61.7%	68.4%	62.1%	69.2%	58.7%	63.5%	62.3%	60.1%	63.5%	69.1%	64.9%	69.2%	61.3%	65.8%
	LoS		19:20	20:08	18:55	20:10	16:08	17:39	18:51	16:48	17:31	19:46	19:05	18:35	18:27	19:13	18:49	18:43	17:27	17:25	16:11	15:44	16:54
AU2	Admissions		146	154	132	142	130	156	139	134	137	143	142	146	138	124	151	146	119	158	137	140	137
	%transferred		47.3%	37.7%	51.5%	41.5%	47.7%	42.9%	42.4%	29.1%	36.5%	42.7%	39.4%	40.4%	38.4%	37.9%	37.1%	49.3%	34.5%	53.8%	35.0%	36.4%	40.9%
	LoS		22:29	24:02	21:20	22:06	20:24	24:15	22:49	18:21	15:27	23:21	25:23	22:56	24:32	24:54	21:07	20:50	20:30	22:49	21:10	20:08	20:44
VHK Bed Utilisation	Occupancy		93.1%	93.4%	96.5%	99.6%	95.5%	93.2%	93.3%	95.1%	94.3%	102.9%	98.6%	95.5%	93.2%	93.3%	95.1%	94.3%	102.9%	98.6%	95.5%	93.2%	93.3%
	Boarding Bed Days Lost		291	414	363	282	305	317	293	280	531	431	366	375	360	365	405	375	278	205	210	254	198
	Delay Bed Days Lost		49	63	42	49	28	35	28	7	7	35	35	42	28	42	35	49	56	42	42	28	28
VHK Discharges	Total		887	967	844	897	847	883	876	891	862	923	906	866	852	891	851	857	851	824	824	872	870
	to Community		55	42	51	38	42	31	47	40	51	39	42	40	44	53	36	34	46	36	37	40	37
	% B4 Noon		13.8%	16.1%	14.2%	14.2%	15.5%	16.4%	15.7%	18.6%	17.9%	16.9%	15.3%	18.2%	18.3%	15.6%	16.3%	15.7%	18.1%	18.4%	18.1%	14.0%	15.5%
	WDWE Ratio		1.7	1.7	1.8	2.1	1.7	1.6	2.0	1.7	1.5	2.1	2.2	1.7	1.6	1.8	2.1	2.1	2.0	2.3	2.1	1.6	2.0
	LoS		4.9	4.7	4.9	4.6	5.0	4.9	5.0	5.0	5.2	5.0	5.0	5.5	5.4	5.3	5.5	5.5	4.8	4.9	4.6	5.8	5.3
	Admissions		87	100	83	90	83	96	91	95	91	91	89	83	97	107	73	85	88	83	88	91	113
	Occupancy		94.0%	95.2%	94.2%	94.5%	93.9%	94.7%	94.4%	91.9%	94.2%	101.0%	100.9%	101.7%	102.4%	101.3%	101.4%	101.3%	102.2%	102.0%	101.1%	101.8%	100.2%
Community Hospital	Delay Bed Days Lost		553	591	567	477	470	615	708	611	642	671	666	687	674	638	594	599	617	637	644	617	560
	Discharges		108	83	94	78	85	78	91	86	90	86	86	84	78	92	102	68	80	83	78	83	86
	LoS		24.3	23.5	27.3	27.4	23.8	28.8	21.7	25.4	24.1	26.0	26.0	24.5	26.7	22.5	31.8	30.3	21.3	25.5	20.9	26.2	21.1

Preparing for Winter 2019/20:
Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Key Partners / Services**

This checklist supports the strategic priorities for improvement identified by local systems from their review of last winter and includes other areas of relevance.

This list is not exhaustive and local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS Special Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service avaible on the associated web links highlighted on the accompanying paper

- There is no requirement for these checklists to be submitted to the Scottish Government.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	**Resilience Preparedness** *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1.1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.The NHSScotland Standards for Organisational Resilience (2018) sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☒ ☒		NHS Fife has established and robust Business Continuity Plans in place. Each ward and department have reseponsibility to review and update their plans at lest once each year. This is supported by the Business Continuity Manager. The Business Continuity Manager and Emergency Planning Officer are involvd in all aspects of contingency planning.
1.2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios. Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☒ ☒ ☒		All NHS Fife Business Continuity Plans consist of a Business Impact Analysis; Risk Assessment; and Continuity Plan.
1.3	The NHS Board and HSCPs have appropriate policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support the transport of staff to and from their places of work during periods of severe weather.Policies should be communicated to all staff on a regular	☒		HR18 - Disruption of Staff Travel Arrangements Policy is in place and staff will be directed accordingly as required. NHS Fife has a Severe Weather Response Plan, which includes

	basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*			H&SCP. This Plan includes the Command & Control structure, staff reporting arrangements, 4x4 responses and access to voluntary agencies.
1.4	The NHS Board's and HSCPs websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☒		Advice and information are issued on NHS Fife website, Twitter and Facebook pages. Links and information from East of Scotland Local and Regional Resilience Partnership, Fife Council, Travel Scotland and the Met Office will also be distributed.
1.5	The NHS Board, HSCPs and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒		The current capacity across NHS Fife is 72 at VHK. Joint working continues with Fife Council and Funeral Directors to ensure contingency plans would increase throughput across local crematoriums and cemeteries. Multi-faith arrangements around mutual aid support are ongoing.
1.6	The effectiveness of winter plans will be tested with all stakeholders by 30 October The final version of the winter plan has been approved by NHS Board and HSCPs	☒		Multi-agency exercises continue on a regular basis which, although not specifically around winter and builds on existing arrangements. A Fife Multi-Agency Winter Preparedness Review is being planned where key members from all partner organisations will be present.

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
2.1	**Clinically Focussed and Empowered Management**			
2.1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		A winter review event of last winter was held late spring 2019 and a winter planning workshop was then held early autumn 2019. These events involved representative from all areas of NHS Fife and HSCP. The outcomes are being implemented.
2.1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☒		The multi-disciplinary daily safety huddle continues to support decision-making in the very early part of the day. This is supported by late morning huddles held at operational level. Weekly operational planning meetings continue to look at operational plans for a week ahead and agree a weekend plan for the site. The balance of accommodating elective and emergency admissions is part of this process and informs the decision to open additional capacity if necessary
2.1.3	A Target Operating Model and Escalation policies are in place and	☒		A full review of our current

	communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*			escalation plan is has taken place.
2.1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☒		As above
2.2	**Undertake detailed analysis and planning to effectively manage schedule elective and unscheduled activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☒		System watch is used routinely to predict on a daily basis current demand and activity is planned (this will include urgent elective care) around these numbers. There a robust escalation plan which includes surge beds also being implemented.

2.2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.*	☒		A full escalation plan with actions re emergency and elective work has been put together and is now in place to avoid unnecessary disruption.
2.3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge.**			
2.3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☒		In planning at present.
2.3.2	Extra capacity should be scheduled for the 'return to work' days after the festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services. The Monday following the festive weekend breaks should not be routinely used as a day off thereby	☒		In planning at present.

	creating a 5 day weekend.			
2.3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☒		In planning at present
2.3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☒		Will take place following confirmation of rotas and service provision.
2.4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**			
2.4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector*	☒		Within the Acute hospital, the Discharge Hub facilitates the discharge of those who require ongoing support from health and social care following an in-patient stay. This service offers a multi-agency, integrated, person centred approach to the assessment of an individual's needs as they approach discharge. The hub has a key role in community and whole system flow.

	partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.			
2.4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Pharmacy services should also be avaible to issue timely prescriptions to support discharge. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☒		Ongoing. Review of all ward and board practices taken place across the Acute hospital under Acute Transformation Programme. Best practice to be rolled out prior to winter period.
2.4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☒		Discharge lounge currently opened with ongoing planning for full staffing throughout winter period, supported by a discharge team.
2.4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre Christmas discharge *There should be a monitoring and communication process in place to avoid delays,*	☒		The H&SC Discharge Model is based on demand for services from last year. Weekly monitoring reporting and escalation plan are in place where provision of services is reviewed and increased if

	remove bottlenecks and smooth patient discharge processes			necessary.
2.5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
2.5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☒		There is a plan incorporating predicted demand into planning for Social Work packages of care.
2.5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Paertnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*	☒		As above
2.5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☒		Processes in place as part of the High Health Gain work
2.5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances.	☒		ACPs in place for High health Gain Cohort

	KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.			
2.6	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
2.6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		This is addressed during the morning safety huddles and weekly winter meetings between NHS Fife and HSCP General Managers.
2.6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *NHS 24 are leading on the 2018/19 'Be Healthwise This Winter' media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☒		A new Flu Fighter and Medicines campaign will be launched.

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
3.1	The OOH plan covers the full winter period and pays particular attention to the festive period. *This should include an agreed escalation process.* *Have you considered / discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☒		The OOH plan covers the full winter period and pays particular attention to the festive period and covers pre-prioritised calls from NHS24. There is an agreed escalation process in place to ensure Senior Management within the H&SCP are aware of any current or potential service delivery challenges real time. In consultation with NHS 24, partner assistance with pre-prioritised calls will be provided by Urgent Care Service Fife (UCSF) on agreed public holidays, covering predicted peak time call volumes. Further consideration to providing triage can only be given once all UCSF sessions are filled. Close consultation with NHS 24 continues and plans will be flexed over the winter period in response to demand.
3.2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☒		This year, as in the previous festive periods, UCSF has reviewed the Business Continuity plan to ensure our contingency plans remain robust, current and flexible to be able to deal effectively with all

				technical and operational issues or demands placed upon the service taking account of the Public Holidays and weekends prior, during and after the festive period. UCSF has referred to previous years and the predicted festive information supplied by NHS24 through as a baseline for formulate festive planning. Updated data will be available from NHS24 closer to Christmas giving Boards the chance to revisit requirements and amend accordingly. Activity rates are reviewed weekly in conjunction with data received from public health and Scottish Government regarding activity. Additional recruitment and training has taken place for both admin and clinical staff to ensure as flexible a workforce as possible is in place to meet the requirements of the service Bank staff are also available organised through the respiratory nurse service for H@H only.
3.3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☒		UCSF plans to increase staffing levels over the winter period on Saturday and Sundays to supplement the home visiting capacity as this has previously

				been identified as critical to the delivery of care. Activity is closely monitored during the winter months and reviewed along with guidance from HPS and SGHD. New ways of working are now established as part of Urgent Care Transformation, including Clinical HUB Supervision, UCP Home Visiting. Evaluation evidences safe, appropriate and effective care. UCPs work within specific clinical criteria, releasing time to care for GPs to manage more complex clinical presentations.
3.4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☒		Direct referrals are encouraged between UCSF and MIU and A & E. Fife Urgent Care Practitioners can directly refer to other specialties, including tertiary services such as ENT, without the need for a GP to be involved. Direct referrals ensure that the patient journey is not added to by an unnecessary reassessment in A&E. Specialist Paramedics can now directly refer to AU1 and other services, removing the need for a further clinical consultation and ensuring an appropriate patient journey and effective use of resources.

				UCSF/A&E staff have worked together to develop a referral protocol to ensure the safe efficient transfer of patients between the services. Practices will be sent reminders to update any relevant information within a patient's eKIS before the start of the festive period. These are particularly for those vulnerable at this time, i.e. Palliative care patients. UCAT (Unscheduled Care Assessment Team) can now accept direct referrals from NHS 24 for patients with mental health reacted conditions allowing for improved pathways of care and effective use of resources.
3.5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☒		UCSF employ Adastra for all documentation and all clinicians are trained in the use of this. Regular reviews of documentation are undertaken and fed back to clinical staff to ensure good, clear, accurate record keeping in line with professional codes is achieved.
3.6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☒		The use of the professional to professional line is encouraged at all times and is routinely used by Pharmacists; District Nurses, Labs and SAS. Calls come directly into Fife's Dispatcher

				and details are entered into Adastra for a clinician to clinically manage. Pharmacists now have repeat prescribing PGDs which have further reduced calls to NHS24 and UCSF. The Chief Pharmacists has also corresponded with pharmacies to maximise patient's access to routine drugs, minor ailments service and over the counter medication. Community pharmacies within the health board area can now manage specific symptoms with application of appropriate PGDs. Each centre and the hub will have a copy of all Pharmacy opening times across NHS Fife. This includes a list of designated palliative care pharmacies. Dispatch and the Centres will utilise the flowchart – "Accessing medicines OOH" which was devised by Pharmacy. Oxygen concentrators are now available in all centres. A robust system for Controlled drug supply is in place and all GPs are aware of the ordering procedure. Drugs are checked

				at the start of each shift and a regular audit is carried out by NHS Fife Pharmacy staff. No major drug issues have been noted. Prior to the festive period all drug levels are assessed, and additional stocks are agreed, for commonly used medications such as, antibiotics, inhalers, steroids, analgesia and emergency contraception. This includes those used in the Centres by GP's and UCP's and those in the mobile bags
3.7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☒		Direct referral to the Unscheduled Care Mental Health team is available. The team is available during the out-of-hours period and will make arrangements to see the patient. Unscheduled Care Assessment Team (UCAT) telephone screening service is available for individuals who have contacted NHS 24, aged between the ages of 18 to 65 with concerns regarding mental health issues or self ham ideation expressed. If the patient's life is in immediate risk or they are actively self harming, it would not be appropriate referral to UCAT and Police / SAS should be

				considered as the safe and appropriate outcome. GPs will attend patients at home if it is considered that due to their clinical condition they may require an emergency detention, this is a necessary step due to current legislation.
3.8	In conjunction with HSCPs, ensure that there is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☒		Provision of dental services is organised through NHS24 as the single point of contact and this has been well established for several years and is robust in its arrangements
3.9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☒		All rotas will be assessed to ensure an accurate reflection of requirements but will be subject to regular review with any increased demand related to winter needs/demands. There is a moderate risk that due to the reduction in available GPs, UCSF may not be able to fill all the additional shifts and there is an agreed contingency to manage this.
3.9.1		☒		**Call Handling /Dispatch staff**: Double staffing required during peak times. Staff will be expected to attend shift as planned.
3.9.2		☒		**Drivers:** Extra drivers required for hired cars, which will cover QMH and VHK and extended floating car coverage of VHK

				evening shift. The floating car will work at peak periods on all 4 holiday days.
3.9.3		☒		**Nursing staff**: Nursing staff rotas will reflect activity, available accommodation and profiling of peak demands from previous years
3.9.4		☒		**GPs:** Extra GPs will be recruited for all centres during peak periods. A review of peak demands on the service has allowed UCSF to predict staffing requirements and plan to meet potential demand.
3.9.5		☒		**Short Notice GP Directory** of those willing to come in and work additional shifts/part shifts throughout festive period will be available.
3.10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☒		NHS Fife will be working with the communication department to ensure effective plans are in place to communicate how services should be accessed over the winter period. NHS24 Winter Campaign messages support the delivery of the out of hours service and routine local communication will signpost to where services are available as well as the need to order repeat prescriptions well in advance.

				Communication strategy will be implemented reflecting previous public holiday arrangements. Primary Care Department will request all practices advertise their opening hours and encourage them to use the facility on all prescriptions to remind patients to order repeat prescriptions early. Advertisements in local papers will be placed.
3.11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☒		There is enhanced partnership working with the Scottish Ambulance Service (SAS). Arrangements with SAS remain in place as in previous years.
3.12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☒		NHS Fife UCSF and NHS24 have worked very closely. This will continue with regular meetings between the services to plan and review service delivery to the population of Fife and Kinross. Pre-prioritised calls are received directly into the hub where the GP/UCP's will be based. This allows liaison between the staff groups for those patients who require face to face consultation and equity in service provision. UCSF are working with NHS 24 using previous year's data from

				both organisations to continue to develop plans. Festive arrangements will be shared in detail with NHS24 and vice versa to enable the two organisations to work in close partnership.
3.13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☒		Planning is shared with colleagues from the Acute Sector, in particular, the Emergency Care Directorate.
3.14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☒		UCSF can refer directly to emergency Social Work if necessary. Public Protection referral polices available to support effective referral in the urgent care period.
3.15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☒		Previously NHS24 escalation plans would be tested with all Health Board areas prior to the festive period and UCSF would participate in the planned teleconferencing meetings to discuss any issues/pressures that have been identified and agree the trigger points for moving towards escalation if required. Pandemic Plan has been reviewed for 2019/2020 winter period.

4	Prepare for & Implement Norovirus Outbreak Control Measures *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
4.1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☒		
4.2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☒		
4.3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.	☒		Control measures described in Infection Control Manual (on intranet)
4.4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☒		ICNs attend / contribute to morning huddle. Use of Boards at entrances to provide information about ward closures. Use of social media.
4.5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☒		

4.6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☒		weekly report distributed to Board and H&SCP
4.7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☒		
4.8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☒		Microbiologists provide 24 / 7 cover. 2 IPCNs on each day over public holidays.
4.9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☒		
4.10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This could include the notification of 'tweets', where appropriate, to help spread key message information. HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☒		
4.11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message. *This could include HPT supporting schools to have awareness raising prior to norovirus season and the notification of 'tweets', where appropriate, to help spread key message information.*	☒		including use of social media via comms team

5	Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
5.1	Staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMOs seasonal flu vaccination letter due to be published in Aug 2018. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*	☒		Peer vaccination in all areas.
5.2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2018) clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.*	☒		"Flu Wars" campaign underway with support from Comms team. Peer vaccination, drop in clinics, in place
5.3	The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☒		Near patient testing in AAU and ED will take place. Test turnaround time reduced to half hour, which assists in bed management decisions

5.4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.*	☒		Weekly distribution of information to key staff
5.5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☒		Winter plan and escalation plan in place

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
6.1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
6.1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☒		The demand for Respiratory Services remain high and a Consultant Nurse post has been developed to focus on treatments that can be supported through our ECAS service or supported at home.
6.1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		Part of Community Discharge Model
6.1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right*	☒		Developed a targeted integrated preventative model called High Health Gains, which improves community focussed health and wellbeing outcomes and

	department, referred directly to acute respiratory assessment service where in place.. *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*			reduces hospital emergency admissions. This model was trialled within 3 GP practice localities and worked well
6.1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☒		
6.2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
6.2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☒		The Emergency Care Assessment Suite within the Victoria Hospital continues to extend the number and types of patient that can be assessed and treated there. This includes an enhanced range of interventions including DVT, IV Antibiotics/Infusions, Lumbar Puncture and Blood Transfusion.
6.2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☒		
6.3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
6.3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.*	☒		These patients are part of High Health Gain patient group.

	Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period. *SPARRA Online: Monthly release of SPARRA data, https://www.bo.scot.nhs.uk/. This release estimates an individual's risk of emergency admission.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*			
6.	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
6.4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☒ ☒ ☒ ☒		
6.5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
6.5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☒		

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☒		
	Nursing / Medical Consultants	☒		
	Consultants in Public Health	☒		
	AHP Leads	☒		
	Infection Control Managers	☒		
	Managers Responsible for Capacity & Flow	☒		
	Pharmacy Leads	☒		
	Mental Health Leads	☒		
	Business Continuity / Emergency Planning Managers	☒		
	OOH Service Managers	☒		
	GP's	☒		
	NHS 24	☒		
	SAS	☒		
	Territorial NHS Boards	☒		
	Independent Sector	☒		
	Local Authorities	☒		
	Integration Joint Boards	☒		
	Strategic Co-ordination Group	☒		
	Third Sector	☒		
	SG Health & Social Care Directorate	☒		

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	**NHS Fife Board Assurance Framework (BAF)** Quality & Safety
EXECUTIVE LEAD:	Helen Buchanan
REPORTING OFFICER:	Helen Woodburn

Purpose of the Report (delete as appropriate)		
	For Discussion **consider the options and any impact**	

SBAR REPORT

Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to this Committee and ultimately to the Board, that the organisation is delivering on its strategic objectives as contained in the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health &Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners.

This report is an update on the Quality & Safety BAF since the last report on 4 September 2019.

Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities
- Provides a brief assessment of current performance. In due course, the BAF will provide detail on the progress of the risk over time - improving, moving towards its target or tram - lining

The Committee is invited to consider the following :

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?

• Do the assurances come from more than one source including independent sources? • Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk? • Is there anything missing you would expect to see in the BAF?
Assessment
Recommendation The Committee is invited to **note** the changes.

Objectives: (must be completed)	
Healthcare Standard(s):	To aid delivery
HB Strategic Objectives:	Supports all of the Board's strategic objectives

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors

Impact: (must be completed)	
Financial / Value For Money	Promotes proportionate management of risk and thus effective and efficient use of scarce resources.
Risk / Legal:	Inherent in process. Demonstrates due diligence. Provides critical supporting evidence for the Annual Governance Statement.
Quality / Patient Care:	NHS Fife's risk management system seeks to minimise risk and so support the delivery of safe, effective, person centred care.
Workforce:	The system arrangements for risk management are contained within current resource. e.g.
Equality:	The arrangements for managing risk apply to all patients, staff and others in contact with the Board's services.

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Quality & Safety																													
1416	Person Centred, Clinically Excellent	**04.06.2019**	**04.08.2019**	There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 - High	15	High	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Medical Director	Clinical Governance Chair: Dr Les Bisset	*Ongoing actions designed to mitigate the risk including:* 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework This is supported by the following: 7. Risk Registers 8. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 9. Performance Reviews 10. Adverse Events Policy 11. Scottish Patient Safety Programme 12. Implementation of SIGN and other evidence based guidance 13. Staff Learning & Development 14.System of governance arrangements for all clinical policies and procedures 15. Participation in relevant national and local audit 16.Complaints handling process 17.Using data to enhance quality control 18.HIS Quality of Care Approach & Framework,Sept 2018 19. Implementing Organisational Duty of Candour legislation 20.Adverse event management process 21.Sharing of learning summaries from adverse event reviews 22.Implementing Excellence in Care 23. Using Patient Opinion feedback 24.. Acting on recommendations from internal & external agencies 25. Revalidation programmes for professional staff 26. Electronic dissemination of safety alerts	Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends,and exceptions to the norm	1. Continually review the Integrated Performance and Quality (IPQR) to ensure they provide an accurate, current picture of clinical quality / performance in priority areas. 2. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 3..Review the coverage of mortality & morbidity meetings. 4.Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes. 5.Review annually, all technology & IT systems that support clinical governance e.g. Datix, Formic Fusion Pro, Clinical Effectiveness Register. 6. Consider the HIS Quality of Care Framework and agree our approach to implementation. 7.Fully understand what the patient experience 'looks like' and take any required actions.	Medical Director	31.10.2018	1. Assurance statements from clinical & clinical & care governance groups and committees. 2. Assurances obtained from all groups and committees that: i. they have a workplan ii.all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. Accreditation systems 7.Quality control process e.g. specific audits 8.External agency reports e.g. GMC 9..Quality of Care review	1. Internal Audit reviews and reports 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt DoC Annual Report 9.Scottish Public Service Ombudsman (SPSO) 10. Patient Opinion	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.Executive commissioning of reviews e.g. internal audit, external peer and 'deep dives'	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 - Unlikely	5 - Extreme	10	Moderate	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1502	3D Temperature Monitoring System (South Lab)	High 20	Ken Campbell
1296	Emergency Evacuation - VHK- Phase 2 Tower Block	High 20	Andrew Fairgrieve
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	High 20	Scott Garden
1524	Oxygen Driven Suction	High 20	Dr Christopher McKenna
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
521	Capacity Planning	High 16	Miriam Watts
529	Information Security	High 16	Carol Potter
637	SAB HEAT TARGET	High 16	Christina Coulombe
1365	Cancer Waiting Times Access Standards	High 15	TBC
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	High 15	Jeanette Burdock

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
356	Clinical Pharmacy Input	Closed Risk		
528	Pandemic Flu Planning	No longer a high risk	Moderate 12	Dona Milne
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk		
1366	T34 syringe drivers in the Acute Division	Closed Risk		

NHS Fife
Clinical Governance Committee

DATE OF REPORT:	06/11/2019
TITLE OF REPORT:	**NHS Fife Board Assurance Framework (BAF)** Strategic Planning
EXECUTIVE LEAD:	Dr Chris McKenna, Medical Director
REPORTING OFFICER:	Susan Fraser, Associate Director of Planning and Performance

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	**For Discussion**	~~**For Information**~~

SBAR REPORT

Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to this Committee and ultimately to the Board, that the organisation is delivering on its strategic objectives in line with the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health &Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners.

This report provides the Committee with the next version of the NHS Fife BAF on 6.11.19.

Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities
- Provides a brief assessment of current performance. In due course, the BAF will provide detail on the progress of the risk over time - improving, moving towards or away from its target.

Assessment

The Annual Operational Plan (AOP) for 2019/20 re-identifies the 4 strategic priorities for NHS and Health & Social Care as:

1. Acute Transformation Programme
2. Joining Up Care (including Urgent Care, Community Hubs & Community Hospital Redesign)
3. Mental Health Redesign
4. Medicines Efficiencies

These priorities are aligned to the 19 recommendations from the Clinical Strategy.

The Joint Strategic Transformation Group (JSTG) has now been replaced by the Integrated Transformation Board (ITB) which will provide transformation oversight of all of the transformation programmes by NHS Fife, Fife IJB and Fife Council. The governance will continue to be with the 4 committees (x2 NHS and x2 IJB).

Each programme has now been agreed by the ITB against the programme management stage and gate framework. The ITB will oversee the transformation programmes and ensure objectives, outcomes and deliverables are met within timescales.

The challenges associated with delivery remain the same, including the delivery of our strategic objectives and workplans (NHS Fife/H&SC/Region), delivery measures and timescales.

Recommendation

The Committee is invited to:

- **Note** the current position in relation to the Strategic Planning risk

Objectives: (must be completed)	
Healthcare Standard(s):	To aid delivery
HB Strategic Objectives:	Supports all of the Board's strategic objectives

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Winter Planning key stakeholders (NHS Fife and H&SCP) Executive Directors Executive Board

Impact: (must be completed)	
Financial / Value For Money	Promotes proportionate management of risk and thus effective and efficient use of scarce resources
Risk / Legal:	Inherent in process. Demonstrates due diligence. Provides critical supporting evidence for the Annual Governance Statement
Quality / Patient Care:	NHS Fife's risk management system seeks to minimise risk and so support the delivery of safe, effective, person centred care.
Workforce:	The system arrangements for risk management are contained within current resource.
Equality:	The arrangements for managing risk apply to all patients, staff and others in contact with the Board's services

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Strategic Planning																													
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	20.08.2019	01.11.2019	There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost. **Key Risks** 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the JSTG remains with 4 committees - 2 from the IJB and 2 from NHS. This may impact on effectiveness of scrutiny. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Joint Strategic Transformation Group has now been replaced with the Integrated Transformation Board after the review of transformation in 2019. Revised processes in place with workplans for transformation programmes at varying stages of development with some programmes more advanced than others. New programme management in place with a stage and gate approach. Joint Strategic Transformation Group has now been replaced with the Integrated Transformation Board after the review of transformation in 2019. Revised processes in place with workplans for transformation programmes at varying stages of development with some programmes more advanced than others. New programme management in place with a stage and gate approach.	Chief Executive	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of Integrated Transformation Board in 2019 to oversee transformation programmes across NHS Fife, Fife IJB and Fife Council to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 2. Establishment of programme management framework with a stage and gate approach. 3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the JSTG. 4. The Service Planning Reviews have taken place for 2019/20 -21/22 which will inform actions to deliver Clinical Strategy and prioritise transformation programmes.	JSTG not performing role adequately and replaced by the newly formed Integrated Transformation Board. but transformation programmes being progressed.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. First meeting of refreshed JSTG chaired by Chief Executive held on 16 April. Transformation Stocktake Workshop took place on 23 July 2019 and a refreshed governance structure is being 1. The NHS Fife CEO chairs the Acute Services workstream of the East Region Health and Social Care Delivery Plan. Plan has not been published so workstreams have been paused and specific work taken forward by SEAT. 2. Chief Executive and Chief Operating Officer participate in Regional planning via SEAT and appropriate sub/working groups.	Chief Executive Chief Operating Officer (COO)	31.08.2019 Ongoing. First plan to be submitted 31/03/2018. Paused	1. Minutes of meetings record attendance, agenda and outcomes. 2. Action Plans and highlight reports from the Joint Strategic Transformation Group. 3. Action plans, minutes and reports from the SEAT Regional Planning meetings and East Region Programme Board. 4. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all services. 5. New governance in place with newly formed Integrated Transformation Group with first meeting taking place on 2 October 2019.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Governance of programmes through Integrated Transformation Board.	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Acute Transformation, Joining Up Care, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole system oversight of operational plans, delivery measures and timescales. Each programme has now been mapped against the stage and gate approach and agreed by the Integrated Transformation Board. More scrutiny of programmes will take place at this board.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce. The delivery timescale for this will be late 2019/early 2020.

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
	Nil currently identified		

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
	NIL APPLICABLE			

Clinical Governance Committee

DATE OF MEETING:	4th October 2019
TITLE OF REPORT:	**NHS Fife Board Assurance Framework (BAF)** eHealth
EXECUTIVE LEAD:	Ellen Ryabov
REPORTING OFFICER:	Lesly Donovan

Purpose of the Report (delete as appropriate)		
For Decision	**For Discussion**	**For Information**

SBAR REPORT

Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to this Committee and ultimately to the Board, that the organisation is delivering on its strategic objectives as contained in the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health &Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners.

This report provides the Committee with the first version of the NHS Fife BAF specifically in relation to eHealth as at the 4th October 2019.

Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities
- Provides a brief assessment of current performance. In due course, the BAF will provide detail on the progress of the risk over time - improving, moving towards its target or tram - lining

The Committee is invited to consider the following :

- Does the risk score feel right?

- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk?
- Is there anything missing you would expect to see in the BAF?

Assessment

The Committee can be assured that systems and processes are in place to monitor eHealth performance and risks.

The high level risk is as set out in the BAF, together with the current risk assessment and the mitigating actions already taken. These are detailed in the attached paper. In addition, further detail is provided on the linked operational risks on the corporate risk register. Each risk has an owner who is responsible for the regular review and update of the mitigations in place to manage the risk to eHealth and the organisations sustainability and strategic planning.

The **BAF current score has been assessed at High** with the target score remaining Moderate

Recommendation

The Committee is invited to:

- **Consider** the questions set out above: and
- **approve** the first eHealth element of the Board Assurance Framework

Objectives: (must be completed)	
Healthcare Standard(s):	To aid delivery
HB Strategic Objectives:	Supports all of the Board's strategic objectives

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors

Impact: (must be completed)	
Financial / Value For Money	Promotes proportionate management of risk and thus effective and efficient use of scarce resources.
Risk / Legal:	Inherent in process. Demonstrates due diligence. Provides critical supporting evidence for the Annual Governance Statement.
Quality / Patient Care:	NHS Fife's risk management system seeks to minimise risk and so support the delivery of safe, effective, person centred care.
Workforce:	The system arrangements for risk management are contained within current resource. e.g.
Equality:	The arrangements for managing risk apply to all patients, staff and others in contact with the Board's services.

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
eHealth - Delivering Digital and Information Governance & Security																													
	Person Centred, Clinically Excellent, An Exemplar Employee, Sustainable	**19.07.2019**	**01.07.2020**	There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce Skills Dilution within eHealth and ability to derive Maximum Benefit from Digital Provision, NHS Fife may be unable to provide safe, effective, person centred care.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 -Extreme	15	High	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	COO & DOF (SIRO)	Clinical Governance - Chair: Dr Les Bisset FP&R - Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Implementation of the NHS Fife Strategic Framework and Clinical Strategy 2. Operational Governance arrangements 3. Risk Management Framework. The risk management framework is underpinned by Robust Policy & Process, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 4. Robust Internal and External Audit reports. 5. Working towards General Data Protection Regulation (GDPR), Directive on security of network and information systems (NIS) & Cyber Essentials Compliance 6. Corporate and eHealth policies & Procedures: GP/A4 Acceptable Use Policy GP/B2 eHealth Remote Access Policy GP/C10 Clear Screen Clear Desk Policy GP/D6 Data Encryption Policy GP/E7 Non NHS Fife Equipment GP/H6 eHealth Equipment Home Working Policy GP/I3 Internet Policy GP/I4 eHealth Procurement Policy GP/I5 Information Security Policy GP/M5 Mobile Device Policy GP/P2 Password Policy GP/M4 Media Handling Policy GP/E6 Email Policy GP/S8 eHealth Incident Management Policy GP/D3 Data Protection and Confidentiality Policy GP/I6 IT Change Management Policy GP/V2 IT Virus Protection Policy This is supported by the following: 7. eHealth Risk Register (incl Programme/project risks)	The organisation is not consistently fully compliant with the following key controls: GDPR/DPA 2018 NIS Directive Cyber Essentials Plus. Compliance is at 'a point in time' , Risks identified, linked and recorded. The organisation is also lacking in training resource to ensure our staff are digitally ready.	1. Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards 2. Ensure new systems are not introduced without sufficient skilled resources to maintain on an ongoing basis. 3. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Head of eHealth - Lesly Donovan	01.07.2020	Second Line of Defence 1. Reporting to eHealth Board, Information Governance & Security Group (IG&SG), clinical & clinical & care governance groups and committees. 2. Annual Assurance Statements for the eHealth Board and IG&SG. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. Accreditation systems. 11. Locally designed subject specific audits. 12. From June 2019	Third line of Defence: 1. Internal Audit reviews and reports on controls and process; including annual governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health.	1. Well developed reporting, which can highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 2. Implementation of improvements as recommended in Internal and external Audit Reports and an internal follow-up mechanism to confirm that these have addressed the recommendations made 3. Improvements to SLA's (in line with 'affordable performance') 4. Output from national Digital maturity due late 2019	Overall, NHS Fife ehealth has in place a sound systems of 1. Governance 2. Reasonable security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network.	2 - Unlikely	5 - Extreme	10	Moderate	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Risk ID	Risk Title	Current Risk Rating	Risk Owner
226	Lost of confidential or personal data	High 16	L Donovan
529	Information Security	High 16	C Potter
537	Failure of local Area Network causing loss of access to IT systems	High 15	A Young
1338	End of support for MS Office 2007	High 16	A Young
1393	Patch Management	High 16	A Young
1422	Unable to meet cyber essentials compliance	High 20	A Young
1424	End of support for MS Server 2003	High 16	A Young

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
913	MiDIS replacement	No longer High risk	Moderate 12	Lesly Donovan

BREXIT ASSURANCE GROUP COMMITTEE REPORTING TEMPLATE

Clinical Governance Committee:

Date of meeting: **6 November 2019**

Reporting Officer: **Dr C McKenna**

AREA	UPDATE FROM MEETING
Access to treatment in the UK/Europe;	Latest agreement was that the current rules would stay in place until 31/12/20. Meeting to be held at St Andrews that may clarify the position.
Cross Border Co-operation on Public Health matters;	In terms of cross border public health work: Health Protection Scotland undertake all cross border liaison and advice on behalf of public health departments in Scotland, liaising with ECDC and the WHO. They will continue to fulfill this role during the planning for and subsequent to EU Exit.
eHealth;	**Costs** - Fluctuation in exchange rates i.e. downward value of the GBP£ against US$ or Euro may impact recurring licensing, support and hardware costs. **Talent leakage** – There is a risk that 'in demand' technical talent in eHealth may be waiting for BREXIT to conclude before seeking opportunities in the private sector. Or EU citizens returning home may create a vacuum in the private sector creating a shortage of talent, which in turn drives up financial incentives that may tempt NHS Fife staff away. **Cyber Security** – A period of general distraction within the UK/EU and general confusion over blurred cyber security defence boundaries etc. may tempt malicious actors / hostile nation states to take advantage and create a period of heightened risk.
Nuclear Medicine, Diagnostic and Treatment	There has been no change in the Nuclear Medicine anticipated affects of BREXIT
Patient Access to Medicines and Medical Technologies;	The Scottish Government Medicines Shortage Response Group (MSRG(Sco)) has issued 5 Medicine Supply Alert Notices (MSANs) (since 23 September) which provide information on out of stock medicines. The Department of Health has issued a list of medicines that cannot be parallel exported from the UK and has written to pharmaceutical wholesalers reminding them of their obligations to ensure the continued supply of medicinal products so that the needs of patients in the UK are met. NHS Fife has policy and procedures in place to ensure that we are adhering to national best practice standards in managing medicines shortages, which are occurring on a regular basis.
Research and Development.	There has been no change on the anticipated impact of BREXIT on R&D activities since the last update.

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	Acute Services Division Transformation Programme Update
EXECUTIVE LEAD:	Ellen Ryabov
REPORTING OFFICER:	

Purpose of the Report (delete as appropriate)		
		For Information for noting

SBAR REPORT

Situation

NHS Fife and the wider Health & Social Care system partners face unprecedented financial and service pressure as a result of :-

- Supporting the care needs of an ageing population
- Patient expectations in light of new and expensive treatment options
- Impact of increased prevalence of long-term conditions
- Urgent workforce challenges, ageing workforce, persistent vacancies in some staff groups and recruitment/retention issues.

Transformational change, including the way in which organisations work, both individually and collectively will be required to address the above challenges and deliver the plan

Background

The Acute Services Division (ASD) Transformation Programme has been set up to provide an overarching and decision making framework to support the aims of the programme and ensure delivery of the plan.

The context of the programme is to improve the efficiency and effectiveness of patient care through service transformation and contribute to the Acute savings target of £10.2m which equates to 59% of Board savings through financial transformation.

External advice has been commissioned to identify the key enablers seen as being integral to the financial balance for NHS Fife in 19/20 and beyond. Priorities from the final report have been overlaid against the transformation plan to ensure the work is focussed and phased to deliver the best outcomes.

The programme will enhance partnership understanding, seek new ways of working and embed collective responsibility for transforming patient care.

Four workstreams have been established and work is ongoing in relation to key prioritised objectives. The governance structure outlining these workstreams is illustrated in ***Appendix 1.***

The Acute Services Division Transformation Programme Committee has been set up to monitor programme progress and provides a robust challenge and scrutiny function to ensure timely delivery and assess impact of savings, changes to service delivery and patient care. The Committee includes representation across clinical groups and representation from Staff Side and HSCP colleagues.

Assessment

Programme Update

- A Programme risk register has been established in Datix.
- Regular high level overlap analysis meetings to avoid duplication and rebalance load between workstreams.
- Consistent project documentation developed and embedded through work streams.
- Metrics and baseline measurements identified and Programme Scorecard developed.
- Reference groups established to ensure appropriate liaison with all stakeholders.

Communication and involvement

Communication planning included for key elements of the Programme. Events include:-

- Banishing Boarding open event for staff change ideas (September 2019)
- ASD Transformation Programme Stakeholders drop in session – 15th November 2019, 11am – 2pm in Staff Club, VHK (for staff)
- Out patients stakeholder event – 20th November 2019 at VHK and 26th November at Queen Margaret Hospital. (for patients and staff)
- Regular directorate briefing sessions
- Information spread for patients on waiting room monitors, social media, etc.
- Banish Boarding initiative, 18 days of reset, running from 1st-18th November 2019. This will allow a dedicated time period for supporting rapid tests of change that enable patients to be placed in the right bed, at the right time, at the point of admission.

Financial Efficiencies

Appendix 2 outlines a schematic illustrating how the ASD Transformation Programme aligns to the ASD Efficiency Opportunity Assessment. Whilst some of the operational opportunities have been picked up through savings schemes with the Productivity & Efficiency Group, the larger transformational items identified will have project plans developed through the transformation workstreams.

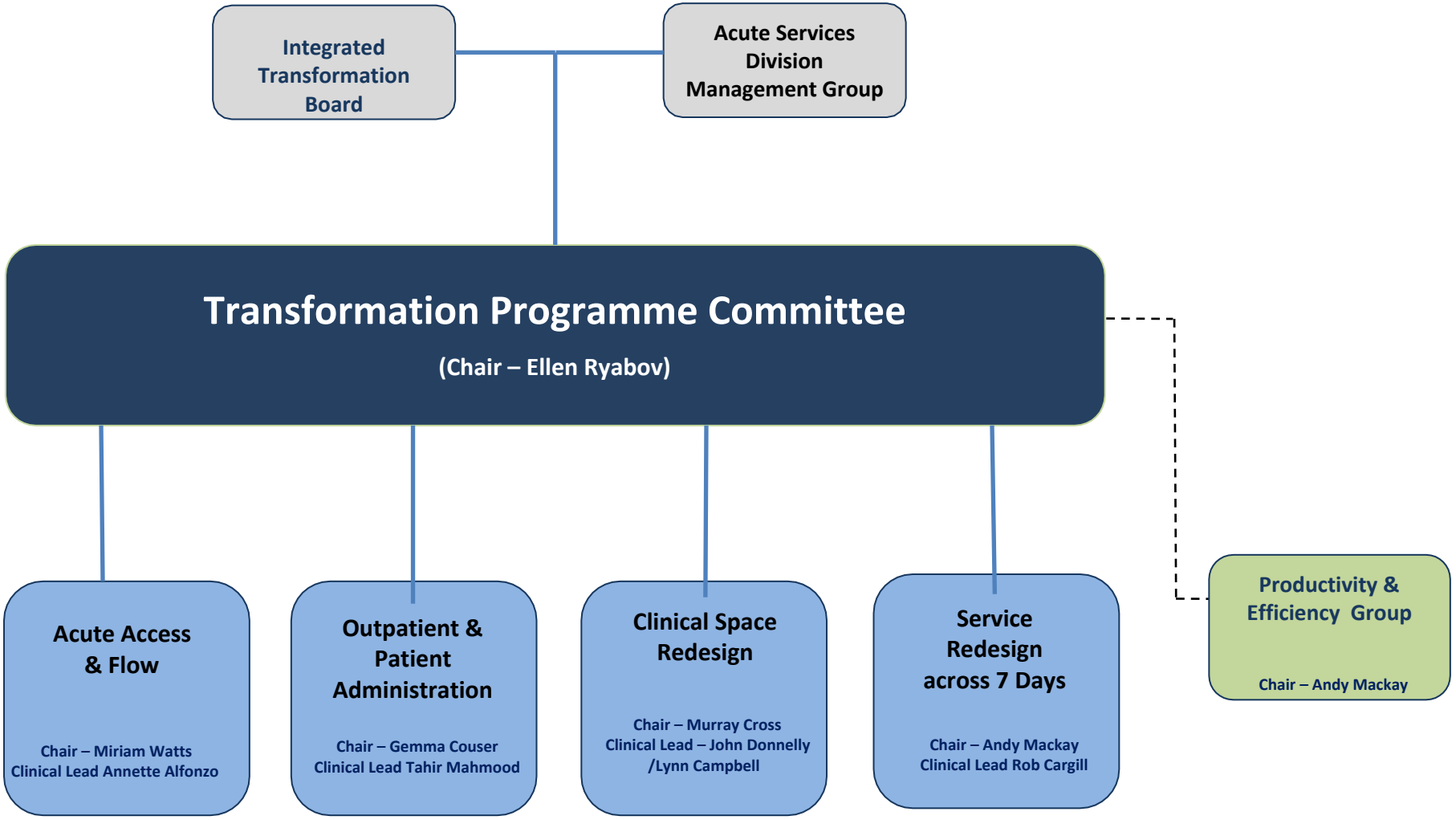
Recommendation

The Committee is asked to note the update from the Acute Services Transformation programme. An update on key objectives will be included in the next update to the committee.

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	Critical linkage to delivery of Acute Services Division financial savings for 19/20 and beyond.
Risk / Legal:	N/A
Quality / Patient Care:	Key objective within all workstreams to enhance patient care.
Workforce:	Possibility for changes to workforce through redesign of services or financial savings through non-backfill of vacancies. Staff Side representation on all workstreams and Programme Committee.
Equality:	EQIAs completed for all workstreams within the Programme.


Integrated Transformation Board
Acute Services Division Management Group
Transformation Programme Committee
(Chair – Ellen Ryabov)
Acute Access & Flow
Chair – Miriam Watts
Clinical Lead Annette Alfonzo
Outpatient & Patient Administration
Chair – Gemma Couser
Clinical Lead Tahir Mahmood
Clinical Space Redesign
Chair – Murray Cross
Clinical Lead – John Donnelly /Lynn Campbell
Service Redesign across 7 Days
Chair – Andy Mackay
Clinical Lead Rob Cargill
Productivity & Efficiency Group
Chair – Andy Mackay

ASD Transformation Workstreams

The schematic below outlines how the ASD Transformation Programme workstreams aligns to the outputs of the ASD Efficiency Opportunity Assessment:

Workstreams	Acute Access & Flow			Outpatient & Patient Administration			Clinical Space Redesign			Service Redesign Across 7 Days		
Efficiency Opportunity Analysis*	A&E conversion rates Length of stay	£0.29m - £3.53m 6,447 bed days (15-20 beds)		New to follow up ratios Did not attends Cancellations	£1.09m to £4.59m £0.59m to £0.81m £- to £4.88m		Theatre utilisation Weekend working British Association of Day Surgery	£1.16m £0.61m Requires validation		Nursing Midwifery Medical and Dental Others	£0.15m £1.15m to £2.40m £- to £0.84m TBC	
Key Transformation Activities		Start	End		Start	End		Start	End		Start	End
1	Unscheduled Care : 95% of all A&E patients should be admitted, discharged or transferred within four hours of arrival at A&E department	Aug-19	Dec-19	Current State : establish baseline	Sep-19	Oct-19	Sustainable bed model: Identify and optimise the inpatient clinical space required for VHK site	Jun-19	Sep-19	Workforce Supply & Demand	Oct-19	Mar-20
2	Direct Access Services: Non ED Patients accessing emergency care are managed through the most appropriate service in a timely manner	Sep-19	Oct-19	Pre appointment Develop clear referral pathways that are easily accessible for patients and referrers	Sep-19	Mar-20	Site Master Plan/Clinical Space: Identify and optimise other clinical space on VHK site	Jul-19	TBC	In Patient Journey	Oct-19	Jan-20
3	Community & System Wide Engagement : Patients requiring care within a non-acute setting have access to appropriate pathways	Nov-19	Mar-20	Patient Administration & Communication: Improving Patient Experience /Patient Follow Up Reduce DNA rate by 2% and N:R in services in line with Scottish Upper Quartile	Sep-19	Jan-20	Theatre Utilisation: Maximise efficiencies of Theatres	Apr-18	Mar-20	Maximising Technology	Jul-19	Jan-20
4	Complex Discharge Process and Implementation: Support safe discharge through efficient patient flow and by system wide engagement	Jul-19	Nov-19	Clinic Utilisation: On the Day Optimise clinic utilisation delivering >85%	Aug-19	Oct 19						
Directorate grip and control activities managing budgetary efficiencies, workforce performance, non-pay etc.												

***Please note that there is a degree of overlap in opportunities in the table and hence the opportunity should not be aggregated. The workstreams will be identifying specific realisable efficiency targets as part of project development.**

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	Medicines Efficiencies update
EXECUTIVE LEAD:	Scott Garden
REPORTING OFFICER:	Euan Reid

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	~~**For Discussion**~~	**For Information**

SBAR REPORT

Situation

NHS Fife launched a three year Medicines Efficiency Transformation Programme in August 2016, with the aim of delivering significant medicines efficiencies, improving safety and quality of prescribing across the organisation.

The Medicines Efficiency Programme is now viewed as a mature programme and it remains a priority for 19/20 as outlined in the Annual Operation Plan. The programme has an efficiency target of £1.2m for HSCP and £1.34m in Acute Services for 19/20.

The three priority areas for the Programme are:

1. **Continue to improve formulary compliance**
2. **Reducing medicines waste**
3. **Reduce polypharmacy / increase realistic prescribing**

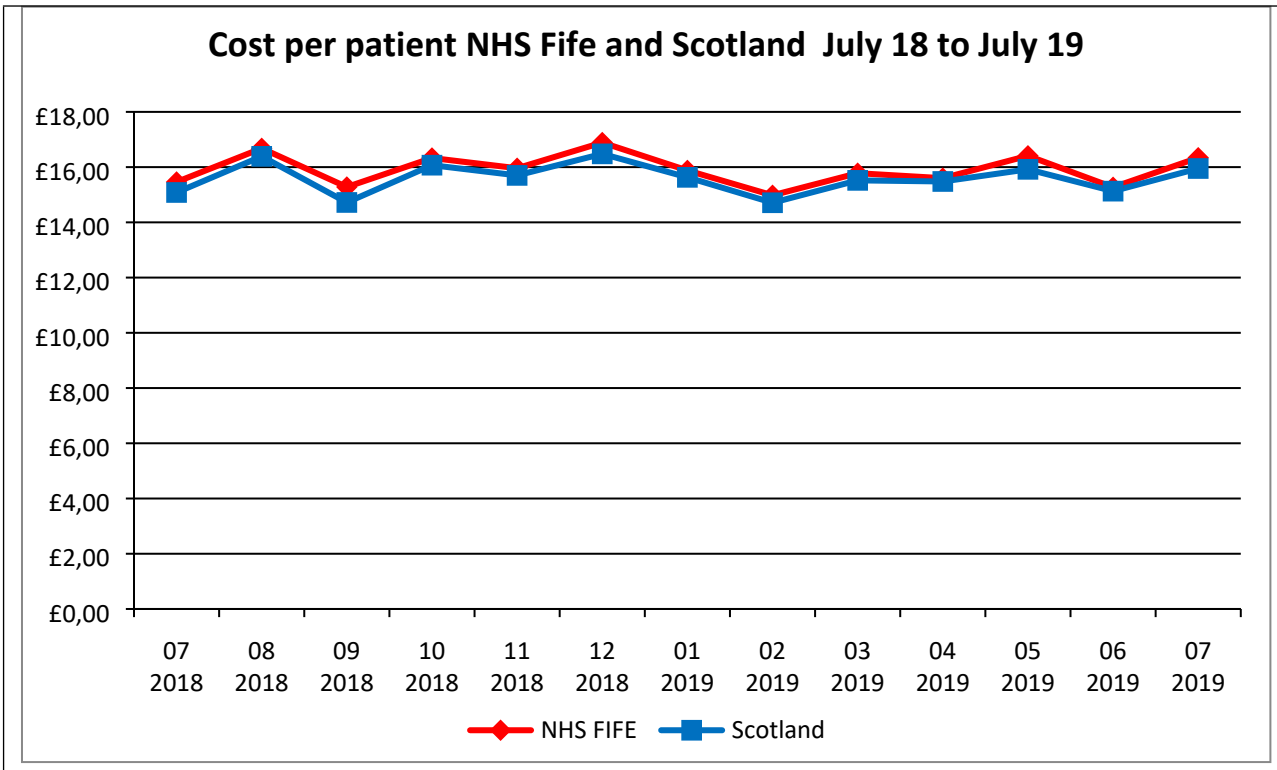
Background

In 2016, NHS Fife had one of the highest cost per patient for GP prescribing, compared to the rest of Scotland. There were a number of reasons for this including: a culture of secondary care/ specialist prescribing newer more expensive medicines and Fife having one of the lowest levels of pharmacy resource in Scotland. Since 2016, NHS Fife has therefore invested in some additional pharmacy, nursing and GP resource to implement the medicines efficiency programme, with the aims of reducing Fife's cost per patient and moving Fife closer to the Scottish average.

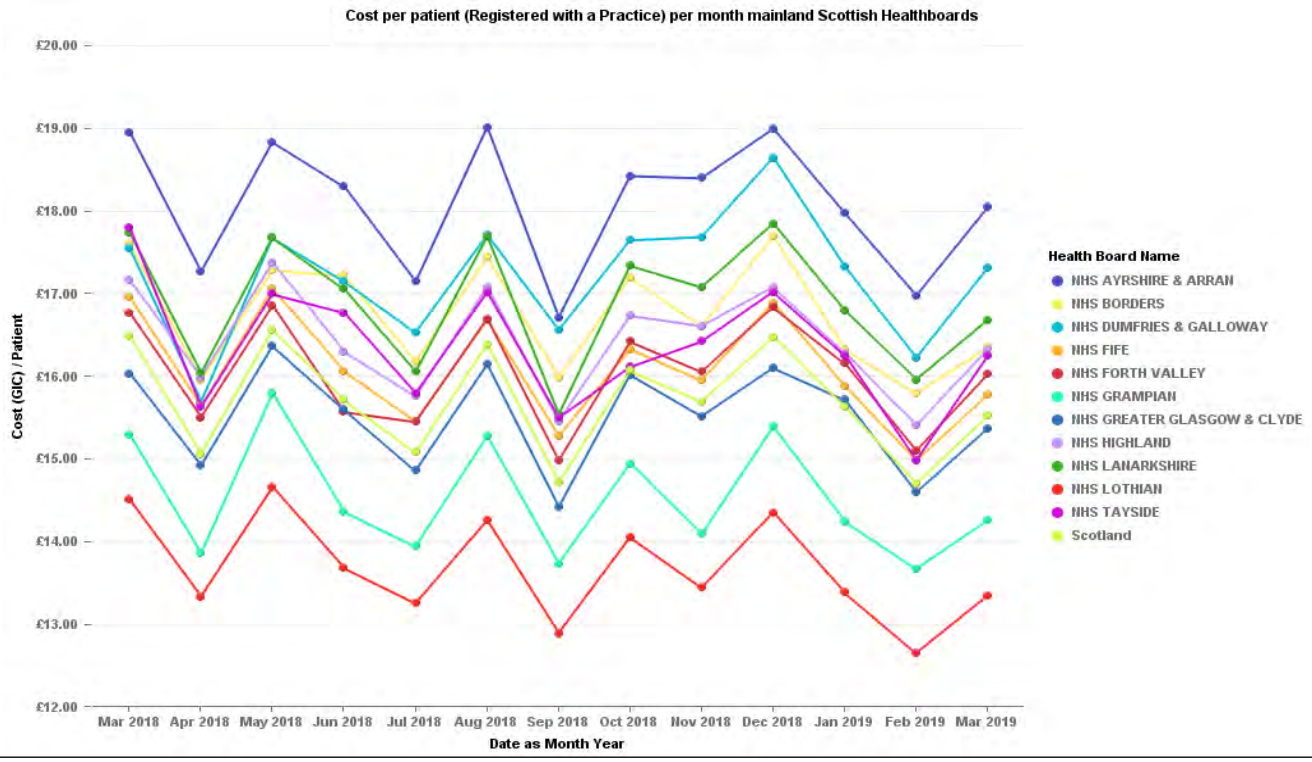
Assessment

GP Prescribing
19/20 year end forecast is to break even.

Please note that primary care data is 3 months in arrears therefore most recent data is July 2019.



In July 2019 the cost per patient for GP prescribing was 39p higher than Scottish average. The distance from the Scottish average varies from month to month; 14p higher in June, 49p higher in May and 12p higher in April.

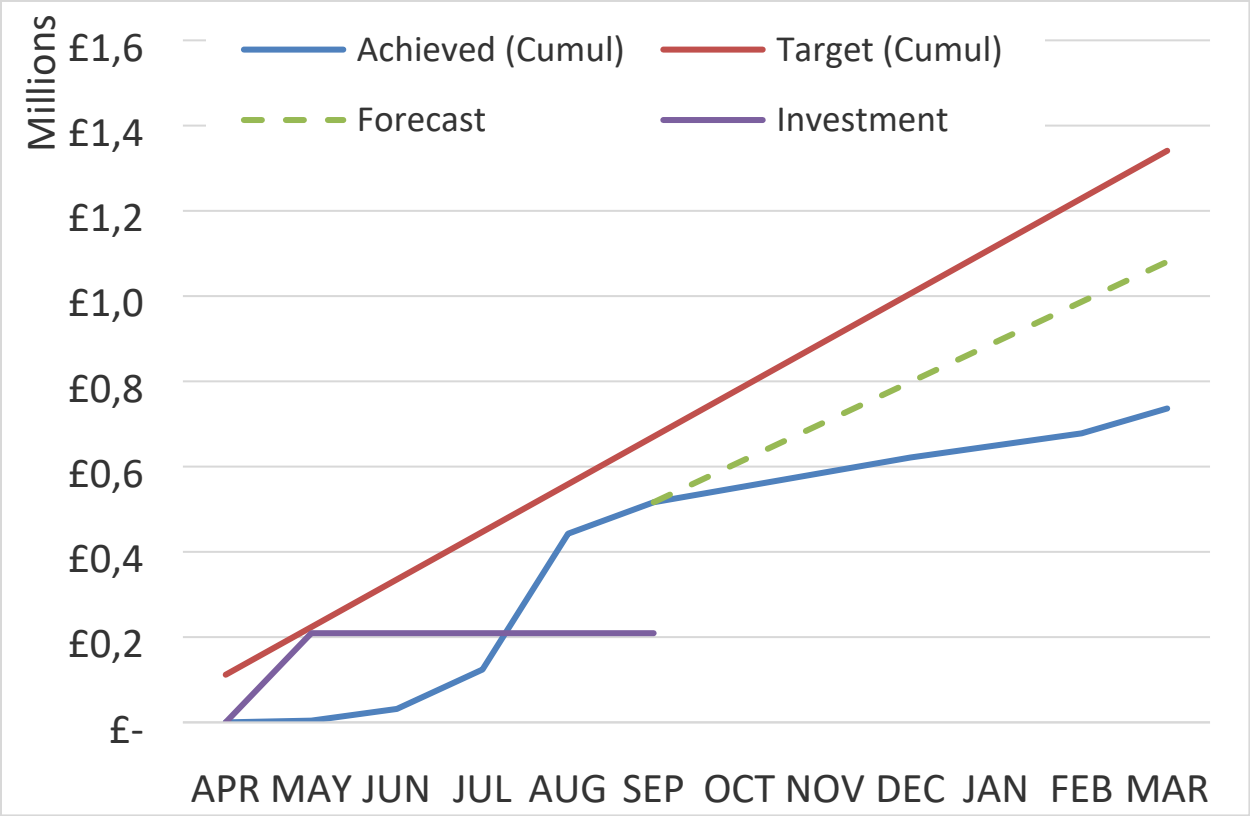


NHS Fife had the 5th lowest cost per patient in July 2019. The position relative to other Health Boards alternates between 4th and 5th lowest.

Acute Services

Current year investment is £209,204 with a recurring investment of £227,950.
Current year savings of £736,367 with a recurring impact of £372,541.

The gap of forecast delivery has widened as Planned Care have now added in a shortfall of £95,270 due to the time delay in implementing a change to Ophthalmology prescribing practice.

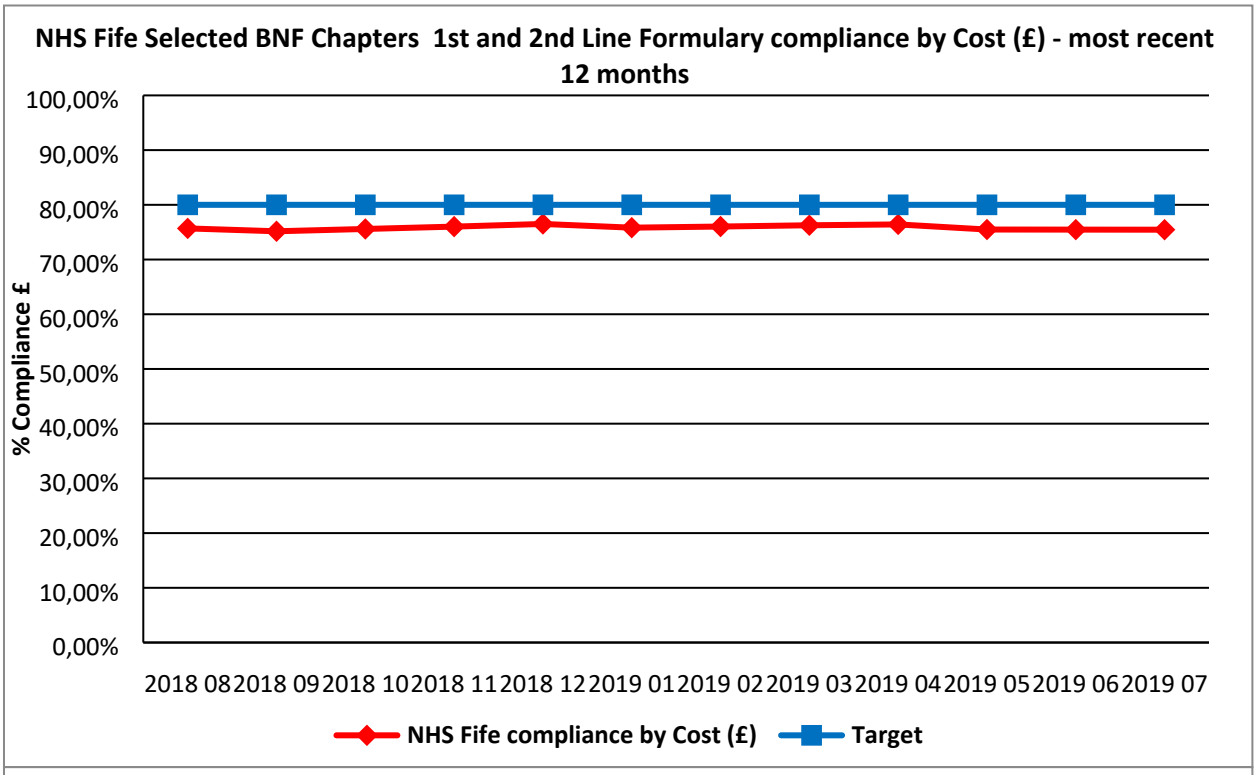


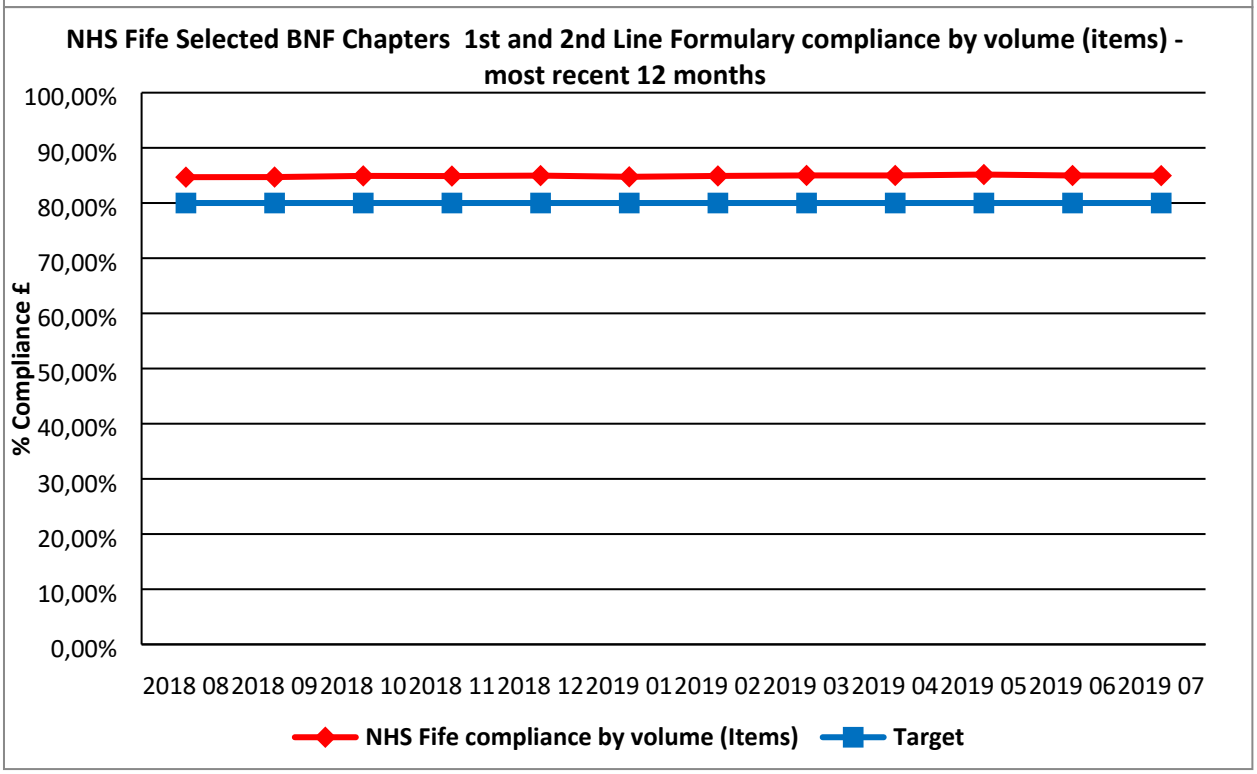
The three key priorities for the Medicines Efficiency programme are:

1. Improving formulary compliance

Fife has increased its compliance with the formulary (list of preferred medicines) from:

- 62% to 76% (by spend) and 79% to 85% (by volume) for GP prescribing which is being maintained
- >90% (by spend) for Acute services





Key actions underway:

- A communication campaign for staff to highlight the key formulary changes, using daily desktop messages, every quarter.
- Medication reviews by the pharmacy team of non formulary prescribing, e.g. respiratory,

diabetes, pain and oral anti-coagulants to change to formulary alternatives.
- Rolling programme to review the Fife formulary choices to maximise safety and cost-effectiveness.
- Maximising the use of electronic prescribing support messages in General Practice.
- Within the Acute Division the main focus in efficiencies is currently on implementing National Procurement contract frameworks.

2. Reducing medicines waste

A multi-professional NHS Fife Medicines Waste Steering group has been established with 2 work streams: care homes and hospitals.
Key actions:

- Medicines waste campaign launched targeting patients and staff in care homes, hospitals and community venues. Radio advertising and social media campaign, targeted at the public.
- Health and social care staff waste campaign during 2019 which includes staff briefings, certificates and some promotional items to reduce medicines waste within their area photos will be shared on social media to raise awareness of the campaign.
- Rollout of a non-prescription ordering process for ordering woundcare and some catheter products in GP practices, treatment rooms and care homes, which has delivered efficiencies of £400,000 to date.
- Roll out of dietetic led non prescription ordering process for the supply of oral nutritional supplements from November 2019.
- Review of patients receiving oral nutritional supplement supply by Dietetics.
- Ongoing rollout of the use of patients' own medicines and increased use of patient packs to ensure continuity of patient care, improved flow and a reduction in duplication of supply of medicines.
- Roll out of new process to allow medicines waste to be destroyed at ward level to increase staff awareness about avoidable medicines waste and reduce it.
- Pharmacy assistant support, from February 2019, in care homes to streamline medicines ordering processes and prevent over ordering.
- Revised returns procedure developed for care homes to reduce avoidable returns.
- Increased reporting of medicines overstocks in care homes with offer of pharmacy support to resolve.
- Introduction of green bag system in care homes to ensure medicines are taken into hospital.

3. Realistic prescribing

The aim of realistic prescribing is to ensure that patients are only prescribed medicines when the potential benefits outweigh the risks and therefore some patients, due to frailty or multi-morbidity, may require a review of their medicines to ensure that the medicines are still appropriate.

The key actions planned/ completed:

- Establishment of a multi-disciplinary Realistic Prescribing Steering group with representation across primary care and acute, including the Realistic Medicine champions for primary care and acute.
- Agreement of 3 key priorities:

- Review of bone health medicines in patients who are prescribed these > 5 years
- Review of patients with dementia who are prescribed anti-psychotics
- Review of frail patients who are prescribed 2 or more anti hypertensive medicines

- A test of change of GPs and practice pharmacists undertaking joint medication reviews in 5 care homes which is being incorporated into revised Local Enhanced Service for Care homes
- Launch of new NHS Fife guideline for managing hypertension in frailty at Realistic Medicine event on 23 October 2019.
- Input to East Region Realistic Medicine Project Board.
- Review prescribing of medicines which are of "low clinical value" due to their lack of clinical effectiveness.
- Develop a culture of Realistic prescribing in NHS Fife which includes alternatives to prescribing medicines, such as, social prescribing.

Risks to delivery

Project support from the Transformation and Change Team has ended. Furthermore, Communications support has reduced due to there being no maternity leave backfill for the Communication Manager who provided support to the Programme. Both project support and communications support have been key enablers to the success of the programme.

Following discussion with the Portfolio Lead, Transformation and Change Team, a band 5 project support officer is to be recruited until March 2020 with 0.5WTE being allocated to the Medicines Efficiency Programme. The recruitment process is underway.

Due to ongoing medicine shortages, Brexit, GP practice sustainability and pharmacy staff recruitment, there are risks to delivery of the programme.

Recommendation

- **For Information**

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	See above
Risk / Legal:	See above
Quality / Patient Care:	See above
Workforce:	See above
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6 November 2019
TITLE OF REPORT:	CONSULTANTS, CAREER GRADE DOCTORS AND GENERAL PRACTITIONERS MEDICAL REVALIDATION AND APPRAISAL REPORT 2018 - 2019
EXECUTIVE LEAD:	Dr C McKenna
REPORTING OFFICER:	Mrs Alison Gracey, Medical Appraisal & Revalidation Coordinator

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	~~**For Discussion**~~	**For Information**

SBAR REPORT

Situation

The purpose of the report is to update the Board on where NHS Fife is with regards to Medical staff Revalidation and Appraisal.

Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

Assessment

NHS Fife responds well to the challenges of Medical Revalidation and Appraisal with few problems, is managing to meet the requirements of the GMC and are actively making efforts to improve the quality of Appraisal through audit and local training sessions. However, Secondary Care have struggled to recruit and retain sufficient NES Trained Appraisers and continue to advertise the role, liaising with NES to gain additional places on courses and enlisting the assistance of Clinical Directors, Clinical Leads etc. for the recommendation and support of suitable candidates and those already in the role.

Recommendation

The Board is asked to note and accept the report and the actions being taken to respond to the recommendations within it.

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	Medical Appraisal & Revalidation Group

Impact: (must be completed)	
Financial / Value For Money	
Risk / Legal:	There may be a risk of being unable to meet the GMC requirements for Medical Revalidation and Appraisal if unable to recruit and retain sufficient numbers of NES Trained Appraisers.
Quality / Patient Care:	Ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards
Workforce:	
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? ~~Yes~~/No (If yes, please supply copy, if no please state reason) N/A • Has a full EQIA been undertaken? ~~Yes~~/No (If yes please supply copy, if no please state reason) N/A • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

CONSULTANTS, CAREER GRADE DOCTORS AND GENERAL PRACTITIONERS

MEDICAL REVALIDATION AND APPRAISAL REPORT

2018 - 2019

1. PURPOSE

This is NHS Fife's tenth Annual Report which will provide the Board with an update on where NHS Fife is with Medical Staff Revalidation and Appraisal which came into effect on 3rd December 2012.

2. BACKGROUND

In February 2007, the UK Government published a White Paper; Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century". The intention of the policy was to "provide for safer patient care in the UK" and to "enable the public and patients to be confident that the health professional who cares for them is practising to nationally agreed standards based on an ethos of high quality care".

To implement this policy, since November 2009, any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise that needs to be revalidated every 5 years.

The Scottish Government Health Directorates (SGHD) has described the purpose of revalidation as being:

"…… to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards. Revalidation will provide a focus for doctors' efforts to maintain and improve their practice, and for the organisations in which they work to support them in doing this. In these ways, it will contribute to improvement in the quality of patient care.

A Revalidation Delivery Board for Scotland (RDBS) was set up to oversee the implementation of effective medical revalidation in Scotland. The Board is chaired by Professor Ian Finlay, Senior Medical Officer – Medical Revalidation, Scottish Government and reports, in governance terms, to Dr Catherine Calderwood, Chief Medical Officer at the Scottish Government. The Board also reports to the GMC's UK Revalidation Programme Board.

Medical revalidation (licence to practice) became a UK requirement on 3rd December 2012. All licensed doctors now need to demonstrate to the GMC on a regular basis that they remain up to date and fit to practice. This process is called revalidation.

Revalidation takes place every five years, and requires annual appraisal, including feedback from colleagues and patients. Evidence of the doctor's range and volume of practice, such as the number of operations carried out or prescribing patterns will also be reviewed.

3. RESPONSIBLE OFFICER

Recommendations for the revalidation of all doctors is achieved through each Health Board's Responsible Officer (RO). In NHS Scotland the Executive Medical Directors of Health Boards, special Health Boards and the CSA are the Responsible Officers for this purpose. Responsible Officers have a key role in developing more effective liaison between Boards and the General Medical Council (GMC) as the regulatory body for all doctors; and they oversee the arrangements within boards for all medical revalidation, including all methods of evaluating fitness to practice. Although Responsible Officers make revalidation recommendations to the GMC, it is the GMC which decides whether doctors should be revalidated. The Responsible Officer has the following recommendation options:

- Revalidate
- Request more time (defer)
- Failure to engage

Every doctor wishing to practise medicine in the UK must be linked to a Responsible Officer referred to as a "prescribed connection".

There is also a requirement to provide appraisal and revalidation support to those doctors not employed or contracted to NHS Boards but who still have a prescribed connection

In Scotland a Responsible Officer's Network was established which provides a forum to discuss what happens "on the ground"; how the Responsible Officers can support each other and how the Responsible Officers interact with NHS Education for Scotland (NES) and Healthcare Improvement Scotland (HIS).

From the Responsible Officer's Network, key issues are brought to the Revalidation Delivery Board for Scotland, the Scottish Government Cross-Professional Fitness to Practice Group and the Scottish Government Overarching Implementation Steering Group as appropriate.

In line with national policy Dr Chris McKenna is NHS Fife's Responsible Officer, Dr Robert Cargill and Dr Seonaid McCallum are NHS Fife's Deputy Responsible Officers. This responsibility covers all Consultants, Career Grade Doctors and General Practitioners employed by NHS Fife.

Dr Elliot, Dr Cargill and Dr McCallum have completed Responsible Officer training and attend Responsible Officer network meetings and training when organised.

Dr Chris McKenna took over as NHS Fife's Responsible Officer from March 2019 when Dr Frances Elliot retired.

The GMC has guidance to help Responsible Officers make revalidation recommendations.

4. ANNUAL APPRAISAL

The Scottish Government agreed that for doctors in Scotland, revalidation will be achieved by using a standardised bespoke "**Enhanced Appraisal"** system designed by the National Appraisal Leads Group for Scotland (NALG). All doctors are required to participate in an annual appraisal

General Practitioners have had a well developed and fully funded appraisal system for some years and whilst there has been a requirement to make some changes to the existing process, this has been minimal. It is important that across primary and secondary care, governance is seen to be equitable and comparable.

NHS Fife has a Medical and Appraisal Revalidation Group, whose membership is made up as follows:

Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife
Dr Rob Cargill, Associate Medical Director – Acute Services Division/Deputy Responsible Officer - NHS Fife
Dr Seonaid McCallum, Associate Medical Director – Health & Social Care Partnership/Deputy Responsible Officer – NHS Fife
Dr Maritta Philp, GP Appraisal Lead
Mr Edward Dunstan, Secondary Care Appraisal Lead
Mrs Joyce Kelly, Primary Care Manager
Mrs Rhona Waugh, Head of Human Resources
Mr Kenny Ward, Business Manager to the Medical Director, NHS Fife
Ms Miriam Watts, General Manager, Emergency Care
Dr Annette Alfonzo, Clinical Director, Emergency Care
Mr Murray Cross, General Manager, Planned Care
Dr John Donnelly, Clinical Director, Planned Care
Ms Gemma Couser, General Manager, Women, Children & Clinical Services
Dr Tahir Mahmood, Clincial Director, Women, Children & Clinical Services
Dr Joanna Pickles, LNC Representative
Mrs Alison Gracey, Medical Appraisal and Revalidation Co-ordinator – NHS Fife

This group assesses and implements any changes which need to be made to the current system to bring it in line with the national enhanced appraisal process.

Doctors in training have regular reviews of their performance and are appraised using an adapted review system based largely on their current processes. The Medical Director of NES is the Responsible Officer for all doctors in training. The Director of Medical Education and Educational Supervisors currently employed in NHS Fife have a role in providing information about these trainees to NES to allow their revalidation to take place.

Major changes have occurred in the appraisal system for Consultants, Specialty and Associate Specialist (SAS) doctors. Although enhanced appraisal remains a largely formative process there is now an element of assessment although documents make it clear that this is not the forum for performance management. The national guidance recommends that an Appraisee has a new Appraiser every three years.

In NHS Fife a Medical Revalidation and Appraisal Policy/Procedure for Doctors in Primary and Secondary Care has been developed and implemented to provide a standardised procedure for the annual appraisal of doctors. This policy/procedure covers key elements of the appraisal process and is reviewed on a regular basis with the policy/procedure last reviewed October 2018.

5. APPOINTMENT AND TRAINING OF APPRAISERS

In **Primary Care (General Practitioners)** there are 14 NHS Fife appointed and NES trained Appraisers. This allows every General Practitioner to have an annual appraisal.

The GP Appraisal Lead meets each new Appraiser after they have been appointed for an induction and then yearly thereafter. Relevant issues as well as learning needs are addressed and a Professional Development Plan for the coming year agreed. At these appraisals a standard format designed by NES is used and feedback, resulting from Appraisees sending Form 6As anonymously to NES, is discussed. A couple of Form 4s are also discussed to ensure appropriate standards around this.

Development needs are discussed at Performance Appraisal and at regular Appraiser meetings or individually by email with the GP Appraisal Lead.

Appraisers are also encouraged to email NES directly with development needs especially in relation to IT problems and use of the SOAR database.

The Fife GP Appraisers group holds a meeting three times per year at which Appraisers exchange ideas and discuss scenarios from their own experiences and from cases provided. In addition to local meetings NES holds a yearly appraisal conference which all appraisers are encouraged to attend.

GP Appraisers are required to attend at least 50% of all training activities over one year, i.e. two training events per year.

GP Appraiser recruitment is undertaken locally.

In **Secondary Care** there are 38 NES trained Appraisers. NHS Fife has faced difficulties with recruitment and retention of appraisers in Secondary Care and enlisted the help of a small bank of retired appraisers to help undertake outstanding appraisals. The number of trained appraisers has fluctuated over the years with appraisers either retiring, moving on to new posts or resigning from the appraiser role due to other work commitments, however, NHS Fife continues to advertise, on an ongoing basis, for additional trained members of medical staff to undertake this training in an effort to ensure there are sufficient trained Appraisers to share the appraisal workload.

In 2018 three ½ day training sessions for NES trained appraisers including were provided giving guidance on good practice with regards to the appraisal process, the opportunity to raise and discuss any issues or concerns they may have and to share their experiences. These were primarily for Secondary Care, however GP Appraisers were invited, some of whom attended, adding their perspective and valuable networking opportunities. In 2019, further sessions are being provided, again, inviting GP appraisers to attend as well.

Appraisers are also encouraged to attend any training provided by NES whether that be a specific training session or in conference format.

A number attended the NES Appraisal Conference which took place on 26th and 27th April 2018.

In accordance with national guidance NHS Fife now only uses NES trained Appraisers for doctors' appraisals.

6. APPRAISAL SYSTEM/DOCUMENTATION

The Scottish On-line Appraisal Resource (SOAR) collects interview details such as date/location/Appraiser, etc and is used to aid the appraisal process for both GPs and secondary care doctors working in Scotland, maintained by the Appraiser and the local admin teams. Appraisees (Doctors) also have access to SOAR where they can review their past appraisal details, complete their relevant forms as well as upload documents to share with their Appraiser and more importantly, sign off the summary of their interview. For GPs and Secondary Care Doctors this is Form 4. The Medical Appraisal & Revalidation Coordinator checks the system on a regular basis to ensure everyone has their annual appraisal.

Doctors within secondary care can still continue to use the paper based system, with specially designed forms to record the outcome of the process, instead of SOAR, however, all are actively encouraged to use SOAR as it is likely to become mandatory in the future and currently no-one continues to use paper.

A signed Form 4 is proof that an individual has successfully engaged in the Appraisal process for that year.

GMC Connect is an area of the GMC's website that allows the GMC to transfer and share data and information securely and has been developed to support Responsible Officers. GMC Connect allows Responsible Officers to manage their responsible officer details; view and manage the list of doctors who have a prescribed connection to a designated body; submit revalidation recommendations when they are due; access revalidation guidance and forms and subscribe to emails that notify them when there are changes on their designated body's list of doctors.

NES reached agreement in 2013 with the GMC over linking their IT system so that ROs in Scotland can make Revalidation recommendations via SOAR.

Trainees also have access to SOAR.

Guidance is available on-line for all users.

7. CLINICAL GOVERNANCE, ACTIVITY, OUTCOME AND ORGANISATIONAL INFORMATION/DATA FOR APPRAISAL

During annual appraisal doctors use supporting information to demonstrate that they are continuing to meet the principles and values set out in "Good Medical Practice". Access to this information relies on effective Clinical Governance and information systems being in place.

There is significant variation across specialties regarding what information is available at individual doctor level to support the process of appraisal and job planning both at local and national level. In NHS Fife, a wealth of information is collected for national reporting and for operational reasons. Work is ongoing to provide doctors with a minimum data set to use to support appraisal and revalidation.
Currently those working within the Health and Social Care Partnership and the Acute Services Division are provided with information on incidents, complaints and medical legal statements.

Supporting information required of all doctors also includes feedback from colleagues and, **where they have direct patient contact**, from patients. All doctors are expected to seek such feedback at least once in every revalidation cycle (5 years).

NHS Fife has adopted the GMC Patient Questionnaire and has pulled together guidance on its use. Primary Care clinicians (General Practitioners) and Secondary Care clinicians (Acute Division, Health & Social Care Partnership and Public Health) use this questionnaire and the MSF tool, on SOAR, for colleague feedback. NHS Fife has also allowed Anaesthetists and OHSAS clinicians to use patient questionnaires adapted for their specialty.

8. GP FUNDING IMPLICATIONS

GP appraisal has been centrally funded from the outset and appraisal administration support is provided by Primary Care Contractor Services.

Dr Maritta Philp, Local Appraisal Adviser is responsible for liaising with the administration support, providing support to Appraisers and addressing their development needs in the role and ensuring quality assurance of the appraisal process.

9. GOVERNANCE STRUCTURE

The implementation of medical staff revalidation including enhanced appraisal is overseen by the Medical Appraisal and Revalidation Group chaired by Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife. This group reports to NHS Fife's Clinical and Staff Governance Committees.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

The GMC has a handbook for boards and governing bodies – "Effective governance to support medical revalidation".

10. QUALITY ASSURANCE

The GMC has put in place a programme of quality assurance which seeks to provide it with assurances that:

- local governance systems and processes are in place to support revalidation and are working as intended;

- local processes for recommendations made by Responsible Officers to the GMC are robust.

On behalf of the Scottish Government, NHS Education for Scotland (NES) have now taken over from Healthcare Improvement Scotland (HIS) and are responsible for providing external quality assurance (EQA) of the revalidation process and for reporting on this. Following on from their work to assess Scotland's **readiness for revalidation,** they continue to monitor all healthcare organisations' progress towards meeting the agreed revalidation targets. This is a stepped process to allow organisations to:

- ensure they have the systems and processes in place to support revalidation,

and

- sufficient trained Appraisers.

The aim of the EQA exercise is to find out how much progress healthcare organisations have made in preparing for revalidation; to find out which areas are working well, and areas where further support may be required. This self-assessment is sent to all organisations (designated bodies) employing doctors in Scotland.

The data collected allows NES to compare information between and within healthcare sectors, and on a national basis. The report for 2017-2018 was published in November 2018. See Appendix 1.

In June 2014 NHS Fife's Medical Appraisal and Revalidation Group agreed to the use of an audit tool which is being used to quality check Secondary Care Appraiser's Form 4s. The audit is conducted annually. Results of the audit are discussed at MARG and shared with Appraisers. The Secondary Care Appraisal Lead, Mr Dunstan is available to give feedback to appraisers regarding their individual results in the audit.

11. REMEDIATION, REHABILITATION AND SUPPORT

The Responsible Officer is responsible for ensuring that appropriate action is taken where there are concerns about a doctor's fitness to practise. In these circumstances remedial and supportive action is taken quickly before problems begin to escalate. As indicated above, the identification of concerns and subsequent actions should not wait until the doctor is due to be revalidated. Medical Directors/Director of Public Health and Clinical Leads play a key role in this process.

Within Primary Care there is a local GP Support Group which is involved in managing GP underperformance.

In Secondary Care a Remediation policy/procedure was developed and approved in January 2016 which supports NHS Fife in how it deals with such matters. This policy was last reviewed October 2018.

NHS Fife deals with individuals on a case by case basis. NHS Fife also applies, as necessary, the relevant NHS Fife Human Resources policies on the Management of Employee Conduct and the Management of Capability. In addition, NHS Fife applies the extant relevant circulars for Medical and Dental staff as prescribed within the nationally agreed terms and conditions of service. Relevant support is also sought from NHS Fife's Staff Wellbeing & Safety Service and externally as required.

12. UPDATE ON APPRAISAL WITHIN PRIMARY AND SECONDARY CARE FOR PERIOD APRIL 2018– MARCH 2019.

See Appendix 2 – NES – Medical Revalidation Self Assessment 2019.

13. SUMMARY

The key issues for 2018/19 are as follows:

1. NHS Fife continues to respond well to the challenges of Medical Appraisal and Revalidation.
2. The GP Appraisal scheme in Fife continues to run well with little or no problems identified therefore no further action is required at this time.
3. The Appraisal process in Secondary Care continues to run well with few problems identified other than recruitment and retention of Appraisers.
4. MARG continues to be instrumental in overseeing the appraisal and revalidation processes and ensuring any issues/challenges that arise are resolved.

The key actions for 2018/19 are as follows:

1. Continue to maintain an up-to-date record of all Consultants, Career Grade Doctors and General Practitioners with whom NHS Fife has a “prescribed connection”.
2. Continue to advertise for doctors to become NES trained Appraisers to ensure that NHS Fife continues to have sufficient NES trained Appraisers to meet the number of Appraisees within NHS Fife.
3. Continue to encourage Consultants, Career Grade Doctors and General Practitioners to use the Scottish Online Appraisal Resource (SOAR) database.
4. Continue to provide appraisal and revalidation support to those doctors not employed or contracted to NHS Fife but who still have a a prescribed connection.
5. Share results of the audit of Form 4s with all appropriate parties in an effort to improve the quality of appraisal within NHS Fife.
6. Continue to provide training sessions for both Appraisers and Appraisees.
7. Action NES Feedback as appropriate.

Appendix 1

medical-revalidation-quality-assurance-rev

Appendix 2

02 MARQA Self Assessment Question

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	06 November 2019
TITLE OF REPORT:	Research & Development Annual Report 2018 - 2019
EXECUTIVE LEAD:	Dr Chris McKenna
REPORTING OFFICER:	Dr Chris McKenna

Purpose of the Report (delete as appropriate)		
		For Information

SBAR REPORT

Situation

This report describes activities within Research & Development (R&D) across NHS Fife, detailing progress made over the last 12 months in relation to ongoing work, previously identified challenges and identifying the key challenges currently facing R&D.
The attached report covers the period April 2018 to March 2019.

Background

The NHS Fife Research and Development (R&D) Department has seen 17 years of significant progress towards the integration of research into everyday practice and policy development by promoting the research agenda and the establishment of a research culture.

Assessment

R&D continues to use innovative models to increase research activities to support NHS Fife's overarching strategic aims of providing the highest quality care to, and improving the health of, the population of Fife. The ability to establish and support high quality research enables R&D to compete in the field of research alongside larger Health Boards.

Working closely with neighbouring Health Boards, Universities and other bodies either under the auspices of the East of Scotland Research Node and NHS Research Scotland Research Networks and in collaboration with our local university and medical school at the University of St Andrews has delivered many opportunities. Further increases in numbers of joint clinical academic appointments with the Universities of Dundee, St Andrews and Edinburgh has produced benefits in terms of delivering major research grants, mentoring of staff and contributing to an expanding NHS Fife research culture, within an established governance framework.

Increased utilisation of the Clinical Research Facility, with research including novel device studies, has benefitted Fife patients. The innovative R&D research nurse model, with research nurses located within the R&D Department, continues to deliver results with increasing numbers of researchers and the amounts of commercial and non commercial research being undertaken within NHS Fife.

Recommendation

- **For Information - the Board is asked to note this report**

Objectives: (must be completed)	
Healthcare Standard(s):	Supports all
HB Strategic Objectives:	Supports all

Further Information:	
Evidence Base:	Referenced within the document
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	NHS Fife R&D Operation Group NHS Fife Research Governance Group

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

Research & Development Annual Report

2018 - 2019

Greater knowledge,
Better services ...

Originator: Dr Amanda Wood
Version 1.0
June 2019
Review Date: May 2020

Executive Summary

The NHS Fife Research and Development (R&D) Department has seen 17 years of significant progress and is increasingly able to support high quality and more complex research related activties in Fife, working with partners in NHS Tayside and NHS Lothian. Throughout these years NHS Fife R&D has utilised new models to help sustain the increasing research activities in Fife. One such example is the R&D research nurse model where research nurses are located within the R&D Department, which has had praise and acclaim due to the efficient and effective results obtained in recruiting, establishing and communicating the research activities within various fields. Another example is the establishment of a Clinical Research Facility at the Victoria Hospital in Kirkcaldy enabling complex clinical trials to occur locally, again for the benefit of Fife patients. These and other examples are only possible due to the R&D department's ability to work with colleagues spanning the clinical and academic divide. The delivery business model around innovation and diversity in investment and activities allow this department to move forward with confidence.

R&D in Fife has utilised the principles of added value and critical mass to good effect. We look forward to the next year, keen to work even more closely with neighbouring Health Boards, Universities and other agencies either under the auspices of the East of Scotland Research Node, Academic Health Science Partnership or other similar national collaborations. We also look forward to continuing to synergise our research strategic priorites with those of our local university and medical school at the University of St Andrews. Our ambitious strategic portoflio will also allow us to work more closely with industry and other private companies to allow NHS Fife R&D to maximise its unique position and diversify on its potential to maximise income generation to NHS Fife, as the quality of research activities improves.

Many thanks are due to the whole R&D team for their consistent hard work and commitment towards the implementation of the R&D strategy. We also welcome Dr Frances Elliot who will be NHS Fife's interim R&D Director for the next 11 months and look forward to another exciting and productive year.

Prof Alex Baldacchino
R&D Director
NHS Fife

June 2019

CONTENTS **PAGE**

1.0 INTRODUCTION

This report details the activities within Research & Development (R&D) across NHS Fife from April 2018 to March 2019. It details progress made over the last 12 months in relation to ongoing work, previously identified challenges and identifies the key challenges currently facing R&D.

Continued significant developments within R&D include our relationships with the Universities of St Andrews and Dundee in relation to research activities. The joint clinical academic appointments with the Universities of Dundee and St Andrews have produced benefits in terms of major research grants and contribution to an expanding NHS Fife research culture. Work has advanced particularly well with the University of St Andrews, building on the experience of developing the teaching agenda, and creating further joint posts, with other universities and colleges.

2.0 RESEARCH ACTIVITY & INCOME

	2018-19	2017-18	2016-17	2015-16
R&D Approval – local reviews:	**73**	**88**	**83**	**91**
average no. of days to approve:	**4**	**5**	**5**	**6**
R&D Approval – amendments:	**209**	**242**	**215**	**166**
average no. of days to approve:	**2**	**3**	**6**	**6**
Total research studies:	**237**	**267**	**290**	**256**
Non commercially funded	**207**	**242**	**268**	**237**
- Unfunded/Non eligibly funded	**77**	74	104	81
- eligibly funded/adopted	**130**	168	164	156
Commercially funded	**30**	**25**	**22**	**19**
Total active researchers: Fife PIs	**243**	**261**	**268**	**232**
eligibly funded/adopted studies	**130**	**110**	**116**	**52**
Total active researchers: Fife CIs	**11**	**20**	**96**	**36**
eligibly funded/adopted studies	**2**	**6**	**5**	**7**
New Honorary research contracts	**0**	**0**	**11**	**11**
New Letters of Access	**74**	**65**	**54**	**48**
Recruitment to all studies	**2070**	**1773**	**2087**	**2093**
Recruitment				
eligibly funded/ adopted studies	**1127**	**1355**	**1549**	**1587**
non eligibly funded/ adopted studies	**854**	**142**	**316**	**476**
Commercial studies	**89**	**276**	**222**	**30**
Income – CSO Funding Allocation	**£881,000**	**£808,000**	**£673,000**	**£676,000**
Income - Commercial	**£111,412**	**£117,641**	**£56,277**	**£54,158**

PI - Principal Investigators **CI - Chief Investigators**

Studies were notably in the categories of: Cancer; Cardiovascular & Stroke. Renal, Musculoskeletal and Neuroprogressive Disease.

Research is categorised as *'commercial'* (funded by the pharmaceutical or medical device industry) or *'non-commercial'*. Non commercial research is further divided into "eligible" (funded by charitable organisations, research councils or Government bodies), or "non-eligible" (NEF - funded by a non-eligible organisation or is unfunded).

R&D funding is provided via NHS Research Scotland (NRS) by the Chief Scientist Office (CSO) in respect of research considered 'eligible' for funding, in recognition of the unfunded costs incurred by the NHS for undertaking and participating in such projects.

CSO funding remains the main source of income to support all non-commercial R&D activities across NHS Fife. It is used to provide and support the R&D infrastructure (Appendix 2), to maximise its activity and to ensure the required management, governance and support of research.

3.0 NHS FIFE RESEARCH STRATEGY & PRIORITIES

Approved by the Board, revised and reported against annually, the ambitious NHS Fife R&D strategy supports NHS Fife's overarching strategic aims to provide the highest quality care to, and improve the health of, the population of Fife in partnership with its staff, Community Health Partners and its citizens. It sets out how the development of R&D will support NHS Fife's overall strategic aims by:

- promoting a **culture** that supports and encourages research as part of routine practice;
- building on opportunities to work closely with **partners** to increase the volume and quality of research;
- promoting research within an appropriate **governance** framework;
- developing the research knowledge and skills of **staff**;
- working in **partnership** with the citizens of Fife;
- ensuring that appropriate financial support and resources are available.

A 13th comprehensive list of annual 'priorities' to be addressed during 2018-19 was produced from the updated R&D Strategy in May 2018. Priorities previously set for 2017-18 were reviewed and progress towards their achievement documented. Progress this year on each of the R&D Strategy's 'themes' is outlined below:

3.1 PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH

CSO R&D support funding has ensured continued progress in supporting research activities, and enabling the establishment / strengthening of links with local academic institutions. Within these finite resources work has continued in a progressive and proactive manner, ensuring research is increasingly accessible and meaningful, and is integrated into everyday practice and policy development.

The facilitation and support of research, driving the delivery of effective systems of research management and governance are key aims of the R&D Department. The NHS Fife Executive Lead for Research and Development and the Research

Director have enabled the organisation and the R&D team to continue to support the development and implementation of the R&D strategy and significantly raise the profile of R&D within and out with NHS Fife.

3.1.1 R&D Leads

Executive Lead for Research and Development

Identified in 2005, the NHS Fife Executive Lead for R&D has continued to represent the Department within the context of the NHS Fife Board and other Executive/Board Level Fife Partnerships.

Research & Development Director

The Research & Development Director is responsible for the strategic leadership, direction and implementation of the Fife R&D strategy with close liaison between the R&D team and the Fife NHS Executive / Board. Their core role is to ensure the research agenda is successful and sustainable. They deliver opportunities that involve universities, council and departments within the NHS, raising the profile of Fife R&D and position it as a leader in its field.

They have established several work streams with partners, currently working as part of the Tayside Academic Health Science Partnership, the East of Scotland Research Node and with the St Andrews University Medical School.

Assistant R&D Director

Promoting and facilitating the delivery of high quality R&D activity, they lead R&D support and activities, playing into Scottish Government's aim for Scotland to become a world class location for clinical research. They work with the R&D Director, to lead and promote 'research' and 'development' activities, coordinating ongoing development and implementation of NHS Fife's R&D Strategy, managing the budget, R&D Office and R&D team.

The role encompasses all aspects of commercial and non-commercial research and the exploitation of Intellectual Property within NHS Fife, for the benefits of improved patient care and income generation.

3.1.2 Researcher Support

NHS Fife R&D team provides support and consultancy advice on trial design, ethics applications, R&D approval, study feasibility, pharmacy, protocol design, participant recruitment strategies and use of health related data to identify and screen for potential participants. Individual posts within the team are described in Section 4.0.

3.1.3 Research & Development Department

R&D continues to provide well-used services for the development and education of Fife staff from its base at the Research and Development Department, opposite the Education Centre within Queen Margaret Hospital.

3.1.4 R&D Clinical Research Facilities (CRFs)

NHS Fife has further enhanced its reputation as a centre of excellence for clinical research via its facility at the Victoria Hospital, Kirkcaldy, enabling an R&D presence at both main hospital sites. The CRF has 4 consulting rooms, a meeting / monitoring room, a small laboratory and hot desks for researchers. This dedicated 104m^2 facility offers a unique research environment for a range of healthcare and life science related research activities with access to an under researched population and high quality R&D support infrastructure. Its close vicinity and working relationship with Victoria Hospital ensure access to all specialist departments and facilities.

The CRF provides a wide range of clinical research and health related services to commercial organisations and contract research firms seeking participation in multicentre and single site trial activities.

A fully equipped clinical room and sample preparation area is also available to researchers at Queen Margaret Hospital, providing an additional area where research participants can be seen and the rapid preparation of samples undertaken.

3.1.5 Clinical Academic Positions

There are currently 18 clinical academic positions supported by NHS Fife and designed to encourage research locally.

(i) Professor of Molecular Psychiatry (St Andrews)
(ii) Professor of Health Psychology (St Andrews)
(iii) Professor of Primary Care (Dundee)
(iv) Professor of Primary Care (St Andrews)
(v) Sir James Black Professor of Medicine (St Andrews)
(vi) John Reid Chair of Pathology (St Andrews)
(vii) Dean of Medicine (St Andrews)
(viii) Professor of Medicine (St Andrews)
(ix) Professor of Medicine, Psychiatry and Addiction (St Andrews)
(x) Professor of Neuroimaging (Dundee)
(xi) AXA Chair of Medical Informatics and Life Course Epidemiology, Public Health (Edinburgh)

Senior Lecturers in:

(xii) Senior Lecturer in Ophthalmology (St Andrews)
(xiii) Senior Lecturer in Infectious Diseases (St Andrews)
(xiv) Honorary Senior Lecturer in Chronic Pain (Dundee)

NRS Research Fellows in:

(xv) Cardiology
(xvi) Respiratory
(xvii) Palliative Care

Visiting Scholar in:
(xviii) Epidemiology

(i) Professor of Molecular Psychiatry (St Andrews)
– appointed 2009

Current research focus: The biological underpinnings of child psychiatric disorders, predominantly Attention Deficit Hyperactivity Disorder (ADHD).

(ii) Professor of Health Psychology (St Andrews)
– appointed 2002

Current research focus: *psychological aspects of cancer*

(iii) Co-Director of Population Health Sciences Division, and Professor of Primary Care Medicine (Dundee)
- appointed September 2007

Current research focus: Mixed quantitative and qualitative methods to understand and improve quality and safety of healthcare

(iv) Professor of Primary Care Medicine (St Andrews)
– appointed 2017

Current research focus: transforming delivery of healthcare in the community, working in multidisciplinary teams alongside Computer Science, Psychology, Demography and Health Geography, and Mathematics and Statistics, to bring cutting-edge analytical tools and methodologies to Health Data research, focusing on health service research and clinical trials.

(v) Sir James Black Professor of Medicine (St Andrews)
– appointed August 2010

Current research focus: *aspects of tuberculosis drug development including evaluation of new antituberculosis agents*.

Research grants obtained in 2018-19

Holistic **A**pproach **T**o **U**nravel **A**ntibacterial resistance in East Africa **(HATUA)** Medical Research Council, with Matt Holden Wilber Sabiiti, Derek Sloan, David Aanenson and East African Colleagues £3m Oct 2017-March 2018.

Evaluation of Molecular Bacterial Load Assay Life Arc £60,000 February -March 2018.

NHS Fife Endowment Funds SLIC Feasibility Study A study to evaluate the application of SLIC in a point of care £64775.00 April 2018-2019.

Royal Society Wolfson Laboratory Development Fund St Andrews Multi-disciplinary Anti-infective Research and Therapeutics Centre £165700 co-PI with Rebecca Goss.

SLIC Susceptibility £388,000 Development of a high growth spin out company to manufacture and market rapid phenotypic susceptibility testing methodology. Scottish Enterprise August 2017 December 2018.

National NHS-related appointments:
Specialty Group Clinical Lead for Infectious Diseases and Clinical Microbiology

(vi) <u>John Reid Chair of Pathology (St Andrews)</u>
– appointed 2012

Current research focus: *understanding how cells and tissue respond to injury.*

(vii) <u>Dean of Medicine (St Andrews)</u>
– appointed July 2014

Current research focus: *Interventional cardiology and heart disease in pregnancy.*

National NHS-related appointments:
Chair of the MRC/NIHR joint Efficacy Mechanism and Evaluation Board

Chief Scientist for Health

(viii) <u>Professor of Medicine (St Andrews)</u>
– appointed 2015

Current research focus: Neurodegenerative diseases

(ix) <u>Professor of Medicine, Psychiatry and Addiction (St Andrews)</u>
- appointed May 2015

Current research focus: *comorbid conditions from chronic abuse of opioids & alcohol, utilising informatics systems, clinical outcomes, neuropsychology and neuroimaging.*

National NHS-related appointments:
President Elect of International Society of Addiction Medicine (ISAM)
Chair of ISAM Education and Training Committee.
Founding member of European Network for Training, Education and Research (ENTER) - Mental Health
Scottish Government Drug Death Research Champion
NHS Fife Research and Development (R&D) Director

(x) <u>Professor of Neuroimaging (Dundee)</u>
- appointed May 2009

(xi) <u>AXA Chair of Medical Informatics and Life Course Epidemiology</u>

(Edinburgh)

- *appointed April 2016*

Current research focus:

Large scale population based approach to further understanding of the pathogenesis and prevention of diabetes complications via the increasing availability of e-health record data (EHR) and new technologies for acquiring high dimensional molecular 'omics data.

(xii) Senior Lecturer in Ophthalmology (St Andrews)

- appointed August 2016

Current research focus: *Development, evaluation and implementation of diagnostic tools for users in low & middle income countries.*

National NHS-related appointments:
Lead Ophthalmologist - National Managed Clinical Network for Children with Visual Impairment.

(xiii) Senior Lecturer in Infectious Diseases (St Andrews)

- appointed January 2016

Current research focus: Clinical Infectious Diseases – especially therapeutics for tuberculosis and the management of communicable disease outbreaks worldwide.

National NHS-related appointments:
Consultant Physician in Infectious Diseases and General (Internal) Medicine, NHS Fife

(xiv) Senior Lecturer in Chronic pain (Dundee)

Current research focus: Pain, Global health, Policy, Prescribing

Chronic Pain, Development of Quality Performance Indicators, Investigation of Non-medical prescribing impact, Opioid prescribing

(xv) NRS Fellow in Respiratory (St Andrews)

Current research focus: *burden of Idiopathic Pulmonary Fibrosis (IPF) – multi-modal study of the prevalence of IPF.*

(xvi) NRS Fellow in Cardiology (Fife)

Current research focus: *Optimising care pathways for patients with suspected acute coronary syndromes.*

National NHS-related appointments:
Trustee of Scottish Heart and Arterial Risk Prevention

Member of the SIGN development group for writing the national guidelines for stable angina.

Visiting Scholar in Epidemiology (St Andrews)

Current research focus: *Bacterial infections and intervention measures in illicit substance injectors. Antimicrobial resistance and capacity building in developing countries.*

Research grants applied for by Clinical Academics in collaboration with NHS Fife staff are detailed in **Appendix 3**.

Research grants obtained by Clinical Academics in collaboration with NHS Fife staff are listed in **Appendix 4**.

3.2 WORKING WITH PARTNERS

The establishment and consolidation of links with research active partner organisations are key to increasing both the quality and quantity of the research undertaken. Such activities also promote and increase opportunities for Fife-based clinicians and other staff to become Chief and Principal Investigators. Key partners with whom NHS Fife has been working to develop research across the region are detailed below:

3.2.1 Disease Specific Research Networks

The R&D Director and Assistant R&D Director have continued to work with the Scottish Research Networks, and Specialty Groups. These have been ably assisted by the national and international recruitment successes of Fife R&D research nurses, supporting clinicians to participate in large, multi-centre clinical trials. Due to ongoing notable successes in numbers of trials opened and patient recruitment, the *Scottish Cancer Research Network, South East Scotland Stroke Research Network, and Scottish Diabetes Research Network* have continued to fund R&D based research nurse positions.

3.2.2 Specialty Group Leads

During 2018-19 two Fife staff continued as appointed leads for the NRS Clinical Research Specialty Groups for Ophthalmology and for Infectious Diseases, supported by members of the R&D Team. Study progress within each of the portfolios for studies led from Scotland and England have been regularly reviewed with the respective Leads, identifying barriers to recruitment, and providing strategies to help overcome them. Assistance has also been provided to help design and deliver national specialty study days and the establishment of a bursary scheme for junior doctors.

3.2.3 NHS Research Scotland Fellowships

Ongoing support has been provided to 3 NHS Fife early stage researchers who

have been awarded these prestigious 3 year CSO Fellowships. These NHS Fife clinicians have backgrounds in Infectious Diseases/Respiratory, Cardiology medicine and Palliative Care.

3.2.4 Research Thematic Groups

Research 'Thematic' groups, based on current areas of research strength within NHS Fife, represent identified priority areas towards which R&D support is targeted. This identification of thematic priorities enables traditional 'boundaries' (Acute/Primary Care/Public Health) to be overcome, enabling and encouraging the involvement of Fife academic partners.

From thematic priority areas identified in November 2005 the following 6 Thematic Research Groups (Learning Disabilities; Children & Young People's Wellbeing; Women and Children's Health; Arthritis and Rheumatology; Occupational Therapy; and the Children and Adolescent Mental Health Services Research Groups), established between 2006 and 2017 have been supported by R&D.

3.2.5 Academic Links

The R&D Executive Lead, Director of Nursing and the R&D Director have continued to establish contacts at a senior level with both St Andrews and Dundee Medical Schools around the development of clinical academic posts.

The formal agreement established between the Medical School in St Andrews University and NHS Fife to create a joint research strategy is consolidated via a Memorandum of Understanding to further strengthen the organisations' commitment to deliver research excellence in Fife.

3.2.6 Targets identified in the NHS Fife R&D Strategy (17-18)

WORKING WITH PARTNERS	**Outcomes**
Increase the number of staff actively involved in Research and Development activity by 10% per year	247 (12 - 13) 256 (13 - 14) 238 (14 - 15) 232 (15 - 16) 268 (16 - 17) 261 (17 - 18) 254 in 2018-19 = - 3.00%
Increase the number of projects, including eligibly funded projects as defined by the CSO, within NHS Fife by 10% per year	234 (12 – 13) 261 (13 – 14) 278 (14 – 15) 256 (15 – 16) 290 (16 – 17) 267 (17 - 18) 237 in 2018-19 = - 11%
Increase the number of publications by NHS Fife Staff in peer reviewed journals by 10% per year *(to date publication numbers have included those of NHS*	80 publications (12 – 13) 49 publications (13 – 14) 130 publications (14 – 15) NHS Fife staff = 34

*staff and clinical academics. Clinical academic publications are indicated by ***** in Appendix 5)*	*Clinical academics = 96 79 publications (15 – 16) NHS Fife staff = 38 *Clinical academics = 41 92 publications (16 – 17) NHS Fife staff = 20 *Clinical academics = 72 109 publications (17 – 18) NHS Fife staff = 26 *Clinical academics = 83 to total of 103 in (18 – 19) NHS Fife staff = 31 *Clinical academics = 72

3.3 PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK

To ensure the quality of research is maintained and continuously improved and high standards of patient care are achieved, research undertaken in NHS Fife must be carried out according to the standards set out in the UK Policy Framework for Health and Social Care Research (2017).

Already robust Research Governance procedures continue to be reviewed and developed to ensure that the R&D governance systems and processes remain fit for purpose.

3.3.1 Research Governance

Research involves an element of risk in both financial and human terms and as such proper governance arrangements must be in place to ensure that the public can have confidence in, and benefit from, quality research. The public has a right to expect high scientific, ethical, and financial standards, transparent decision-making processes, clear allocation of responsibilities and robust monitoring arrangements. The Research Governance Framework (RGF) sets out the underlying principles applicable to all research concerned with the protection and promotion of public health.

The NHS Fife Research Governance group established in 2003, continues to provide advice, support and governance to the R&D Department. It provides regular review and monitoring of the R&D Strategy, ensuring it is delivered within an appropriate governance framework, supporting the delivery of NHS Fife's objectives.

The group's Terms of Reference were again reviewed during 18-19 to ensure its membership and activities remained relevant and responsive to the organisation's developing R&D needs. Chaired by the Executive Lead for R&D, the Research Governance Group meets quarterly, and has a membership drawn

from Directors and Heads of key Departments across the organisation, R&D staff, the Public, Research Ethics and neighbouring academic and NHS institutions.

Oversight of the group's minutes, Summary Report, Annual Report, R&D Strategy and achievement against strategic priorities by the NHS Fife Clinical Governance Committee provides assurance to the Board that all research conducted within Fife is of the highest standard and fully compliant with all relevant guidance and legislation.

3.3.2 Research Study Approval

The Research Coordinator provides a robust single point entry system to ensure the appropriate receipt and consistency of requests for management approvals and that all required documentation is in place prior to Medical Director Approval. Research must have a favourable ethical opinion (where appropriate) and NHS Fife Management Approval before commencing. Once approved, studies are recorded on the national R&D database (SReDA) Scottish Research Database Application. Research lacking appropriate approval and not on the Research Register is not subject to the legal cover afforded by the NHS Fife Indemnity scheme. Annual monitoring of staff, targeted at grades most likely to engage in research, assist in the identification of any unapproved studies.

3.3.3 Monitoring

Projects Sponsored by NHS Fife are subject to monitoring of both the study and research team by the R&D Trials Facilitator in order to identify any areas of concern with their ongoing research. The main issue highlighted was the requirement for improved document control. As a result, the R&D Trials Facilitator is now meeting all CIs at study set up to discuss required documentation and the required processes and SOPs relating to this.

3.3.4 Financial Probity

The R&D Business Accountant has continued to provide support, providing appropriate financial management and guidance on the accurate costing of research and cost recovery. Regular reports are received and figures for completion of the Annual report and quarterly reports on expenditure to the CSO are provided. They monitor, invoice and disseminate funds received into research trial accounts in payment for researcher participation in pharmaceutical sponsored trials. Costings are also checked for all hosted, PI studies and for 10 Fife-led CI grant applications.

3.3.5 Intellectual Property (IP)

An Intellectual Property policy allows for the protection and exploitation of activities generating IP by staff across the organisation. Increased commercialisation activity resulting from the exploitation of IP increases the financial and healthcare benefits for NHS Fife.

The emergency caesarean simulator, invented by a Fife Consultant in Obstetrics and Gynaecology, was jointly developed with experts from Guy's and St Thomas' NHS Foundation Trust. 'Desperate Deborah' allows doctors to experience and practice dealing with life threatening scenarios that can arise during emergency

caesareans which affect around 20,000 births per year in the UK. The simulator continues to be marketed and has sold worldwide generating income to NHS Fife of £706 this year.

Eight new IP disclosures were made this year. An ongoing awareness raising programme during 2018-19 with Scottish Health Innovations Limited (SHIL) helped ensure staff remain aware of the importance of protecting IP for the NHS.

3.3.6 Review of R&D policies/documents

The R&D Research Strategy was updated in August 2010 to include annual 'priorities' designed to ensure achievement of Strategy targets. These priorities are reviewed annually, and outcomes against them reported to the Fife Research Governance Group. Revised priorities for 2018-19 were included in the updated 2018-19 R&D Research Strategy.

3.3.7 Ethical Review - Site Specific Assessments

Site Specific Assessment (SSA), the process by which the suitability of local researchers and facilities is determined, has continued to be undertaken and coordinated within R&D. Of in-depth SSAs which would previously have been undertaken by the REC, 10 Site Specific Information forms (SSIs) requiring SSAs were carried out during 2018-19.

3.3.8 Targets identified in the NHS Fife R&D Strategy (18-19)

PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK	**Outcomes**
Provide R&D support for every research project registered in NHS Fife	Continues to be achieved
Provide assurance to NHS Fife Board that all research activity meets the requirements of the Research Governance Framework	Continues to be achieved
Increase commercialisation activity resulting from the identification and protection of intellectual property thereby increasing the financial and healthcare benefits for NHS Fife	Projects with potential IP identified: 1 in 13 – 14 1 in 14 – 15 3 in 15 – 16 6 in 16 – 17 4 in 17 – 18 8 in 18 – 19
Ensure that 10% of all 'high risk' NHS Fife Sponsored projects are audited	Continues to be achieved (100% of Fife Sponsored studies audited)
Provide accurate quarterly/6monthly updates and Annual Reports on financial expenditure to the CSO	Continues to be achieved (100% delivered)
Provide financial information for the R&D Activity & Expenditure report	Continues to be achieved
Identify the actual cost of research undertaken in NHS Fife and maximise our returns from commercial	Continues to be achieved

research	

3.4 WORKING IN PARTNERSHIP WITH STAFF

Within Fife, research is undertaken by and with staff for the benefit of patients. It is essential to work with staff to promote the benefits of research activity for individual staff members as part of their commitment to personal and professional development.

Research activity depends on staff having appropriate skills. Local access to regular research education and workshops is available to all NHS Fife staff and open to staff outside NHS Fife.

3.4.1 Research Education Programme

A high quality, multidisciplinary programme addressing the education requirements identified by NHS Fife staff was provided by specialist trainers and the R&D team. Education was offered/provided in 28 full or ½ day sessions including 19 workshop topics offered as part of the scheduled R&D Education programme.

R&D workshops provided / attendance:

Title:	Attendees:				Duration:
Statistics for the Terrified	6	-			½ day
Good Clinical Practice	8	11	9	6	full day
Half Day GCP Update	5	7	4	-	½ day
Selecting a Sample and Calculating Statistical Power	-				½ day
Systematic Reviews	8	-			½ day
Critical Appraisal	7				½ day
Preparing a Scientific Poster	14	5	4		½ day
Developing your Research Question & Proposal	4				½ day
Making Sense of Numbers	3	-			½ day
Writing a Research Grant Application	-				½ day
Writing an Abstract	3				½ day
An Introduction to Research	4				½ day
Writing Up & Getting Your Work Published	3				½ day
Achieving Success with your Dissertation	2				½ day
An Introduction to Research Methods & Design	5				½ day
Using Survey Methods For Research	2				½ day
How to Interview Participants & Run Focus Groups	-				Full day
Innovation & Intellectual Property	1				½ day
Thematic Analysis	-				½ day

- offered but cancelled due to limited bookings

Free courses were open to staff from outside Fife and advertised on the Clinical Research Training for Scotland website:
http://www.crts.org.uk/national/Courses.aspx

The number of participants attending courses was 123 (113 NHS Fife staff and 10 from outside the organisation). This was significantly down on previous years when sessions on statistics had been provided to over 100 people at the Wellcome Trust Clinical Research Facility (WTCRF) in Edinburgh.

Ad hoc sessions are offered for departments at their request to tie in with pre-existing study days, minimising disruption to clinical commitments for staff that would otherwise have had to request time off to attend.

Two of the team retained their accredited GCP (Good Clinical Practice) trainer status, enabling them to deliver GCP training across NHSScotland. R&D staff also taught undergraduate medical students at the University of St Andrews.

Evaluations of the training provided are available in Appendix 2.

3.4.2 Targets identified within NHS Fife R&D Strategy (17- 18)

WORKING IN PARTNERSHIP WITH STAFF	**Outcomes**
Increasing the number of staff actively involved in research and development activity	See 3.2.6 above
Deliver a research education and development programme aimed at increasing the capability of staff to undertake research	Continues to be achieved
Increase the number of staff participating in the research training programme	Places booked: 153 (12 – 13) - 40% 256 (13 – 14) + 67% 353 (14 - 15) + 38% 296 (15 – 16) - 16% 168 (16 - 17) - 43% 154 (17-18) - 8% 123 (18 -19) - 20%
Support staff registered for higher degrees	Continues to be achieved

3.5 PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH

Ensuring the involvement of consumers in both the development and execution of research projects should be key for every NHS organisation. Findings over the decade have shown a marked increase in the success of research which has involved service users in its design and implementation.

Our Public Involvement representative with a special interest in research is a member of the joint University of St Andrews and NHS Fife Community Research Advisory Group. She has been an active member of the NHS Fife Research Governance Group in her role as Lay Advisor. The Research Community Advisory Group assist in providing lay view /input into the development of

research proposals and ongoing research, and help raise awareness and understanding of research being undertaken locally.

The Fife and Forth Valley Research Ethics Committee also continues to have a strong lay representation.

3.5.1 Targets identified in the NHS Fife R&D Strategy (17 -18)

PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH	Outcomes
Ensure that there is patient and public representation on relevant R&D groups	Achieved
Involve patients and the public in the development of patient information relating to research projects	Ongoing

3.6 COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE

Two-way communication of Research information across NHS Fife has presented challenges due to the dispersed nature of the organisation. To help facilitate communication, key research information is available via a dedicated NHS Fife R&D webpage.

3.6.1 Internal Communications

Updates on the research training programme, R&D support and details of the research conferences are circulated regularly. Monthly electronic research 'bulletins' are sent to all research active staff (past and present), providing up to date information about advice clinics, seminars, workshops and recently issued commissioned bids / grants - within and out with NHS Fife.

Details of events and training opportunities have been regularly included in the electronic organisation-wide 'Dispatches'. To reach staff that do not have access to email, details of the R&D Department, its staff and the support offered have been placed on notice boards across the organisation.

3.6.2 External Communications

Work has been completed on a fully functioning R&D website www.nhsfife.org/research with a dedicated Clinical Research Facility page. Further development of R&D communications is being progressed via a regular R&D newsletter which will be circulated widely and made available via the R&D website.

A generic R&D email address has been created to maximise the efficiency of responses to queries to the department: fife-uhb.randd@nhs.net

The NHS Fife Research & Development Twitter account @NHSFifeResearch has been in operation since January 2018. Regular tweets have been well received with an increasing number of followers raising the Department's profile. R&D Facebook and LinkedIn accounts are being investigated.

3.6.2 Targets Identified in the NHS Fife R&D Strategy (17 -18)

COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE	**Outcomes**
In advance of a fully operational NHS Fife intranet, research information will be provided as a monthly electronic bulletin	Continues to be achieved

4.0 RESEARCH & DEVELOPMENT SUPPORT FOR RESEARCH

R&D staff support and manage research to ensure its quality, compliance with legislation and guidance, and good governance, with the ultimate aim of improving patient care. They advise on and manage the R&D process registering, administering and monitoring all research; providing help and support to researchers; coordinating and facilitating research; identifying and addressing research training and education needs; negotiating optimal terms with study sponsors and funders to ensure full cost recovery; identifying, protecting and exploiting intellectual property.

The R&D Department also coordinates the preparation and submission of the NHS Fife Research Strategy, NHS Fife's Annual R&D report, reports on Research Activity and Expenditure to the Scottish Government (which determine the financial support received) and Research Governance Compliance reports.

The R&D Department accommodates the: NHS Fife R&D Director, Assistant R&D Director, R&D Commercial Manager, Senior Research Advisor, Research Coordinator, R&D Trials Facilitator, Lead R&D Research nurse, Generic and Network-specific R&D Research Nurses, the R&D Business Accountant and R&D Support Officer.

R&D Commercial Research Manager

The Commercial Research Manager is tasked with establishing a portfolio of commercial research, maximising opportunities for NHS Fife's involvement, and also supporting utilisation of the new Clinical Research Facility.

An NHS Fife-wide awareness raising program about R&D activity and the support available to staff wishing to undertake research was undertaken during 18-19 and is planned for the coming year. Contact with all national and local Pharmaceutical, Medical and Device companies has alerted them to NHS Fife R&D and the resources available. Increased commercial activity has resulted along with increased submission of study feasibilities to R&D - often requiring a rapid response (within 12hrs to 1 week).

Senior Research Advisor

A source of expert advice, this post provides guidance and support on all aspects of NHS research including protocol development, grant applications, statistical advice, data analysis, interpretation and dissemination.

Dr Crawford designs and delivers the majority of the R&D Education Programme, with topics offered in *ad hoc* sessions to individual departments if requested.

One-to one support is provided to staff during Research & Statistics Advice Clinics, providing practical help with research design, data analysis and the preparation of papers and dissertations.

During 2018-2019 66 advice sessions were delivered 1:1 to 47 staff (compared with 100 sessions to 74 staff in 18-19). Advice sought continued to relate to study design (36%), statistics (4%), approvals – R&D, ethics, IRAS (11%), grant applications (25%), degree projects 6%), general support (17%) and writing up (1%).

Senior Research Advisor

A source of expert advice, this post provides guidance and support on all aspects of NHS research including assisting protocol development, grant applications, statistical advice, data analysis, interpretation and dissemination.

The Senior Research Advisor organises and delivers a majority of the R&D Education Programme, with topics offered in *ad hoc* sessions to individual departments if requested. One-to one support is provided to staff via the monthly Research & Statistics Advice Clinics, providing practical help with data analysis and preparation of papers and dissertations.

During 2018-2019 66 advice sessions were delivered 1:1 to 47 staff (compared with 100 sessions to 74 staff in 17-18). Advice sought continued to relate to study design (36%), statistics (4%), approvals – R&D, ethics, IRAS (11%), grant applications (25%), degree projects 6%), general support (17%) and writing up (1%).

Research Coordinator

Responsible for managing research approvals, liaising with the national permissions coordinating centre, projects review and registration the Research Coordinator provides a knowledgeable approvals advice service. Coordinating the approval of studies and amendments they record studies and generate reports of research activity. They assist with costing studies and grants, liaising with other NHS organisations/HR Depts/Universities for the issue of Honorary Research Contracts and Letters of Access.

Some 73 projects were approved during 2018-19, along with approval for 209 amendments to ongoing studies. Average local approval time for studies is 4 days, remaining significantly below the national target of 15 days. Ninety six percent of local reviews were completed within the nationally specified timeline which compares favourably with the other research Nodes (groupings of health boards into 4 groups for the purposes of research collaboration).

R&D Trials Facilitator

The Trials Facilitator attends pre-study/initiation visits, liaising with the R&D team, Sponsors and Support Departments to facilitate prompt study set-up and commencement of recruitment. Working closely with the R&D research nurses they assist with data collection, query resolution and provision of reports relating to the research data. They collate recruitment data for review against targets, updating figures for reporting. They continue to review and develop a suite of

R&D Standard Operating Procedures and Working Instructions and lead on monitoring 100% of NHS Fife Sponsored studies.

R&D Research Nurses

R&D continues to 'house' generic, network-specific and other study specific funded research nurses within the department. This provides a base for their development, education and support, enabling them to support and advise NHS Fife staff.

Our research nurses help prepare ethics and management approval documentation, provide clinical/administration time to facilitate recruitment, consent research participants and maintain case report forms. They communicate/link with trial co-ordinators and busy clinicians who would otherwise be unable to participate. Generic research nurses continue to focus on increasing the number of 'eligibly funded' research studies undertaken within NHS Fife, this year working on 68 multi-centre trials, (44 actively recruiting and 24 in follow-up).

The Lead R&D Research Nurse provides expert professional and clinical leadership to the expanding research nurse team, responsible for their professional supervision and management. Alongside ongoing duties as a clinical research nurse supporting their own portfolio of studies, they liaise with national Topic Specific Research Networks, local service managers and academic colleagues.

R&D Support Officer

The R&D Support Officer provides a central contact point for researchers, directing them to the most appropriate source of assistance. They promote and coordinate bookings for the Research Education Programme, assisting with management of the R&D website and compile and circulate research related information across the organisation.

They provide extensive administrative support to the Assistant R&D Director and other members of the R&D team, administering room and CRF bookings. They also coordinate arrangements for R&D events.

R&D Business Accountant

The R&D Business Accountant maintains a strong financial management and reporting service underpinned by effective financial controls to ensure compliance with statutory, regulatory and local requirements in setting up, management and closing down of R&D projects. They manage the portfolio of research accounts, invoicing as required. This part-time post supports the Assistant R&D Director, R&D team and researchers costing research, assisting with all financial enquiries, grant applications, reporting and analyses.

5.0 RESEARCH PUBLICATIONS

A number of NHS Fife researchers had research papers published in peer reviewed and professional health-related journals during 2018-19 (Appendix 5). Research presentations and posters presented at conferences are also detailed. In total there were 103 peer reviewed publications in 2018-19, 72 of these (those

marked *) attributed to NHS Fife clinical academics with the remaining 31 produced by NHS Fife staff.

6.0 UPDATE ON CHALLENGES IDENTIFIED IN THE 2017-18 RESEARCH & DEVELOPMENT ANNUAL REPORT FOR 18-19

In order to ensure the successful implementation of the NHS Fife Research Strategy a series of annual 'priorities' have been selected from it, to be progressed. An update on identified priorities / challenges to be taken forward within Research & Development in 2018 -19 were as follows:

a. We have continued with the long process of encouraging discussion of research as part of Personal Development Plans within the operational division and CHPs during appraisals of health care staff and this is now part of the e job planning framework

b. R&D participation in the development of the medical and nursing clinical academic career development in Fife has been continued.

c. Preparations for an inspection by the Medicines and Healthcare products Regulatory Agency have continued.

d. Although details of research-related academic degree programmes and bursaries, encouraging staff to apply, have been circulated there were fewer Fife applicants for NRS Research Fellowships.

e. Liaising closely with universities and other academic institutions to establish research programmes by identifying opportunities via NHS Fife endowment funds.

f. We have continued to support and participate in the NHS Research Scotland (NRS) East Node, establishing joint documentation and actively participating in membership of groups and committees.

g. We have continued to support the Health Informatics Centre (HIC), consolidating and adding to the joint Tayside and Fife HIC Database to facilitate service based evaluations/research.

h. The infrastructure and processes required for NHS Fife to act as Sponsor for increasingly complex studies is being delivered.

i. Greater activity and collaboration with academics, pharmaceutical and medical device companies are resulting in increased utilisation of the Clinical Research Facility.

7.0 CHALLENGES FOR RESEARCH & DEVELOPMENT IN 2019-20

During 2018-19 the research culture within NHS Fife was maintained recent advances, delivering: consistent levels of research activity and research active staff; increased number of publications by NHS Fife staff; increased numbers of clinical academics; compliance with research governance

framework, monitoring 100% of Fife Sponsored studies; and the delivery of a comprehensive R&D Education Programme.

The following challenges have been amalgamated from unmet objectives from the 2018-19 R&D Strategy Key Performance Indicators (KPIs), and the NRS objectives & associated performance metrics to be delivered during 2018-19:

Unmet KPIs (R&D Strategy 2018-19):

- Increase the number of staff actively involved in research
- Increase the number of projects
- Increase the number of publications
- Increase the number of staff participating in the research training programme.

R&D Strategy priorities (2018-19):

All activities detailed in prioritised plan of in the R&D Strategy 2018-19 are ongoing or have been achieved.

8.0 CONCLUSIONS

Significant progress continues to be made implementing many aspects of the Research & Development Strategy, promoting the research agenda, developing a research culture and raising the profile of R&D, whilst continuing to build strong alliances with colleagues with the wider research communities. The NHS Fife Executive Lead for R&D, R&D Director and Assistant R&D Director have ensured a significant raising of the profile of NHS Fife R&D and the promotion of Fife as an important, emerging player in the current, and future Scottish research agenda.

DR AMANDA WOOD
Assistant R&D Director

PROFESSOR ALEX BALDACCHINO
R&D Director

With grateful thanks to **ROY HALLIDAY,** R&D Support Officer for input into this report.

July 2019

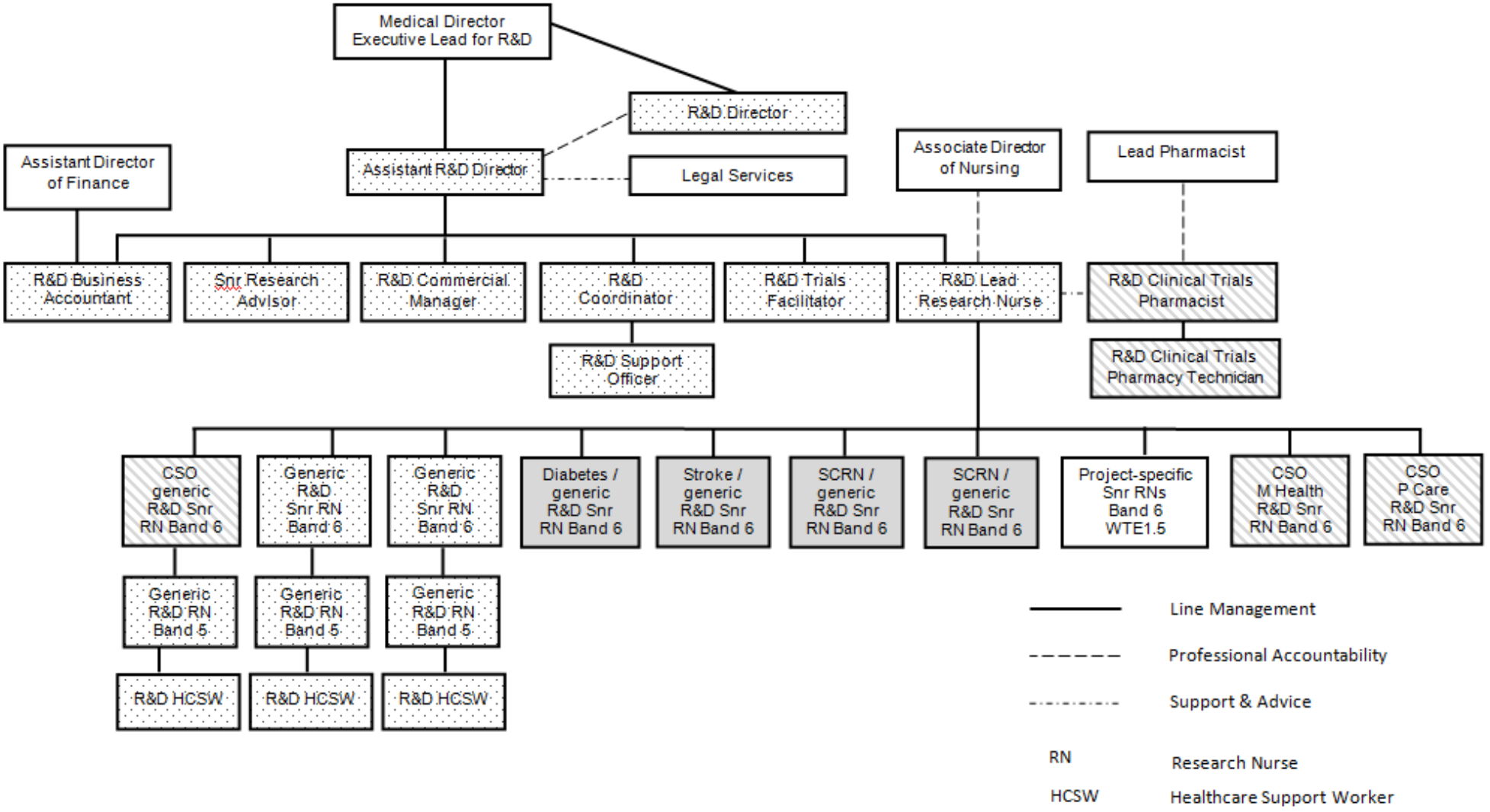
9.0 RECOMMENDATION

The Clinical Governance Committee is asked to:

- Note the contents of this paper.

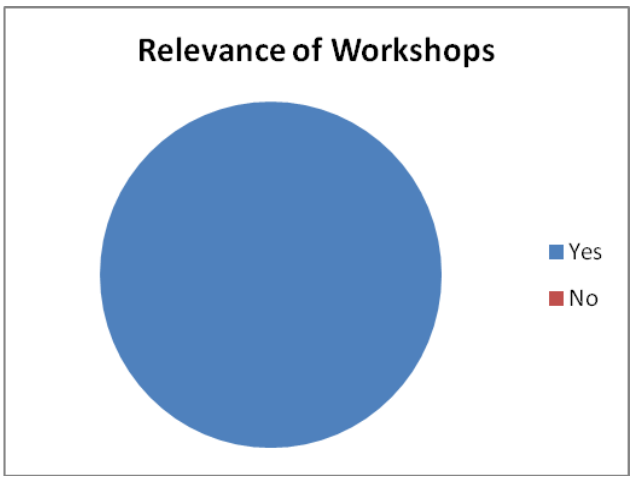
APPENDIX 1

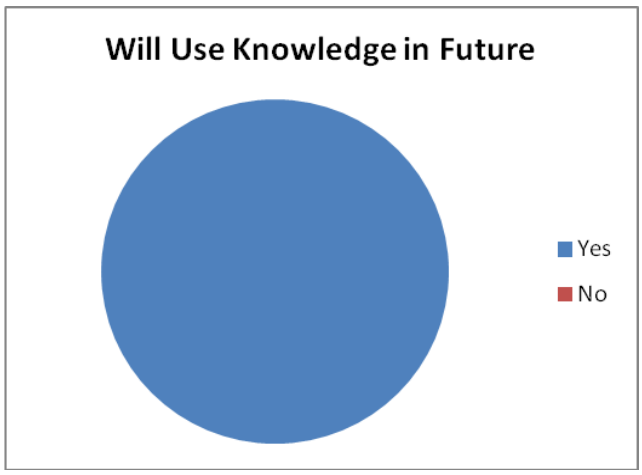
NHS FIFE RESEARCH & DEVELOPMENT SUPPORT STRUCTURE 2018-19

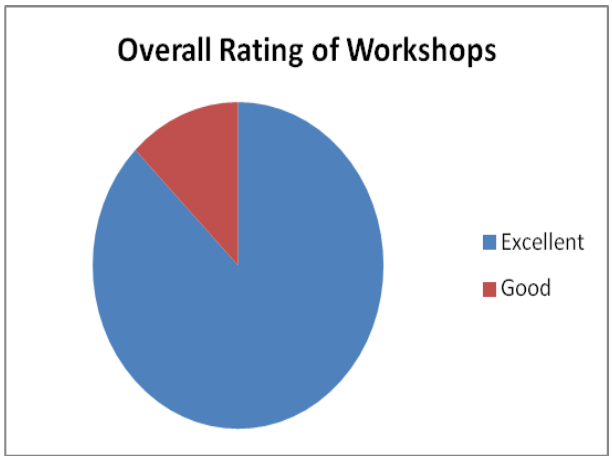


APPENDIX 2

EVALUATIONS OF R&D EDUCATION TRAINING PROGRAMME 2018-19






Overall Rating of Workshops
Excellent
Good

APPENDIX 3

RESEARCH GRANTS APPLIED FOR BY CLINICAL ACADEMICS IN COLLABORATION WITH NHS FIFE STAFF DURING 2018 - 19

Honorary Senior Lecturer in Chronic Pain (Dundee)

MRC Grant (submitted)
CSO Grant (submitted)
NHS Fife Bursary Grant (successful)
University of Dundee Global Challenges Grant (successful)

Visiting Scholar in Epidemiology (St Andrews)

Global Challenges Research Fund/Scottish Funding Council
Fleming Fund – Commonwealth Partnerships for Antimicrobial Stewardship

APPENDIX 4

RESEARCH GRANTS OBTAINED BY CLINICAL ACADEMICS DURING 2018 - 19

Honorary Senior Lecturer in Chronic Pain (Dundee)

The Global Challenge to Manage Persistent Pain. University of Dundee Global Challenges Research Fund (GCRF), £3,650, 01.05.19 – 31.07.19

Development of a Validation Protocol for a Case Identification Algorithm for Chronic Pain in Primary Care. NHS Bursary Grant, £13,648, 01.08.18 – 31.07.19

Improving chronic pain services across Scotland, Scottish Government (Healthcare Quality and Strategy Directorate), £87,500, 01.09.18 – 31.08.19

Visiting Scholar in Epidemiology (St Andrews)

Global Challenges Research Fund/Scottish Funding Council

APPENDIX 5

NHS FIFE RESEARCH PUBLICATIONS, PRESENTATIONS AND POSTERS DURING 2018-19

Publications

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NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	06 November 2019
TITLE OF REPORT:	Research & Development Strategy 2019-20 (including Outcomes vs Strategic Priorities 2018-19)
EXECUTIVE LEAD:	Dr Chris McKenna
REPORTING OFFICER:	Dr Chris McKenna

Purpose of the Report (delete as appropriate)		
		For Information

SBAR REPORT

Situation

The attached R&D Strategy has been reviewed and updated to cover the period April 2019 to March 2020. A number of strategic priorities, identified for 2018-19, are included annually to ensure delivery of the strategy. Also attached are the reported outcomes versus last years strategic R&D priorities.

Background

Scottish Government is committed to increasing the level of high quality research conducted in Scotland for the health and financial benefits of our population, so Scotland is recognised globally as a leader in health science (Delivering Innovation through Research, 2015). The Chief Scientist Office has highlighted the need for the NHS to be an innovative and research active environment, to ensure that good ideas are translated into wider practice and that ideas with commercial potential are identified and promoted.

The R&D Strategy aims to support these goals across the following domains: promoting a culture that supports and encourages research as part of routine practice; working closely with academic and community planning partners to increase volume / quality of research; ensuring research is appropriately governed; developing research knowledge and skills of staff; and working in partnership to ensure research is patient-centred.

Assessment

The R&D strategy continues to support NHS Fife's overall strategic aim to provide the highest quality care to, and improve the health of, the population of Fife, within the resources available and in partnership with its staff, community planning partner organisations and the citizens of Fife.

As a result of utilising dedicated R&D support funding considerable progress has been made in NHS Fife, encouraging, developing and supporting research activities. Work continues to be taken forward within existing resources, to make research meaningful and increasingly accessible and to ensure its integration into everyday practice and policy development.

The R&D Strategy first received Board approval in November 2005. Its structure and composition have remained relatively constant, with initially identified overarching domains for development being retaining due to their ongoing relevance. Whilst annual iterations of the R&D

Strategy and its associated strategic priorities have been presented to the Clinical Governance Committee, the strategy has not been re-reviewed by the Board since 2005.
Recommendation • **The strategy is presented to the committee for approval and request it is submitted to the Board of NHS Fife to approve the update.**

Objectives: (must be completed)	
Healthcare Standard(s):	Supports all
HB Strategic Objectives:	Supports all

Further Information:	
Evidence Base:	Referenced within the document
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	NHS Fife R&D Operation Group NHS Fife Research Governance Group

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be

	found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

RESEARCH & DEVELOPMENT STRATEGY 2019-20

Greater knowledge
Better services …

Last review date: June 2019

Next Formal Review: May 2020

Implementation Date: September 2019

Authors: Prof A Baldacchino Research & Development Director, NHS Fife

Dr A Wood, Assistant R&D Director, NHS Fife

Approval Record	Date
NHS Fife Research Governance Group	12th September 2019
NHS Fife Clinical Governance Committee	06th November 2019
NHS Fife Board	29th November 2005

1. INTRODUCTION

1.1 NHS Research Scotland (NRS) via the Chief Scientist Office (CSO) has highlighted the need for the NHS to be an innovative and research-active environment, to ensure that good ideas are translated into wider practice and that ideas with commercial potential are identified and promoted.

1.2 The Scottish Government Health Department (SGHD) is committed to increasing the level of high quality research conducted in Scotland for the health and financial benefits of our population, so we are recognised globally as a leader in health science (Delivering Innovation through Research – Scottish Government Health and Social Care Research Strategy, 2015). The SGHD strategy highlights what needs to be done to achieve this vision, detailing the areas where we can and should make a difference and the need to increase the scope, relevance and quality of research to meet the health and healthcare needs of the people of Scotland.

1.3 The 4 national Research Governance Frameworks (RGF) for Health and Community Care (2006), updated to create an overarching UK Policy Framework for Health and Social Care Research (2017), promotes improvements in research quality and sets the standards for good practice.

1.4 At a local level NHS Fife, as part of Fife Partnership is working towards greater integration of research activities in order to:

'Develop and make best use of knowledge from research and information resources to help achieve Fife's Strategic Plan'.

1.5 For the purposes of this strategy 'Research' is defined as:

- All forms of clinical and population research involving patients or members of the public in Fife. This includes work that entails new data collection as well as the analysis of routinely collected data. It also includes research into care pathways that cross boundaries with other agencies.

'Development' is defined as:

- any systematic evaluation of the application of the results of research into practice.

And 'Partners' are defined as:

- academic institutions, regional and national research networks and other agencies involved in for example Fife's Health and Social Care Partnership.

2. CURRENT RESEARCH ACTIVITY

2.1 NHS Fife's annual research budget allocation of Support Funding from CSO (Chief Scientist's Office) is £843,000 in 2019-20. This funding is provided for research considered eligible for funding, in recognition of the costs incurred by the NHS of undertaking and participating in such projects. This is currently the

main source of funding available to support research in NHS Fife. Additional funding can be secured by increasing the number of eligibly funded projects[1] undertaken by an NHS organisation, increasing the number of NHS Fife Chief Investigators and the recruitment into such studies. Additionally, commercial research and a small number of specific grant funded projects undertaken across NHS Fife also provide funding to support key staff to be employed to enable the research to be undertaken. Commercial research does not attract support funding from CSO since all costs to the NHS of participating in such activities must be met in full by the participating companies. Income from commercial recruitment activity during 2018/19 was £111,412 (compared with 2017/18 in £117,641).

2.2 Funding is used to support research and development activities in NHS Fife. It provides the responsive and collaborative infrastructure (Appendix 1) necessary to ensure the required management and governance of the research undertaken. Appendix 2 illustrates the NHS Fife committee structure in relation to R&D.

2.3 There are currently 237 research projects registered across NHS Fife (compared with 267 in 17-18, 290 in 16-17, 256 in 15-16, 261 in 13-14, 234 in 12-13, 265 in 11-12 and 253 in 10-11). Studies were notably in the categories of: Cancer Cardiovascular & Stroke, Renal, Musculoskeletal and Neuroprogressive Disease. This research tends to be limited to a few individuals working independently or as part of large national multi-centre trials. There are currently 254 NHS Fife staff who are registered as being active in research within these areas.

2.4 Despite ongoing achievements it is recognised that there is still scope to increase the research capacity within NHS Fife. Although it has not been determined locally exactly what the main barriers to research are, drawing on surveys in other similar healthcare organisations, they are likely to include a lack of protected time and/or dedicated funds for research, a lack of peer group support, lack of training in research skills and a perceived lack of the relevance / importance of research.

2.5 Every NHS organisation requires an appropriate balance of service delivery, research and learning in order to deliver the healthcare needs of the population. NHS Fife is predominately involved with service delivery supported by lifelong learning. Taking account of future demographic, social and technological change NHS Fife requires to contribute to increase the emphasis placed on research activity in order to support the delivery of the local health plan and Clinical Strategy into the future.

3. NHS FIFE'S VISION FOR RESEARCH

3.1 Strategy Aim

The R&D strategy will support NHS Fife's overall strategic aim to provide the highest quality care to, and improve the health of, the population of Fife, within

[1] projects funded by any of the non commercial charitable or government organisations detailed in the list of qualifying funders on the CSO website.

the resources available and in partnership with its staff, community planning partner organisations and the citizens of Fife.

The R&D Strategy will support this by:

- promoting a culture that supports and encourages research as part of routine practice;
- building on the opportunities to work closely with academic and community planning partners to increase the volume and quality of research;
- promoting research within an appropriate governance framework;
- developing research knowledge and skills of staff and appropriate independent contractors;
- working in partnership with the citizens of Fife to ensure that research is patient-centered.

4. PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH

4.1 As a result of receiving R&D support funding from NRS, considerable progress has been made in NHS Fife, supporting and encouraging research activities. Work will continue to be taken forward within existing resources to make research meaningful and increasingly accessible and to ensure its integration into everyday practice and policy development.

4.2 We (NHS Fife) will continue to achieve this by:

- supporting the NHS Fife Executive Lead and Director for Research and Development;
- supporting the NHS Fife Research Governance Group;
- including R&D information in recruitment and induction materials, personal development plans, knowledge and skills frameworks, contracts and terms of employment;
- enabling access to the evidence base to support research by providing access to a full range of library services;
- promoting research and researchers' achievements in Fife as part of clinical governance activities;
- producing an annual report on research activity for submission to Fife NHS Board and Clinical Governance Committee;
- ensuring R&D is a high profile item for discussion on the agenda of appropriate NHS Fife meetings e.g. Clinical Governance Committee;

- including measurable objectives for research within NHS Fife's Research & Development Strategy.

5 WORKING WITH PARTNERS

5.1 NHS Fife currently works with a number of partners to take forward research. By improving the co-ordination and links at a senior level we aim to increase the volume and quality of research and the opportunities for Fife-based clinicians and other staff to become Principal / Chief Investigators.

5.2 In addition to supporting an NHS Fife Executive Lead/Director for Research and Development we have achieved this by:

- enabling joint senior clinical appointments with our university partners;
- seeking opportunities to improve research collaboration with NHS Fife's Social Care Partners;
- promoting multidisciplinary and multiagency research;
- identifying local research education/training needs;
- working with established regional and national networks (such as the Scottish Cancer Research Network (SCRN), Scottish Primary Care Research Network (SPCRN), Scottish Diabetes Research Network (SDRN), Scottish Stroke Research Network (SSRN), Scottish Mental Health Research Network (SMHRN), Scottish Neuroprogressive and Dementia Research Network (SDCRN), and Social Dimensions of Health Institute (SDHI)) to identify resources and mentors to provide support for staff undertaking research;
- concentrating on developing and supporting current areas of research strength through thematic groups, fellowships and collaborative workshops.

<u>Thematic Research Groups</u>:

- Women & Children's Health
- Learning Disabilities
- Children and Young Peoples Wellbeing
- Arthritis and Rheumatology
- Children and Adolescent Mental Health Services
- Occupational Therapy

<u>NRS Fellowships:</u>

- Stroke
- Cardiovascular
- Infectious Diseases
- Palliative Care

Collaborative workshops:

- Digital Health Science
- Supporting the work of NRS Scottish Speciality Groups within Fife particularly those led by NHS Fife (Ophthalmology and Infectious Diseases) by increasing patients enrolled in trials.

Over the next 2 years we will:

- Continue to identify and prioritise joint clinical academic positions between NHS Fife and the University of St. Andrews
- Continue to improve the research culture within the clinical environment in Fife by supporting the nursing, allied health professional and supporting staff to establish their research priorities
- Support NHS Fife's vision in helping to shape /deliver the Clinical Strategy that meets the demands of future populations.

5.3 As a result of the above actions we will aim to:

- *increase the number of staff actively involved in Research and Development activity by 7.5% each year;*
- *increase the number of ongoing projects, including eligibly funded /adopted projects as defined by the CSO, and commercial research within NHS Fife by 10% per year;*
- *increase the number of publications by NHS Fife Staff in peer reviewed journals by 10% per year;*
- *Increase the number of clinical academic positions by 20% over the next 3 years.*

6 PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK

6.1 Research Governance is the framework through which NHS Fife Board can be assured that the quality of research is maintained and continuously improved and that high standards of patient care are maintained when research is carried out.

Research Governance is used as an overarching term to describe the cohesive set of management and quality improvement systems to ensure NHS Fife meets its commitment to deliver high quality research, whilst protecting patients and researchers alike.

The UK Policy Framework for Health and Social Care Research (2017) highlights 'the need for organisations to be aware of the activity involved in supporting research and of what it costs'. Further, as a minimum requirement, the CSO expects that as part of sound research governance

arrangements NHS organisations should ensure that expert accounting input is available for the costing and monitoring of all research (both commercial and non commercial). NHS Fife needs to be able to demonstrate to its auditors that it is covering the entire cost of undertaking research, including appropriate R&D Department costs and organisation overheads for commercial research. NHS Fife, therefore, needs to deliver rigorous and effective costing mechanisms and financial management in R&D.

This has been achieved in Fife through delivery of efficient research management and approval processes, developing research databases, providing support & training for researchers, improving financial probity, monitoring ongoing research and the publications arising from it.

Our approach to Research Governance demonstrates to staff, users and carers that improving the quality of research provided by NHS Fife is viewed as an important issue across the organisation.

6.2 In order to achieve this we will:

- ensure that all externally (out with NHS Fife) and internally (within NHS Fife) commissioned research undertaken in NHS Fife is registered and accurately costed;
- ensure that policies are in place to support invention and innovation in NHS Fife while exploiting the potential these activities present for the organisation;
- update, improve and develop NHS Fife policy, procedures and guidelines for commercial and non-commercial research;
- ensure we undertake an annual monitoring exercise to identify all ongoing research;
- ensure we undertake an annual audit of all research Sponsored by NHS Fife;
- ensure accurate data capture systems are in place to record R&D activity for analysis and dissemination;
- Update R&D pages on the NHS Fife intranet and the R&D website;
- Hold regular awareness raising sessions around R&D and Intellectual Property (IP);
- Continue to employ a dedicated R&D Business Accountant from the Finance directorate and have:
    - appropriate financial management and guidance on the costs of research and recovery of such costs
    - costing mechanisms for commercial and non-commercial research

- systems to identify patient recruitment to studies, raise invoices and track payments
- systems that comply with financial probity to facilitate appropriate transfer of monies from one organisation to another
- systems to accept, manage, monitor and disseminate funds;

- ensure that financial systems and audit trails are in place to capture and account for support funding expenditure and NHS Fife overheads from commercial research.

6.3 As a result of the above actions we will continue to:

- *provide R&D support for every research project registered in NHS Fife;*

- *provide assurance to NHS Fife Board that all research activity meets the requirements of the UK Policy Framework for Health and Social Care Research;*

- *increase the identification and protection of intellectual property by 10% each year thereby increasing commercialisation activity, increasing both financial and healthcare benefits for NHS Fife;*

- *ensure that a minimum of 10% of all 'high risk' projects[2] Sponsored by NHS Fife are audited annually;*

- *continue to provide accurate quarterly updates and Annual Reports on financial expenditure and research activity to the CSO;*

- *continue to provide financial information for the R&D Annual Report;*

- *continue to identify the actual cost of research undertaken in NHS Fife and maximise our returns from commercial research;*

- *Maximise utilisation of the Clinical Research Facility.*

7 WORKING IN PARTNERSHIP WITH STAFF

7.1 Research is undertaken by and with staff for the benefit of patients and members of the public. It is essential that we work with staff and the Public Partnership Forum to promote the benefits of research activity for individual staff members as part of their commitment to personal development.

Research activity depends on staff having appropriate skills. However, a lack of research skills is frequently reported as the main barrier to undertaking research activity. The Assistant R&D Director and R&D Team will, in collaboration with other NHS organisations and within existing resources,

[2] projects where the potential for an adverse event is deemed to be higher, such as those involving investigational medicinal products, devices or investigations. NB NHS Fife does not currently sponsor Clinical Trials of Investigational Medicinal Products.

provide access to regular research education and workshops which will be open to all staff in NHS Fife.

7.2 In order to achieve this we will continue to:

- Identify / determine research education needs within NHS Fife;
- encourage staff to consider R&D education and the development of evidence based practice as part of their CPD;
- work jointly with other external organisations e.g. the Tayside Academic Health Science Partnership, Public Partnership Forum and specialist trainers to provide a high quality multidisciplinary/multiagency programme which addresses identified research training requirements
- encourage and assist NHS Fife staff to apply for NRS Research Fellowships, details of which will be circulated throughout NHS Fife;
- identify sources of funding and work towards securing funds in partnership with new and established researchers to undertake research within the identified priorities and needs areas.

7.3 As a result of the above actions we will, in addition to increasing the percentage of staff actively involved in research and development activity:

- *review the previous year's research education programme, plan and deliver an updated programme aimed at increasing the capability of staff to undertake research;*
- *increase the number of staff participating in the research education programme annually;*
- *support staff registered for higher degrees.*

8 PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH

8.1 It is important that the organisation has systems in place to identify the involvement of consumers in research and to ensure their involvement in the development and execution of research projects.

8.2 In order to achieve this we will continue to:

- ensure that there is patient and public representation on relevant R&D groups;
- encourage the involvement of patients and the public in the development of studies and patient information relating to research projects.

9 COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE

9.1 Two-way communication of research information across NHS Fife presents a significant challenge due to the dispersed nature of the organisation. In light of this, established communication networks are used where possible.

9.2 Health & Social Care Partnerships, the Division and Corporate Directorates use current systems such as local newsletters, briefing sheets or web sites to disseminate information about local and National research initiatives.

9.3 R&D has both NHS Fife Internet pages along with a website, in addition to using the NHS Fife intranet. Research information will also continue to be provided via a monthly electronic bulletin. Updates to this information will be co-ordinated by the Assistant R&D Director.

9.4 The NHS Fife Research Governance Group continues to be actively involved in promoting research awareness, the Research Strategy and communicating the benefits of research to staff, users, carers and other partner organisations in Fife, Scotland and the rest of the UK.

10 PLAN OF ACTIVITIES AND PRIORITIES FOR 2019-20

11.1 In order to ensure the continued implementation of this wide-ranging strategy, it has been agreed that a number of strategic 'priorities' will be selected annually, to be advanced throughout the year, and reported on at the year end. These priorities are included in Appendix 3.

12 REVIEW

This Strategy and Plan of Activities and Priorities will be reviewed in May 2020.

References

1. Delivering Innovation through Research (2015)
2. Scottish Office Department of Health Research Strategy (2009)
3. UK Policy Framework for Health and Social Care Research (2017)
4. Scottish Office Department of Health Funding Manual (2004)
5. Policy Framework for the Management of Intellectual Property within the NHS Arising from Research & Development MEL (1998)23.
6. Management of Intellectual Property in the NHS. HDL (2004) 09

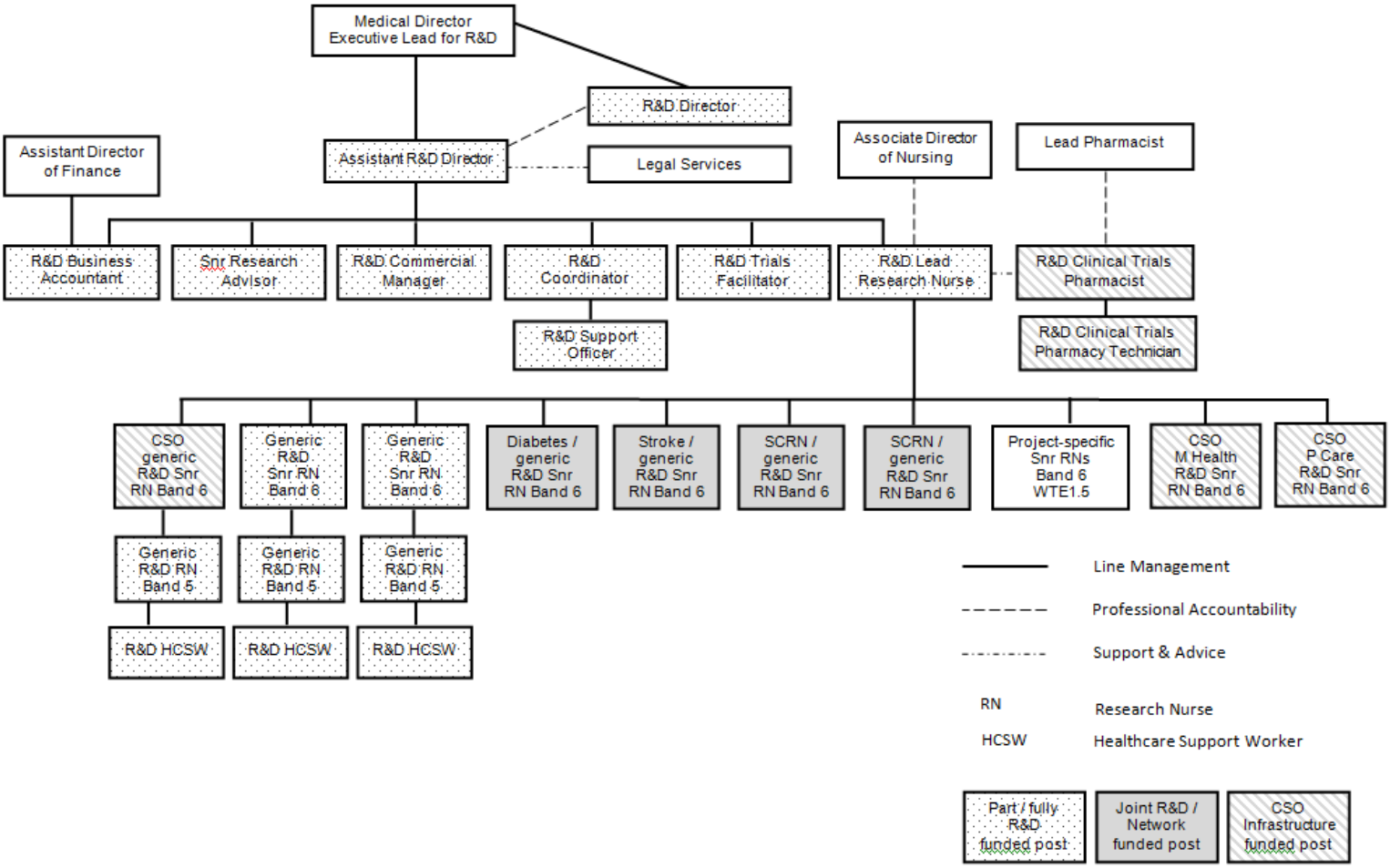
13 RECOMMENDATION

The Clinical Governance Committee is asked to:

- note the contents of this paper

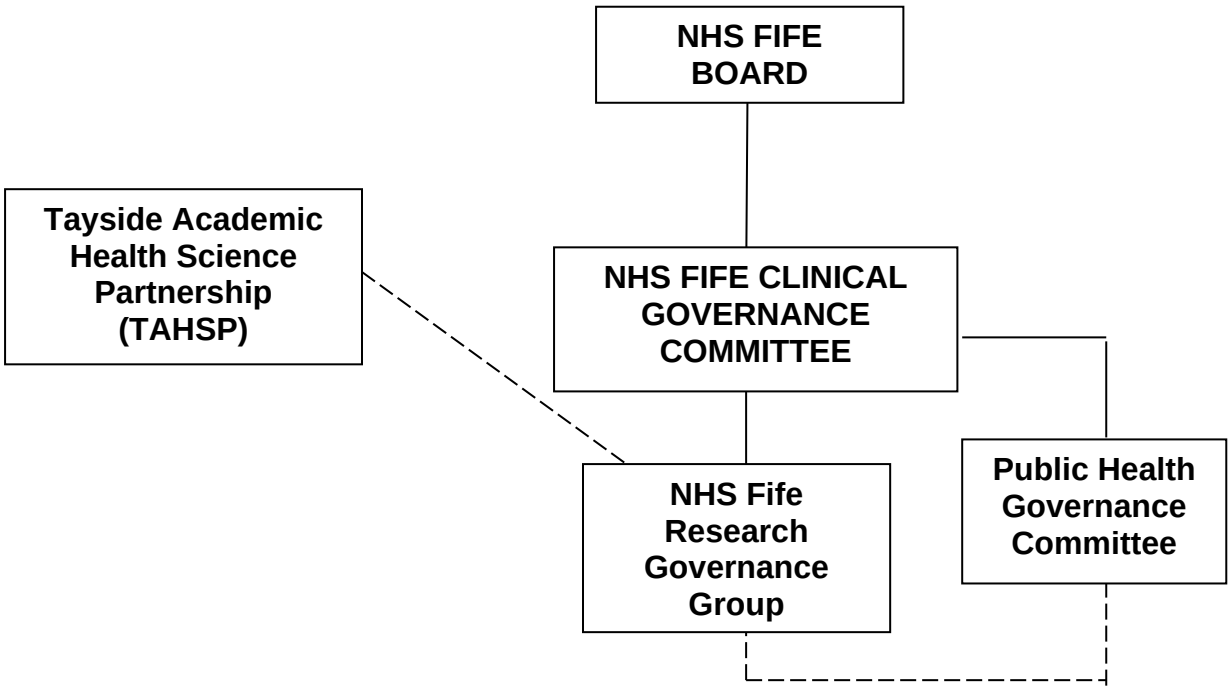
Appendix 1

NHS Fife Research & Development (R&D) Support Structure 2018-19



Appendix 2

COMMITTEE STRUCTURE / NHS FIFE IN RELATION TO RESEARCH



Accountability ————

Communication _ _ _ _ _ _ _ _ _

PLAN OF ACTIVITIES AND PRIORITIES FOR 2019-20

The following plan of activities has been developed from the current NHS Fife Research Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research agenda; compete in the national research arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH.

Investment in new clinical posts (medical, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers with identified and protected research time.

A1. To continue to encourage discussion of research as part of normal Personal Development Plans and appraisals of health care staff.

A2. To continue R&D participation in the development of the medical and nursing clinical academic career development in Fife.

A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

B1. Identify and understand corporate arrangements with institutions such as St Andrews, Dundee, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.

B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research active individuals, employed/seconded by NHS Fife and/or universities to build research capacity and governance structures.

(C) PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

In consolidating the research governance structure the current areas that need to be considered include:

C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, information and educational governance structures within NHS Fife.

C2. Preparing for a potential inspection(s) from Medicines and Healthcare products Regulatory Agency.

C3. Establish a regional consortium with TASC, St Andrews and Dundee Universities to maximise facilities and available expertise, in order to increase clinical trial and other complex interventional studies in the region.

Increasing the income generated from an increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:

C4. Maximising commercial research opportunities locally and in collaboration with external partners.

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE.

Consolidate a research communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research focused culture. During 2019-20 we will:

D1. Deliver a regular NHS Fife Research Newsletter.

D2. Produce and disseminate an NHS Fife Research Annual Report.

D3. Provide research workshops for patients, carers and other citizens of Fife

(E) PATIENT AND PUBLIC INVOLVEMENT

E1. Develop ongoing, meaningful engagement of the public in research

Dr Alex Baldacchino
R&D Director
NHS Fife

Dr Amanda Wood
Assistant R&D Director
NHS Fife

June 2019

These priorities have been discussed and agreed by the NHS Fife R&D Operational Group and the NHS Fife Research Governance Group.

OUTCOME OF ACTIVITIES AGAINST R&D STRATEGIC PRIORITIES 2018-19

The following plan of activities has been developed from the current NHS Fife Research Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research agenda; compete in the national research arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH.

Investment in new clinical posts (medical, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers with identified and protected research time.

	OUTCOME
A1. To continue to encourage discussion of research as part of normal Personal Development Plans and appraisals of health care staff.	**ONGOING**
A2. To continue R&D participation in the development of the medical and nursing clinical academic career development in Fife.	**ONGOING**
A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.	**ONGOING**

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

	OUTCOME
B1. Identify and understand corporate arrangements with institutions such as St Andrews, Dundee, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.	**ONGOING**
B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research active individuals, employed/seconded by NHS Fife and/or universities to build research capacity and governance structures.	**ONGOING**

(C) PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

In consolidating the research governance structure the current areas that need to be considered include:	**OUTCOME**
C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, information and educational governance structures within NHS Fife.	**ONGOING**
C2. Preparing for a potential inspection from Medicines and Healthcare products Regulatory Agency.	**ONGOING**
Increasing the income generated from an increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:	
C3. Maximising commercial research opportunities locally and in collaboration on with external partners.	**ONGOING**

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE.

Consolidate a research communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research focused culture. During 2018-19 we will:

	OUTCOME
D1. Deliver a regular NHS Fife Research Newsletter.	**ACHIEVED**
D2. Produce and disseminate an NHS Fife Research Annual Report.	**ACHIEVED**
D3. Provide research workshops for patients, carers and other citizens of Fife	**ONGOING**

(E) PATIENT AND PUBLIC INVOLVEMENT

	OUTCOME
E1. Develop meaningful engagement of the public in research	**ONGOING**

Dr Alex Baldacchino
R&D Director NHS Fife

Dr Amanda Wood
Assistant R&D Director, NHS Fife

June 2019

These priorities have been discussed and agreed by the NHS Fife R&D Operational Group and the NHS Fife Research Governance Group.

NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	6th November 2019
TITLE OF REPORT:	NHS Fife Immunisation Annual Report 2019
EXECUTIVE LEAD:	Dona Milne, Director of Public Health
REPORTING OFFICER:	Lynn Burnett, Health Protection Nurse Consultant / Immunisation Coordinator

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	~~**For Discussion**~~	**For Information**

SBAR REPORT

Situation

The purpose of this paper is to provide an annual monitoring report of vaccine preventable disease surveillance data and vaccine uptake data, and summarise the key developments and learning in relation to the delivery of immunisation programmes in NHS Fife.

The Clinical Governance Committee are asked to **note** this report for information.

Background

Delivery of effective population immunisation programmes is an NHS Scotland priority. Vaccination programmes aim both to protect the individual and to prevent the spread of these diseases within the wider population. As a public health measure, immunisations are very effective in reducing the burden of disease.

Monitoring the proportion of the eligible population vaccinated is a key measure of the immunisation programme performance, as well as monitoring of vaccine preventable disease surveillance data. It is of public health concern should immunisation rates decrease, as this makes the possibility of disease transmission more likely.

This is the second annual Immunisation Report for NHS Fife. Variation in data release timings and reporting intervals mean that the period covered in this report varies by programme.

Assessment

This report identifies consistently low rates of vaccine preventable disease in Fife. However, there is lower uptake of some vaccines among eligible groups across the life course – teenagers, pregnant women and older people. People living in poorer areas, who may be at greater risk of diseases and illnesses that immunisation can prevent, are least likely to take up the offer of vaccines.

Uncertainty and opposition concerning vaccines are challenges to immunisation programmes that risk achieving a high level of protection against vaccine preventable diseases. Vaccine hesitancy is a rapidly evolving issue across Europe that can be associated with access to

services, convenience, and lack of knowledge. An increase in vaccine preventable disease has been apparent with a number of outbreaks across Europe. Declining vaccination rates in Fife/Scotland leave populations susceptible to risk of disease. Therefore, it is essential to ensure that eligible groups are given clear and correct information about vaccines, their safety and impact. The role of the health professional cannot be understated, and all opportunities to promote immunisation should be utilised.

The report was reviewed by the Area Immunisation Steering Group (AISG) on 23rd August 2019. The report incorporates a number of additions to the text and appendices advised by the AISG. The report will also be presented at the H&SCP Care and Clinical Governance Committee.

Recommendation

The Clinical Governance Group is asked to:

Note this report for information.

Objectives: (must be completed)	
Healthcare Standard(s):	Safe and Effective Care
HB Strategic Objectives:	Clinically Excellent Person Centred (Reduce Health Inequalities in terms of access and services)

Further Information:	
Evidence Base:	ISD Vaccine Uptake Statistics Health Protection Scotland Immunisation and Vaccines Surveillance & Epidemiology data NHS Fife HPZone database
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Area Immunisation Steering Group (AISG) – 23rd August 2019

Impact: (must be completed)	
Financial / Value For Money	This report has no financial impact or capital requirements
Risk / Legal:	Risks are considered for individual elements of the immunisation programme at the Major Changes Immunisation Programme group. Strategic oversight of risk appraisal is provided by the Area Immunisation Steering Group.
Quality / Patient Care:	This report is part of renewed governance arrangements for public health in NHS Fife which aim to ensure that the immunisation programmes are operating to the highest standards and that there is equity of provision across Fife.
Workforce:	None
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? *No. This report does not alter service delivery. The report includes analysis of the uptake of immunisation programmes by socio-economic deprivation where possible.* • Has a full EQIA been undertaken? *No. As above.* • Please state how this paper supports the Public Sector Equality Duty – further information can be found here *The programme aims to ensure equitable access to immunisation across Fife.*

	• Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here *The report provides a high level overview of the outcomes being achieved through the immunisation programmes in Fife and highlights differences in uptake by socio-economic deprivation where possible.* • Any potential negative impacts identified in the EQIA documentation - *No*

NHS
Fife

IMMUNISATION ANNUAL REPORT 2019

Lynn Burnett
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Consultant in Public Health Medicine / Deputy Director of Public Health
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Contents

NHS FIFE

IMMUNISATION ANNUAL REPORT 2019

1 EXECUTIVE SUMMARY

1.1 Vaccination programmes aim both to protect the individual and to prevent the spread of diseases within the wider population. April 2018 marked the official start of the 3 year Vaccination Transformation Programme (VTP) which will modernise the delivery of vaccinations. As a public health measure, immunisations are very effective in reducing the burden of disease.

1.2 This is the second annual immunisation report for NHS Fife. The report summarises surveillance data on vaccine preventable disease and uptake rates for each vaccine (including inequality data where this is available), and identifies key developments and learning across the programmes.

1.3 Surveillance data of vaccine preventable disease demonstrate low incidence rates of measles, mumps, rubella, haemophilus influenza type b, tetanus, invasive meningococcal infection and invasive pneumococcal infection in Scotland. In 2018 there were a number of measles outbreaks across Europe. However, there were only 2 confirmed cases in Scotland and none in Fife. In 2018, there were 280 laboratory-confirmed mumps cases in Scotland, a decrease compared to 2017 in which there were 385 cases reported. Mumps activity was high at the beginning of the year and was associated with an outbreak in NHS Lothian which began in the student population in the latter part of 2017 and then spread into the wider community. The Health Protection Team in Fife work closely with GP's and University staff in St Andrews to ensure as much as possible that our student population in Fife are appropriately immunised and the spread of vaccine preventable infections is minimised.

1.4 National data demonstrates reductions in cancer-causing HPV types since the HPV vaccination programme began in 2008. New research has shown that the Human Papilloma Virus (HPV) vaccine has reduced the highest grade of cervical pre-cancer by almost 90%. In future years, the massive reduction in cervical pre-cancer should translate to reductions in cervical cancer. These results are promising and have contributed towards the decision in 2019 to extend the programme to boys.

1.5 National figures reveal reductions in rotavirus hospital admissions for children <5 years since the introduction of rotavirus vaccine in 2013.

1.6 Shingles vaccine uptake rates for 2017/18 (Sept 17 to Aug 18) for the 70 year old cohort were 48.4% in Fife (Scotland 44.4%), but with wide variation at GP practice level. As in the rest of Scotland, there has been a gradual downward trend in uptake rates since the introduction of the programme in September 2013. There are plans to transfer the shingles programme under VTP, however, this has been delayed and at present is still being delivered in Fife by GP's. The introduction of a new non-live Shingrix® shingles vaccine and widening of the shingles vaccination programme is being explored. The non-live vaccine would remove the current assessment for vaccination that is required for the live vaccine.

1.7 Uptake rates in 2018 of the childhood immunisation programme at age 12 months were over 95% for the six-in-one vaccine ('DTP/Pol/Hib/HepB) which protects against diphtheria, tetanus, pertussis, polio, Hib and Hepatitis B, and also reached the 95% target for PCV and Men B vaccine. Rotavirus uptake was slightly below target at 93.7% but above the Scottish average. There was a drop in 12 month vaccine uptake from 2017. It is too early to know if this reflects a temporary or more sustained fall in rates. A short life working group and action plan have been established by members of Fife's Area Immunisation Steering Group to monitor and implement improvement actions, and evaluate the childhood and teenage immunisation programmes and rates.

1.8 Uptake at age 24 months in Fife in 2018 for Hib/MenC, PCV booster vaccine and first dose MMR were below the 95% target in 2018, below the Scottish average. By 5 years of age, uptake of second dose MMR was 88.4% in 2018 and for DTP/Pol booster was 88.7%. These rates increase slightly by 6 years. In an attempt to increase immunisation rates and access to services, new innovative ways of delivering the immunisation programme to this group are being explored. Immunisation delivery in Nurture Hub nurseries have been piloted in some areas, and are receiving positive feedback from parents.

1.9 The most recently available published teenage vaccination rates are for the 2017/18 school year. Uptake of MenACWY by S4 in Fife was 78.2%, below the Scottish average of 85.9%. Uptake of the combined booster immunisation for tetanus, diphtheria and polio was 77.7% in Fife, below the Scottish average of 85.8%. HPV uptake among girls in S3 in Fife was 87.8% for dose 1, and 79.1% for dose 2 in 2016/17, below the Scottish average for both dose 1 and dose 2 (91.8% and 86.6% respectively). An action plan has been developed in an attempt to increase the uptake of senior school vaccinations across Fife. The action plan focuses on increased availability and flexibility of immunisation programmes in senior schools, and assurances around the accuracy of Fife's data.

1.10 Inequalities increase with age across the childhood and teenage programmes. There was a decrease in inequalities of first and second dose HPV uptake at S3 in the 2017/18 school year compared with the 2016/17 school year. However, inequalities in uptake of MenACWY and Td/IPV at S4 have increased.

1.11 Pertussis uptake among pregnant women in 2018 was 64.7% (Scotland 66.8%), but with large variation observed at individual GP practice level. Under the VTP this programme transferred in 2019 from delivery by GP, to delivery by midwifery services. Women receiving antenatal care in Fife will now be offered the vaccine at a routine antenatal appointment and there will be no requirement to make a separate GP appointment for the vaccine. It is hoped that the new system of delivery will increase uptake.

1.12 Seasonal influenza vaccination rates for the 2018/19 season for the adult programme were 78.8% for the 75-and-over age group (Scotland 79.3%); 68.6% for the 65-75 age group (Scotland 69.3%); 38.1% for under 65 years at risk group (Scotland 42.4%); and 43.4% for healthy pregnant women (Scotland 44.5%). In the childhood programme, uptake was 71.1% for primary aged children (Scotland 72.9%) and 55.5% for pre-school children aged 2-5 years (Scotland 55.6%). Uptake targets for both the childhood and adult programme are 75%. Overall NHS Fife staff flu vaccination uptake rate was 54.9% (Scotland 51.2%; national target 60%)

1.13 Significant developments in 2018 included:-

The ongoing implementation of the national VTP, and the expansion of the centralised immunisation team. All childhood and school immunisations previously delivered by GP's and health visitors are now delivered by this team.

The replacement of the 5 in 1 vaccine with a 6 in 1 vaccine to include Hepatitis B; the vaccine is offered to all children at 2, 3 and 4 months of age.

A Fife wide procedure for babies born to mothers with Hepatitis B infection and/or babies born into a household where a member (other than the mother) is known to be infected with Hepatitis B was published and implemented for use from April 2019. The procedure aims to ensure that all babies in these groups receive the full schedule of immunisations and screening as per national guidance.

1.14 In summary, this report has identified consistently low rates of vaccine preventable disease in Fife. However, there is lower uptake of some vaccines among eligible groups across the life course – teenagers, pregnant women and older people. People living in poorer areas, who may be at greater risk of diseases and illnesses that immunisation can prevent, are least likely to take up the offer of vaccines. Uncertainty and opposition concerning vaccines are challenges to immunisation programmes that risk achieving a high level of protection against vaccine preventable diseases. Vaccine hesitancy (a World Health Organization term) is a rapidly evolving issue across Europe that can be associated with access to services, convenience, and lack of knowledge. An increase in vaccine preventable disease has been apparent with a number of outbreaks across Europe. Declining vaccination rates in Fife/Scotland leave populations susceptible to risk of disease. Therefore, it is essential to ensure that eligible groups are given clear and correct information about vaccines, their safety and impact. The role of the health professional cannot be understated, and all opportunities to promote immunisation should be utilised.

Whilst the delivery of the programme undergoes significant change over the next two years with the full implementation of the VTP, it will be essential that close monitoring of uptake rates continue, and that inequalities are addressed in the new models of delivery.

2 INTRODUCTION

2.1 Delivery of effective population immunisation programmes is a key NHS Scotland priority. Vaccination programmes aim both to protect the individual, and to prevent the spread of these diseases within the wider population. As a public health measure, immunisations are very effective in reducing the burden of disease.

2.2 Immunisation uptake is the proportion of the eligible population who have received the recommended doses of the relevant vaccines. Monitoring the proportion of the eligible population vaccinated is a key measure of the immunisation programme performance, as well as monitoring of vaccine preventable disease surveillance data. It is of public health concern should immunisation rates decrease, as this makes the possibility of disease transmission more likely.

2.3 In Scotland the target of the national childhood immunisation programme is for 95% of children to complete courses of the following childhood immunisations by 24 months of age: diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib), Hepatitis B and Meningococcal group B (MenB). This aligns with the European Region of the World Health Organisation recommendations for vaccine uptake. An additional national target of 95% uptake of one dose of MMR vaccine by 5 years of age (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts on reducing the number of susceptible children entering primary school.

2.4 The UK immunisation schedule is continually reviewed and updated (Appendix 3). Changes in the schedule such as the introduction of new vaccines, changes to the number of doses required and/or the timing of vaccines need to be considered when interpreting trends in uptake rates.

2.5 This is the second annual Immunisation Report for NHS Fife. The report summarises surveillance data on vaccine preventable disease; uptake rates for each vaccine (including inequality data where this is available); and key developments and learning across the programmes. Variation in data release timings and reporting intervals mean that the period covered in this report varies by programme.

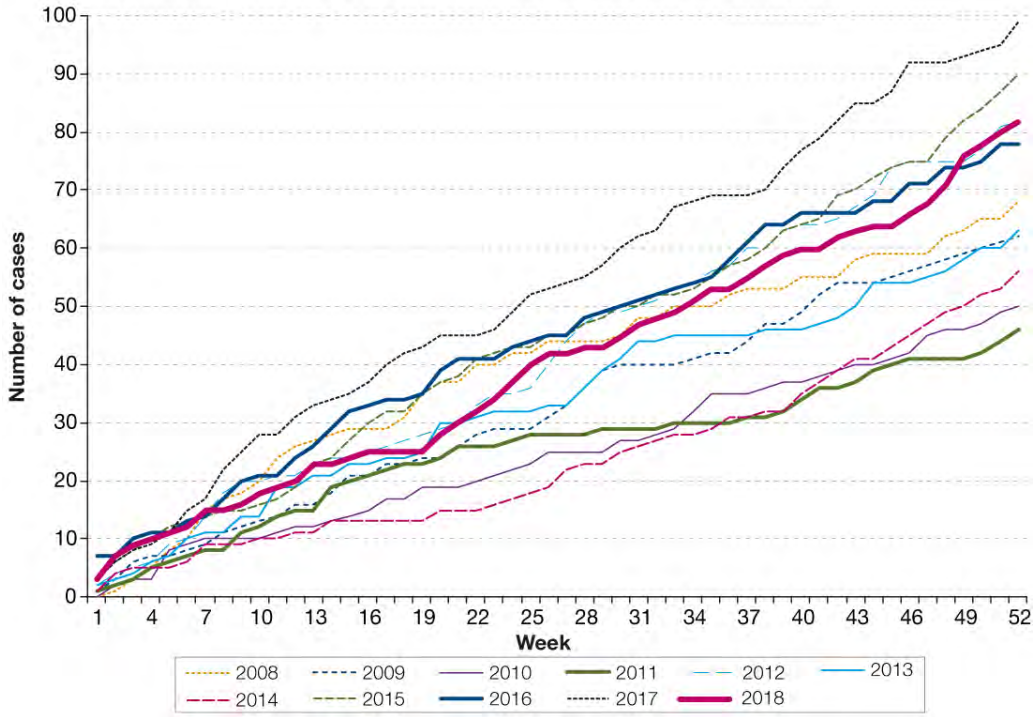
3 VACCINE PREVENTABLE DISEASE

3.1 Data for vaccine preventable diseases are summarised at both a national and local level where data is available. For the purposes of this report local surveillance data is based only on laboratory confirmed cases. Depending on the disease, incidence in the population will be higher. This is because cases notified to Public Health, meeting clinical case definitions but without laboratory confirmation are not included, and secondly, individuals may not present to healthcare, or be tested if they have milder presentations of diseases such as mumps and whooping cough.

Haemophilus influenza

3.2 Although commonly carried in the respiratory tract, Haemophilus influenzae can cause acute invasive disease including meningitis, septicaemia, and acute respiratory infections. The case fatality ratio of invasive H. influenzae is approximately 5%. Vaccination provides the most effective strategy for prevention of type b H. influenzae (Hib), which is the most pathogenic of the six different serotypes (a to f). In Scotland, the number of Hib cases fell dramatically after vaccine introduction in 1992. The marked reduction was not just in the vaccinated high-risk age group, but also in older age groups as the vaccine prevents carriage of the organism, decreasing transmission of the organism in the wider community. Figure 1 shows the cumulative number of invasive H. influenzae cases in Scotland reported to HPS from 2008 to 2018. The total number of cases reported in 2018 was 82. This is lower than the number of cases reported in 2017. Of the 82 cases only one was type b (Hib), whilst 77% were non-typeable. In Fife, there have been 5 cases of invasive *H. influenzae* type b infection since 2009.

Figure 1: Cumulative number of *H. influenzae* cases reported to HPS 2008-2018



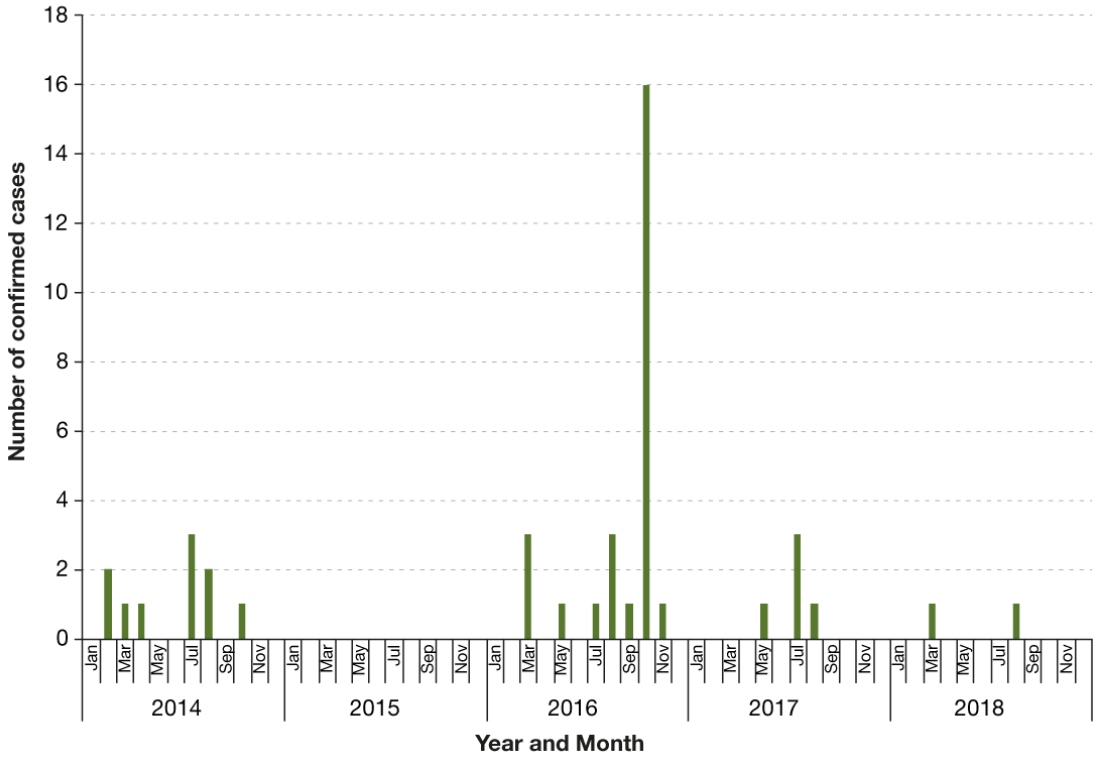
Source: Health Protection Scotland https://www.hps.scot.nhs.uk/media/1363/hinfluenzae-surv-fig-1-1100px.png

Measles

3.3 Measles virus can affect people of all ages but infants less than one year are at increased risk of complications and death. It is one of the most highly communicable diseases in susceptible populations. Complications of measles occur in around 1 in 15 notified cases, and include otitis media, pneumonia, convulsions, encephalitis and death. A rare complication of measles is sub acute sclerosing panencephalitis (SSPE), a fatal degenerative neurological disorder. The case fatality ratio is approximately one death per 5000 cases with it being highest in children under one year of age. Vaccination with measles-mumps-rubella (MMR) vaccine is the most effective strategy for preventing measles transmission within the population.

3.4 Before vaccination, measles was a very common childhood disease in Scotland, and deaths attributable to measles were substantial. Following the introduction of measles vaccine in 1968 and the subsequent introduction of the measles-mumps-rubella (MMR) vaccine in 1988, the incidence of the disease has decreased dramatically, especially in recent years (Figure 2). However, outbreaks still occur in under immunised populations and the decrease in MMR rates in Fife leave some of our population susceptible to outbreaks.

Figure 2: Number of laboratory-confirmed cases of measles by month in Scotland from 2014 to 2018



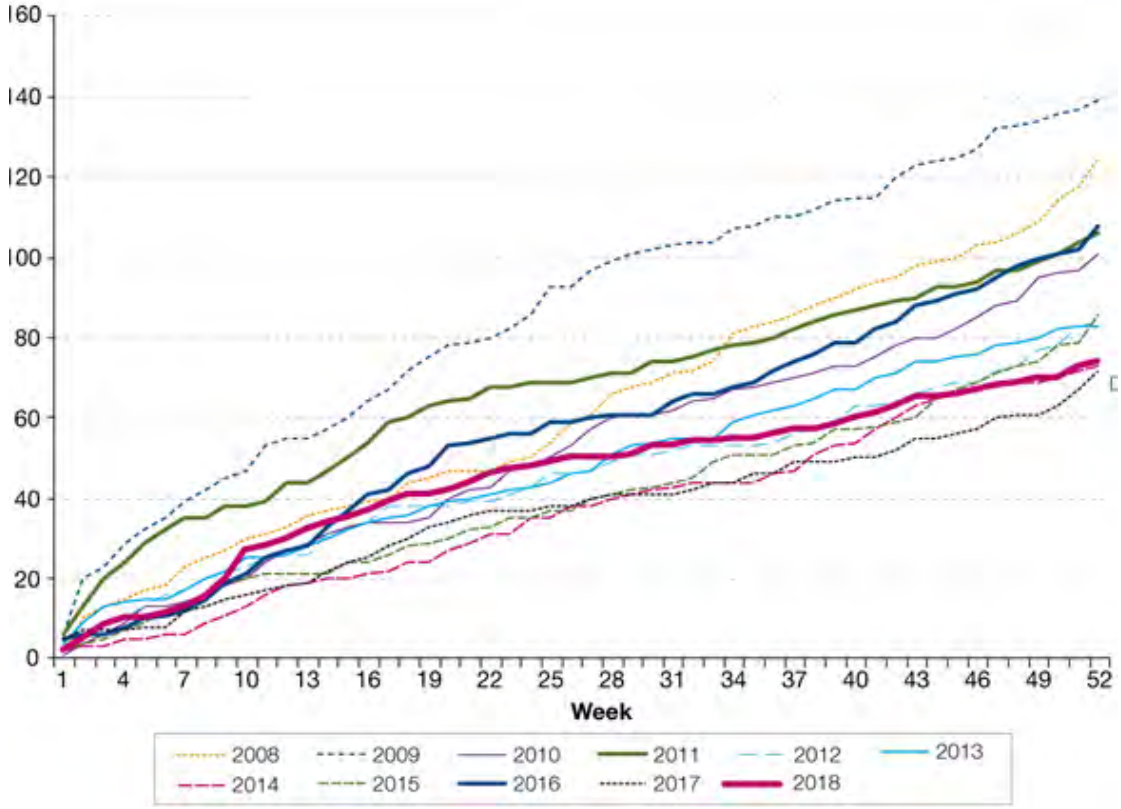
Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/measles/

3.5 There have been a total of 25 confirmed cases of measles in Fife since 2009. Generally there has been <5 confirmed cases per year, apart from 2013 when there was a local outbreak in an under immunised population group.

Meningococcal disease

3.6 Meningococcal disease is an invasive infection of *Neisseria meningitidis* in blood, cerebrospinal fluid (CSF), or other normally sterile site. Meningococcal disease cases present with meningitis, septicaemia, or a combination of both. Meningococcal disease is a significant cause of morbidity and mortality in children and young people. There are a number of different serogroups, the most common of which in Scotland and the UK is serogroup B, followed by serogroup W. Cases of Y and C disease are also reported.The total number of cases reported in 2018 across Scotland was 74. (Figure 3).

Figure 3: Cumulative number of meningococcal disease cases reported in Scotland 2008 to 2018



Source: Health Protection Scotland https://www.hps.scot.nhs.uk/media/1389/meningococcal-surv-fig-1-1100px.png

3.7 In Fife there have been a total of 54 confirmed invasive meningococcal infections between 2009 to 2018 (table 1). All probable and confirmed meningococcal disease notifications are followed up by the Health Protection Team, including arranging chemoprophylaxis for close contacts and vaccination where appropriate. In 2018 an incident management team was established to investigate a potential outbreak of meningococcal disease at the University of St Andrews. As per national guidance for the management of meningococcal infection a number of contacts in a defined social group were offered prophylactic antibiotics and Meningitis B vaccination. Communications were circulated to the University cohort highlighting the symptoms of the disease, and prompting those who were not fully vaccinated to seek vaccination.

Table 1: Confirmed Invasive Meningococcal Disease cases in Fife 2009 to 2018

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Cases	<5	<5	<5	<5	8	<5	<5	8	8	12

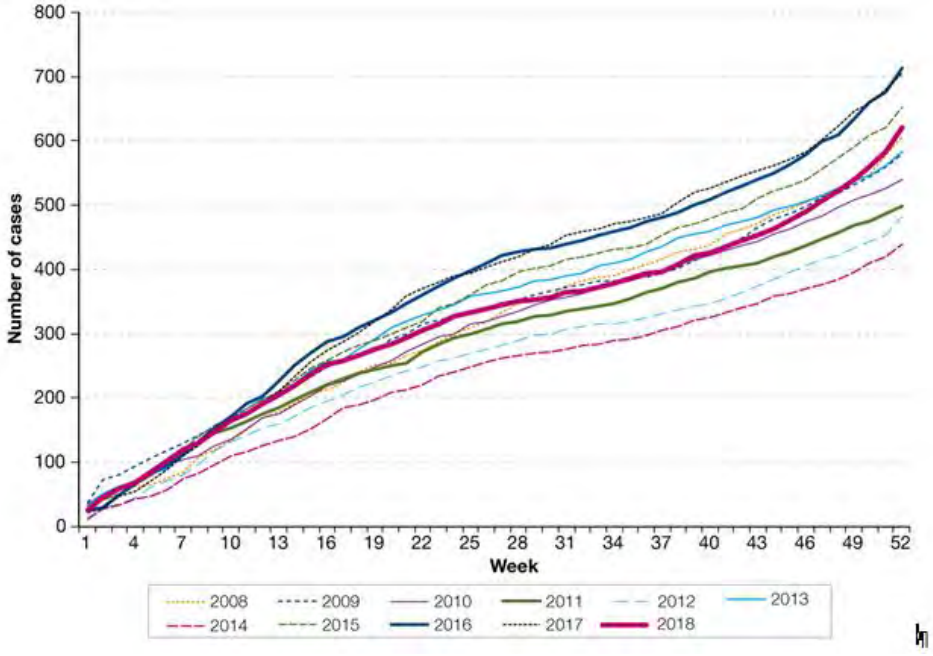
Pneumococcal disease

3.8 Pneumococcal infections are defined as invasive or non-invasive according to the body site they affect. Invasive pneumococcal disease (IPD) is caused by infection of normally sterile sites e.g. blood and cerebrospinal fluid. IPD is a major cause of morbidity and mortality, especially amongst the very young, the elderly, and those with impaired immunity. Non-invasive forms of the infection commonly cause middle ear infection (otitis media), exacerbations of bronchitis, and pneumonia. As with most infectious respiratory diseases, the numbers of cases of pneumococcal infection peak in winter. Many people (up to 50%) carry pneumococci in their nose and throat without developing serious infection.

3.9 Two pneumococcal vaccines are available that help to protect against pneumococcal disease. A one-off pneumococcal vaccination (PPV23) offering protection against 23 serotypes of IPD was introduced in 2003 for all people aged 65 years and over, in addition to those aged under 65 with certain underlying conditions. Pneumococcal conjugate vaccine (PCV-7) was introduced into the routine childhood immunisation schedule in September 2006. In spring 2010, PCV-7 was replaced with PCV-13 to provide broader protection against more pneumococcal serotypes.

3.10 During 2018, a total of 621 cases were reported across Scotland (Figure 4), of these 48% were aged 65 and over. The total rate in 2018 was the lowest since 2015. In Fife there were 7 confirmed cases of invasive pneumococcal disease in 2018, of which <5 were aged ≤5 years.

Figure 4: Cumulative number of Invasive Pneumococcal Disease cases in Scotland 2008 to 2018



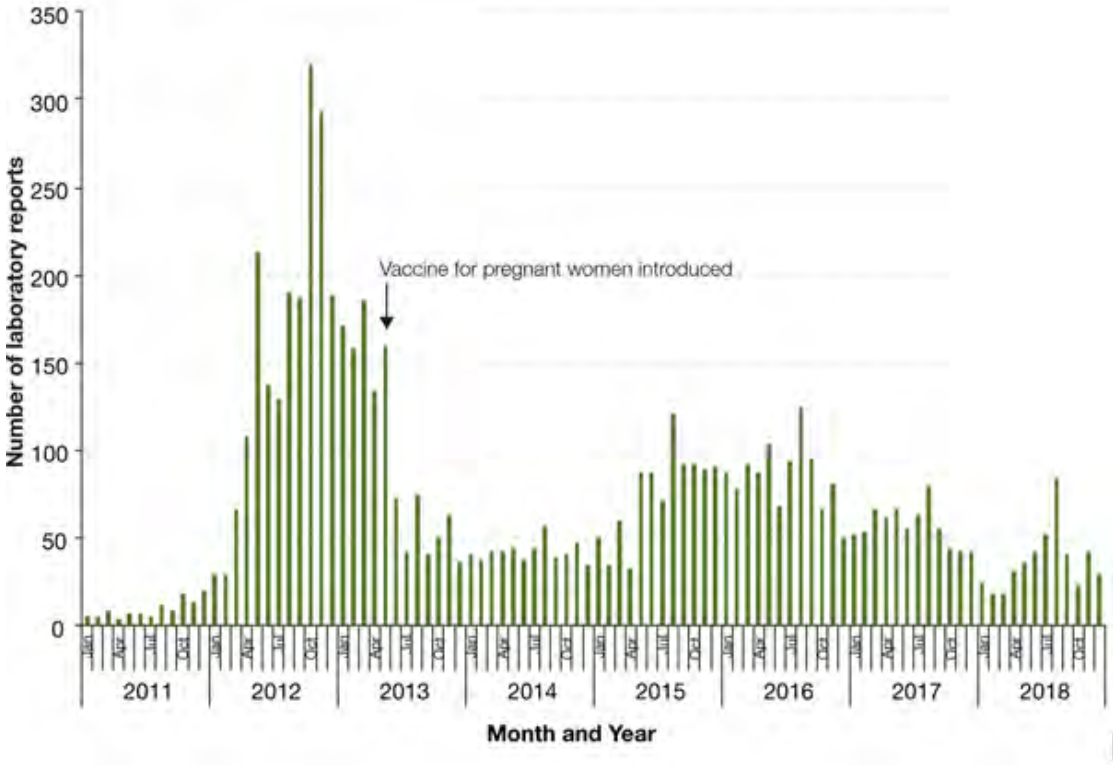
Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/pneumococcal-disease/

Pertussis (whooping cough)

3.11 Young infants are the group most likely to develop complications from infection with pertussis, which can require hospital treatment, and in severe cases can be fatal. In response to an increase in cases, and to protect young infants in the first few weeks of life until starting the routine childhood immunisation programme at eight weeks, a programme was introduced in October 2012 to offer pertussis vaccination to all pregnant women. Vaccine is now offered between gestational weeks 16 and 32 to maximise protection of the baby from birth.

3.12 A total of 443 cases were seen in Scotland in 2018 (Figure 5), this represented a significant decrease on 2017. In 2018 there were 12 cases in infants aged two months and under, compared to 26 cases in 2017.

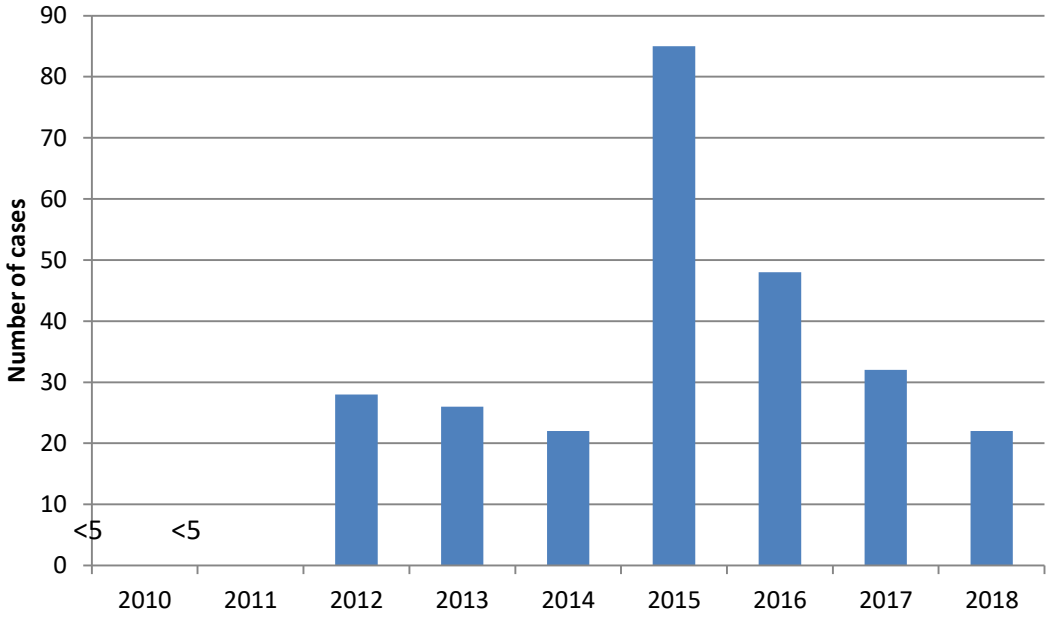
Figure 5: Number of laboratory reports of Bordetella pertussis by month in Scotland from 2011 to 2018



Source: Health Protection Scotland
https://www.hps.scot.nhs.uk/a-to-z-of-topics/whooping-cough/

3.13 Confirmed cases of pertussis by year of onset in Fife 2009 to 2018 are shown in figure 6. As with the data for the rest of Scotland, the number of cases has decreased since 2017, there were a particularly high number of cases in 2015. In 2018 there were a total of 22 confirmed cases, of which 0 were infants aged <2 months at onset. National data trends have demonstrated a fall in cases in the <2 month age group over previous years, demonstrating the positive impact of the vaccination programme for pregnant women in reducing the incidence in young infants.

Figure 6: Number of confirmed pertussis cases in Fife 2009 to 2018



Human Papilloma Virus (HPV)

3.14 Human papillomavirus (HPV) infections are very common and over 200 types of HPV have been identified, 40 of which infect the genital tract. Transmission of HPV is mainly facilitated through sexual contact, with the exception of some low-risk types. The most common HPV-induced cancer is cervical cancer with HPV 16 and 18 responsible for 70% of cervical cancers worldwide. The remaining 30% of cervical cancers are caused by the other 16 high-risk HPV types. High-risk HPV infection is also responsible for a subset of vulvar, vaginal, oropharyngeal, anal and penile cancers. Low-risk HPV types 6 and 11 cause 90% of genital warts.

3.15 In the UK, high uptake of both HPV vaccines is associated with a significant reduction in both low and high-risk HPV types in young women. Reductions in cervical disease and genital warts are now being demonstrated, with a decrease in cervical cancers expected within the next few years. New Scottish research has shown that the human papilloma virus (HPV) vaccine has reduced the highest grade of cervical pre-cancer by almost 90%. In future years, the massive reduction in cervical pre-cancer should translate to reductions in cervical cancer. These results are promising and have contributed towards the decision in 2019 to extend the programme to boys.

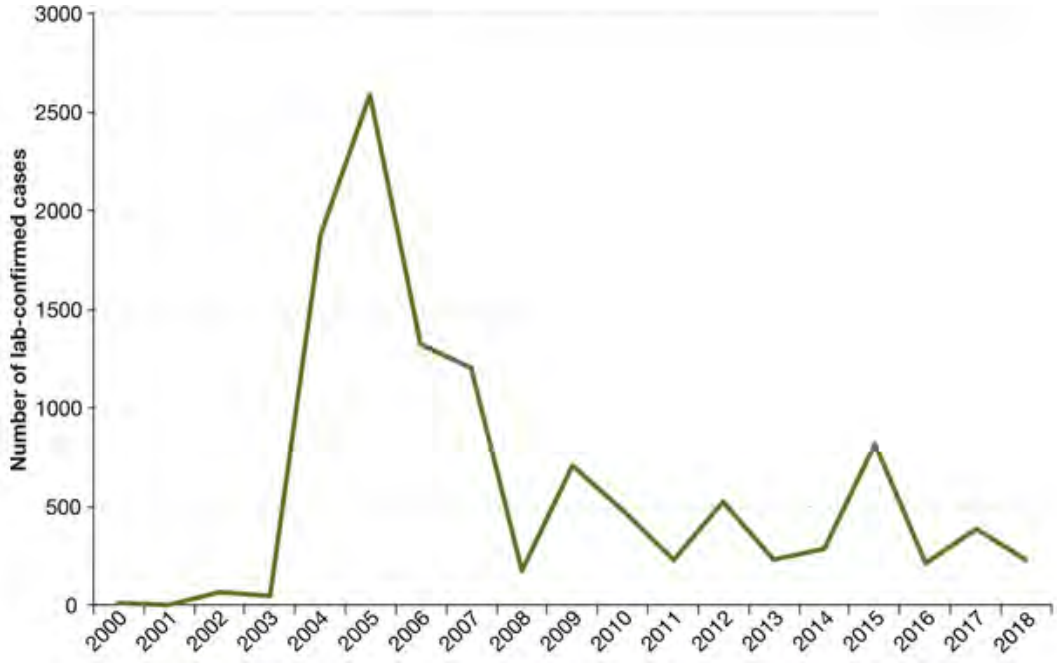
Mumps

3.16 Mumps infection can lead to serious complications, including aseptic meningitis, encephalitis, inflammation of the testes (orchitis), pancreatitis, oophoritis and permanent deafness. Neurological involvement occurs in 10-20% of cases and may precede or follow parotitis, and can also occur in its absence. Orchitis is the most common complication of mumps in adult males (4 out of 10 cases).

3.17 Vaccination with measles-mumps-rubella (MMR) vaccine is the most effective strategy for preventing mumps transmission within the population. Mumps was a common childhood

disease before the introduction of the MMR vaccine, with more than 85% of adults having evidence of previous mumps infection. Following the introduction of the MMR vaccine in 1988, the incidence of mumps substantially decreased. However, since 2004 there has been ongoing widespread increased incidence of mumps throughout the UK, with the number of laboratory-confirmed cases peaking in 2005. Smaller outbreaks have occurred in 2009, 2012 and 2014/15 (Figure 7).

Figure 7: Number of laboratory-confirmed cases of mumps by year in Scotland from 2000 to 2018.



Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/mumps/

3.18 In 2014/15 a widespread outbreak of mumps occurred in Scotland, it mainly affected those in higher education with many cases having evidence of receiving two doses of MMR vaccine. The observed increase in cases during this period may represent poor initial immune response to the mumps component of the MMR vaccine, and/or waning immunity within the fully and/or partially vaccinated population.

3.19 Of the 10 confirmed cases in Fife in 2018 (figure 8), 8 cases were aged 18-21 years. The incidence of mumps varies greatly between NHS Boards (figure 9). The incidence in Fife was much lower than neighbouring Lothian where there has been a sustained mumps outbreak among the student population in recent years. However, each year a co-ordinated communications programme between NHS Fife and the University of St Andrews ensures that all students coming to Fife to study are encouraged to ensure that they have had 2 MMR vaccinations.

Figure 8: Number of confirmed cases of mumps in Fife 2009 to 2018

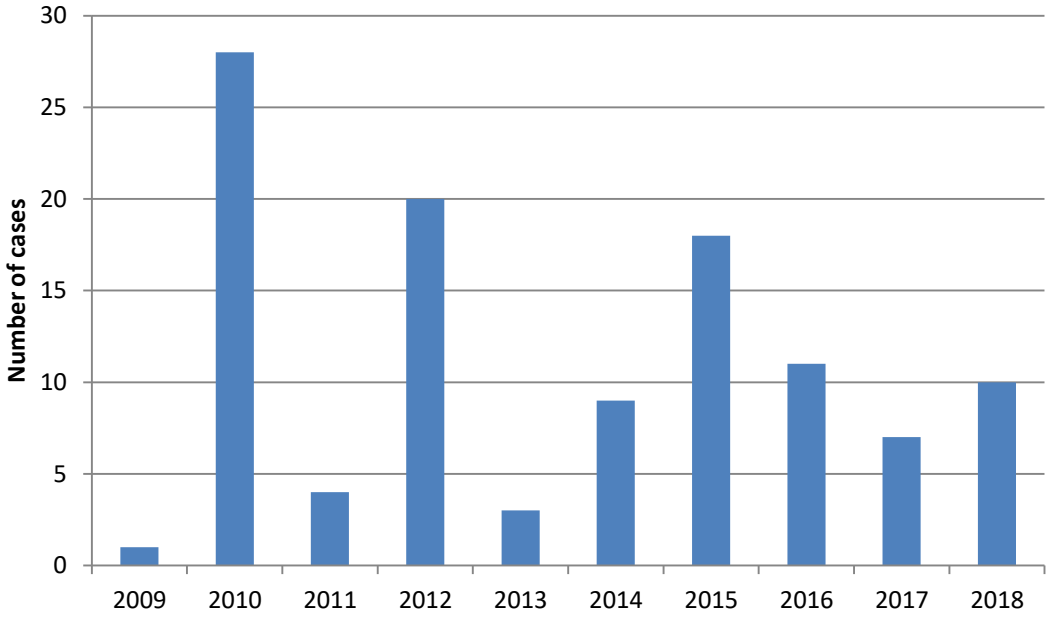
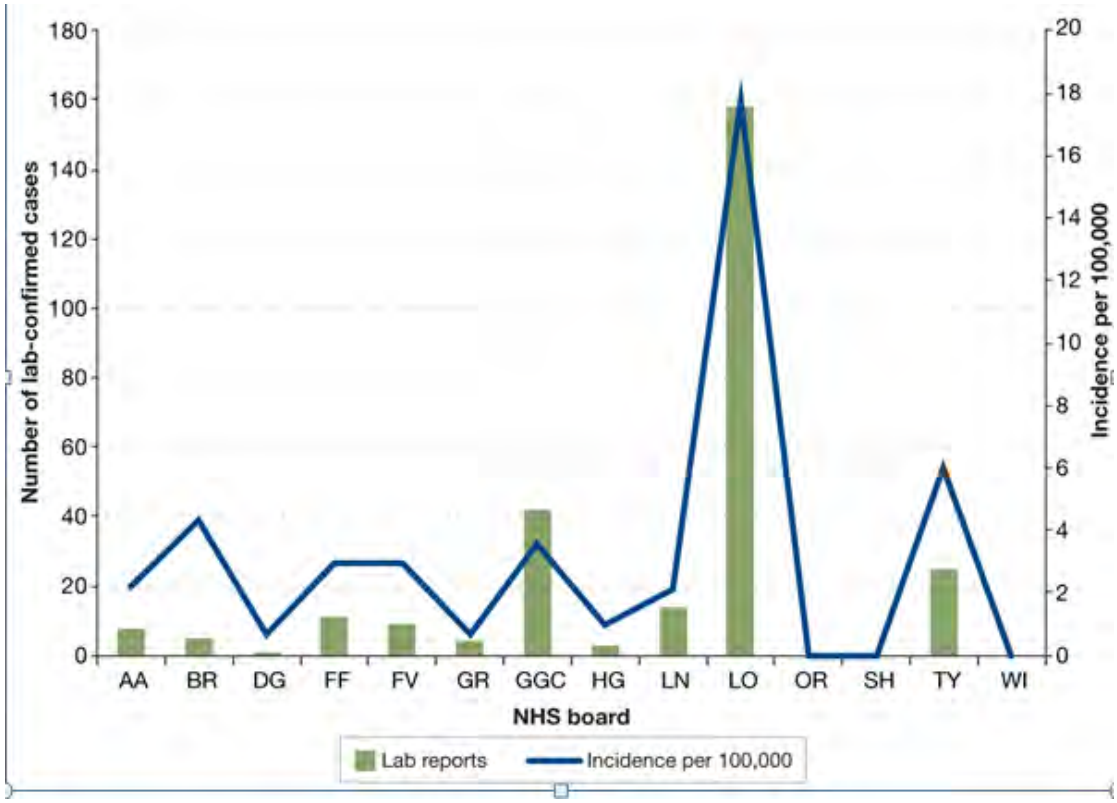


Figure 9: Number of confirmed cases by health board and rate per 100,000 2018



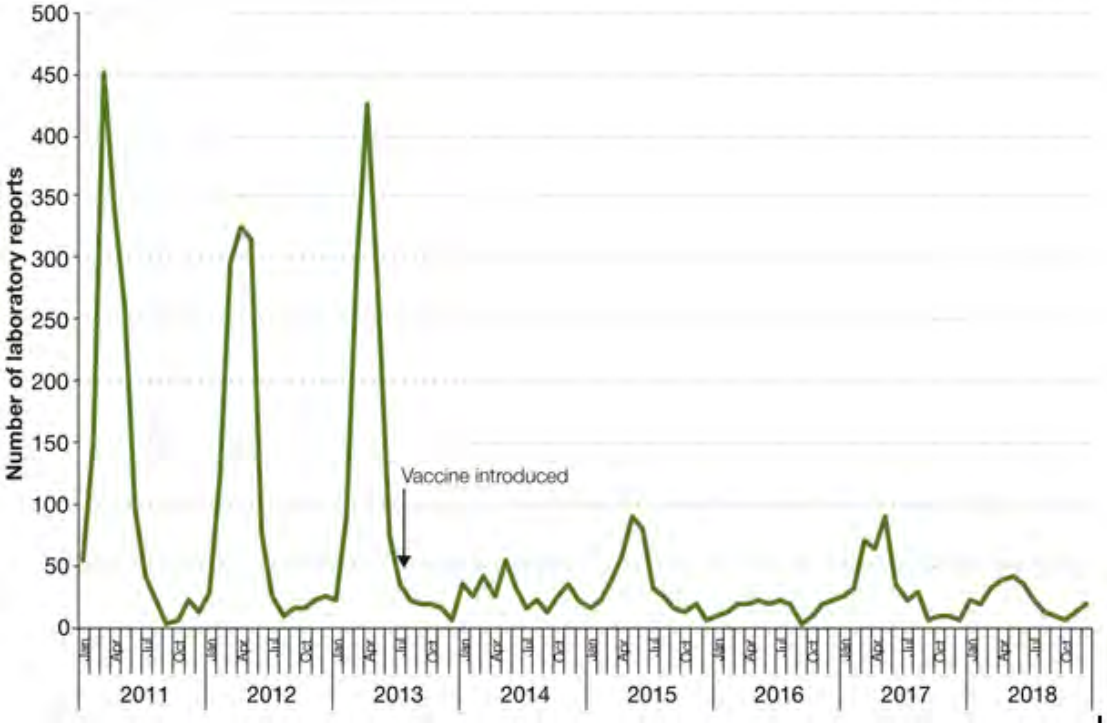
Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/mumps/

Rotavirus

3.20 Rotavirus infections in children and adults can last approximately 3 to 8 days and cause severe diarrhoea, vomiting, stomach cramps and mild fever. The combination of symptoms can lead to dehydration, requiring admission to hospital, especially in young infants. Prior to the introduction of a national infant rotavirus vaccination programme in 2013, an estimated 55,000 episodes of rotavirus-induced gastroenteritis occurred each year in children of less than 5 years in Scotland, and approximately 1200 of these children were hospitalised with a distinct seasonal pattern evident peaking February to April.

3.21 Figure 10 shows the number of rotavirus laboratory reports in Scotland from 2011 until 2018. Following the introduction of the immunisation programme there has been a marked reduction in numbers of laboratory reports and absence of the seasonal peak, which clearly demonstrates the impact of the vaccine. A reduction of laboratory confirmed rotavirus samples has also been seen in unvaccinated children suggestive of indirect herd protection due to the vaccine.

Figure 10: Laboratory reports of rotavirus in Scotland from 2011 to 2018



Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/rotavirus/

3.22 National level data on hospital admissions for rotavirus in children <5 years and also GP consultation rates for infants <1 year with gastrointestinal illness (only a small proportion of cases will be severe enough to lead to hospitalisations, but can nevertheless cause significant morbidity in the community) also demonstrate a clear impact on rates since the introduction of the rotavirus vaccine.

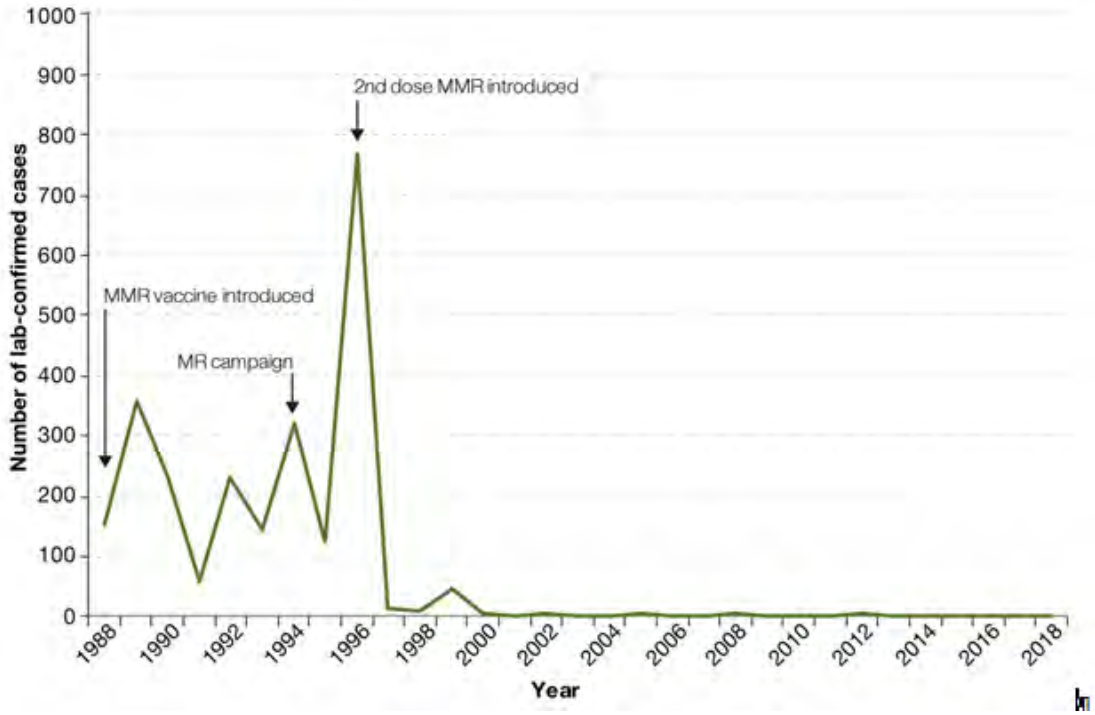
3.23 Data on hospital admissions due to rotavirus has not been analysed at board level, but it is hoped this data will be included in future reports.

Rubella

3.24 Rubella is an acute infection caused by rubella virus. It is generally a mild illness, but if acquired by women in early pregnancy (in the first 16 weeks) can have devastating effects on the unborn child, leading to congenital rubella syndrome. Before the introduction of rubella vaccination, more than 80% of adults had evidence of previous exposure to rubella. A vaccination programme targeting girls and non-immune women of child-bearing age was introduced in the UK in 1970 which reduced the number of congenital rubella syndrome births and terminations. In 1988, the measles-mumps-rubella (MMR) vaccine was introduced for both boys and girls and further decreased cases of rubella to near elimination levels.

3.25 In 2018, no laboratory-confirmed rubella cases were reported to Health Protection Scotland (Figure 11). This highlights the success of the MMR vaccination programme.

Figure 11: Number of laboratory-confirmed cases of rubella by year in Scotland from 1988 to 2018.



Source: Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/rubella/

Shingles

3.26 Herpes zoster or shingles is characterised by a painful vesicular skin rash. The disease is caused by reactivation of latent varicella zoster virus. The main complication of shingles is post-herpetic neuralgia (PHN), a long-lasting neuropathic pain after the rash has resolved. PHN can persist for months or years, and the risk and severity increases with age. In Scotland an estimated 7000 people aged 70 years and over develop shingles every year. Of these between 700–1400 develop PHN, with approximately 600 shingles-related hospitalisations each year. A national Shingles vaccination programme was introduced in the UK in September 2013. As it is a live attenuated vaccine, it is contra-indicated for some patients.

3.27 In the fifth year of the programme (1 September 2017 to 31 August 2018), the vaccine was offered to those aged 70 years old, and to a catch-up cohort of those aged 76 years. In addition, people eligible since the beginning of the programme in 2013 but who had not previously taken up the offer continued to be eligible until the age of 79.

3.28 As yet it is difficult to see a clear impact of the national programme on shingles hospitalisations at a national level. Most cases of shingles will be managed in the community without requiring hospitalisation, but the lack of impact on severe cases requiring hospitalisation may be in part due to the variable uptake with low rates overall.

Tetanus

3.29 Tetanus is a rare disease resulting from a neurotoxin produced during infection with *Clostridium tetani*. The case-fatality ratio can range from 10%-90%, with it being higher in the young and elderly. Immunisation against tetanus is the most effective method of disease prevention, and has been part of the childhood immunisation schedule since 1961. Altogether, five doses of tetanus vaccine are administered in the childhood immunisation schedule.

3.30 There have been no confirmed cases of tetanus in Fife since 2009.

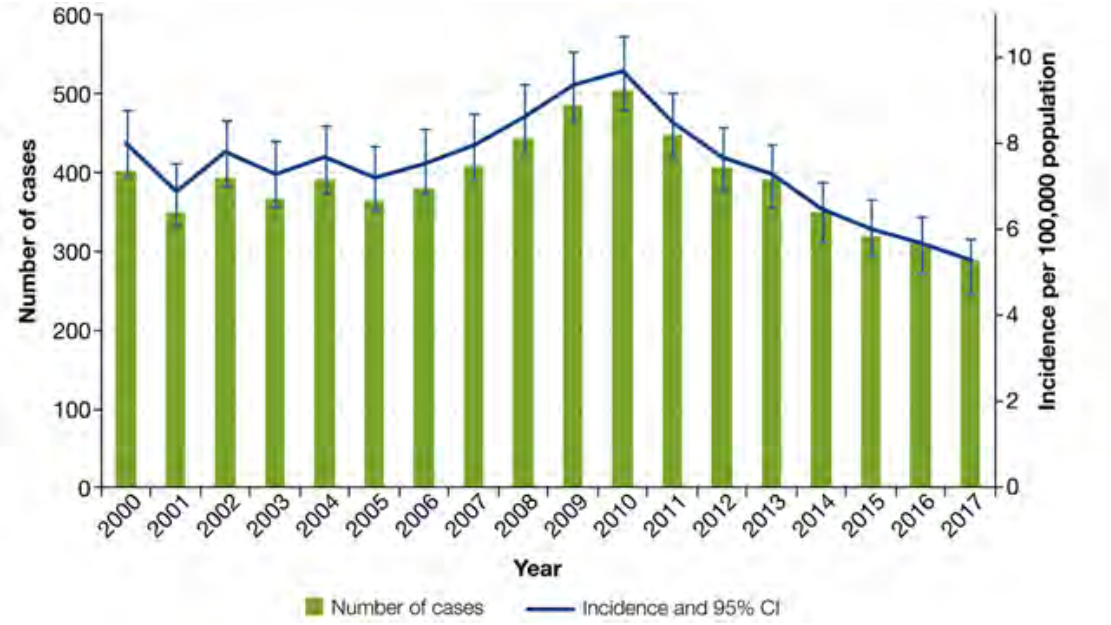
Tuberculosis

3.31 Transmission of tuberculosis (TB) is by inhalation of infected droplets, and requires prolonged close contact (e.g. sharing sleeping quarters) with an infected individual. An important feature of TB is that after infection, the bacteria can remain latent in the body for a long time causing no symptoms of disease. People with latent TB infection are not infectious. Under favourable conditions, the bacteria can start multiplying and cause clinical disease.

3.32 The BCG (Bacille Calmette Guérin) vaccine is offered to those babies who are more likely than the general population to come into contact with someone with TB. This is because they either lived in an area with high rates of TB, or their parents or grandparents came from a country with high rates of TB. These include countries in South-East Asia, sub-Saharan Africa and some countries in Eastern Europe.

3.33 The number of TB notifications in Scotland since 2000 has varied year to year, but with an overall downward trend (Figure 12). The proportion of cases seen in Fife remained low, with a total of 9 active cases diagnosed in 2017.

Figure 12: Number of TB cases and incidence in Scotland 2000 to 2017



Influenza

3.34 Influenza is an acute viral infectious disease, characterised by the sudden onset of fever, cough, malaise, headache and myalgia. Transmission is by inhalation of infected aerosols/droplets. Spread can occur very rapidly in the community, and especially in hospital and institutional settings. The most effective means of prevention against flu is inactivated flu vaccine, which is specifically tailored to the likely viruses in circulation each season. The vaccine is currently recommended for those aged 65 and over and other at risk individuals, as well as health and social care services staff.

4 VACCINE UPTAKE

4.1 This section of the report is divided up into three parts:

- Childhood routine immunisations
- Teenage routine immunisations
- Adult & selective immunisation programmes

Childhood routine immunisations

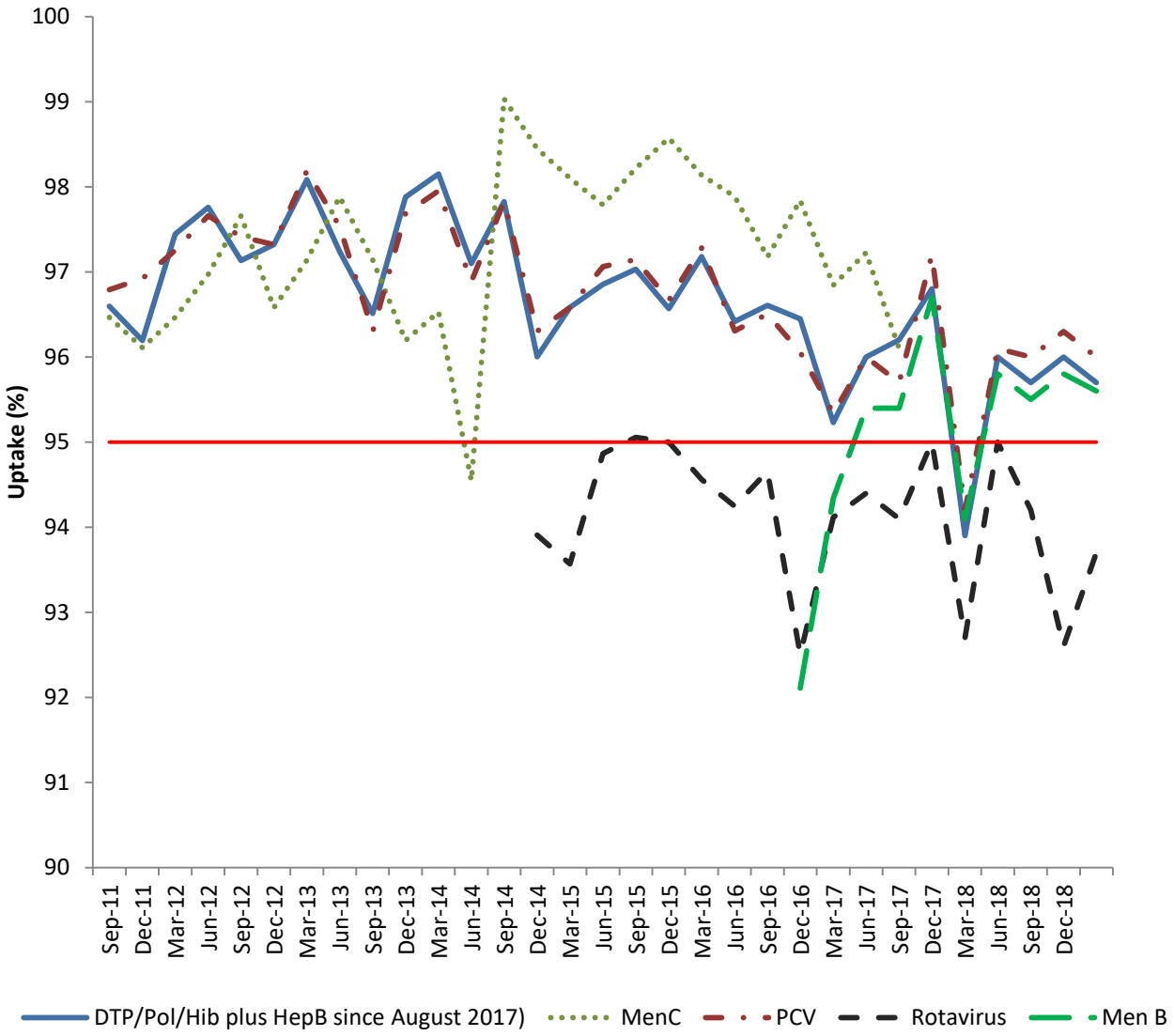
4.2 The standard reporting ages for childhood vaccine completion rates in the UK is 12 months, 24 months and five years of age. The childhood immunisation statistics are taken from the most recently available published data (ISD 26/03/19) which includes data to year end 31st December 2018.

4.3 Children should receive three doses of the DTP/Pol/Hib/Hep B vaccine, which protects against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and Hepatitis B before their first birthday. Since the introduction of Meningococcal C (MenC) vaccine to the immunisation schedule in 1999 there have been several amendments to the number and timing of required doses. The PCV vaccine was introduced to the routine childhood vaccination schedule in September 2006 and in September 2015, the UK was the first country to introduce the MenB vaccine into its routine immunisation schedule for children. The vaccine is offered alongside other routine immunisations at two and four months of age, with a booster dose at 12 to 13 months.

4.4 Overall in 2018, the 95% target for uptake at **12 months** (cohort = 3522) was met for DTP/Pol/Hib/Hep B (95.7%), PCV (96%) and MenB (95.6%) although all were slightly below the Scottish average (Figure 13). In 2018 overall uptake of the rotavirus vaccine at 12 months was 93.7%, slightly below the 95% target but above the Scottish average in 2018 of 92.8%[1].

[1] Rotavirus vaccination is unique in the routine childhood immunisation schedule in that administration of the vaccine is bound by strict age limits. Children require two doses of vaccine, given at least four weeks apart. The first dose should be given before 15 weeks of age. The second dose should be given before 24 weeks of age. These age limits mean that if a child is not vaccinated with the first dose early enough, due to missed appointments for example, then it may not be possible for them to complete the full two dose course before 24 weeks. This probably explains why uptake of the completed course of rotavirus vaccine is slightly lower than completed courses of the other vaccines offered in the first year of life.

Figure 13: Primary immunisation uptake rates by 12 months of age, by quarter, Fife.



4.5 Scottish Index of Multiple Deprivation (SIMD) data is available based on the registered GP - GP practice level data, these are matched onto national reference files to obtain information on SIMD, with SIMD quintile assigned based on the postcode of the practice (Figures 14, 15 & 16).

Figure 14: DTP/Pol/Hib/Hep B vaccine uptake rates by 12 months of age by SIMD 2016 quintile in NHS Fife; January to December 2018

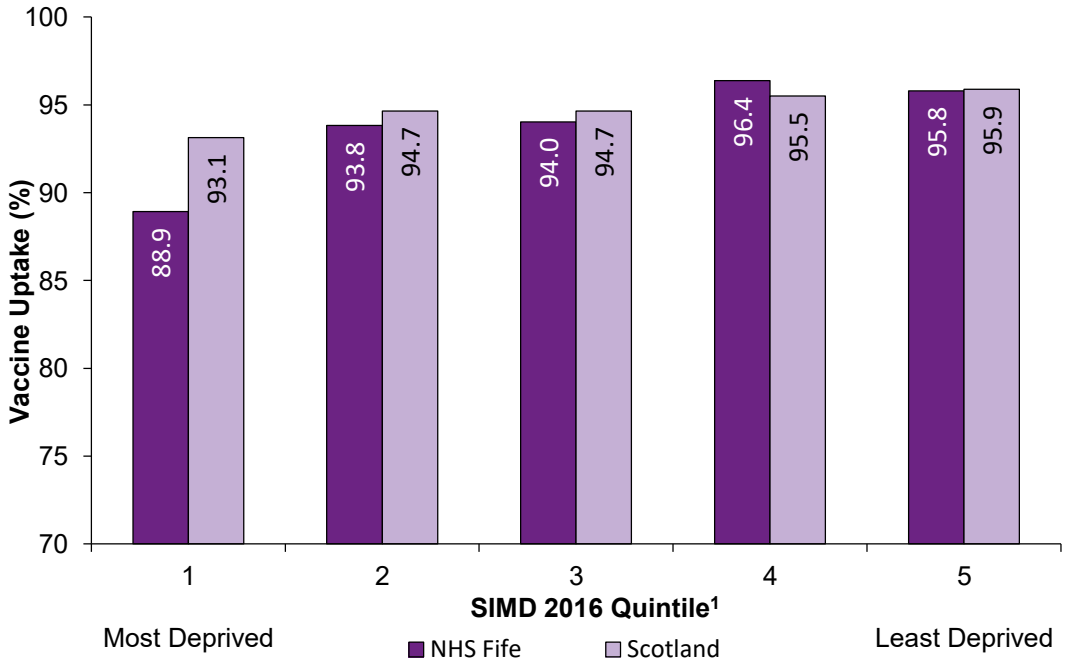


Figure 15: Rotavirus vaccine uptake rates by 12 months of age by SIMD 2016 quintile in NHS Fife; January to December 2018.

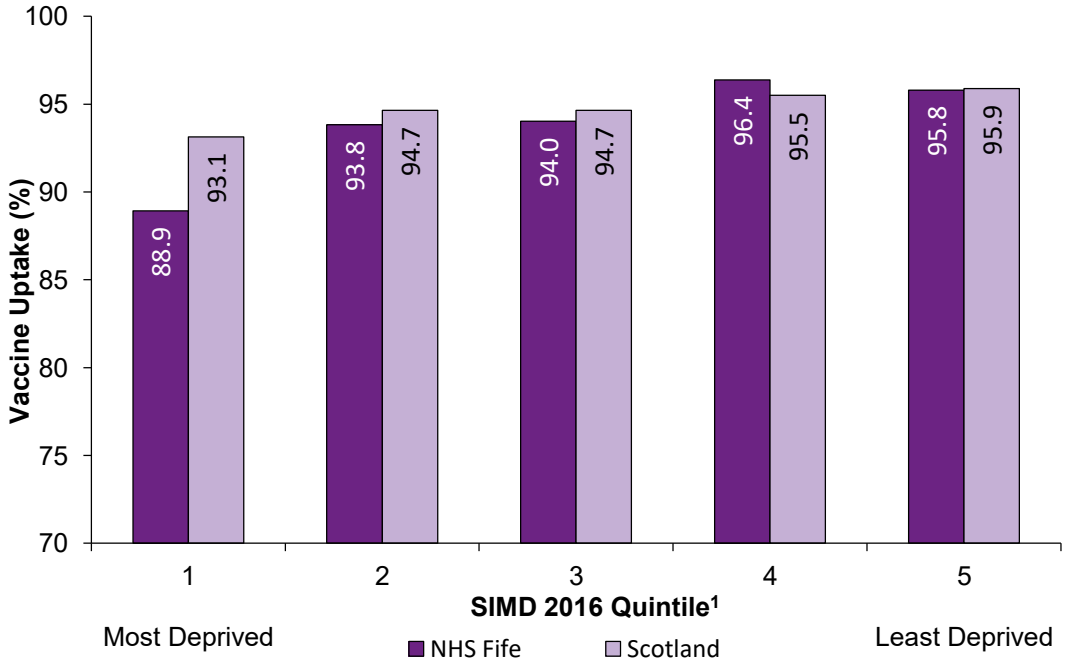
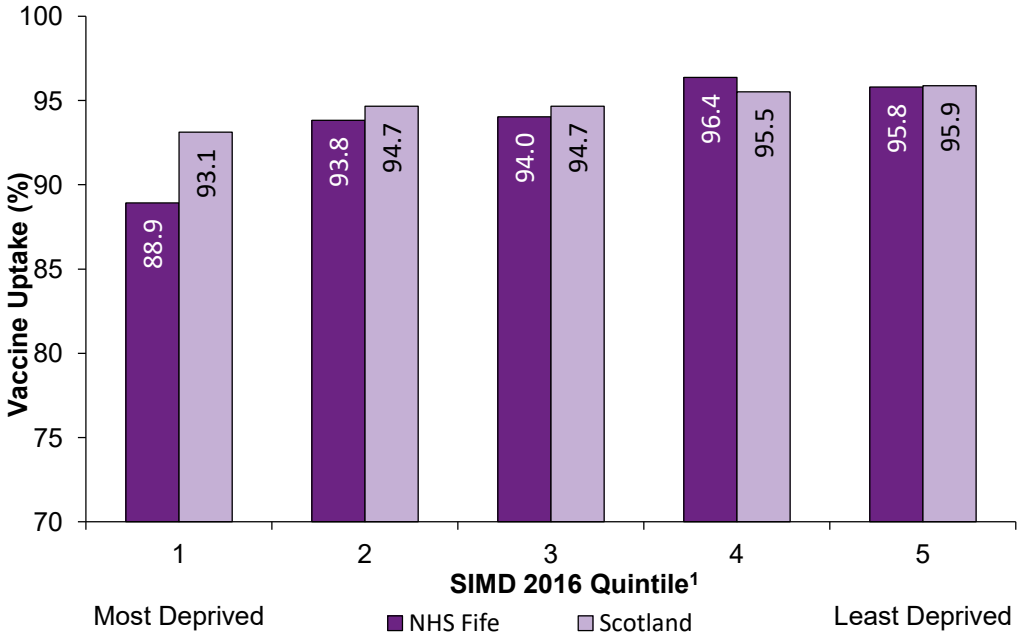
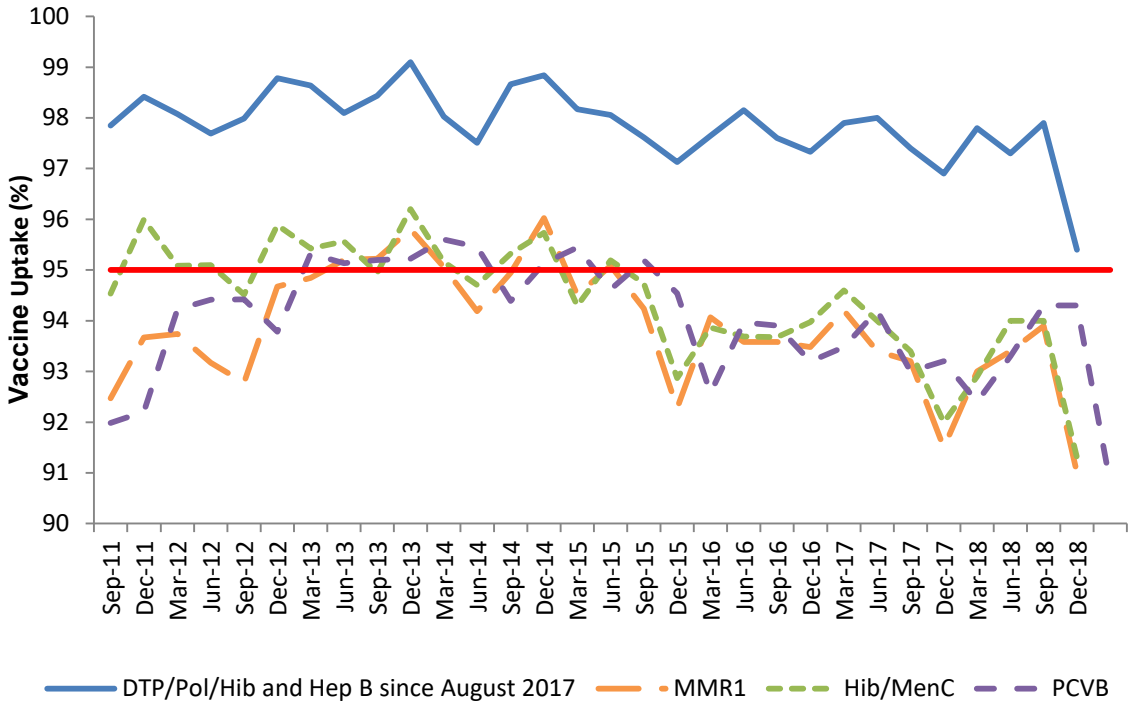


Figure 16: MenB vaccine uptake rates by 12 months of age by SIMD 2016 quintile in NHS Fife; January to December 2018.



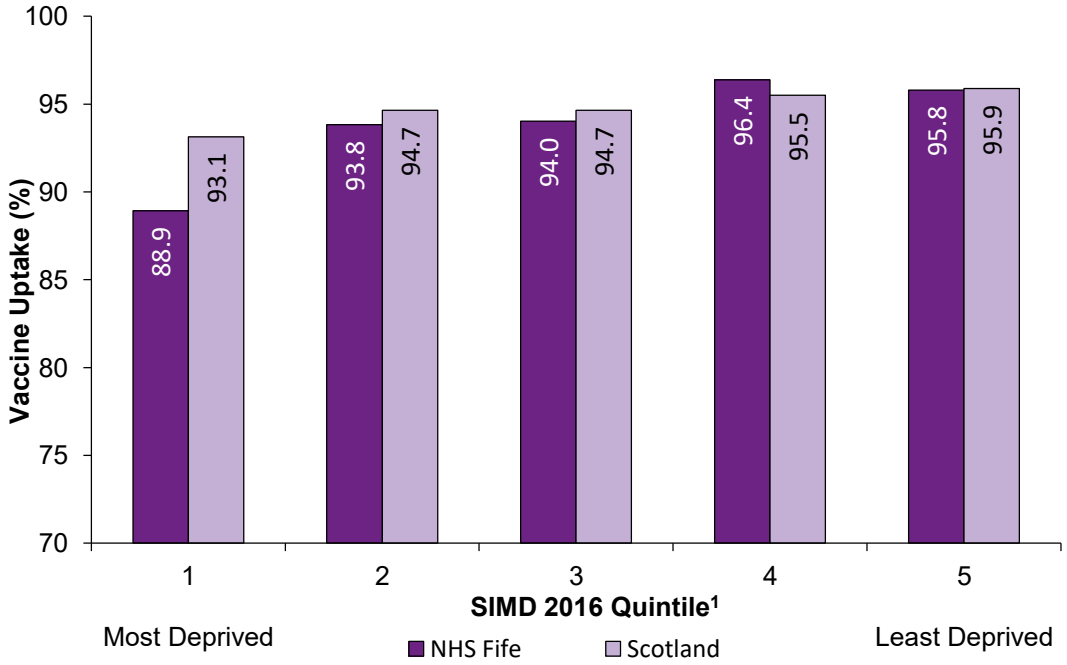
4.6 Uptake rates in 2018 by 24 months of age (cohort = 3522) are below the 95% target for Hib/MenC (93.2%), PCV boosters (93.3%), first dose of MMR vaccine (93.2%), Men B booster (92.6%), (Figure 17). Uptake rates at 24 months are below the Scottish average for all vaccines.

Figure 17: Primary and booster immunisation uptake rates by 24 months of age, by quarter



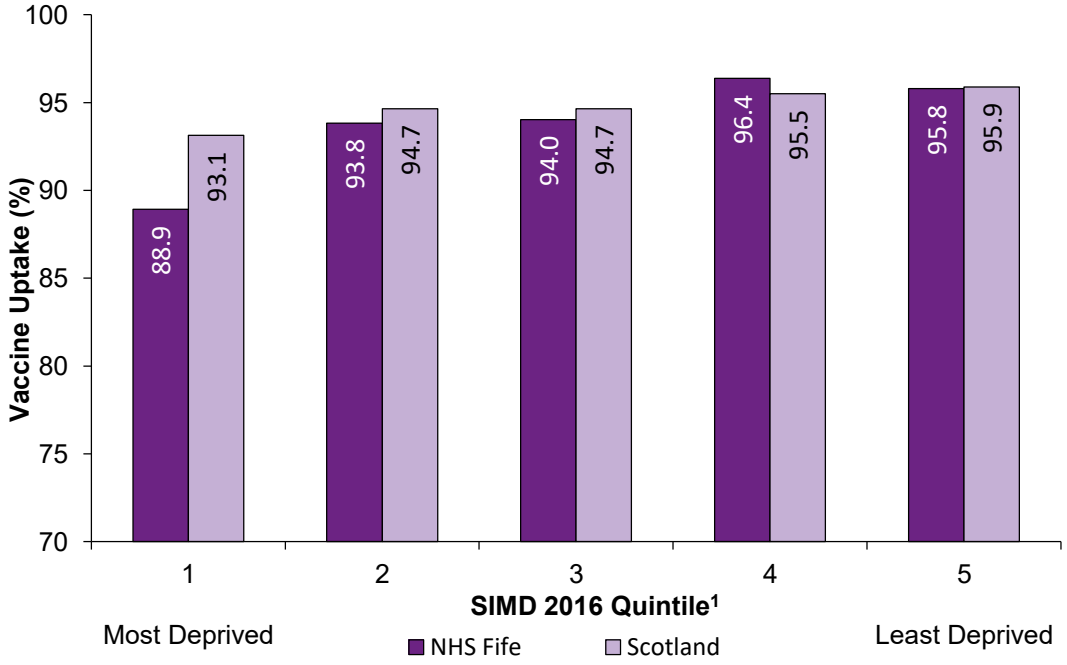
4.7 Scottish Index of Multiple Deprivation (SIMD) for MMR1 is available based on the registered GP - GP practice level data (Figure 18)

Figure 18: MMR1 vaccine uptake rates by 24 months of age by SIMD 2016 quintile in NHS Fife; January to December 2018



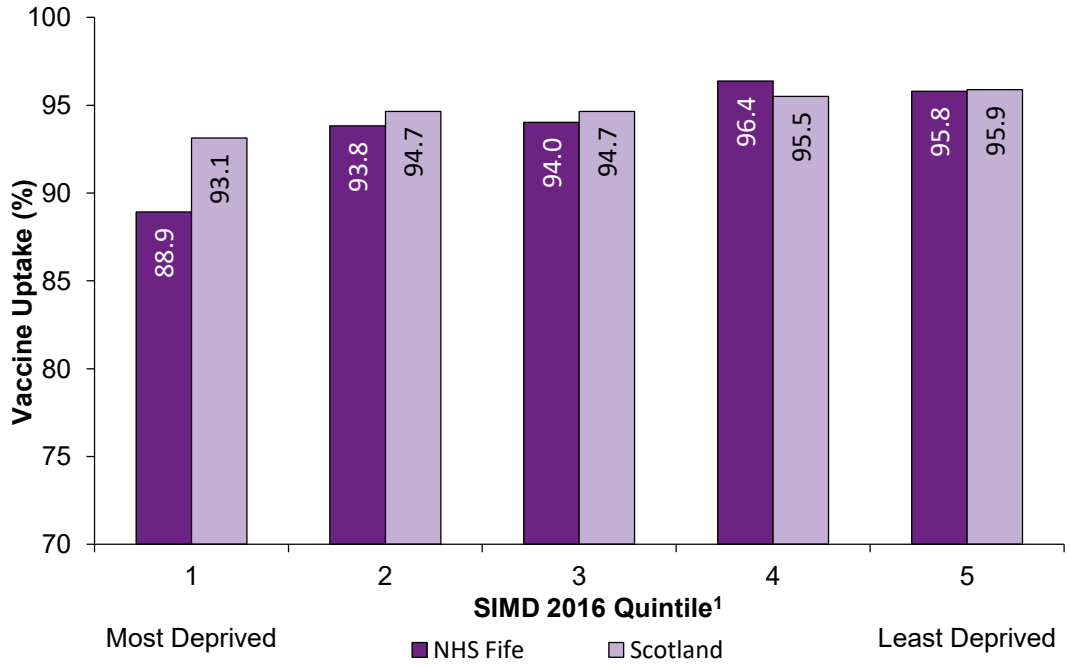
4.8 Scottish Index of Multiple Deprivation (SIMD) for Hib/MenC is available based on the registered GP - GP practice level data (Figure 19)

Figure 19: Hib/MenC vaccine uptake rates by 24 months of age by SIMD 2016 quintile in NHS Fife; Evaluation period: January to December 2018.



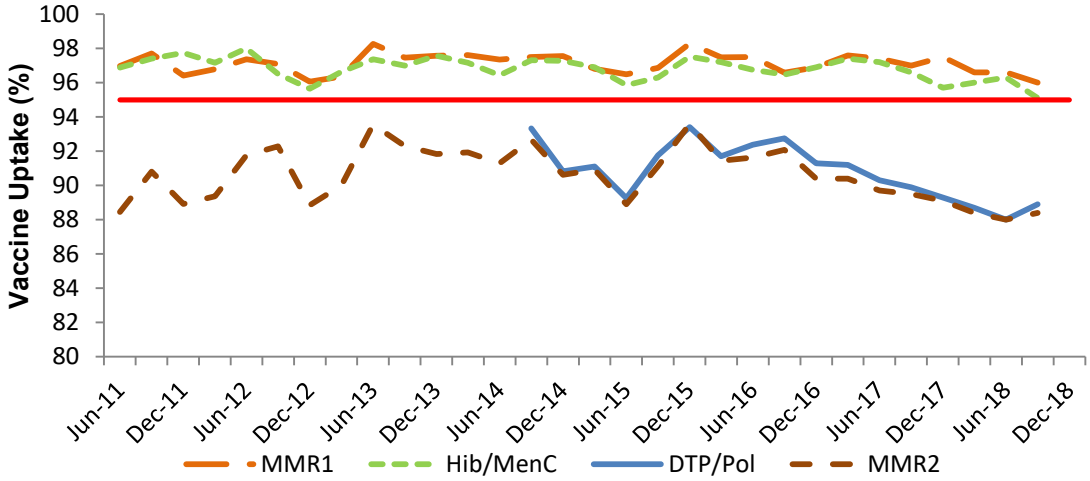
4.9 Scottish Index of Multiple Deprivation (SIMD) for PCV booster is available based on the registered GP - GP practice level data (Figure 20)

Figure 20: PCV booster vaccine uptake rates by 24 months of age by SIMD 2016 quintile in NHS Fife; Evaluation period: January to December 2018



4.10 Uptake of the vaccines normally given around three years four months of age has remained below the 95% target (figure 21). By **five years** of age uptake of two doses of MMR vaccine was 88.4%, and 88.7% had received the booster course of immunisation against diphtheria, tetanus, pertussis and polio. A short life working group has been established in Fife by members of the Area Immunisation Steering Group to produce an action plan for improving uptake rates. The actions in the plan include the implementation of stricter monitoring of uptake rates, innovative new ways of delivering immunisations including piloting of service delivery in Nurture Hub nurseries.

Figure 21: Immunisation uptake rates by 5 years of age, by quarter in Fife



4.11 Data is also available at six years of age (prior to 2006 this was the standard reporting age instead of five years); rates are slightly improved at this age indicating that some children are receiving pre-school immunisations after 5 years, with MMR2 at 92.4% and DTP/Pol at 92.9% in 2018.

4.12 From August 2018 a more robust system of identifying those with outstanding MMR was introduced. Schools with lower uptake are being targeted and pupils recalled ensuring that all school age children between the ages of 5-18 have greater opportunity to access MMR vaccinations.

Teenage routine immunisations

4.13 The teenage immunisation schedule includes a combined booster immunisation for tetanus, diphtheria and polio (Td/IPV, given around 14 years of age); an immunisation protecting against four strains of meningococcal bactieria (MenACWY) (Table 2) and two doses of HPV vaccine, which is offered to girls in Fife in S1 and S2 (Table 3).

4.14 Difficulties with ensuring accurate denominator pupil figures (for example, ongoing inclusion of children who are no longer at school still being included in school data) are estimated to contribute a potential 2-3% margin of error. This is exacerbated by higher than average between-school mobility within Fife compared with elsewhere in Scotland. Efforts are being made for the 2019-20 school year to cross-check against September school census data.

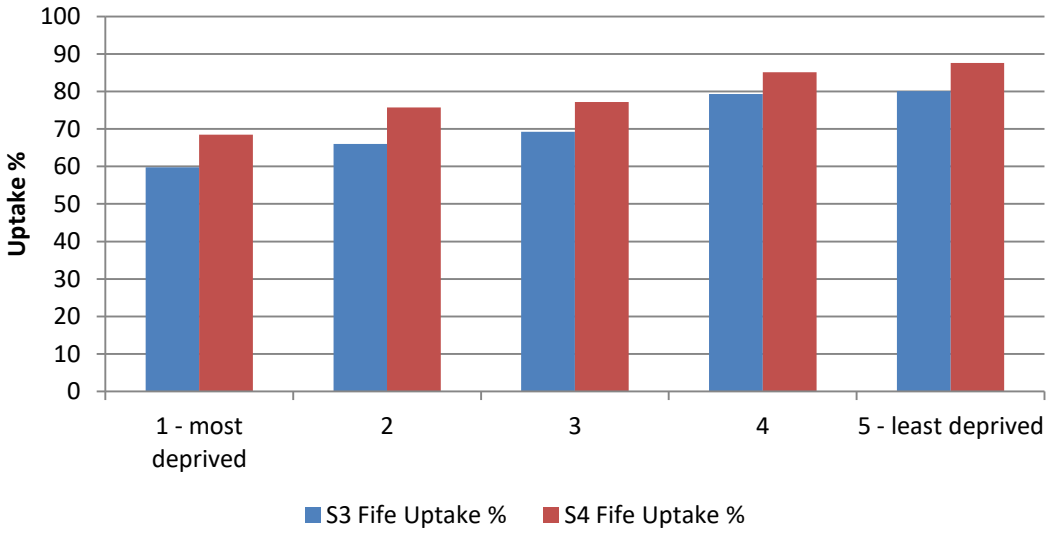
Td/IPV and MenACWY

Table 2: Td/IPV and MenACWY immunisation uptake rates by the end of the school year 2017/18

	Pupils in S3 (Fife cohort=3789)		Pupils in S4 (Fife cohort=3629)	
	Teenage Td/IPV booster	Teenage MenACWY	Teenage Td/IPV booster	Teenage MenACWY
Fife	69.5%	70.4%	77.7%	78.2%
Scotland	81.4%	81.9%	85.8%	85.9%

4.15 The socioeconomic gradient in MenACWY in S3 starts to narrow by S4 (Figure 22), indicating that opportunities for catch up are particularly important for pupils living in the most deprived neighbourhoods. A similar trend is evident for the booster immunisations for tetanus, diphtheria and pertussis (data not shown).

Figure 22: MenACWY immunisation uptake rates by the end of the school year 2017/18 by school year and deprivation category



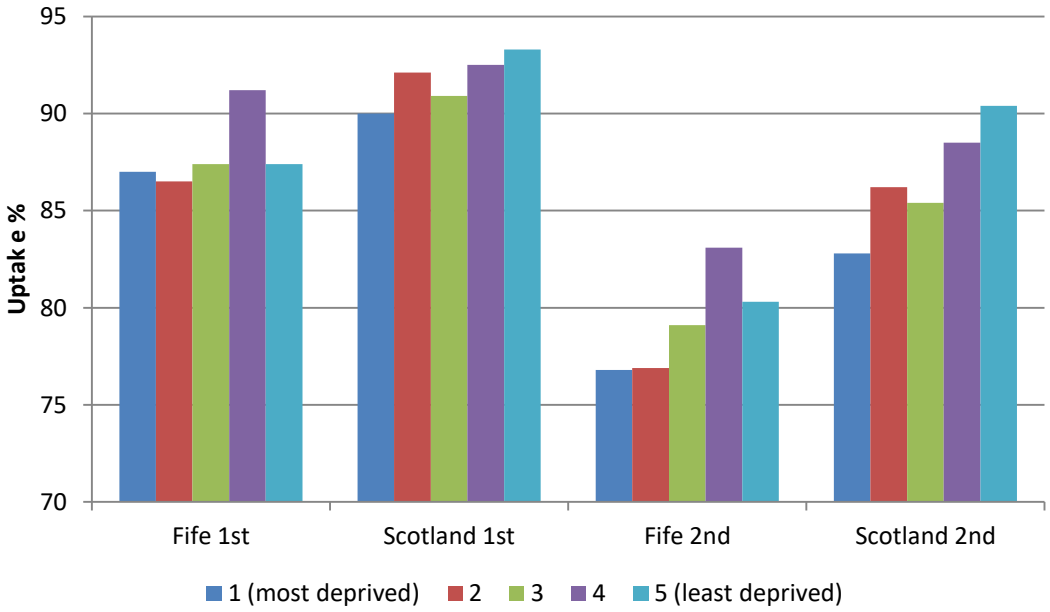
HPV vaccination

Table 3: HPV immunisation uptake rates by the end of the school year 2016/17 (Girls in S3)

	Dose 1 Uptake	Dose 2 Uptake
Fife (cohort = 1881)	87.8%	79.1%
Scotland	91.8%	86.6%

4.16 It can be seen that there is a socioeconomic gradient in HPV first dose uptake in Fife that is steeper than the gradient in Scotland (Figure 23). The gradient is exacerbated in both Fife and Scotland when you look at second dose rates. Of particular concern is that almost a quarter (24%) of S3 girls living in the most deprived areas of Fife have not received a second HPV dose. Since early 2019 an outcome is now required for every pupil eligible for a vaccination, a pro-active system is now in place to follow-up non-attendees on the day, either in school or by a telephone call to their parent. This will ensure that the pupil is reappointed for vaccination either at another time in school or at a community clinic.

Figure 23: Uptake of the first and second doses of HPV immunisation by the end of the school year 2017/18 by deprivation category (Girls in S3).



Summary of vaccine uptake inequalities in childhood and teenage programmes

4.17 Appendix 1 provides a summary of inequalities in vaccination uptake using four different measures of inequalities. Data from 2017 and 2018 are shown for comparison. The first two measures are straightforward calculations of the absolute range (difference between rates in the most and least deprived quintiles) and the relative range (the ratio of the uptake in the most deprived group compared to uptake in the least deprived group). These two measures overlook the changes in the intermediate groups and do not take into account the sizes of the groups being compared.

4.18 As such, we have also calculated two alternative measures of absolute and relative inequality - the Slope Index of Inequality (SII) and Relative Index of Inequality (RII). The SII can be interpreted as the absolute effect on uptake of moving from the most deprived to the least deprived grouping. The RII is a measure of the relative inequality of uptake rates and compares ratios rather than absolute differences.

4.19 The data shows that inequalities increase with age across the immunisation programme. Absolute and relative inequalities (measured by SII and RII) are greatest in the teenage MenACWY programme at S4. There has been a welcome decrease in inequalities (SII and RII) in the HPV programme at S3 in the 2017/18 school year compared with the 2016/17 school year. However there has been an increase in inequalities in the S4 uptake of Td/IPV and MenACWY. We will continue to measure inequalities in the annual data to see if this trend continues.

4.20 Catch-up opportunities for vaccination are offered through to S6 through an active call-recall system, and further innovative work is under way in 2019 to improve teenage uptake and recall all young people who have outstanding vaccinations.

4.21 A short life working group (SLWG) has been established by members of the Area Immunisation steering group. The SLWG has been tasked with monitoring and evaluating the service and implementing an action for the 2019/20 school year.

Adult and selective immunisation programmes

Pneumococcal

4.22 The pneumococcal polysaccharide vaccine (PPV23) is recommended for individuals from 2 years or over in clinical risk groups, and all individuals aged 65 years and over, with prioritisation given to those newly diagnosed in high and moderate clinical priority groups as specified by Health Protection Scotland. Supply constraints have made it more difficult in previous years for practices to offer this one off vaccine to low priority groups (e.g. healthy people aged 65 and over) alongside the annual influenza vaccine during the 2017-18 flu season.

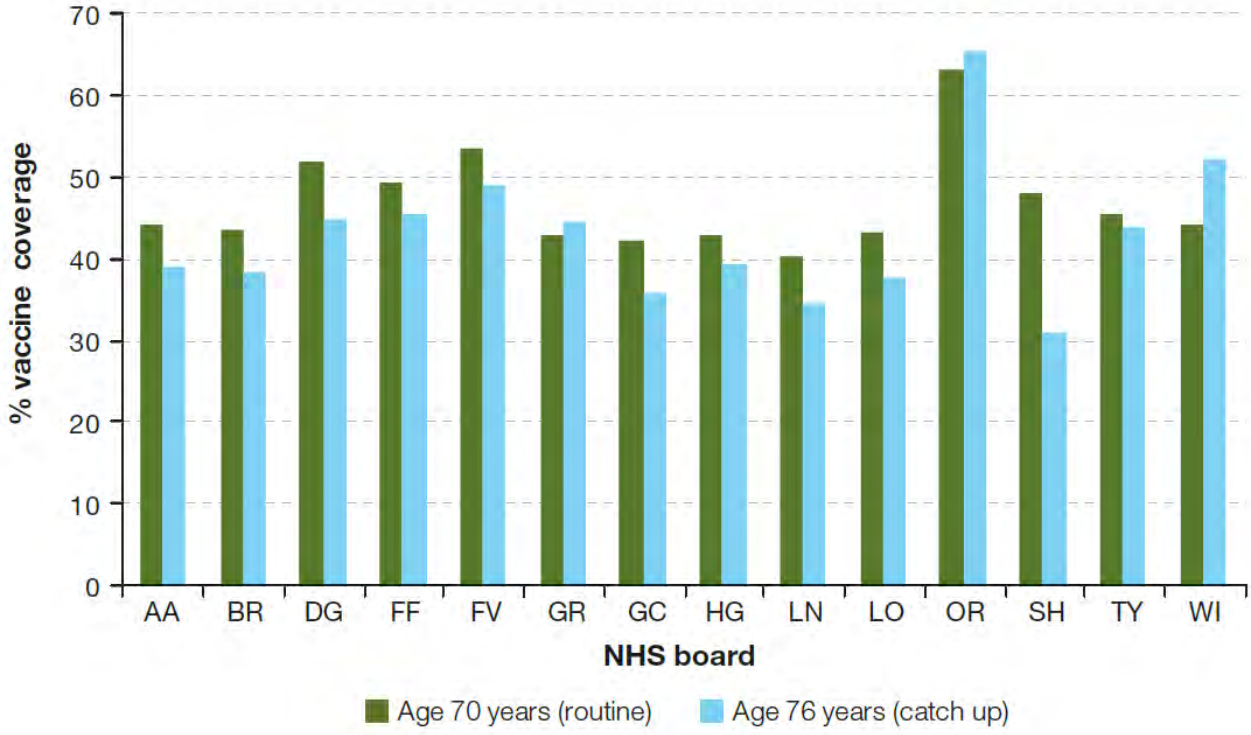
4.23 This is the first year that PPV23 uptake and coverage data has been available for Scotland and by NHS board. In the 2017/18 season the Fife uptake for those aged 65 years and over, having ever received PPV since the start of the programme was 70.5%, this was higher than the Scottish average of 67.9%. For those over the age of 75 the uptake rates were 82.6% for Fife and 79.8% for Scotland. There is a clear increase in coverage in each year of age, with the Fife rates increasing from 30.3% uptake at age 65 to 73.2% for ages 70-74, which suggests that vaccination is taking place opportunistically even if not within the first year of the programme.

Shingles

4.24 In Fife uptake for the 70 year old cohort was 49.48%, and 45.78% for the 76 year old cohort during 2017/18 (Figure 24), representing a decrease from the previous years (Figure 25). Practice level data for the 2017/18 season demonstrate a wide variation in coverage between GP practices in Fife, with uptake for the 70 year old cohort (total n=5202) ranging from 0% to 94.44% in Fife practices, and for the 76 year old catch up cohort (total n=2645) uptake ranging from 0% to 80.00%. Similar wide variation in vaccine coverage between GP practices is seen in other Boards in Scotland. This may be due to a number of factors including confusion over the eligible cohorts, and separation from flu vaccine clinics because of the additional time needed to identify patients contra-indicated for vaccine.

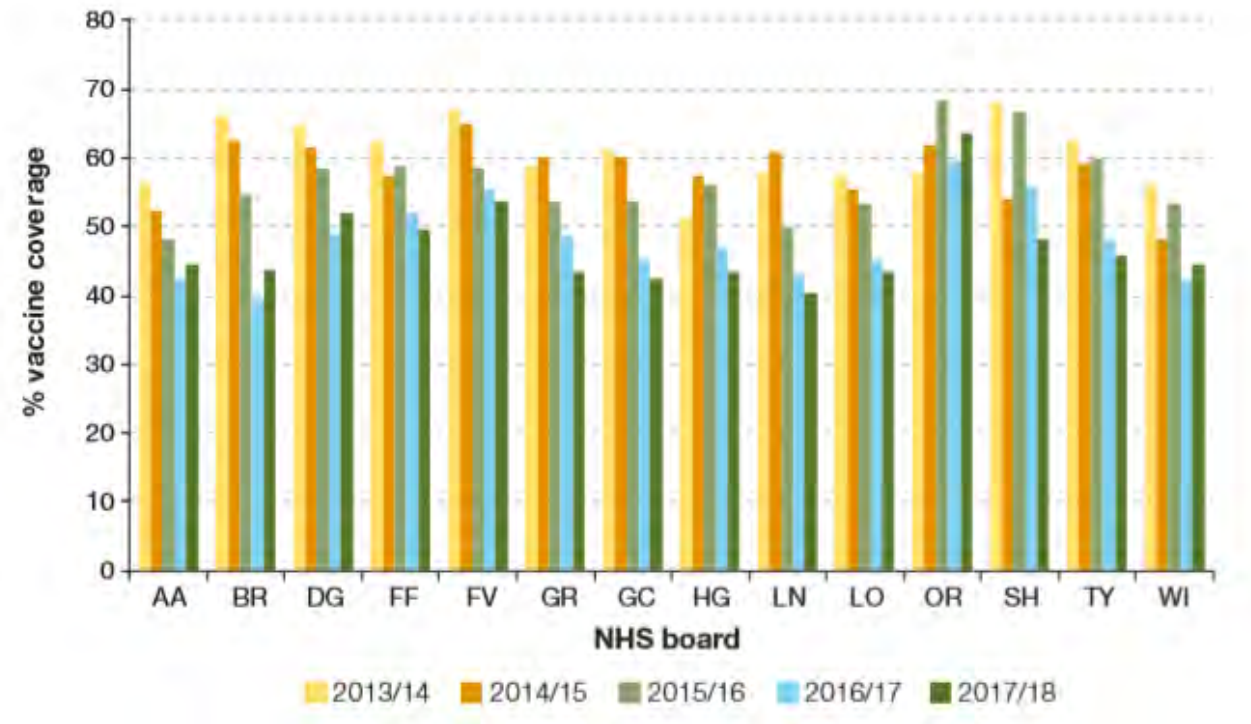
4.25 The introduction of a new non-live Shingrix® shingles vaccine and widening of the shingles vaccination programme is being explored. The Joint Committee on Vaccination and Immunisation recently recommended that the zoster vaccination programme be changed. The Committee recommended that those aged between 60 and 70 years should also be offered Shingrix®. The Committee recommended a two-dose schedule. This vaccine does not require the complex assessment required for the current live vaccine and it is hoped that this will increase uptake rates and reduce variation.

Figure 24 :Vaccine coverage for the routine and catch-up cohorts by NHS board, 2017/18



4.26 Figure 25 presents the annual shingles vaccine coverage in the routine cohort by NHS board from the start of the programme until 2017/18 and shows a continued overall decreasing trend in coverage across all of the NHS boards. A slight increase in coverage from the 2016/17 season was observed however in 5/15 NHS boards.

Figure 25 Annual shingles vaccine coverage for routine cohorts by NHS board from 2013/14 to 2017/18



4.27 For both males and females, vaccine coverage was higher in the routine cohort compared to the catch-up cohort (43.2% compared to 37.9% for males, 42.6% compared to 36.4% for females). In the routine cohort, coverage for males and females was not significantly different ($p = 0.245$), whereas in the catch-up cohort uptake for females was significantly lower than for males ($p < 0.023$).

Season Influenza 2018-19

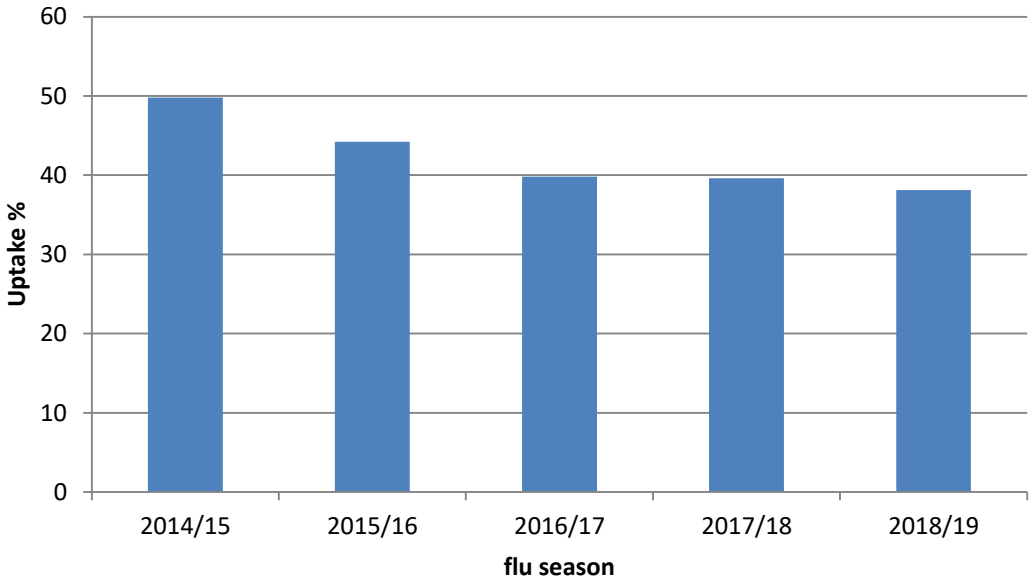
4.28 Uptake targets for both the 65 years and over group, and the under 65's "at-risk" population for seasonal influenza vaccine are 75%, in line with World Health Organisation targets.

4.29 During the 2018/19 season, different vaccines were offered to the cohort aged 75 and over, and the cohort aged 65-74 years. Uptake in Fife was 78.8% for the 75-and-over age group (Scotland 79.3%) and 68.6% for the 65-74 age groups (Scotland 69.3%). Uptake of seasonal flu vaccine for the combined cohort of those aged 65 and over (n=75,959) was 73.0% in Fife, which is slightly below the Scottish average (73.7%) and close to the 75% target.

4.30 Uptake of seasonal flu vaccine in those falling into under 65 at-risk groups (cohort n=53,060; excludes healthy pregnant women and carers) was poor at 38.1%. This compares to a Scottish average of 42.4% and is well below the target of 75%. There has been a general trend in falling rates for this group across Scotland over the period from 2014-15, and this drop has been marked in Fife (figure 26). This year we have seen a targeted media campaign in Scotland to encourage people in the under 65 at-risk groups to attend for flu vaccination, as uptake is low across the country. In Fife options appraisals for delivery of adult flu are being considered in an attempt to improve uptake.

4.31 Immunisation of primary school aged children was 71.1%, similar to uptake in previous years (Scotland 72.9%). Pre-school seasonal flu vaccine uptake (delivered by GP practices) was 55.5% in Fife, just below the Scottish average of 55.6%, below the 75% target but an increase from the previous year.

Figure 26: Scottish influenza uptake for NHS Fife for under 65 at risk group compared to previous 4 seasons.



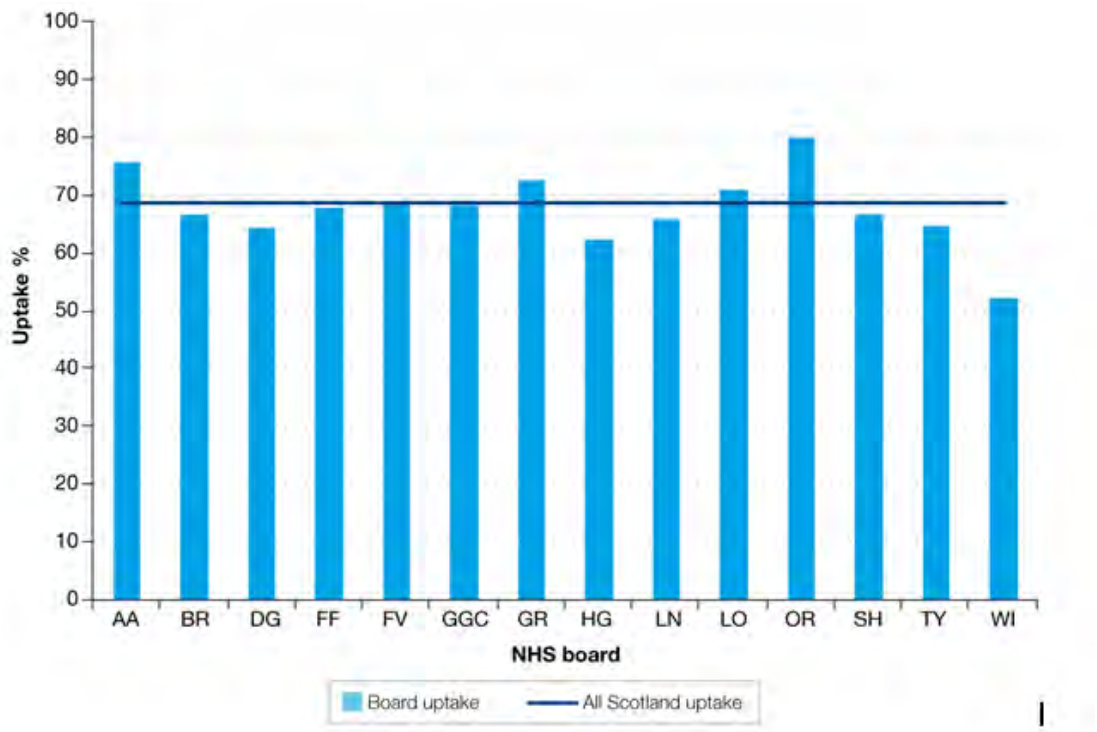
4.32 Vaccine uptake in healthy pregnant women in Fife (cohort n=2,442) was 43.4%, slightly below the Scottish average of 44.5% and well below the 75% target.

4.33 The NHS Fife staff flu uptake rate was 54.9% overall (Scotland 51.2%). Of the 14 territorial health boards, NHS Fife had the fifth highest uptake but did not meet the 60% national target. The uptake among frontline staff was 56.0%, and the uptake among non-frontline staff was 52.6%. Overall staff uptake was slightly lower than that achieved in the previous 2017/18 season (56.6%) but sustained the marked improvement from years prior to this (2016/17 = 26.9%). Plans for the 2019/20 staff vaccination programme are in progress, with a team looking at extending peer vaccination to increase availability of vaccination and increase in uptake rates.

Pertussis – pregnant women

4.34 Overall pertussis vaccine uptake among pregnant women during 2018 in Fife (cohort n=1852) was 65.9%, slightly under the Scottish average (66.76%) (Figure 27). Uptake rates at practice level ranged from 18.9% to 100%. Nine practices in Fife sat below the 60% figure and 15 sat above the 75% figure. As part of the vaccine transformation programme in Fife this vaccination has recently transferred to Midwifery services. The vaccine is now offered at a routine midwife appointment and removes the requirement for women to make a separate GP appointment. It is hoped that this move will increase the uptake of pertussis vaccination for pregnant women.

Figure 27: Pertussis uptake among pregnant women, by NHS Board 2018



Hepatitis B - babies born to hepatitis B infected mothers

4.35 In 2018 <5 babies in Fife were born to hepatitis B positive mothers and required vaccination. Vaccine uptake for 2018 was 75%. A new protocol has been developed in an attempt to increase uptake, vaccination rates are prone to fluctuations due to the small numbers.

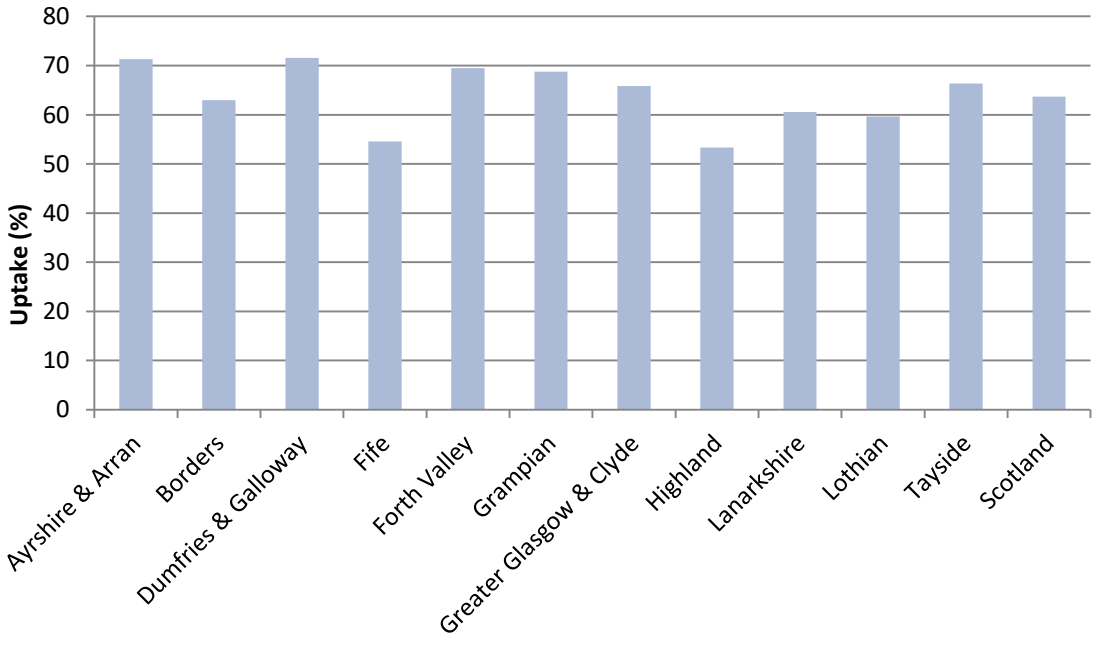
Infant BCG

Data on BCG vaccine uptake rates for infants in high risk groups in Fife are not available for this report. The infant BCG programme in Fife is provided by paediatric services, children over the age of 1 year are referred to a Health Protection Nurse clinic where they are screened for Tuberculosis before vaccination is given.

HPV – Men who have sex with Men (MSM)

4.36 Introduction of HPV vaccination for MSM was initiated in Scotland on 1st July 2017, the vaccine is offered to MSM ≤45 years attending sexual health or HIV clinics. From the period 1st July 2017 – 30 June 2018 there was a cohort of 407 MSM in attendance at clinics in NHS Fife and uptake rate for HPV was 54.5% (Figure 28)

Figure 28 – MSM HPV uptake by board, 1 July 2017 - 30 June 2018



5 DEVELOPMENTS IN 2018

5.1 The Vaccination Transformation Programme (VTP) has progressed across Scotland, to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

5.2 The VTP is part of a portfolio of work to reconfigure GP services under the new GMS contract over a three year period to 2021. At a national level this portfolio is overseen by the Primary Care Programme Board.

5.3 Key developments in 2018 under the VTP included the significant expansion of the immunisation team to enable centralised delivery of all school and childhood immunisations that had previously been delivered by GP's, school nurses, and health visitors.

5.4 A Fife wide procedure for babies born to mothers with Hepatitis B infection and/or babies born into a household where a member (other than the mother) is known to be infected with Hepatitis B.

5.5 In September 2018 the immunisation team collaborated with the Student Support Service at St Andrew's University to support immunisation of new students that had not received MenACWY vaccination prior to arrival.

5.6 Promoting Effective Immunisation Practice is an online education resource developed by NHS Education for Scotland and Health Protection Scotland, based on national standards for immunisation practice. The total number of participants completing the online training module in Fife in 2018 was 7. Face-to-face immunisation training sessions have been held in 2018, 430 participants booked places on this course.

5.7 A short life working group was established to monitor and evaluate childhood and teenage immunisation programmes and rates. Innovative targeted delivery methods are being piloted in an attempt to increase uptake rates.

5.8 Governance arrangements have been finalised (Appendix 5).

6 SUMMARY

6.1 This report has highlighted the findings from surveillance data on vaccine preventable disease in Fife, as well as vaccine uptake rates across childhood, teenage and adult immunisation programmes. Whilst rates of vaccine preventable disease are generally low in Fife, outbreaks elsewhere in the UK and Europe (for example, the measles outbreak in England) are a reminder of the importance of maintaining high vaccination uptake rates in the population. Pro-active actions are being taken in Fife to increase uptake rates across all groups, with particular focus on areas of higher deprivation where uptake is lower.

6.2 Historically Scotland has generally performed strongly for vaccination uptake rates of the childhood programme, compared to the rest of the UK. However, whilst uptake still remains high, there have been recent concerns that completion rates at 12, 24 months and 5 years are showing a downward trend. In Fife, performance on many of the routine childhood immunisations is slightly below the Scottish average. An action plan that sets out the measures required to extend access in communities has been established, with an aim to increase uptake rates in the childhood programme.

6.3 Further work is needed to explore and understand areas of inequality in childhood teenage immunisation rates in Fife. It is encouraging that inequalities in HPV vaccination appear to have reduced, but data in future years is needed to see if this is sustained. Inequalities in the teenage booster and MenACWY programme require further attention. It is hoped that an inequalities strategy, alongside the implementation of VTP in Fife, will be able to address inequality issues that exist.

6.4 Uptake rates of the shingles vaccine and seasonal flu vaccine in under 65 at risk groups are a concern. Whilst rates in Fife reflect similar national trends, the wide variation in rates at GP practice level demonstrates that significant improvements can be made. Whilst delivery of these immunisations has not yet transferred to the centralised team, they are working closely with GP Cluster Quality Leads, to look at the best approaches and models of delivery to improve uptake in these programmes over the next two years.

6.5 Overall this report has identified low rates of vaccine preventable disease in Fife, but declining immunisation uptake rates in the childhood, pre-school and senior school programmes. This fall in uptake rates leaves our young populations at risk of seeing a re-emergence of communicable diseases, which for some years have been in decline or no longer circulating in Fife. It is clear that over the next two years it will be essential that close monitoring of uptake rates continues, immunisation services are as accessible and flexible as possible, and that inequalities are addressed in the new models of delivery.

7 ACKNOWLEDGEMENTS

7.1 The provision of immunisation programmes in Fife is dependent on the combined continued efforts of:

- Dr Esther Curnock, Consultant in Public Health/Deputy Director of Public Health and Chair of Fife Area Immunisation Steering Group.
- Ms Dona Milne, Director of Public Health and Executive Lead for Immunisations.
- Fife General practitioners, practice nurses, and practice administration staff
- Fife Immunisation Team
- Child Health Department, Children's Services
- Pharmacy, Community Services
- Public Health Department, NHS Fife
- Immunisation and Vaccine Preventable Diseases Team at Health Protection Scotland
- Population Health Analytics and Intelligence, NHS National Services Scotland
- Scottish Immunisation Programme, Scottish Health Protection Network

7.2 For their contribution to the compilation of this report I would like to thank members of the Immunisation Team, members of the NHS Fife Health Protection Team, and colleagues from Health Protection Scotland and National Services Scotland.

8 APPENDICES

Appendix 1: Childhood and teenage vaccine uptake inequalities (12 & 24 month uptake data 2018; teenage uptake data 2017/18 school year)

Vaccination	Age	Absolute range		Relative range		Slope Index of Inequality		Relative Index of Inequality	
		2017	2018	2017	2018	2017	2018	2017	2018
DTP/Pol/Hib/HepB*	12 months	4.15	4.67	0.96	0.95	5.24	6.00	0.05	0.06
MenB	12 months	3.96	4.11	0.96	0.96	4.73	4.87	0.05	0.05
PCV	12 months	4.58	3.99	0.95	0.96	5.58	5.11	0.06	0.05
Rotavirus	12 months	3.93	4.70	0.96	0.95	4.92	5.83	0.05	0.06
MMR1	24 months	6.35	8.34	0.93	0.91	8.31	10.76	0.09	0.12
Hib/MenC	24 months	6.19	7.30	0.94	0.92	8.27	9.28	0.09	0.10
PCV booster	24 months	6.68	6.88	0.93	0.93	8.64	8.88	0.09	0.10
Men B Booster	24 months		7.85		0.92		9.83		0.11
HPV Dose1	Teenage (S3)	8.26	0.43	0.91	1.00	10.35	2.60	0.11	0.03
HPV Dose2	Teenage (S3)	12.82	3.49	0.86	0.96	14.66	6.53	0.18	0.08
Td/IPV booster	Teenage (S4)	10.59	19.07	0.88	0.78	15.82	24.23	0.19	0.31
MenACWY	Teenage (S4)	10.84	19.09	0.88	0.78	16.05	23.98	0.19	0.31

**DTP/Pol/Hib only in 2017*

Appendix 2: Abbreviations

Hib = Haemophilus influenzae type b (Hib) vaccine

DTP/Pol/Hib = the 5-in-1 vaccine which protects against diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib).

DTP/Pol/Hib/Hep B = the 6-in-1 vaccine which protects against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and Hepatitis B.

MenC = Meningococcal serogroup C conjugate vaccine

PCV = Pneumococcal conjugate vaccine

MenB = Meningococcal Group B

MMR1 = Measles, mumps, and rubella vaccine (1st dose)

Hib/MenC = Hib/MenC booster vaccine

PCVB = Pneumococcal conjugate vaccine booster

MenB (Booster) = Meningococcal Group B booster

DTP/Pol = the 4-in-1 booster vaccine which protects against diphtheria, tetanus, pertussis and polio.

MMR2 = Measles, mumps, and rubella vaccine (2nd dose).

Appendix 3: Routine childhood immunisation schedule from autumn 2018

The routine immunisation schedule			from Autumn 2018	
Age due	**Diseases protected against**	**Vaccine given and trade name**		**Usual site**
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[2] or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age groups[1]	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[2, 3]	Fluenz Tetra[2, 3]	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[2] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumococcal Polysaccharide Vaccine	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[2]	Upper arm

Source: https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

Appendix 4: Immunisation Catch-up Programmes

Meningococcal B (MenB) vaccination was introduced from 1 September 2015 for infants due to receive their primary immunisations starting at two months of age (i.e. those babies born on or after 1 July 2015). The vaccine is offered alongside other routine immunisations at two and four months of age, with a booster dose at 12 to 13 months. A limited one-off catch-up programme was also delivered targeting infants born in May and June 2015 who were receiving other routine immunisations, at three and four months of age.

The HPV Immunisation programme in Scotland started on 1 September 2008. The programme aims to help protect girls against developing cervical cancer later in life by routinely immunising them in early secondary school. A catch-up programme for older girls ran over the three-year period from 1 September 2008 to 31 August 2011 and applied to girls who were aged 13 to under 18 years on 1 September 2008.

On 4 September 2006, Pneumococcal Conjugate Vaccine (PCV) was introduced to the routine childhood immunisation programme to protect children from pneumococcal infection. A catch-up campaign started on 4 September 2006 to offer PCV vaccine to children aged two to 24 months (born 05/09/2004 to 03/07/2006). These children were too old to receive the vaccine at their regular scheduled appointments.

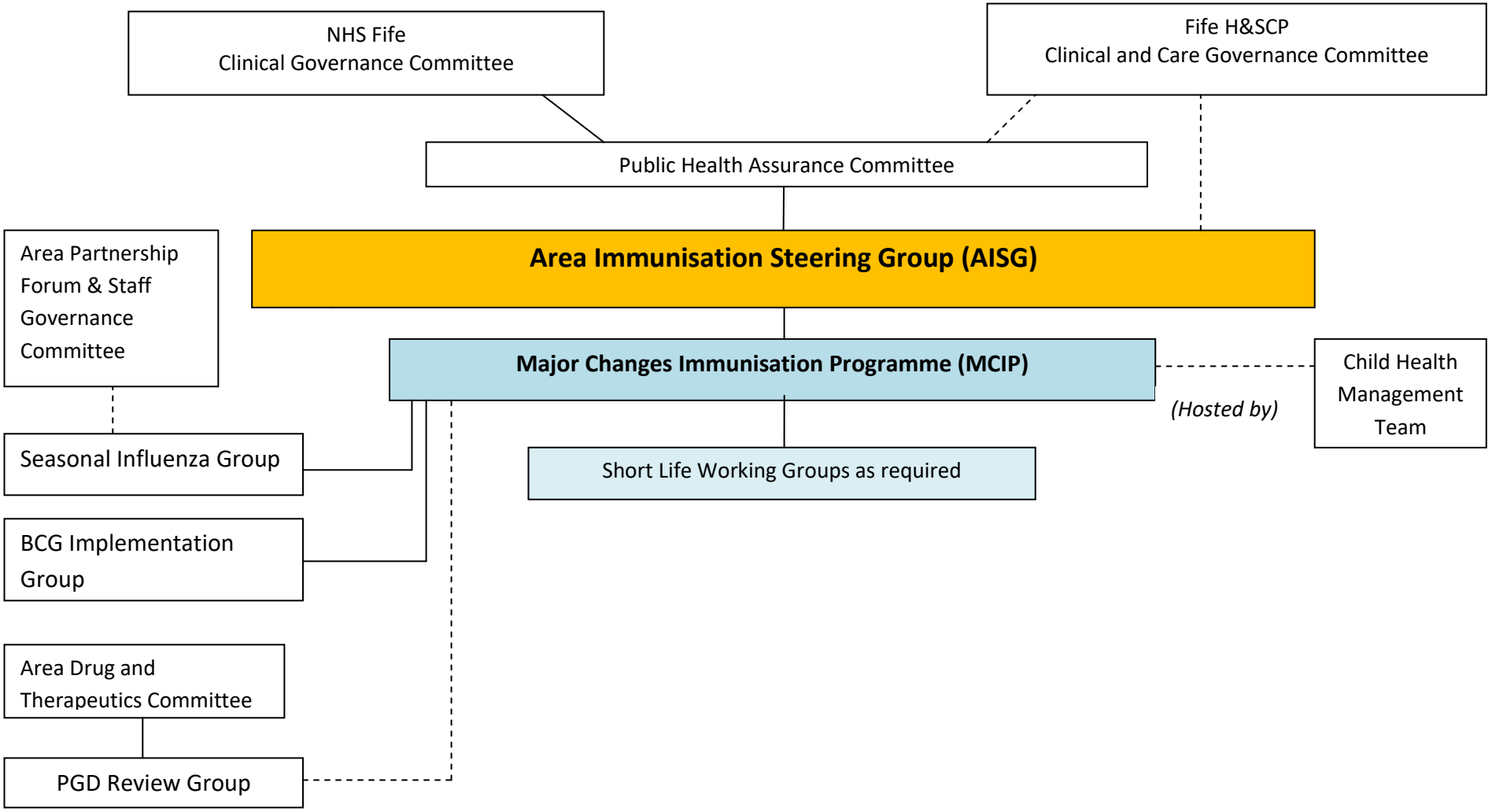
A Hib catch-up programme ran from 5 November 2007 to 3 March 2009 to offer a booster dose of Hib vaccine to a defined cohort of young children (born 04/04/2003 to 03/09/2005). These children were too young to have had a booster as part of the 2003 Hib catch-up programme and too old to have received the new Hib/MenC booster vaccine at 12 months of age as part of the routine programme.

In June 2003 a Hib catch-up programme started for children who were aged six months to four years old (born between 02/04/1999 and 03/04/2003).

In the autumn of 1999 the MenC vaccine was added to the schedule of primary immunisations offered in three doses to babies at ages two, three and four months. A catch-up programme was also set up around this time to offer the vaccine to everyone of school age and, from January 2000, to pre-school children too old to be included in the programme of primary immunisations. The MenC vaccine was also offered to everyone under the age of 18 by December 2000.

Appendix 5: Governance Structure

Solid line = Direct line of reporting for quality assurance
Dashed line = Reporting for information & cross-assurance



NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	Acute Services Division Clinical Governance Committee
Date of Group/Sub-committee Meeting:	24th July 2019
Release: draft/final minutes	FINAL
Author/Accountable Person:	Mrs L Campbell

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
This should include good practice • Note the work of the Water Safety Group
What are the concerns/issues/risks you want to bring to the attention of the committee?
Include any actions taken to date • Implementation of the Falls Toolkit

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 24th JULY AT 2.00PM WITHIN TRAINING ROOM 2, DINING ROOM, VICTORIA HOSPITAL

Present	**Designation**
Dr Annette Alfonzo	Clinical Director - ECD
Mrs Norma Beveridge	Head of Nursing – Emergency Care (Until end Item 8.1 – 4.00pm)
Mrs Lynn Campbell	Associate Director of Nursing – ASD (CHAIR)
Dr John Donnelly	Clinical Director – Planned Care Directorate
Mrs Carol Duncan- Farrell	Head of AHP
Ms Aileen Lawrie	Head of Midwifery
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator
Mrs Nicola Robertson	Head of Nursing – Planned Care Directorate

Apologies	**Designation**
Ms Jeanette Burdock	Radiology Services Manager
Dr Robert Cargill	Associate Medical Director - ASD
Ms Gemma Couser	General Manager - WCCS
Mrs Donna Galloway	Laboratory Manager - Women, Children & Clinical Support
Mr Scott Garden	Chief Pharmacist
Dr Tahir Mahmood	Clinical Director – Women, Children & Clinical Services
Miss Arlene Saunderson	Head of Nursing, Planned Care

In Attendance:	
Mrs Chrissie Coulombe	Infection Control Manager
Mrs Margaret Dodds	Senior Nurse – Quality & Risk – Emergency Care Directorate (Until Item 8.1 - 3.55pm)
Miss Lynn Godsell	PA to the Associate Medical Director & Associate Director of Nursing (minutes)
Mrs Geraldine Smith	Pharmacist (rep Mr S Garden)

ACTION

1 Welcome and Introductions

LC welcomed those present to the meeting.

Mrs Campbell advised that going forward with these meetings, in an attempt to keep the agenda to a workable size, that an SBAR covering the key points of reports will be required. This was not to devalue any of the reports that are presented to the Committee, more to highlight key successes, challenges and points for escalation by exception.

2 Apologies for Absence

Apologies for absence were noted from the above named members.

3 Unconfirmed Minute of ASDCGC Meeting held on 24th April 2019

Mrs Campbell referred to the notes of the meeting from April and asked members for any issues.

There were no issues raised, hence the note was approved as an accurate record.

4 Matters Arising

Action List

Action 91 – Spinal Governance – PAA Spinal Governance Interventional Procedure. This has been signed off electronically. Dr Donnelly to send to Miss Godsell for onward circulation. **JD/LG**

Action 197 – SPSO Outcomes – Dr Donnelly advised this was an action from an SPSO outcome/case. It was noted a scoring sheet has been introduced for QMH surgery to raise awareness who may be high risk for day case surgery. The SPSO may refer back to this so will require to show some sort of audit trail. Dr Donnelly added that when the test of change has been completed, he will do a protocol or guidance. The report from the audit is not yet complete and will be reported to the September meeting. **JD/LG**

Action 199 – Mrs Duncan-Farrell advised that Radiology is using something for gathering Patient Feedback. Mrs Campbell commented that some streamlining could be done to the Your Care Experience tool that could be adapted to incorporate AHP questions. Mrs Duncan-Farrell to liaise with Donna Hughes. **CDF**

Action 218 – ECD – New Interventional Procedure – Agenda Item.

Action 225 – FEWS/NEWS Update – There was still ongoing debate on whether to move to the NEWS system. The Clinical Governance Oversight Group noted that we currently still use the Fife EWS (FEWS) instead of NEWS2 and this was a measured decision. NHS Fife use Patientrack to electronically capture all observations for all adult patients in the Victoria Hospital. This alerts all high EWS patients to the relevant clinician through the hospital pager system. Preliminary work shows that the sensitivity of NEWS 2 increases the alerting of deteriorating patients significantly. (3 fold increase of all level alert calls from 4000 to 13,000 per month March 2019). Our response system would potentially be overwhelmed with this increase and careful consideration is ongoing to help appropriately develop our strategy for a safe changeover.
Mrs Beveridge said that we need to look at an escalation plan as this would have a significant impact. Follow up with Gavin Simpson. **NB**

Action 226 - Falls – Agenda Item.

Action 232 – Day Surgery for Hip Patients – c/f to Jan 2020 **LG**

Action 242 – Medication Related Incidents– Mrs Robertson said that she had been unable to speak to Ms Saunderson about the errors in the reports prior to the meeting. Mrs Robertson to follow up. **NR**

Action 243 - Leak Analysis – Dr Donnelly advised that this has been actioned. Regard as complete.

Action 244 - Cleft Care Report – Dr Donnelly to follow up with Mr Sharma. Update at September meeting. **JD/LG**

Action 245 – Laparotomy Audit – Agenda Item.

Action 246 - L2 to L3 Grader – Agenda Item.

Action 248 - Prostrate Cancer Report – Mrs Campbell advised that she recalled the discussion with Dr Cargill around governance for patients not having repeat biopsies. Mrs Campbell advised that work was planned.

Action 249 – HPB Cancer Report – HPB Action Plan – follow up with Mrs Nicoll **AS**

Action 250 - TAMIS Outcome Audit – c/f to September 2019. **PCD/LG**

Action 251 – WCCS – SBAR for Water Cooler – Mrs Duncan-Farrell advised that the water cooler was an incorrect model and a further SBAR has been submitted, however it has been agreed in principle.

Action 252 – WCCS - MLD leaflets – Mrs Duncan-Farrell said that there were no Patient Information Groups to submit this leaflet to. It was largely for information for patients. Mrs Campbell advised there was a policy under Patient Relations. Mrs Muir agreed to liaise with Donna Hughes. **EM**

Action 253 – WCCS - Vaccine Programme – Agenda Item.

Action 254 – ECD – SBAR for Management of Dysphagia – Mrs Beveridge confirmed Katrina McCormick has the protocol.

Action 255 – Divisional Risk Register – Mrs Campbell advised that she and Dr Cargill have reviewed the register and there were two risks for updating. Regard as complete. **EM**

5 Hospital/Board or Population Level Reports
<u>Scheduled Governance Items</u> :

- **Acute Hospital Mortality**

The report noted that in retrospect, the rise in mortality rate in December 2018 was particularly sharp, the hospital mortality rate was higher and took longer to fall back to median rate than the previous winter. A stable pattern is observed for Quarter 2 of 2019. The median weekly mortality rate remains unchanged at 3.5%.

- **Patient Feedback reports**

Mrs Campbell advised that the there was a request for the Patient Experience Feedback report and it will be ready for the September meeting. Add to agenda. **LG**

Mrs Campbell suggested that the Quality report could come to the Committee as it may be helpful to see what the contribution is from Acute. Mrs Campbell to pick up with Dr Cargill although noted this report is currently being refreshed. **LC/RC**

- **Clinical Policies (new and for review)**

Mrs Muir advised that there had been 5 NHS Fife policies submitted to EDG.

Mrs Muir added that following an SAER there was an action to review NHS Fife Policy COD-02: Care of the Deceased and the Bereaved.

Two additional paragraphs were added into the policy

11.3.1 In the event that in-patient dies out with the clinical area in which they are being cared for (e.g. Radiology department), staff should contact the patients ward who will be responsible for arranging to bring the deceased back to the clinical area. The deceased will be transferred using the mortuary trolley to maintain privacy and dignity. Where possible, the deceased will be cared for in a side room to allow Last Acts of Care to be performed.

11.4.1 In the event of the death of an outpatient, member of the public or a member of staff within the Hospital, the death must be reported to Police Scotland in the first instance and will advise on what steps need to be taken. Following "Confirmation of Death" the deceased can, with the agreement of Police Scotland, be taken to the Emergency Department where, if appropriate, Last Acts of Care will be performed (see Policy COD-04: Last Acts of Care; Section 7 Unexpected Deaths).

The Committee noted the update.

- **FEWS/NEWS Update (Action 225)**

This item was discussed under Action List – Action 225.

<u>One Off Reports</u>

- **National Cardiac Arrest Data (Q4 2018-2019)**

The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. NCAA monitors and reports on the incidence of and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest. The NCAA dataset was developed to ensure that all hospitals collect the same standardised data, so that accurate comparisons can be made.

Mrs Campbell said this was a good news story for Fife as there has been significant work done and in terms of outcomes, Victoria is the best performing hospital in Scotland, hence the reluctance to move to NEWS. Dr Alfonzo added there were not many Scottish units participating in this as Boards have to pay to be included. The cost of this is £1000 per annum Mrs Muir advised that from November 2019, Fife will no longer be participating and the Clinical Effectiveness Team will create a similar report– this was agreed at the Resuscitation Committee.

Mrs Beveridge said that it was always helpful to review our data around resuscitation and cardiac arrests and was picking up some work in the interim due to the Head Of Nursing (Quality) vacancy. Mrs Muir advised that the Cardiac Arrest Annual Report would be coming to the Committee via Dr Simpson. Mrs Beveridge to pick up and update at next Committee meeting. **NB**

- **Tissue Viability Report**

Mrs Beveridge referred to the Tissue Viability report and said that she had not yet gone through this detailed report. Mrs Campbell added that the report was very much a team effort and the team deal with a wider and broader remit than pressure ulcers. The Tissue Viability team are involved with education and other specific activities.

Mrs Campbell asked that a 1 page SBAR summary be brought back to the September meeting. **NB**

The report was noted.

- **Water Report**

Mrs Coulombe spoke to the Water report but noted that she was mindful that it had been written by Kathryn Brechin who had now left NHS Fife.

The Water Safety Group commissioned compliance audits for High Risk Areas for Pseudomonas. Health Protection Scotland (HPS) published guidance notes for use in neonatal units and critical care areas to minimise the risk of pseudomonas infection in water. Mrs Coulombe said that the Neonatal unit policy and guidance has been updated. Mrs Coulombe agreed to send to Miss Godsell.

The Water Safety Group has provided assurance to the Board that we are compliant and all flushing units meet the requirements. The high risk units were noted as being:

- Neonatal Unit (NNU)
- Paediatric Ward
- Intensive Care Unit (ICU)
- Surgical High Dependency Unit (SHDU)
- Medical High Dependency Unit (MHDU)
- Ward 34 (Haematology In-Patient Ward)
- Ward 34 (Haematology Day Unit)
- Haematology Day unit (QMH)
- Ward 22 (Renal In Patients and Dialysis Day-care)
- Renal Dialysis (QMH)
- Renal Dialysis (STACH)

Mrs Coulombe advised that the audit tool identified 9 measures of compliances, reflecting key standards within the HPS guidance.

Overall, the feedback from audits was very positive with good awareness of pseudomonas risks associated with water safety, and control measures required to mitigate risk. There were taps identified as generating a splash risk in 3 out of the 12 areas audited. In all cases flushing was taking place, however the reliability and recording was variable with some days missed. Mrs Coulombe asked about reminders going out and Mrs Campbell said it would be via this Committee.

The audit team noted variance in some teams re time of day when flushing undertaken – as per the guidance, advice given to flush in the morning.

Mrs Campbell asked the frequency of this audit – Mrs Coulombe was unsure.

The Committee noted that it was a robust audit with very good data and would be

presented to the Water Safety Group on 5/8/19. Mrs Coulombe was unsure of the reporting cycle and Mrs Campbell advised that the actions should be owned by this Committee. Mrs Coulombe to advise Mrs Selbie regarding the actions. **CC**

Dr Alfonzo raised an issue regarding a water sample which failed on 20/7/19 within the dialysis unit in Phase 3. Dr Alfonzo said that Haemofiltration was stopped. Mrs Campbell said that Engie are responsible for the Phase 3 building. Dr Alfonzo was advised to Datix the incident and progress it from there. **AA**

Mrs Campbell commented that this was a generally positive report with a few areas of concern and she would share across the Division and request that the Heads Of Nursing create divisional action plans which will be submitted to the Water Safety Group. **LC**

Mrs Campbell noted that she would attempt to find representation to attend the meeting. **LC**

- **HAI Assurance Framework**

Mrs Coulombe advised that the HAI Assurance Framework has been recently refreshed and now provides a detailed activity and assurance of what goes on. Mrs Coulombe thanked the clinical teams for their input in finalising the framework document.

Following a robust consultation, the framework has been approved at the Infection Control Committee and is presented here for noting.

Mrs Coulombe asked where we should feedback/report back to? Mrs Campbell suggested the Clinical Governance Oversight Group and also through this Committee in some format.

Mrs Coulombe added that Mrs Brechin had updated all the cleaning schedules in advance of leaving NHS Fife. Mrs Coulombe said that a local consultation should be carried out and the whole package will be complete. **CC**

The updated Framework was noted by the Committee.

- **Falls Report**

Mrs Campbell advised that this report includes data and along with summary of locations within NHS Fife inpatient areas that report the highest number of patient falls. The data is up to the end of May 2019.

Mrs Campbell noted that we have seen an increase in falls with harm within the Division. Mrs Campbell added that a deep dive has been arranged for two areas – Ward 9 and Ward 54 – with acknowledgement that these areas have mixed specialty patients. Ms Lawrie asked that Wendy or Sandra be included for Ward 9. It was noted that Bed modelling is also going on and the Falls toolkit will be re-launched.

Mrs Campbell informed the Committee that a Harm Reduction event is being planned for mid September.

Mrs Campbell also advised that Dr Pound had sent an email voicing concerns

around the number of falls and to note that we are keeping Dr Pound updated with any actions/information. **NB/LC**

Mrs Beveridge advised that she has been working with Mrs Muir and a Falls audit tool suitable for use with formic has been agreed. A meeting with the Heads of Nursing is now required to determine audit frequency and compliance bundle.

The Falls update was noted.

6 Emergency Care Directorate

6.1 Clinical Director/Head of Nursing Report

Incidents
There were 910 Incidents reported from 1st April to 30th June 2019.

The breakdown of these were:

- Extreme – Nil
- Major – 73
- Moderate – 54
- Minor – 21
- No Harm – 159

There continues to be a decrease in all reported incidents of harm over the last 3 quarters.

The top themes for the major incidents related to:

- 33 on admission pressure damage
- 19 cardiac arrests
- 9 patient falls
- 5 on-ward pressure ulcers

There have been 6 SAER's commissioned this quarter.

The top five reported incidents are consistently:

- Patient Falls
- Tissue Viability
- Medication
- Other Clinical Events
- Unwanted behaviours

Falls
There were 211 patient falls this quarter, a decrease of 22. It was noted that 31 falls resulted in varying degrees of harm. This quarter 9 falls resulted in major harm, 3 moderate harm and 18 minor harm.

Ward 32 continues to have patients with hyperactive delirium who had multiple falls. Intensive supervision was put in place for these patients as all other preventative measure were unsuccessful. Ward 42 saw an increase in the number of falls and a small cohort of patients had multiple falls. The correct actions were taken.

The review of falls indicates that several were at times when the ward would have been at its busiest.

Tissue Viability
There have been 187 Tissue Viability incidents reported over the quarter, 21 of which developed on ward. It was noted that all incidents of pressure damage are reported on Datix and all Grade 3 and 4 require an LAER.

ICU has a recurrent theme of device related pressure damage. This is being reviewed through the pressure ulcer collaborative. All other areas have shown an improvement.

Medication
There have been 131 reported medication incidents this quarter – a slight increase. 112 resulted in no harm, 13 minor harm, 5 moderate harm and 1 major harm. The 3 main categories of errors are:

- Missed doses
- Prescribing
- Supply (delayes/missing/wrong)

Cardiac Arrest
There have been 19 reported cardiac arrests this quarter. June saw an increase with 12 of these taking place that month. It was noted that 13 cardiac arrest resuscitations were successful. Mrs Beveridge added that a short life working group (SLWG) may need to be reconvened regarding the reliability of the cardiac arrest data.

SABs
Mrs Beveridge advised that Ward 44 have had a cluster of PVC and CVC SABs which have identified areas of learning. Mrs Beveridge has asked the Infection Prevention Control Team (IPCT) for a report for Ward 44. Mrs Coulombe added that there will be weekly improvement programme meetings supported by the IPCT.

Risk Register
There are no new risks this quarter.

Complaints
There were 24 Stage 2 complaints this quarter. The main themes remained consistent:

- Co-ordination of clinical treatment
- Disagreement with treatment/care plan
- Staff attitude

SPSO Complaints
There are a number of SPSO cases which remain under investigation.

LEARN Summaries
There were a number of LEARN summaries for the Directorate which have local learning. The themes identified included:

- Falls
- Documentation
- Misdiagnosis (case presented at the recent Inter-Specialty Event)

Adults with Incapacity (AWI Audit)
A Fife wide audit was undertaken over a two week period in June 2019. The results are awaited. Update to follow at the next Committee meeting.

MHDU (Mortality audit)
There is a new process within MHDU to support Consultants with the completion of M&M audit forms. The completion rate of M&M forms for patients who had died within MHDU from January to May 2019 was 21%, this has now increased to 71%. M&M meetings will now be held quarterly.

Medicines Administration Observation Audit
The Medicines Administration Observational Audit – Controlled Drugs took place between September 2018 and January 2019. The reports have been shared with the Directorate and the common themes for learning which emerged were:

- Ensure the patient's identity is checked against the prescription chart using a reliable source – either a wristband or a photograph.
- Registrants re-check a patient's allergy status at the bedside as part of medication administration checks
- All patient medication is stored securely and not left unattended.

There were recommendations to:

- Audit tools to be added to the SSUMPP intranet pages to allow SCN/HON and CNMs to undertake self-assessment in between main audit cycles.
- Include medicines as part of the Excellence In Care Indicators

Ward 43 – Palliative Care Improvement Project
Mrs Beveridge advised that Ward 43 has the highest number of deaths per year across all wards (including the hospice) in NHS Fife. It was noted that many patients who are admitted either die within a short time from admission or receive a life limiting diagnosis/deterioration. Funding has been secured for a nurse with specialist Palliative Care skills to work in the Respiratory ward to provide an enhanced service focusing on earlier identification of the frailest patients, ensuring end of life/palliative care needs are met.

Mrs Beveridge to speak to Gillian Malone re mentoring.

Mrs Beveridge added that part of this focussed work is around raising awareness and compliance with HACP with patients who have a DNACPR. A weekly audit is being undertaken by the Clinical Effectiveness team thereafter a flash report is shared with the Charge Nurse for discussion at the weekly team meetings.

6.2 Directorate Governance – Specialty National Reports

There were no Specialty National reports.

6.3 Directorate level outcomes data:

- **Clinical Audit**
- **Falls Toolkit**

Mrs Campbell advised that the Inpatient Falls Group chaired by herself and Dr Aylene Kelman commissioned a review of the toolkit. A short life working group was set up, led by Joy Reid and included wide multidisciplinary representation from the acute services and the community hospitals. The toolkit was reviewed and all key colleagues, appendices were updated, including the Falls Intervention Plan, NHS Fife Bedrail Assessment, the post -falls documentation and the post falls chart was modified – with a focus on Neurological Observations.

The toolkit was submitted to the Frailty Managed Care Network and Clinical Governance Group in March and was approved with a view to final ratification by the Clinical Governance Committee. Mrs Beveridge advised the Committee that there was some urgency in getting this distributed and asked the Committee for approval.

Mrs Campbell asked members if they were happy to ratify the Toolkit. The Committee noted and approved the Toolkit for rollout. Mrs Campbell said she was happy to support and to advise Joy Reid to proceed with the launch.

The Falls Toolkit was noted and approved.

- **Boarding Procedure**

The Boarding Procedure focuses on Acute capacity pressures which will, on occasion, require patient transfers out with their speciality base for non-clinical reasons (boarding) to support patient flow and appropriate patient placement across the Acute Services Division of NHS Fife.

Mrs Beveridge referred to the Procedure and noted that the procedure has been revamped and is now simpler and improved. The review looked at the exceptional criteria and has been made more user friendly and significantly reduced in size. The policy sets out the procedures which must be followed to ensure patient safety and quality clinical care is maintained and this procedure is applied to all Acute Services Division inpatient services with the exception of maternity and paediatric services.

Mrs Campbell noted that there were comments on this version of the procedure , Mrs Beveridge said there had been no further feedback. Mrs Campbell agreed to take this to the SLT meeting on 30/7/19. Mrs Beveridge and Mrs Duncan-Farrell to liaise regarding the wording: the escalations all need to be revised for AU1 and it was noted that the nursing handover has been revised. **LC** **NB/CDF**

Mrs Campbell suggested that this be submitted to a relevant group for discussion. Mrs Campbell to send final version to Mrs Watts and added to the agenda for the Acute Access and Flow meeting as a matter of urgency. **LC/MW**

The Boarding procedure was noted.

- **Medicine Of The Elderly**

The Knowledge & Skills Framework for Medicine of the Elderly has been developed to support education, knowledge and skills development of registered and non-registered nursing and Allied Health Professional staff working with older people a framework has been developed. The framework was developed by a multi-professional group, led by Joy Reid, to support staff provide high quality effective evidence-based care for older people across the organisation.

The MOE development group ask the Committee to note the work and note that it would be useful in multiple areas.

Mrs Campbell advised that she was happy to support the framework.

- **Compromised Swallow**

Mrs Beveridge informed the Committee that the Fife Inpatient Compromised Swallow protocol was last reviewed 2 years ago and following an LAER it was felt that prompt review was required to support staff decision making when a patient has a compromised swallow not thought to be due to a stroke as there is a clear stroke swallow pathway.

Mrs Beveridge added that a short life working group was set up which comprised of medical and nursing staff, dietetics and speech and language therapy staff. The group reviewed the existing protocol and this was tested in two inpatient clinical areas with positive feedback from staff. This was also presented at a recent Inter-Specialty Clinical Governance Event which returned good feedback.
Mrs Beveridge asked the Committee for ratification of the Protocol. The Committee agreed. The Protocol will now be progressed within the relevant areas.

- **SAER Learn Summaries**

The LEARN Summaries were discussed within the Directorate report.

6.4 Specialty/departmental audit & assurance data (incl guidance)

Clinical Quality Indicators

- **Lung Cancer**

The Lung Cancer report presents analyses of data collected on lung cancer patients who are newly diagnosed with lung cancer between 01 January 2017 and 31 December 2017. The Quality Performance Indicators (QPIs) have been developed collaboratively with the three Regional Cancer Networks; Information Services Division (ISD); and Healthcare Improvement Scotland (HIS).

The overarching aim of the cancer quality work programme is to ensure that activity at NHS board level is focussed on areas most important in terms of improving survival and patient experience whilst reducing variance and ensuring safe, effective and person-centred cancer care.

QPI Review Process
QPIs are kept under regular review, are updated and, crucially, are responsive to changes in clinical practice and emerging evidence. Baseline Review took place at the end of Year 1 when some changes were introduced – these are highlighted throughout this report as appropriate. Formal Review (covering the first 3 years of QPI reporting) took place on 9th September 2016. Two QPIs were archived at this time, taking effect from Year 4 (2016) onwards: QPI 3 was adjudged to be surpassing aims and objectives with targets easily met by all regions. Secondly, since QPI 5 results were not reflecting actual clinical practice or achieving the intended terms of improvement.

The report was noted by the Committee.

- **Leukaemia**

This report covers patients newly diagnosed with Acute Leukaemia in Borders, Fife, and Lothian Health Board areas between 1st July 2017 and 30th June 2018.

The QPIs have been developed collaboratively with the three Regional Cancer

Networks, Information Services Division (ISD), and Healthcare Improvement Scotland. QPIs will be kept under regular review and be responsive to changes in clinical practice and emerging evidence.

The overarching aim of the cancer quality work programme is to ensure that activity at NHS board level is focused on areas most important in terms of improving survival and patient experience whilst reducing variance and ensuring safe, effective and person-centered cancer care.

The following QPIs have been updated:
QPI 3: MDT Discussion. The maximum time from diagnosis to MDM was increased to 8 weeks (previously 6 weeks)
QPI 5: Early Deaths This is now calculated from the first day of chemotherapy rather than the last day of chemotherapy as previously
QPI 10i: Intensive Chemotherapy in Older Adults. The target was increased to 30% (previously 20%)
QPI 10ii: Intensive Chemotherapy in Older Adults in Trials. The target was decreased to 70% (previously 80%).
QPI 12: Palliative Treatment. The target was decreased to 55% (previously 70%).

The following new QPI has been added:
QPI 13: Early Deaths in Patients with Acute Promyelocytic Leukaemia

The following QPIs have been archived:
QPI 2: Diagnostic Classification
QPI 4: Minimal Residual Disease Marker
QPI 6: Access to ATRA for Patients with Acute Promyelocytic Leukaemia

The report was noted.

6.5 New Interventional Procedures

- **Update re Botox Injections for Stroke Patients procedure (Action 218)**

This item was not discussed. Defer to September 2019. **ECD/LG**

6.6 SPSO Recommendations

There were no SPSO recommendations.

7 Planned Care Directorate

7.1 Clinical Director/Head of Nursing Report

Incidents
There were 364 incidents reported from 1 April 2019 to 30 June 2019.

The breakdown of these were:
- Extreme – 1
- Major – 11
- Moderate – 68
- Minor – 11
- No Harm – 220

The top themes for the major/extreme incidents related to:

- 3 cardiac arrests (1 extreme severity)
- 1 patient falls
- 2 Tissue Viability
- 2 Urinary Catheter related Trauma
- 1 Urinary Catheter Discharge Communication
- 1 Healthcare associated Infection
- 1 Theatre/Surgery incident
- 1 Wrong sized implant/prosthesis fitted

The top five reported incidents are consistently:

- Medication Incidents
- Patient Falls
- Tissue Viability
- Patient Information
- Access/Appointment/Admission/Transfer or Discharge

There were 3 SAER's and 5 LAER's commissioned.

The SAER's related to the sudden deterioration (cardiac arrest) of an ENT patient, a patient fall resulting in a hip fracture and variable discharge information from different areas resulting in a Catheter being in situ for 6 months.

Patient Falls
There were 62 falls reported across the Directorate (an increase from the last quarter). It was noted that 13 falls resulted in varying degrees of harm. This quarter 1 falls resulted in major harm, 4 moderate harm and 8 minor harm.

Mrs Robertson added that some of the falls were graded incorrectly and had a process in place that the Clinical Nurse Manager (CNM) had to review a fall. Mrs Robertson has now shared the process and asked the CNM's to be vigilant.
Mrs Dodds said there is also a falls guidance document which can be utilised in the wards.

The wards with the highest number of falls were:

- Ward 33
- Ward 53
- Ward 53

This was noted as being due to the patient group that occupy these wards.

Surgical Site Infection
There were 300 Orthopaedic procedures performed in Q1 2019 which fall under surveillance categories resulting in a total of 2 confirmed SSI within the surveillance period of 30 days.

Large Bowel SSI
There were 72 operations in Q1 2019 which fit into the planned large bowel surveillance programme, resulting in 9 confirmed SSI within the 30 day surveillance period. Mrs Robertson advised that the Large Bowel SI Surveillance form has now been simplified to make it less time onerous and to encourage completion by Consultants.

Medication Incidents
There were 65 medication related incidents.

These were noted as:

- 81% severity outcome no harm
- 17% minor harm
- 2% moderate harm

Controlled Drugs audit was the highest theme and to further understand the audit results the Head of Nursing, Planned Care has commissioned a focused piece of work involving various staff and they will focus on CD audits carried out in June and July 2019.

Risk Register
The risk register is up to date.

Complaints
The Directorate received 27 Stage 2 complaints during the reporting period.
The main themes identified are:

- Disagreement with treatment/care plan
- Co-ordination of clinical treatment
- Lack of a clear explanation

Mrs Robertson noted that when the Directorate return the complaints they are now including the decision i.e.' upheld/not upheld.

The Directorate received 70 Stage 1 complaints for the period, 10 of the Stage 1 complaints were escalated to Stage 2.

SPSO Investigation
There were 4 SPSO cases – the Investigations have commenced for three of the cases and a final decision has been received for the fourth case.

Fluid Balance Monitoring
Fluid chart audit was carried out following raised concerns in relation to fluid balance documentation on the charts and lack of escalation in one of the Planned Care wards.

The aims of the fluid management charts include:

- Clearer planning of expected fluid intake.
- Early detection and action for people with suboptimal fluid balance.
- More reliable and accurate documentation.

The Improvement Fluid Nurse has also mirrored this work across several in-patient wards within VHK.

Emergency Laparoscopic and Laparotomy Scottish Audit (ELLSA)
An update was provided for the Laparotomy Audit.

Patients who undergo emergency laparotomy for acute intra-abdominal pathologies represent one of the highest risk groups of surgical patients. The 30-day mortality for these patients had been reported to be as high as 15%1.

The ELLSA project was launched in June 2017 following the success of the National Emergency Laparotomy Audit (NELA) in England and Wales. The aim of ELLSA was to recruit Scottish Hospitals to form a collaborative network and describe current processes of care across different hospitals by data collection. This should ultimately lead to quality improvement and patient outcome for patients undergoing emergency abdominal surgery in Scotland.

Victoria Hospital performed slightly below the national average in accessing the CT scanner with a median time of around 85 minutes (national median 72) and mean time of 240 minutes (national mean 216) in difference between CT requested to CT performed. Around 95% of the CT scans were available pre-operatively, which was above the national average of 93%.

The update was noted.

Alzheimer Scotland Dementia
During June Fiona McQueen and Henry Simmons visited NHS Fife to celebrate the launch of the Alzheimer Scotland Dementia Nurse Consultant report. The visit was very positive and they also visited Phase 3 Recovery and Ward 31 during the time spent at VHK.

Patient Experience Report
The recent report reflects the huge amount of positive feedback and experiences patients have had. Some of the areas mentioned are Orthopaedics, Day Intervention Unit and Ophthalmology.

Legal Claims
There is one potential legal claim this quarter.

Mrs Campbell acknowledged the good work going on within the Directorate.

7.2 Directorate Governance – Specialty National Reports

There were no Specialty National reports.

7.3 Directorate level outcomes data:

- **Clinical Audit**
- **Head & Neck Cancer**

Dr Donnelly spoke to the SCAN Head & Neck Cancer report. The following points were noted:

- Clinical trials enrolment is again a national issue and one we have failed to meet in 2017-18. However, since 2018 two members of the team now have dedicated research time and this figure is likely to rise as a result. Therefore the only issues that are of significance are the failure to comply with the aim that all patients receive speech therapy and dental review prior to treatment (QPI 5 data is not reported for 2017/18 but the QPI attainment summary for years 1-3 is shown). The group's position has been that given the resources available we have focused these resources on those patients most likely to benefit. This is now being considered by the dental and

speech therapy groups in order to decide how best to proceed.

- There has been much focus on the dental QPI over the past year which in part relates to who provides the service rather than *that* the service is provided. Although SCAN are compliant with the personnel providing the service they are not in terms of which patients are reviewed. In particular, patients who are edentulous (without teeth) and go on to be managed non surgically are felt to be the group who most often do not receive dental review prior to treatment.

- In summary, there has been no QPI data for the past few years. Therefore this report represents a significant step forward. There remain significant challenges in collecting accurate data. Recent changes in the clinical team now represent a stronger position with regards to research. In terms of compliance with chemotherapy, it will be of interest to compare SCAN outcomes with that of the national group. It remains to be seen how the team respond to challenge of meeting speech therapy and dental targets but now that we have data to inform the team plans can be made to address this issue going forward.

The update was noted.

- Bladder Cancer – N/A – c/f to September 2019 **LG**
- Testis Cancer – N/A – c/f to September 2019 **LG**
- Renal Cancer – N/A - reported in April 2019 **LG**
- Summary of the Laparotomy Audit – b/f from April 2019

This was included within the Directorate report.

- QFit Project Update – Not Available – c/f to September 2019 **LG**
- **Summary of the Cleft Care Report** –

It was advised that this report could not be sourced.

Mrs Campbell asked for a conclusion to this. Dr Donnelly to follow up with Mr Sharma and update at the September meeting. **JD**

- TAMIS Outcome Audit - Not available - c/f to September 2019 **LG**

- **SAER LEARN Summaries**

There were numerous LEARN summaries included for the Directorate.

These related to:
- Controlled drug incidents
- Unexpected death post major bowel surgery
- SAB – PICC line was the source

- Severe pancreatitis following ERCP
- Fall at home resulting in fracture of neck of femur
- Patient fall in bathroom resulting in left hip fracture. Section of swab became attached to cement during procedure and required Consultant to return to theatre to remove.
- Deterioration post Orthopaedic procedure

Mrs Robertson advised that a procedure regarding the Nasogastric tubes requires finalisation with Dr Donnelly. **NR/JD**

7.4 Specialty/departmental audit, assurance data (incl guidance)

- **Clinical Quality Indicators**

- **Update re L2 to L3 Grader (Action 246)**

Mrs Robertson advised that NHS Fife's level 3 grader for the Diabetic Retinopathy Screening (DRS) programme, Dr Anne Sinclair, retired at the end of September 2018. The ophthalmology department has advertised for a replacement for this associate specialist/ consultant post twice and had no applicants. This reflects the national shortage of ophthalmologists. It was noted that neither Grampian nor Tayside have had any applicants for similar posts in 2018.

The Fife DRS service proposes that the senior level 2 DRS grader takes on the role of level 3 grading. If approved to be the level 3 grader for Fife DRS, Mrs Scott will be responsible for keeping her skills up to date, seeking advice where appropriate and undertaking EQA biannually. Dr Caroline Styles (national clinical lead for DRS and clinical led for Fife) will be responsible for providing support and supervision and ensuring that appropriate protocols and pathways are in place for this. This appointment also has the support of Dr Esther Curnock, DRS board coordinator.

Mrs Campbell said that this situation would require to be assessed and asked the Directorate for an SBAR to come to the next meeting. **AS/NR**

7.5 New Interventional Procedures

- **Update on PAA Spinal Governance Interventional Procedure (Action 91)**

This was discussed under item 4.1 – Action 91.

- **Procedure for Surgical Care Practitioner**

Dr Donnelly advised that an Interventional Procedure had been submitted by Mr Yalamarthi.

The procedure for a Surgical Care Practitioner (SCP) will insert secondary ports under vision for laparoscopic procedures in theatre with supervision from surgeon. The Association of Peri-operative Practice states that a SCP is consultant led, they work alongside a variety of healthcare practitioners to provide safe patient care, they meet service demands and educate future surgical workforce. The Royal College of Surgeons defines the SCP role as a non medical practitioner, working in clinical practice as a member of the extended surgical team, who performs surgical intervention under the direction and supervision of a consultant surgeon.

Mrs Campbell noted that the audit data and criteria had not been completed on the form. Dr Donnelly to liaise with Surgical team and bring back completed document to a future meeting.

JD

7.6 SPSO Recommendations

This item was covered with Item 7.1 – Directorate report.

- **Update re VTW day case work & test of change (Action 197)**

This item was discussed under item 4.1 – Action 197.

8 Women, Children & Clinical Support Directorate

8.1 Directorate Report

Mrs Duncan Farrell presented the information for Clinical Services:

Incidents
There were 152 incidents reported between 1 March 2019 and 31 May 2019.
This was a very slight decrease since the last quarter.

The breakdown of these were:
- Major – 1
- Moderate – 3
- Minor – 34
- No Harm – 114

The top five key themes are namely:
- Patient Information
- Radiation
- Blood Transfusion
- Major Haemorrhage
- Specimen Management

Patient Information
There were 55 patient information incidents reported by Labs which resulted in minor or no harm. The most common incident is incorrect or mislabelling of specimens sent to labs from multiple areas.

Radiation Incidents
There were 30 Radiation incidents and 4 of these were reportable to the HIS. The four were all minor or no harm.

Patient Falls
There were 3 patient falls within different departments of Radiology.
Two of these were minor harm and 1 no harm. The detail of the falls were:
- a Bariatric patient lost lower limb strength
- wheelchair brakes failed as patient being transferred
- manual handling incident with sliding sheet on an MRI table

Medication Incidents

There was no medication incidents reported.

Personal Accidents
There were 5 personal accidents within Radiology and Labs.

Risk Register
There are 20 risks on the Risk Register and there were no new risk added.

Health & Safety
There remain two outstanding issues within Therapies and Rehab.
The first is the lack of drinking water in the Rehab department – an SBAR for a water cooler has been submitted to the Water Safety Committee. The second is poor ventilation within the department – there are no external doors or windows so a reliance on an ageing air conditioning unit. Complaints are being received from both staff and patients about this issue.

Complaints
There were three stage 1 complaints and one Stage 2 complaint this quarter.

The Directorate also received 4 compliments and 2 concerns.

Papers for Submission
Mrs Duncan-Farrell agreed to send a list of reports for the workplan.

Issues for Escalation
The SBAR for the water cooler has been outstanding for over a year. The Water Safety Group has requested more clinical impact information in the new report format.

Mrs Lawrie presented the Women & Children's Information:

Incidents
There were 230 incidents reported between 1 March 2019 and 31 May 2019.
This was a very slight decrease since the last quarter.

The breakdown of these were:
- Major – 3
- Moderate – 15
- Minor – 105
- No Harm – 107

The major incidents included:
- 1 extreme major obstetric haemorrhage resulting in significant blood loss
- 1 case of neonatal IV medication given via an arterial line
- 1 stillbirth which could have resulted in a different outcome if managed differently

The themes for the incidents are namely:
- Obstetrics
- Medication
- Neonatal
- Patient Information
- Sharps

Medication Incidents
These incidents related to storage of medication and missed doses.
It was noted that recruitment and dedicated Pharmacy support for Obstetrics was proving challenging at the moment.

Patient Information
There were 12 reported incidents – just under half of these related to information being recorded to the incorrect patient on Badgernet. This continues to be monitored.

Sharps Incidents
There were 8 incidents across four different departments. There were no trends identified.

8.2 Directorate Governance – Specialty National Reports

- **Neonatal Unit Report**

Mrs Lawrie presented the Neonatal report. The following are the main findings from the data:

In 2018 there were:

- 349 total admissions
- Gradually increasing numbers of preterm infants when looking at those born before 30 weeks, 32 weeks and 34 weeks (numbers of infants less than 30 weeks are double what they were in 2001; the numbers of infants less than 32 weeks and those less than 34 weeks has trebled in the same time-frame)
- An average of just over 29 (range 16 – 38) infants were admitted to the neonatal unit during each month of 2018
- There were 36 admissions from home of infants with problems during the first 10 days of life.
- Infants who were term (i.e. gestational age 37 weeks or more) were the largest group in terms of numbers accounting for 53.9% of the total number of neonatal unit admissions. The planned implementation of transitional care where babies stay in an enhanced post-natal ward setting is shortly to be implemented as part of the "Best Start" and should see the numbers of term admissions to the neonatal reduce.
- Describing neonatal mortality (i.e. mortality in the first 28 days) was complicated for a number of reasons; several deaths were infants who were previable others died after discharge or transfer elsewhere (but within the neonatal period. The overall Neonatal Mortality Rate for the Victoria Hospital was 1.88 per 1000 livebirths; however, this includes the ***all*** infants born with "*signs of life*" after 20 weeks gestation. If extremely preterm (i.e. pre-viable) infants are ***excluded*** the Neonatal Mortality Rate is 1.26 per 1000 livebirths.

Mrs Lawrie added that these are extremely good figures – the national Scottish

neonatal mortality rate for infants >24 weeks gestation in 2017 was 2.3 per 1000 live births.

The report was noted.

8.3 Directorate level outcomes data

Clinical Audit

- **SBAR re SSI Caesarean Section**

Mrs Lawrie advised that NHS Fife submitted the Surgical Site Infection (SSI) surveillance data for Q1 2019 in May 2019. The Infection Prevention Surveillance Team who collects the data identified 12 cases (one still under review) for Q1 2019. This number of cases is likely to result in an exception report being issued to Fife (SSI rate ~6.5%).

The report noted that NHS Fife has made changes to the management of women undergoing a caesarean section to reduce the risk of SSI including regular education to all permanent staff and rotating clinical staff, reviewing the use of surgical dressing, implementing a new antibiotic prophylaxis regimen, correcting anaemia prior to surgery, external peer review and reviewing all deep or organ/space CS SSI.

Mrs Lawrie commented that NHS Fife needs to continue to report the figures as they are and requests assistance from Health Protection Scotland to review the current reporting methodology. It maybe that NHS Fife is not the outlier but other boards have a different method of identification and reporting which may explain the difference in rates reported.

Mrs Lawrie added that she would feedback to the Committee in September.

- **SBAR Cancer Waiting Times**

The waiting times report was submitted for information.

Cancer waiting times continues to work across the various Directorates.

The waiting times are important to patients and are a measure of how the NHS is responding to demand for services. Measuring and regular reporting of waiting times highlight where there are delays in the system and enables monitoring of the effectiveness of NHS Scotland's performance. Information Services Division (ISD) Scotland continues to be committed to improving the information on waiting times along with our key stakeholders, the NHS Boards and the Scottish Government.

The **62 Day Standard** states that 95% of patients urgently referred with a suspicion of cancer will wait a maximum of 62 days from referral to first cancer treatment.

- There were **3692** eligible referrals within the 62 day standard, an increase of 290 (8.5%) on the same period in 2018.
- In Scotland **81.4%** of patients started treatment within the 62 day standard, an **decrease** from **82.7%** in the previous quarter.

The **31 Day Standard** applies to all eligible referrals, regardless of route of referral and states that 95% of all patients will wait no more than 31 days from decision to treat to first cancer treatment.

- There were **6245** eligible referrals within the 31 day standard for this period, an **increase** of **409 (7.0%)** on the same period in 2018.
- **94.9%** of patients started treatment within the 31 day standard, the same as the previous quarter.

The report was noted.

- **SAER LEARN Summaries**

The LEARN summaries for the Directorate related to:

- Unexpected neonatal death – emergency caesarean as a result of a Road Traffic Accident
- A routine labour appointment – discovered that baby had sadly died in utero.

8.4 Specialty/departmental audit, assurance data and clinical guidance

- Clinical Quality Indicators

There were no Clinical Quality Indicators for discussion.

- MLD Leaflet – b/f from April 2019

The MLD Leaflet was discussed under Action List – Action 252.

8.5 New Interventional Procedures

- Vaccine Programme – b/f from April 2019

Mrs Lawrie informed the Committee that the Vaccination Transformation Programme (VTP) which makes up part of the Primary Care Transformation Programme (PCTP) will see all general practice based vaccines being transferred to Board delivery over the next three years. Each vaccination programme is being appraised in order to find the best route of delivery for safety, consistency, accessibility and sustainability for service users.

The three main vaccinations for the programme are:
- Pregnancy Pertussis
- Pregnancy Influenza
- Shingles

The programme is working well and it has been a relatively smooth embedding process.

It was suggested that an audit be carried out to determine if there is significant difference on uptake. **WCCS**

8.6 SPSO recommendations

9 Divisional Risk Register – Active Risks (for review)

Mrs Campbell said that she and Dr Cargill had gone through the Risk Register. Mrs Coulombe pointed out that one of the risks was still "owned" by Scott McLean and this would need amended. **LG**

Mrs Coulombe said that with the Diabetic clinic launch it was a good time to update the risk. Mrs Coulombe to ask Margaret Selbie to send on the information for updating as appropriate. **CC**

10 ASD CGC Terms of Reference – Updated May 2019

Mrs Campbell referred to the Terms of Reference and advised that this remained a draft version. It was noted that this membership includes the Heads of Nursing, the General Managers and the Clinical Directors for each Directorate which seemed excessive. Mrs Campbell to pick up with Dr Cargill. **LC/RC**

It was agreed that this would be deferred to September. **LG**

11 Items for information only:

11.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

11.2 SIGN Guidance

Mrs Muir referred to the SIGN Guidance and advised that SIGN 152: Cardiac Arrhythmias in coronary heart disease had been reviewed by the Heart Managed Clinical Network (MCN) and it was felt that this should be adopted Fife wide but, at present this is not feasible due to a couple of issues. The Committee said that a business case would be required to cover these issues. Mrs Muir agreed to action. **EM**

11.3 ASD CGC Workplan 2019/2020

The workplan for 2019/2020 was noted.

11.4 Infection Control Committee (1st May 2019 & 5th June 2019 – N/A – c/f to September 2019) incorporating AMT meeting of w/c 29th April 2019)

The Infection Control Committee minutes were noted.

11.5 HAIRT Report

The HAIRT report was noted.

11.6 SRTC Minutes of 23rd April 2019 & 13th June 2019

The SRTC Minutes were noted.

11.7 NHS Fife CP&PAG Minute of 29th April 2019 & 1st July 2019 – N/A c/f to September 2019

The NHSF CPPAG minutes were noted.

11.8 Resuscitation Committee Minutes of 4th July 2019 – N/A – c/f to

September 2019

The Resuscitation minutes were noted.

11.9 Hospital Transfusion Committee Minutes of 10th May 2019 – Unavailable – c/f to September 2019

The Hospital Transfusion Committee minutes were unavailable.

11.10 Vascular Access Strategy Group Minutes of 16th May 2019

The Vascular Access Strategy Group minutes were noted.

11.11 NHS Fife Point of Care Testing Committee

These minutes are now reported via NHSF CGC only.

12 Future structure and meetings of ASD CGC

The future structure of the ASD CGC meetings was noted.

13 AOCB

Specialty/Annual Reports
Dr Alfonzo referred to the reports submitted from the Specialties within the Directorate and noted that they would schedule the reports into the workplan accordingly. Dr Alfonzo added that the teams ask for feedback from the reports as there is a considerable amount of time and effort given to compiling the reports. Mrs Campbell said that we need consistency in our approach with feedback to the teams and we need to consider if there is anything from the Directorates to be fed into the NHSF Clinical Governance Committee. Mrs Campbell to discuss with Dr Cargill. **LC/RC**

14 Date of Next Meeting/s:

ASD CG OVERSIGHT MEETING –
Tuesday 27th August 2019 at 2.00pm within Training Room 2, Dining Room, VHK

ASD CG COMMITTEE MEETING –
Tuesday 17th September 2019 at 2.00pm within Training Room 1, Dining Room, VHK

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	Acute Services Division Clinical Governance Committee
Date of Group/Sub-committee Meeting:	17th September 2019
Release: draft/final minutes	UNCONFIRMED
Author/Accountable Person:	Dr R Cargill

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
This should include good practice • Cardiac Arrest Audit Data • Site Specific Cancer QPI reports
What are the concerns/issues/risks you want to bring to the attention of the committee?
Include any actions taken to date • National Early Warning Score changes – review required

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON TUESDAY 17TH SEPTEMBER 2019 AT 2.00PM WITHIN TRAINING ROOM 1, DINING ROOM, VICTORIA HOSPITAL

Present	**Designation**
Mrs Norma Beveridge	Head of Nursing – Emergency Care
Dr Robert Cargill	Associate Medical Director – ASD (CHAIR)
Ms Gemma Couser	General Manager – WCCS (from Item 5 – Cardiac Arrest Report)
Dr John Donnelly	Clinical Director – Planned Care Directorate
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator
Mrs Nicola Robertson	Head of Nursing – Planned Care Directorate
Dr Tahir Mahmood	Clinical Director – Women, Children & Clinical Services (from Item 5 – Cardiac Arrest Report)
Miss Arlene Saunderson	Head of Nursing, Planned Care
Dr Gavin Simpson	Consultant Anaesthetist/ICU (For Item 5 – to present Cardiac Arrest Report)

Apologies	**Designation**
Dr Annette Alfonzo	Clinical Director - ECD
Mrs Lynn Campbell	Associate Director of Nursing – ASD
Mrs Chrissie Coulombe	Infection Control Manager
Mrs Carol Duncan- Farrell	Head of Allied Health Profession
Mrs Donna Galloway	Laboratory Manager - Women, Children & Clinical Support
Ms Aileen Lawrie	Head of Midwifery
Professor Morwenna Wood	Director of Medical Education

In Attendance:

Mrs Margaret Dodds	Senior Nurse – Quality & Risk – Emergency Care Directorate
Miss Lynn Godsell	PA to the Associate Medical Director & Associate Director of Nursing (minutes)

ACTION

1 Welcome and Introductions

Dr Cargill welcomed those present to the meeting.

2 Apologies for Absence

Apologies for absence were noted from the above named members.

3 Unconfirmed Minute of ASDCGC Meeting held on 24th July 2019

Dr Cargill referred to the notes of the meeting from July and asked members for any issues.

There were a couple of typos highlighted. Miss Godsell to amend and regard the minutes as confirmed thereafter. **LG**

4 Matters Arising

Action List

Action 91 - PAA Spinal Governance Inter. Procedure - Dr Donnelly still to source

this. The Standard Operating Procedure is complete and ready for implementation with a review date of 1 year on it which coincides with the next review. Dr Donnelly to feedback next time for approval.	**JD**
Action 197 – SPSO Outcomes – Dr Donnelly asked for this to be left open as this may take some time to complete. Dr Cargill advised that it would be added to the workplan under PCD for an update in 6 months and the action will be closed off. Miss Godsell to update workplan.	**LG/PCD**
Action 199 – CSA – Patient Feedback – Ms Couser advised that she had not received any feedback from Mrs Duncan-Farrell. Ms Couser to ensure this is available for the next Committee meeting.	**GC**
Action 225 – NEWS 2 – Mrs Beveridge said that although we were clear about the risks there is a desire nationally to move to NEWS2. Dr Simpson to do an SBAR regarding risks/options for submission to this Committee, the HSCP Committee and then onto NHSF Clinical Governance Committee.	**GS**
Action 232 – Day Surgery for Hip Patients – Audit regarding cases to be submitted to January 2020.	**LG/PCD**
Action 242 – Medication Related Incidents – Miss Saunderson advised that there was a discrepancy which did not match the narrative – this was due to human error and has since been corrected. Regard as complete.	
Action 244 – PCD – Cleft Care Report – Dr Donnelly has emailed Mr Sharma who was unsure there was such a report. Dr Cargill advised he remembered reading it. Dr Donnelly to follow up.	**JD**
Action 249 – PCD – HPB Action Plan – Miss Saunderson said that all Cancer reports will form part of the Directorate submission. Mrs Muir said that she is meeting with Kathy Nicoll to look at the timetable for reporting and will forward onto the Directorates.	**EM**
Action 250 – PCD – TAMIS Outcome Audit – The Directorate do not have sufficient numbers yet to provide a meaningful audit. c/f to March 2020.	**LG/PCD**
Action 252 – WCCS – MLD Leaflet – Mrs Muir met with Donna Hughes re this. Regard as complete.	
Action 258 – Patient Feedback Reports – Dr Cargill advised that performance and quality reports can be presented at the Oversight meetings. Regard as complete.	
Action 259 – National Cardiac Arrest Data – Mrs Beveridge reported as complete.	
Action 260 – Tissue Viability Report – SBAR unavailable – c/f to November 2019.	**NB/LG**
Action 262 – Water Report – A Datix was raised regarding the water incident. The outcome was that the water was not contaminated but it did highlight that disinfection had not been carried out by Engie. An SAER will come to the Committee in due course. Regard as complete.	
Action 265 - Falls report – Mrs Campbell and Dr Pound content with the falls information and actions. Regard as complete.	

Actions 266/267/268 - Boarding Policy – The Boarding Policy had been submitted to SLT. Comments were received and once incorporated/amended the policy should now go back through the Clinical Policy Group as the governance sits with this group.

Action 269 – New Interventional Procedure – Stroke – Agenda Item. Regard as complete.

Action 275 – Directorate Level Outcomes – Mrs Robertson has liaised with Dr Donnelly re the standard operating procedure for Nasogastric Tubes. It was noted that comments have been received around the procedure. The Directorate is keen to implement it.

Action 276 – Clinical Quality Indicators – Agenda Item. Regard as complete.

Action 277 – New Interventional Procedures – Proc. for Surgical Care Practitioner - Dr Donnelly said that the results are now deposited into a log book and the Consultant Surgeon is content that these are sufficient. An annual formal review will be done by the Clinical Lead. R Cargill asked how do we know if this has happened? Dr Donnelly advised it would form part of the appraisal discussion.

Action 278 - New Interventional Procedures – Vaccine Programme – Ms Couser advised that this programme had been taken into the remit of Antenatal from the Community. Ms Couser said that we need to ensure there is an appropriate mechanism for uptake. Dr Cargill commented that one of the quality governance outcomes is Vaccination uptake. c/f to November 2019 **GC**

Action 279 – Divisional Risk Register – In progress to have author amended.

Action 280 – Divisional Risk Register – Dermatology Dept - Improvement work to commence at the beginning of year (Jan/Feb 2020). (Email update provided by Chrissie Coulombe). Regard as complete.

Action 281 – ASD ToR – Dr Cargill said he thought that the ToR were now finalised pending a response from Scott Garden re future attendance. A General Manager will now attend (Miriam Watts has volunteered) as well as the Deputy COO.

Action 283 – SIGN Guidance – Mrs Muir said the SIGN 152 Cardiac Arythmas required full compliance and would be progressed via the Managed Clinical Network (MCN). Regard as complete.

5 Hospital/Board or Population Level Reports
Scheduled Governance Items :

- **SSR Audit**

The SSR audit is not due until November however it was requested that it be carried forward to January 2020 on the workplan. **LG**

One Off Reports

- **Cardiac Arrest Report**

Dr Simpson attended to speak to the Cardiac Arrest report.

Dr Simpson described the various patient management measures that have been implemented for deteriorating patients which can avoid avoidable deaths.

Dr Simpson advised that the Know the Score Campaign was introduced to improve this. It had 5 elements to prioritise early and decisive communication for Deteriorating patients to help optimise treatment and triage patients effectively. Patientrack Early Warning Scoring has helped achieve this. The Emergency Bleep Meeting (EBM) was one of the elements which now ensures we review all cardiac arrests in ASD and this means we have senior clinical review for all unexpected deaths in ASD.

Dr Simpson added that when NHS Fife joined the National Cardiac Arrest Audit (NCAA) audit the Acute Services Division had one of the highest Cardiac Arrest rates in the UK from data submitted to (NCAA) for analysis. Cardiac arrest numbers continue to fall despite an increase in admission numbers over the last few years. Data shows there were 47,288 admissions in 2015/2016 increasing annually to 54,676 admissions in 2018/2019.

Dr Simpson referred to the report which listed all the individual outcomes of all cases reviewed and noted that themes are now evident.

Dr Simpson asked about distributing this report and how to go about it as it would be beneficial to share the learning and themes. Dr Cargill commended Dr Simpson for his commitment and leadership on this initiative and added that this was fantastic work. Dr Cargill said that we will report it to the NHSF CGC and also it can be presented at a future Inter Specialty Clinical Governance Event. The report can also be disseminated to the Senior Charge Nurse Forum and Clinical Leads via the Directorates. **LG**

- **End of Life Audit**

The End of Life Audit will be reported to November 2019. Miss Godsell to invite Dr Kim Steel to speak to the report. Dr Cargill asked that the workplan reporting cycle for this also be checked out. **LG**

- **Patient Experience Report**

Mrs Beveridge reported that the feedback was good for some areas but not others. Dr Cargill asked if these reports should be submitted o the Committee or the Oversight Meetings? It was decided that the Oversight Meetings would be the appropriate forum. Remove this item from workplan for future Committee meetings.

6 Women, Children & Clinical Services Directorate

6.1 Clinical Director/Head of Nursing Report

- **SBAR re Incidents**

The SBAR for Incidents within Clinical Support & Access was noted.

Dr Cargill asked if this would be submitted to the next Oversight group meeting? Ms Couser advised that she wanted to come to the Committee to see what reporting and information was expected from the Directorate.

- **Clinical Support & Access**

Ms Couser presented the Clinical Support & Access Report.

Incidents
There were 152 incidents reported between 1st June and 31st July 2019. This is a reduction in severity and number of incident per month. There were no major incidents reported but there were 2 moderate incidents reported. These related to:

- patient experience delay to the correct treatment pathway
- an ultrasound probe had not been decontaminated following previous use.

The top 5 themes of all incidents are:

- Patient information
- Radiation
- Specimen Management
- Blood Transfusion
- Other Clinical Events

Patient Information
There were 40 patient information incidents. 38 related to Labs and 2 to Radiology. The most common incident was incorrect or mislabelling of specimens sent to Labs.

Radiation Incident Breakdown
There were 17 incidents and none of these were reportable to Healthcare Improvement Scotland (HIS) as all resulted in minor or no harm.

Patient Falls
There was 1 patient fall recorded in Radiology.

Medication Incidents
There were no medication incidents.

Personal Accidents
There was 1 personal accident within Labs when a member of staff dropped a vial whilst removing it from the controlled drugs fridge. The appropriate actions to clean up and remove the spillage were taken.

Risk Register
There are 19 risks on the risk register and this is reviewed regularly.

Health & Safety
The water coolers for Therapies & Rehab have been approved by the Water Safety Committee.

A walk round and focus group is planned to address the poor ventilation in Therapies & Rehab department affecting both staff and patients.

Patient Feedback
There was no new patient feedback collected over the reporting period.
The new Care Experience questionnaires have been shared across AHP's in Fife.

Complaints
There were no stage 2 complaints and only 1 stage 1 complaint relating to waiting times for a scan.

The Directorate also received 1 complaint and 1 concern relating to the availability of a hoist within Radiology. This was addressed positively.

- **Women & Children**

Dr Mahmood presented the report for Women & Children.

Incidents
There were 177 incidents reported between 1st June and 31st July 2019. This was an increase from the previous two months.

There were 6 moderate and 3 major incidents.

The moderate incidents related to:

- Antenatal stillbirths
- Anaesthetic problem in theatre leading to escalation of care to Intensive Care Unit
- Birth injury sustained during forceps delivery
- Delay in diagnosis resulting in child having emergency transfer to Royal Hospital Sick Children's

The major incidents related to:

- Two medication incidents involving missing stock
- Unexpected sudden infant death

The major incidents are currently under review through the Significant Adverse Event Process (SAER).

The top 5 themes of all incidents are:

- Obstetrics
- Neonates
- Medication Incident
- Patient Information Records
- Access/Appointment/Admission etc

Dr Mahmood referred to the Obstetrics incidents and noted that the highest number of incidents related to:

- Post Partum Haemorrhage (PPH) with a blood loss over 1000mls
- 3rdand 4th degree tears

Dr Mahmood said that NHS Fife figures are within the national average for PPH. Dr Cargill asked about an annual audit for PPH? Dr Mahmood advised that he wants to instigate this and PPH will be one of the subject reports as well as 3rd and 4th degree tears, aa well as a Sepsis monthly audit and other high profile issues within the service.

Neonatal Incidents
There were 26 incidents relating to admissions of term babies to our Special Care Baby Unit (SCBU) from home or the Maternity Unit. This is an increase on the previous 3 months but on checking Badgernet it appears there are several cases which were not reported for the previous period. As a result, more accurate reporting has been encouraged. It was noted that the readmission rate was higher than the national average.

Dr Mahmood advised that all cases are reviewed and there are no trends or deviations from good practice identified.

Dr Mahmood agreed to bring service relevant annual reports to the November meeting. **TH**

Medication Incidents
There were 16 Medication incidents.
14 of these resulted in no harm and 2 missing stock incidents were categorised as major – organisational harm.

Patient Information Incidents
There were 13 Patient Information incidents. These related to various departments including:

- Wrong information recorded on Badgernet
- Incomplete or mislabelled specimen request forms.

None of the incidents resulted in harm.

Access/Appointments/Admission/Transfers/Discharges
There were 9 incidents relating to the above. 5 of the cases were postnatal re-admissions.

6.2 Directorate Governance – Specialty National Reports

- **Maternity Unit Report**

The Maternity Unit report was carried forward to November 2019. **LG**

- **Detect Cancer Early**

The Detect Cancer Early report was included and the following information was noted:

The Detect Cancer Early programme was a four year programme with the aim of increasing the patients diagnosed at Stage 1 by 25% from the 2010 baseline. The proportion of patients with cancer diagnosed with stage 1 disease can vary because of a number of factors, including the presence and uptake of national screening programmes.

In Scotland, for the two-year period 1 January 2017 to 31 December 2018 (year 7):

- There were 24,786 patients diagnosed with breast, colorectal and lung cancer.
- For people with breast, colorectal or lung cancer, one in four (25.5%) were diagnosed at the earliest stage (stage 1). This is a 9.4% relative increase

from the baseline percentage of 23.3%

- The Local Delivery Plan standard is a 25% relative increase from baseline, which would mean the percentage diagnosed at stage 1 would need to increase to 29.2% to meet this
- People living in the most deprived areas are less likely to be diagnosed at an earlier stage than those from least deprived areas. For people with breast, colorectal or lung cancer in the most deprived areas, 22.6% were diagnosed at the earliest stage (stage 1) compared with 29.1% in the least deprived areas.
- Patients diagnosed at stage 1 with breast cancer increased over the time period but we have seen small decreases each year since 2014 and 2015. The percentage of patients diagnosed at stage 1 for colorectal cancer has decreased over the time period although there have been increases since 2015 and 2016. Lung cancer has seen an increase in patients diagnosed at stage 1 although the increases have flattened over the last few years.

Issues of significance to the Committee:

- For the two year period 1 January 2017 to 31 December 2018, the proportion of patients in Fife diagnosed with breast, colorectal and lung cancer at the earliest stage (stage 1) was 25.1%. This is a 7.6% increase from the baseline (2010 and 2011 combined) and is comparable to year 6 figures.

Ms Couser commented that we have seen an increase in Stage 1 cancers and asked what more we can do? Dr Cargill asked if this was an annual report? Ms Couser advised that the cancer structure lay within all Directorates and everyone needed to take some ownership of this. Dr Cargill said that decisions would be made within each pathway.

- The proportion of patients in Scotland with a 'not known' stage recorded at diagnosis is 6.0%. In mainland NHS Boards this varied from 2.9% (NHS Fife) to 13.2% (NHS Grampian). There has been an increase in NHS Grampian unknown stage for lung cancer for 2017. This is due to a known local recording issue.

Ms Couser said that the reporting metric being captured as "not known" is concerning and that we need to understand more about this cohort and pathways.

6.3 Directorate level outcomes data:

- **Clinical Audit**

Nothing submitted for discussion.

- **SAER LEARN Summaries**

There were no LEARN summaries submitted.

6.4 Specialty/departmental audit & assurance data (incl guidance)

- **Clinical Quality Indicators**

There was no audit or assurance data submitted for discussion.

6.5 New Interventional Procedures

- **Vaccine Programme**

Discussed under Action List – Action 278. It was agreed that this will be a quality measure in Ante-natal care. c/f to November 2019. **WCCS**

6.6 SPSO Recommendations

There were no SPSO recommendations.

Dr Mahmood asked for clarity on what sort of response the SPSO are looking for? Dr Cargill commented that once the SPSO make a determination, they require evidence of actions as a follow up to confirm that the relevant failings have been corrected.

7 Emergency Care Directorate

7.1 Directorate Report

Mrs Beveridge presented the Directorate report.

Incidents
There were 629 incidents reported during the reporting period.
There was 1 incident reported as extreme and 48 as major.

The Major/Extreme incidents related to:

- On admission pressure damage
- Cardiac arrests
- Delay in treatment
- PVC SABs
- CVC SABs
- CVC Line infection
- Patient Falls
- On ward developed pressure ulcers
- Medication storage transportation
- Medication administrations
- Equipment failure

Mrs Beveridge advised that there were 7 SAERs and 4 LAERs commissioned during this period.

The top 5 incident categories are consistently:

- Patient Falls
- Tissue Viability
- Medication
- Other clinical
- Unwanted behaviours

Patient Falls
There have been 158 falls of which 17 have resulted in varying degrees of harm.
It was noted that although there has been a increase in the total number of falls, there has been a continual decrease in harm sustained. The 17 falls were categorised as 14 minor harm, 2 major harm and 1 moderate harm.

Mrs Beveridge advised that a falls bundle was being tested over 5 wards which has contributed to the transformational work which is going on. Mrs Beveridge added that a new falls toolkit was rolled out last week with ongoing education being provided. A further audit will be redone in January 2020.

Mrs Beveridge said that Ward 42 and Ward 32 have the highest fall rates. Dr Cargill asked why it was calculated by occupied bed days and not by number of inpatient spells?

Tissue Viability
There have been 145 Tissue Viability incidents reported over the quarter, 34 of these were developed on ward. These incidents are reported on Datix and graded accordingly due to severity of the damage.

Dr Cargill asked if the Directorate was content with the accuracy of the grading? Mrs Dodds said that the accuracy of reporting was improving but added that with having frequent bank and newly qualified staff they have not had the same training for this.

Medication
There were 97 medication related incidents. The categories for these were:

- 48% administration/missed doses
- 21% prescribing
- 9% supply

Cardiac Arrests
There have been 7 reported cardiac arrests and also 2 cardiac arrest resuscitations which were successful.

The 7 cases are awaiting Emergency Bleep Group review although one case has already been escalated to SAER.

SABs
Mrs Beveridge advised that there has been a flurry of PVC SABs within Wards 44 and 23 which have progressed to SAER status. Infection Control have supported the cluster in Ward 44 which has identified some areas of learning.

There were 2 CVC SABs reported – one in Renal Outpatients and one in Haematology. These will be reviewed at SAER.

Mrs Beveridge added that a hickman line infection has also been reported in Ward 34 (not SAB) pathogens are associated with water contamination but unable to identify if the source is hospital or at home.

Risk Register
The Risk register is robustly reviewed regularly. There were no new risks this quarter.

Complaints
There were 32 Stage 2 complaints, this was a significant increase and 8 of these were upheld. Mrs Beveridge said there was difficulty in complying to the 20 days response time.

The main themes were:

- Co-ordination of clinical treatment
- Poor nursing care
- Poor medical treatment

Ward 43 Palliative Care Improvement Project
Ward 43 at VHK has the highest number of deaths per year of all ward areas in NHS Fife. This is due to the patient cohort in the ward – there are patients who die within a short time following admission and others who are admitted and receive a life limiting diagnosis, therefore a palliative care approach is needed as part of the core culture in the ward. The work focuses on raising awareness and compliance with HACP with patients who have a DNACPR. Weekly audits are being undertaken to determine uptake of HACP use in Ward 43.

Mrs Beveridge said that there is a project group but trying to change this to a business meeting which is being led by a Palliative Care Consultant.

Annual Reports
Mrs Beveridge said that the timetable for annual reports was included for information. Dr Cargill advised that it was not essential for medical specialties to provide an annual report, the Directorate need to be assured about the quality and safety of the specialty at their discretion, and if by an annual report then that was up to the Directorate to decide.

7.2 Directorate Governance – Specialty National Reports

There were no Specialty National reports.

7.3 Directorate level outcomes data:

- **Clinical Audit**

The directorate has a number of audit and projects ongoing. Some of these are solely ECD but some other projects involve ECD along with other directorates/divisions. Some of these are noted below.

- Glycaemic control and complications in adult diagnoses >50 yrs of type 1 DM in Fife
- Monitoring Take-Home Opioid Prescriptions from A&E
- Evaluation of the waiting time for specialist assessment following a suspected first seizure in NHS Fife
- What Matters to Me?
- Advanced care planning for movement disorders.
- Acute Services Cardiac Arrest Audit.
- PU case Note Review
- Adults with Incapacity (AWI) Documentation Audit
- Bring your medicines in to hospital - Are patients bringing their medicines in?

- Hip fracture anaesthetic audit

- **AWI Audit Results**

Mrs Beveridge informed the Committee that and Adults with Incapacity audit was undertaken over two weeks during June 2019.

The assessment from the audit highlighted:

- Sixteen inpatient areas were audited; out of these 81% (13/16) had AWIs in place at the time of the audit. A total of 43 AWI forms were audited within the Emergency Care Directorate.
- Completion of the patient name dropped slightly from the previous audit to 98% (40/41) as did the patient CHI at 95% (39/41). The patient DOB rose from 67% in the previous audit to 83% (34/41). In particular, the address was only completed on 51% (21/41) of the forms. This may be due to staff using patient labels that no longer have the patient address printed on them.
- On the new form on the front page there is section to be completed which has the date of assessment, signature and print name. The date of assessment was completed on 90% (36/40) and the signature and printed name were completed on 93% (37/40) of the new forms that were in place.

Dr Cargill highlighted that the "Welfare Attorney/Guardian" – completion of this section has again decreased in this audit from 74% to 63% (26/41).

Dr Cargill added that he thinks this report should have a higher profile on the agenda. Mrs Beveridge suggested that Dr Alfonzo speak to this report at meetings.

Mrs Beveridge asked the Committee to note the report and asked members to be aware that some results had declined and efforts would be made to improve for the next audit. The next audit report should also include Planned Care wards.

- **SBAR – Effective Patient Flow within ED**

Mrs Beveridge referred to the SBAR regarding Effective Flow within ED which had been prepared by Dr Kinnon. The paper highlights a test of change to support effective direction of patients to the right place, at the right time when attempting to access Urgent Care as opposed to Emergency Care from the Emergency Department (ED) at Victoria Hospital, Kirkcaldy (VHK). The SBAR notes that patients who present to ED, VHK can present with symptoms or conditions which could be managed effectively using alternative pathways for care which would direct patients away from ED. These clinical pathways would be assured as clinically safe, appropriate and evidenced based created in collaboration between Services with senior clinicians. In 2017, clinical criteria were agreed between PCES and ED which supported safe redirection of patients between services. This has worked effectively and does support safe redirection. In the period February to May 670 people were redirected from ED, this includes the patients cohort identified above.

Dr Cargill asked the Committee for any comments or concerns. Ms Couser asked if this links in with transformation of care? Dr Cargill replied that this was an enhanced redirection pathway from A&E to PCES. There were no further comments received. Dr Cargill asked the group to consider the content and

support the SBAR. Mrs Beveridge said this was more about out of hours and it seemed sensible. There were no objections.

The Committee were content to support the SBAR.

- **SAER LEARN Summaries**

There were no LEARN summaries to report.

7.4 Specialty/departmental audit, assurance data (incl guidance)

- **Clinical Quality Indicators**

There were no Clinical Quality Indicators to report.

7.5 New Interventional Procedures

- **Update re Botox Injections for Stroke patients procedure**

Mrs Beveridge referred to the very detailed SBAR provided by Charlie Chung in relation to post-stroke spasticity botulinum toxin A injecting clinic. It was noted that Fife is one of the few Scottish health board regions to lack a botulinum toxin injecting post-stroke spasticity clinic.

There is a need to establish a post-stroke spasticity clinic in Fife for the following three reasons:

1. The Scottish Stroke Improvement Plan adding the requirement of a clinic in 2017. Fife stroke services undergo an annual service evaluation and current RAG status is amber (spasticity clinic is available but not throughout Fife).
2. The Rehabilitation Consultant who has delivered an ad hoc clinic for many years, will be retiring in the near future and as yet, there is no succession plan in place.
3. The clinic, alongside a Fife network of clinicians working to manage people's spasticity, has the potential to reduce complications such as skin breakdown, infection and permanent muscle shortening (contractures), and be cost-effective by reducing the costs associated with managing these complications

Dr Cargill asked the group for any comments regarding this procedure. The question was raised whether this was just acute or if it included the partnership too?

The desire to run clinics would need to be approved by operational management, where after a view from the Clinical Governance Committee would be sought. Ms Couser agreed to liaise with Carol Duncan-Farrell. It was noted that if is agreed as a desirable business development then a business case to establish a post-stroke spasticity clinic in Fife would be required. Ms Couser to feedback to the Committee. **GC**

7.6 SPSO Recommendations

There was one case and the information has been submitted to SPSO.

8 Planned Care Directorate

8.1 Directorate Report

Ms Saunderson presented the information for Planned Care.

Incidents
There were 231 incidents reported during the period 1 July to 31 August 2019. There was 1 incident reported as extreme and 12 as major.

The Major/Extreme incidents related to:

- Cardiac Arrests
- Unexpected complication following theatre procedure
- Unexpected deterioration and death following assessment in A&E
- Delay in emergency operative treatment in theatre
- Missed Endoscopy biopsy result
- Tissue Viability incidents
- Medication incident
- Theatre/Surgery incident

The top 5 key themes are noted as:

- Patient Falls
- Medication Incident
- Tissue Viability
- Other Clinical Events
- Access/Appointment/Admission/Transfer

Patient Falls
There were 37 falls reported across the Directorate – 7 of these resulted in minor harm.

Surgical Site Infection
There were 296 Orthopaedic procedures performed during Apr – June 2019 which fall into the surveillance categories. There was 1 confirmed Surgical Site Infection (SSI) for a patient who had a hip replacement and developed wound infection.

Large Bowel Summary
There were a total of 99 operations which fall under the planned large bowel surveillance programme. There were 10 confirmed SSI within the 30 day surveillance period. It was noted that form completion remains low for large bowel SSI surveillance and it has been agreed that the surveillance team will attend various general surgery theatre briefs to remind staff and offer support as necessary to surgeons and theatre staff.

Medication Related Incidents
There were 30 medication related incidents reported. Prescribing was the highest theme.

Risk Register

The Risk Register is reviewed regularly and no new risks have been added.

Complaints
The Directorate has closed 25 Stage 2 complaints for the period.
The breakdown for these are:

- Fully upheld - 4
- Partially upheld - 8
- Not upheld - 13

The Directorate has closed 32 Stage 1 complaints for the period.

SPSO Outcomes
There were three final decisions received and two investigations have commenced.

8.2 Directorate Governance – Specialty National Reports

There were no specialty reports for discussion.

8.3 Directorate level outcomes data

Clinical Audit

- **QFit Project Update (Action 273)**

Ms Saunderson advised that Mr Cruickshank has commenced with the QFit project but no audit had been done as yet. Add to workplan. **LG**

- **Summary of the Cleft Care Report**

Discussed under Action List – Action 244.

- **TAMIS Outcome Audit**

Nothing submitted by Directorate – February 2020. Add to workplan. **LG**

- **Bladder Cancer**

Ms Saunderson referred to the Bladder cancer report.

- This is 4th year of the Bladder Cancer QPIs. The formal national review meeting has allowed for much needed and appropriate change to definitions, measurability criteria and targets.
- NHS Fife met 10 out of the 18 QPIs for Bladder cancer (includes sub QPIs). Reasons are documented within the report.
- The process following final sign-off is that the report is sent to the Clinical Governance groups within the four health boards and to the Regional Cancer Planning Group. Action plans and progress with plans will be highlighted to the groups.
- An action plan has been agreed and urological teams in SCAN (clinicians, nurses, and audit staff) who work collaboratively to review data regularly to identify possible areas for improvement and actively participate in driving improvements and, where appropriate, make changes to the way care is delivered. The process following final sign-off is that the report is sent to the Clinical Governance groups within the four health boards and to the Regional

Cancer Planning Group. Action plans and progress with plans will be highlighted to the groups.

- One action was identified - Clinicians should be using bladder proforma to ensure that all data items are documented appropriately – Action complete. Bladder proforma updated/uploaded to allow electronic completion.

The update was noted.

- **Testis Cancer**

The Testis Cancer report focussed on the period October 2016 – September 2017.

The following points were noted:

NHS Fife achieved an overall accuracy of recording of 99.5% exceeding the 90% target.

- NHS Fife met 8 of the 14 Quality Performance Indicators (QPIs) for testicular cancer.
- There were no service specific actions identified for this report.
- Since the testicular pathway has been reviewed all patients have received treatment within two week of ultrasound diagnosis.

The question was raised about who was the "owner" of the QPIs? Ms Couser suggested that a Urologist be involved in order to improve in the QPIs. Dr Donnelly said that there was no identified Urologist but he would feed back the cancer reports to the relevant clinical lead to prepare the commentary. **JD**

Discussion took place around the QPIs and as we only met 8 out of the 14 actions it was assumed that the QPIs either don't matter or they are someone else's responsibility. Ms Couser commented that if Kathy Nicoll is preparing these cancer reports then the service really do not have ownership of them.

- **Breast Cancer**

The SCAN Breast Cancer Quality Performance Indicator Annual Comparative Report for 2017 highlighted the following points:

- Reviewing of results determined that no Action Points have been identified and this report offers reassurance that, in the areas examined, all units are performing well.
- Where targets have not been met this is frequently due to individual patients electing not to pursue certain offered treatments.
- There were 182 patients diagnosed with Breast Cancer in Fife in 2017 (180 in 2016).
- NHS Fife met 12 of the 19 QPIs (includes sub QPIs). Reasons for not achieving the QPI are documented in the report.
- There were no Fife actions identified.

Dr Donnelly to look into the reason for not achieving the QPIs and update at the next meeting. **JD**

- **SAER LEARN Summaries**

The LEARN summaries for the Directorate related to:

WEB 88403
A patient sustained a burn from the use of diathermy with bruising on skin during their theatre procedure. The surgical team were unaware that this had occurred at the time. As a result, training and education has been re-inforced for staff.

WEB 96464

Patient underwent a laparoscopic cholecystectomy at QMH. A few hours later the patient returned to theatre for surgical intervention. Shortly after the patient's return to theatre, the Major Haemorrhage protocol was activated. As a result, the majority of staff in theatres at QMH have recently attended a session on the activation of the Major Haemorrhage (MH) policy as a means of refreshing their knowledge and skills.

8.4 Specialty/departmental audit, assurance data and clinical guidance

- Clinical Quality Indicators

SBAR re L2 to L3 grader (Action 273)

Ms Saunderson presented the SBAR, which had been presented at a previous meeting. Dr Styles, Consultant Ophthalmologist was noted as being the lead.

Ms Saunderson summarised the SBAR and indicated that the Diabetic Retinopathy Service (DRS) sits within the community who work with the Ophthalmologists. There is a risk to the service as the Level 3 grader for NHS Fife retired at the end of 2018 and replacement was unsuccessful.

The DRS proposes that Level 2 graders will undertake Level 3 grading work. Only the most qualified and experienced Level 2 graders will be supported by the Scottish Diabetic Retinopathy Screening Programme Lead Clinician to be appointed as Level 3 graders within NHS Fife and this would only take place if the Level 2 grader meets the conditions and definitions of a Level 3 grader.

The current situation is that a Level 2 will assess the patient and decide whether they need to be seen urgently or referred. A level 3 grader will oversee the decision and make the final decision re referring the patient to the Ophthalmologist.

Ms Saunderson said that the perceived risk of allowing Level 2 graders to carry out Level 3 grading can be offset against the actual risk of having no Level grader available. It was noted that there is no automatic right for Level 2 graders to be appointed to Level 3 grading event if they meet the standards above.

Ms Saunderson added that there is robust external quality assurance checks which involves the external checking of 100 images from each grader, with precise high percentage accuracy target expected.

Dr Cargill said that he would liaise directly with Dr Styles regarding this request as there was some confusion as to the ask of this SBAR. **RC**

POST MEETING NOTE – this issue has now been resolved post meeting and approval has been given for the proposal.

8.5 New Interventional Procedures

- **Update re VTE day case work & test of change (Action 197)**

Discussed under Action List.

- **Surgical Care Practitioner**

The Directorate tabled a new Interventional Procedure for a Surgical Care Practitioner (SCP) who would be responsible for insertion of secondary ports under vision for laparoscopic procedures in theatre with supervision from the surgeon.

The evidence base taken from the British Medical Journal (BMJ) states that a SCP is a consistent member of the team trained as a generalist therefore versatile and can carry out routine and minor techniques. This extended role complements rather than competes with medical staff and is cost effective.

It was noted that audit measures are in place with a log book being maintained which will include all secondary ports inserted as well as continual assessment with yearly formal review process.

The procedure was approved.

8.6 SPSO recommendations

There were no SPSO recommendations.

9 Divisional Risk Register – Active Risks (for review)

The risk register is under review and the risk owner for one of the risks is currently being reviewed.

10 ASD CGC Terms of Reference – Updated May 2019

The Terms of Reference was noted and will be reviewed and updated as necessary.

11 Items for information only:

11.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

11.2 SIGN Guidance

Mrs Muir advised there was one SIGN Guideline out for consultation with Dr Fairbairn.

The guidance was noted.

11.3 ASD CGC Workplan 2019/2020

The workplan was noted by the Committee.

11.4 Infection Control Committee (5th June 2019 incorporating AMT meeting of w/c 31st July 2019)

The Infection Control Committee and Anti-Microbial Management Team minutes were noted.

11.5 HAIRT Report

The HAIRT report was noted.

11.6 SRTC Minutes of 13th August 2019

Dr Cargill advised that very few NHS Fife procedures were being done now at Stracathro.

The SRTC Minutes were noted.

11.7 NHS Fife CP&PAG Minute of 1st July 2019

The NHSF CPPAG minutes were noted.

11.8 Resuscitation Committee Minutes of 4th July 2019

The Resuscitation minutes were noted.

11.9 Hospital Transfusion Committee Minutes of 10th May 2019

The HTC minutes were unavailable – c/f to November 2019.

12 Future structure and meetings of ASD CGC

The future structure of the ASD CGC meetings was noted.

13 AOCB

Dr Mahmood asked about the Cervical Screening Standards. Mrs Muir agreed to find out.

Mrs Muir advised that the Clinical Supervision policy had now been uploaded to the Intranet.

14 Date of Next Meeting/s:

ASD CG OVERSIGHT MEETING –
Wednesday 16th October 2019 at 2.00pm within Training Room 2, Dining Room, VHK

ASD CG COMMITTEE MEETING –
Tuesday 26th November 2019 at 2.00pm within Training Room 1, Dining Room, VHK

NHS Fife Clinical Governance Committee
6 November 2019

Agenda item no

Title of Group/Sub-committee	Fife Area Drug & Therapeutics Committee
Date of Group/Sub-committee Meeting:	21 August 2019
Release: draft/final minutes	Draft
Author/Accountable Person:	Dr C McKenna

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
This should include good practice • Shared Care Agreements. Positive progress with approval of SCAs for Methylphenidate, Lisdexamfetamine and Atomoxetine for Children (aged 6 years and over) and Adolescents with ADHD. Review of the policy and procedures for Shared Care Agreements is ongoing. • Policies approved - "NHS Prescribing Following Private Consultation" and "Introduction, Availability and Safe and Effective Use of Medicines, Including Newly Licensed Medicines". • Format agreed for NHS Fife response to MHRA Drug Safety Alerts that require action within NHS Fife (ADTC agenda items 7.5, 7.6, 7.7).
What are the concerns/issues/risks you want to bring to the attention of the committee?
Include any actions taken to date

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 12.30PM ON WEDNESDAY 21 AUGUST 2019 IN DINING ROOM 1, THE TRAINING CENTRE, VICTORIA HOSPITAL, KIRKCALDY.

Present: Mr Scott Garden (Chair)
Ms Karen Baxter
Ms Jill Chambers
Ms Claire Fernie
Dr Iain Gourley
Dr David Griffith
Dr Helen Hellewell
Mr Euan Reid
Ms Andrea Smith
Ms Geraldine Smith

In attendance: Dr Glyn McCrickard, GP
D Joan Ederton, GP
Mrs Sandra MacDonald (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were noted from Ms Lynn Barker, Dr Rob Cargill, Ms Claire Dobson, Dr John Donnelly, Dr John Kennedy, Dr Alan McGovern, and Dr Chris McKenna.

Mr Garden welcomed everyone to the meeting and introductions were made.

2 MINUTES OF PREVIOUS MEETING ON 19 JUNE 2019

The minutes of the meeting held on 19 June 2019 were confirmed as a true record.

3 SUMMARY OF ACTION POINTS FROM JUNE 2019 MEETING

The summary of action points was reviewed and updated.

Risk Register - Clinical Guidance Documents
Mr Garden provided feedback from his meeting with L Donovan, General Manager eHealth & IM&T, to discuss a suitable platform for hosting Clinical Guidance documents. L Donovan has agreed to look at the suitability of Macroguide and also explore any other alternative solutions. Mr Garden to report back to the ADTC in due course. **SG**

Mr Garden also briefed the Committee on developments regarding a potential regional approach to Clinical Guidance. The East Region Directors of Pharmacy Group has been approached to take the lead on a proposed regional approach to the Single National Formulary. Further information on the Scottish Government's expectations is awaited before this is progressed. Initial observations of the proposed website platform look positive.

Comments have been fed back around inclusion of the facility to manage Clinical Guidance documents. Mr Garden to update the ADTC following discussions at the next East Region Directors of Pharmacy group meeting. **SG**

BNF Distribution
Mr Reid advised that he has contacted National Services to request information on the volume of paper copies ordered and a response is awaited. Mr Reid to follow up. **ER**

Realistic Prescribing Group - Patient Representative
Mr Reid confirmed that membership of the group does not currently include a patient representative. Dr Helen Hellewell and Fiona Forrest to discuss this going forward.

Patient Group Directions Group Update - Funding for PGD Pharmacist Role
Mr Garden and Mr Reid are progressing in discussion with the Finance Business Partner.

Lithium SBAR
Mr Reid clarified that the data previously presented to the ADTC did not include three practices within North East Fife that did not take part in the audit. There are ongoing discussions about the prescribing of lithium and the management of patients in Day Hospital/General Practice. A short life working group has been set up to look at the issues. Mr Reid to clarify membership of the short life working group and request that the group bring an update to the ADTC meeting in December. **ER**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

4.1 Cover Sheet for MCN Minutes

The proposed cover sheet produced to accompany minutes submitted to the ADTC was discussed.

It was noted that the cover sheet is in line with the template currently in use by other NHS Fife Governance Committees. It was noted that minutes from the ADTC subgroups that produce 6-monthly update reports are not currently included on the ADTC agenda. It was proposed that all subgroups reporting into the ADTC should routinely submit minutes. The cover sheet/minute is in addition to the 6 monthly update reports.

It was noted that the cover sheets currently produced by the Fife Formulary Committee and Managed Service Drug & Therapeutics Committee contain further detail for consideration by the ADTC and it was agreed that they should continue to be submitted in their current format subject to an amendment to incorporate the additional information requested in the minute cover sheet.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 Fife Formulary Committee

Dr Griffith introduced the update report from the Fife Formulary Committee meeting on 31 July 2019.

Two Formulary Submissions for relapsing remitting MS (Cladribine and Ocrelizumab) were approved. Dr Spelmeyer, Consultant Neurologist, attended the Formulary Committee meeting to clarify the proposed place in therapy of Cladribine and Ocrelizumab. Ezetimibe was approved for secondary prevention of hypercholesterolaemia only on the advice of a specialist. Updated Formulary Chapters 2 Cardiovascular and 6 Endocrine were approved. The updated Minor Ailments Formulary and Infant Colic Advice Sheet were also approved.

The ADTC noted the update report from the Fife Formulary Committee and supported the recommendations made.

Mr Garden highlighted that part of the remit of the ADTC is to look at predicted spend against actual spend for Formulary submissions approved within NHS Fife. Ms Chambers advised that a finance check was carried out in the last year and it was reassuring to note the accuracy of Formulary applications.

6.2 MSDTC

The minutes and update report from the MSDTC meeting on 25 June 2019 were noted.

Mr Reid highlighted that a number of documents were approved by the MSDTC including the Guidance for the Use of Disease Modifying Treatments in Adults with Relapsing Remitting Multiple Sclerosis.

Mr Garden noted an increase in Guidance documents submitted to the MSDTC with good attendance by authors of documents to talk to their submissions and answer Committee queries.

The ADTC noted the update report from the MSDTC.

6.3 Controlled Drugs - Local Intelligence Network / Safer Management of Controlled Drugs

Ms G Smith introduced the update report from the Controlled Drugs - Local Intelligence Network and annual report on the Safer Management of Controlled Drugs.

Ms Smith highlighted the patient information leaflet “Looking After Your Medicines” and invited comments from the Committee on proposed distribution and identification of a potential funding stream.

The ADTC noted the following:

- The leaflet sends a good clear message and is in line with other work around managed repeats and medicines waste.
- It was proposed that the order of the bullet points be changed, to move current bullet point three to the top of the list.
- The wording in the second bullet point to be amended to include “don’t **want** or need any medicines”.
- It was noted that a one-off awareness campaign is proposed, with distribution of the leaflets to various professionals including Hospital sites, Community Pharmacies, GP Practices, Health Centres and District Nurses. It was highlighted that due to storage restrictions, only a small volume of leaflets should be distributed to GP Practices. An electronic version hosted on the GP intranet site, along with a small supply of posters would be useful. Care homes to be included in the awareness campaign.
- It was noted that the budget for the campaign has been estimated at approximately £400. Mr Garden to discuss funding with Kirsty MacGregor, Head of Communications. **SG**

Ms Smith took the ADTC through key items from the Controlled Drugs - Local Intelligence Network/Safer Management of Controlled Drugs Reports for the period April-March 2019. The ADTC noted the progress and proposed work plan going forward.

Ms Smith highlighted ongoing issues regarding online prescribing services and governance concerns regarding non regulated pharmacies/prescribers not registered within the UK. It was noted that updated strengthened guidance has now been issued by the GPhC.

The ADTC noted the update report from the Controlled Drugs - Local Intelligence Network/Safer Management of Controlled Drugs.

6.4 Antimicrobial Management Team

Dr Griffith introduced the update report from the Antimicrobial Management Team and highlighted key items.

The ADTC noted that the Primary Care Empirical Antimicrobial Guidelines have been finalised. Revision of the Hospital Guidelines has also been completed and the aim is for distribution within the next month. The workplan for the next six months includes the development of the planned OPAT service which will facilitate the effective management of infections requiring intravenous antibiotics in patients otherwise well enough to be discharged.

Dr Griffith also highlighted issues around interruption of antimicrobial supplies, impact of an ongoing Antimicrobial Pharmacist vacancy and the

impending expiry of the Microguide app licence in 2020.

The ADTC noted the update report from the Antimicrobial Management Team.

7 SBARs

7.1 Alogliptin Switch

Mr Reid introduced the SBAR relating to the proposed alogliptin switch and briefed the ADTC on the background to this.

A proposed Medicines Efficiencies project to switch to the Formulary first choice gliptin (alogliptin) has identified efficiencies of approximately £150K per annum. Following discussion at the Diabetes MCN Prescribing Group a decision was made to restrict the switch to patients on non Formulary gliptins and exclude those currently prescribed the Formulary 2nd line choice gliptin (sitagliptin) due to anticipated patent expiry for sitagliptin in Summer 2022. The ADTC noted the implications of restricting the switch project to patients on non Formulary gliptins and the potential loss of efficiencies during the period prior to the expected patent expiry of sitagliptin.

Following discussion the ADTC noted that if no clinical/care reasons for restricting the proposed switch are identified, due to the time period until patent expiry of sitagliptin and the potential for significant medicines efficiencies, the advice of the ADTC would be to proceed with the switch as originally proposed. Mr Reid to draft a response to the Diabetes MCN to seek clarification. **ER/SG**

7.2 Prescribing of Progestogens to Delay Menses

Dr McCrickard introduced the SBAR relating to the prescribing of progestogens to delay menses and briefed the ADTC on the background to this.

The ADTC were asked to consider advice from the LMC on the prescribing of progestogens for women holidaying outwith the UK using a private prescription. The ADTC noted that the LMC advice is in line with NHS GMS Regulations for the prescribing of drugs solely in anticipation of the onset of an ailment whilst outwith the UK but for which the patient does not require treatment when the medicine is prescribed.

Following discussion the ADTC agreed to endorse the advice from the LMC. It was suggested that the LMC communicate to GP practices to highlight the NHS GMS Regulations and the ADTC's endorsement of the LMC advice regarding the issuing of private prescriptions for progestogens to delay menses for women travelling outwith the UK.

7.3 SOP for Intermittent Catheter Reviews

Mr Reid introduced the SBAR and Standard Operating Procedure (SOP) for

the transfer of existing users of non Formulary intermittent catheters to Formulary choice products and briefed the ADTC on the background to this.

The ADTC noted that the SOP was developed in partnership between the Continence Team Lead and the Medicines Management Team Senior Prescribing Support Nurse for use by Registered Nurses in the community setting who are not independent prescribers. The ADTC were asked to approve the SOP and agree that similar SOPs could be approved by the local service.

The ADTC noted that it was a well written, very clear SOP. A discussion ensued about the appropriate governance route for approval of the SOP and medical devices/health technology in general and a gap was identified. The ADTC supported the SOP but agreed that it did not have a role in its approval. It was noted that the Clinical Policy and Procedure Authorisation and Co-ordination Group has wide representation including nursing and pharmacy and it was suggested that this would be a more suitable forum to take the SOP forward for approval. Mr Reid to discuss with Elizabeth Muir, Co-ordinator of the Clinical Policy and Procedure Authorisation and Co-ordination Group. **ER**

7.4 Shared Care Agreements

Mr Reid briefed the ADTC on the background to development of the Shared Care Agreements for Methylphenidate, Lisdexamfetamine and Atomoxetine for Children (aged 6 years and over) and Adolescents with ADHD.

The ADTC noted that the Shared Care Agreements were produced in discussion with relevant secondary care clinicians and have been to the GP Clinical Steering Group, LMC and MSDTC. The Shared Care Agreements were produced in Autumn 2018 in line with the current NHS Fife Policy and Procedure for the Shared Care of Medicines. The Policy is beyond its review date but remains extant pending revision.

The ADTC approved the Shared Care Agreements for Methylphenidate, Lisdexamfetamine and Atomoxetine for Children (aged 6 years and over) and Adolescents with ADHD. An amendment to be made to change the term "relatives" to "guardians" throughout the documents. Mr Garden and Dr Hellewell to discuss joint communication to GP Practices. **ER** **SG/HH**

7.5 DOACs and Antiphospholipid Syndrome - Drug Safety Update

Mr Reid introduced the update report on the actions taken within NHS Fife in response to MHRA Drug Safety Update on direct oral anticoagulants (DOACs) and increased risk of recurrent thrombotic events in patients with antiphospholipid syndrome.

The ADTC noted that Rheumatology patients with antiphospholipid syndrome who are prescribed a DOAC have been identified for review and recommendations will be made to GP Practices. The Primary Care Pharmacy Team is also supporting GP Practices to identify all patients with

antiphospholipid syndrome who are prescribed a DOAC and a switch to warfarin will be considered where appropriate.

The ADTC noted the NHS Fife response to MHRA Drug Safety advice on DOACs.

7.6 Febuxostat - Drug Safety Update

Mr Reid introduced the update report on the actions taken/proposed within NHS Fife in response to MHRA Drug Safety advice for healthcare professionals issued in July 2019 relating to an increased risk of cardiovascular death and all-cause mortality in clinical trial in patients with a history of major cardiovascular disease taking febuxostat (Adenuric®).

The ADTC noted that the place in therapy of febuxostat (Adenuric®) is clearly defined within the Fife Formulary and a hyperlink to MHRA advice has been added. Formulary Appendix 10C has also been updated to reflect the MHRA advice. The Primary Care Pharmacy team are supporting GP Practices in identifying patients who require to be reviewed as a result of the MHRA advice.

It was noted that a clinical trial (FAST study - Febuxostat versus Allopurinol Streamline Trial) led by the University of Dundee is currently underway. The Chief Investigator of the FAST study has written to all GP Practices involved in the study advising that no changes to the study are planned as a result of the MHRA advice. The situation is still under discussion with MHRA and GP Practices will be advised of any update.

The ADTC noted the NHS Fife response to MHRA Drug Safety advice on febuxostat (Adenuric®).

7.7 Oral Retinoid Medicines - Drug Safety Update

Mr Reid introduced the update report on the actions taken/proposed within NHS Fife in response to MHRA updated advice for oral retinoid medicines.

Pregnancy prevention educational materials to support healthcare professionals and female patients using acitretin, alitretinoin and isotretinoin have been simplified and are now consistent, irrespective of which brand of medicine the patient receives. Advice about the risk of neuropsychiatric reactions has also been made consistent for all oral retinoid medicines.

The ADTC noted the actions taken/proposed within NHS Fife in response to MHRA updated advice for oral retinoid medicines.

The ADTC welcomed the update reports in this format and agreed this process going forward for MHRA Drug Safety Updates/Advice that require action within NHS Fife.

8 RISKS DUE FOR REVIEW IN DATIX

Mr Reid took the ADTC through the updated risk register and agreed current risk levels and review dates.

Risk 1575 - Insufficient Representation on ADTC and Sub-committees
It was noted that this replaces risk 356 - Clinical Pharmacy Input. The ADTC agreed the proposed wording and current risk level of moderate. Review date of December 2019 agreed.

Risk 1504 - Lack of Central IT repository for NHS Fife Guidance Documents
Current risk level to remain as moderate. Review date of December 2019 agreed.

Risk 522 - Prescribing Budget
Mr Reid to update to reflect withdrawal of project impact support and reduction in communications support. Current risk level to remain as high. To be brought back to the next meeting in October. **ER**

Risk 1347 - Out of Date Shared Care Protocols
Mr Reid to update to include progress with approval of the Shared Care Agreements for Methylphenidate, Lisdexamfetamine and Atomoxetine for Children (aged 6 years and over) and Adolescents with ADHD. Risk level to remain as moderate. To be brought back to the next meeting in October. **ER**

Risk 1442 - Single National Formulary
Mr Reid to update when further information becomes available. Risk level to remain as moderate. Review date of December 2019 agreed. **ER**

9 POLICIES

9.1 NHS Prescribing Following Private Consultation

Mr Reid introduced the Policy "NHS Prescribing Following Private Consultation" and briefed the ADTC on the background to this. The Policy sets out guidance within NHS Fife to ensure appropriate prescribing when patient care moves between non-NHS and NHS providers.

It was suggested that the Policy be taken to the LMC for comment. Mr Reid to discuss with Dr McKenna in the first instance to clarify the proposed governance route for the Policy and comments raised by the ADTC in relation to relevance to non-medical prescribers/dentists. Mr Reid to clarify that the wording relating to travel medicines (section 3.2) is consistent with regulations. **ER** **ER**

9.2 Updated Policy on the Introduction, Availability and Safe and Effective Use of Medicines, Including Newly Licensed Medicines

Mr Reid took the ADTC through the updated Policy "introduction, availability and safe and effective use of medicines, including newly licensed medicines"

and highlighted key changes.

Changes include an update to reflect the new Scottish Government pathway for ultra-orphan medicines; addition of sections on medicines not recommended by the SMC due to non-submission and Car-T therapies; and simplification of terminology “PACS Tier One” and “PACS Tier two” to “PACS”.

A discussion followed about monitoring requirements for Cannabis-based products for medicinal use access scheme and an issue with identification of requests for Cannabis-based products for medicinal use for Fife patients that are managed through NHS Lothian. G Smith to take forward. **GS**

The ADTC approved the updated Policy “introduction, availability and safe and effective use of medicines, including newly licensed medicines”.

10 NEW MEDICINES FUND/HORIZON SCANNING

Ms Chambers gave an update on behalf of New Medicines Fund/Horizon Scanning Group and briefed the ADTC on the position with regard to this year’s new medicines fund budget and expenditure for the first two months of the year. Based on last year’s data a quarterly growth in expenditure of 18% is predicted. Criteria for the classification/definition period of “new medicines” to be refined.

The ADTC noted the update. ADTC members to give consideration to what information is presented to the Committee going forward.

11 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

11.1 PACS Tier Two - report of 6 month review and invitation to comment on 12 month review

Mr Reid highlighted the report from the Scottish Government on the six month review of the implementation of the new PACS tier two. Boards have been invited to submit further comments for consideration in the 12 month review.

It was noted that the information has been circulated to the PACS Panel for comment. ADTC members were also asked to email any comments on the PACS process to S MacDonald by 23 September. **ALL**

11.2 ADTCC July Newsletter

The Area Drug and Therapeutics Committee Collaborative Newsletter July 2019 was noted.

12 EFFECTIVE PRESCRIBING

12.1 SMC Not Recommended Drugs

The ADTC discussed the SMC Not Recommended Drugs report for NHS Fife for the period January-March 2019.

Mr Reid to bring back a paper to the next ADTC meeting highlighting the medicines now off patent that were not recommended by the SMC on cost effectiveness grounds. **ER**

An issue with the information currently being presented by Community Health Partnership was highlighted. Mr Reid to feed this back to National Services Scotland. **ER**

Dr Hellewell to consider how the information would be used within the Health and Social Care Partnership. **HH**

12.2 Off-Patent Specialty Generic Medicines Pricing and Supply Briefing

The report on Primary Care reimbursement prices for low-volume off-patent medicines and the recommendations for Board ADTCs was noted.

12.3 Access to Medicines for Extremely Rare Conditions via the NHSScotland Ultra-Orphan Pathway

The communication from the Scottish Medicines Consortium was noted.

12.4 EAMS Operational Guidance

12.4.1 Polatuzumab Vedotin

The ADTC noted the EAMS operational guidance for polatuzumab vedotin in combination with bendamustine and rituxumab for the treatment of relapsed/refractory diffuse large B-cell lymphoma in adult patients who are not eligible for hematopoietic stem cell transplant.

12.4.2 Atezolizumab

The ADTC noted the EAMS operational guidance for atezolizumab in combination with carboplatin and etoposide for the first-line treatment of adult patients with extensive-stage small cell lung cancer.

12.5 Biosimilar Update June/July 2019

The ADTC noted the Biosimilar Uptake Data Reports for June and July 2019 and the good progress made within NHS Fife. It was noted that a Biologics Reference Group comprising representatives from a range of specialties is to be established.

13 PACS/SMC Non Submissions

13.1 Latest Submissions

The table detailing the latest PACS/SMC non submissions was noted.

14 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

It was agreed that the following items should be highlighted to the Clinical Governance Committee: **CMcK**

- Shared Care Protocols. Highlight positive progress with approval of the three SCPs for ADHD and ongoing review of policy and procedures.
- Policies approved – "NHS Prescribing Following Private Consultation" and "Introduction, Availability and Safe and Effective Use of Medicines, Including Newly Licensed Medicines".
- NHS Fife response to MHRA Drug Safety Alerts.

15 ANY OTHER COMPETENT BUSINESS

A Smith highlighted the expanding role of Pharmacists clinically in various settings, particularly GP Practices and the need for clarity and guidance when there are differing governance approaches to the recording of potential adverse events. Mr Garden to discuss with Dr McKenna. **SG**

<u>Other Information</u>

a **Minutes of Diabetes MCN Prescribing Sub-Group.** Next meeting 20 August 2019.

b **Minutes of Heart Disease MCN Prescribing Sub-Group.** Next meeting 21 August 2019.

c **Minutes of Respiratory MCN** - not available.

d **Date of Next Meeting**

The next meeting is to be held on **Wednesday 23 October 2019 at 12.30pm in Training Room 1, Dining Room, Victoria Hospital, Kirkcaldy**. Papers for next meeting/apologies for absence to be submitted by 11 October.

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	**THE CLINICAL & CARE GOVERNANCE COMMITTEE HSCP**
Date of Group/Sub-committee Meeting:	FRIDAY 9th of August
Release: draft/final minutes	Final
Author/Accountable Person:	Dr Helen Hellewell

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
This should include good practice The clinical quality report was discussed. There was discussion highlighting the good work around comfort rounds which helps with fall and pressure ulcer prevention. It was agreed that a summary of the learning from adverse events would be shared. Falls and the reasons for them were discussed and the work that was on going to understand causes and thus prevent them. There has been training rolled out in the treatment and prevention of pressure ulcers. The mental health strategy was presented there was good discussion around this and assurance was given about how this links to other strategies. Alan Adamson presented the draft Strategic Plan 2019-2022 which sets out the vision and future direction of health and social care services in Fife, and it included some detail of the planned activities that will achieve this. There was discussion around this. The plan was supported with some small changes for added clarity especially around the new target for children's services. Norma Aitken presented the report which details governance arrangements surrounding the IJB and its committees. Members discussed and agreed it was helpful to have clinicians and other relevant staff join the Committee for specific items. Dr Helen Hellewell presented the report of the Glenrothes Hospital inspection which provided

an update on the three requirements from the inspection which took place on 19th and 20th March.

Cllr Ross asked if it was a good/moderate/poor inspection report. Nicky Connor confirmed it was a balanced report and commended staff involved in addressing the three requirements so quickly.

Julie Paterson introduced the child protection report which was presented to the NHS Fife Clinical Governance Committee in January 2019. It has been suggested the report come to this Committee on an annual basis at the same time as it is presented to NHS Fife Clinical Governance Committee.

Cllr Brett agreed that the report can be added to the CCGC workplan. Members requested an introduction to child protection and glossary be included in the next report.

Alan Adamson introduced the report which provided an overview of progress and performance within the Partnership for the period from 1st April 2018 to 31st March 2019.

Cllr Brett felt the report was lengthy and asked whether the report can be condensed next year. Alan Adamson advised there is guidance which states the information which has to be included in the report. There is currently work being undertaken by a Group at the Scottish Government to look at the format of all HSCP reports across Scotland to determine if a standard format can be introduced.

There was discussion from the linked committees:

Cllr Brett asked for details regarding the three consultants short in Rheumatology. Dr Hellewell reported there is a national shortage of Rheumatology Consultants. Work is currently underway to look at service redesign to establish a multi disciplinary team approach with pharmacy and nurses

What are the concerns/issues/risks you want to bring to the attention of the committee?

Include any actions taken to date

The role of IPAG is currently being reviewed. Development work is ongoing to revitalise this group and ensure that its role is strengthened within the partnership.

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

CONFIRMED MINUTES OF CLINICAL & CARE GOVERNANCE COMMITTEE, FRIDAY 9 AUGUST 2019, 2PM, CONFERENCE ROOM 2, GROUND FLOOR, FIFE HOUSE

Present:	Councillor Tim Brett (Chair) Wilma Brown, NHS Board Member Eugene Clarke, NHS Board Member Christina Cooper, NHS Board Member Councillor David J Ross Councillor Jan Wincott
Attending:	Alan Adamson, Service Manager, Quality Assurance Nicky Connor, Interim Director Health and Social Care Partnership Simon Fevre, Staff Side Representative Cathy Gilvear, Quality Clinical & Care Governance Lead David Heaney, Divisional General Manager (East) Dr Helen Hellewell, Associate Medical Director Kathy Henwood, Chief Social Work Officer Julie Paterson, Divisional General Manager (Fife Wide)
Apologies for absence:	Martin Black, NHS Board Member Helen Buchanan, Nurse Director, NHS Fife Claire Dobson, Divisional General Manager (West) Scott Garden, Director of Pharmacy Paul Madill, Consultant in Public Health Carolyn McDonald, Associate Director of AHPs Fiona McKay, Head of Strategic Planning, Performance & Commissioning Dr Chris McKenna, Medical Director & Responsible Officer for NHS Pauline Cumming, Risk Manager
In attendance:	Norma Aitken, Head of Corporate Services Dr Frances Baty, Consultant Clinical Psychologist Elaine Dodds, PA (Minutes)

NO	HEADING	ACTION
1.	**CHAIRPERSON'S WELCOME & OPENING REMARKS**	
	Cllr Brett welcomed everyone to the meeting. Cllr Brett expressed concern about the volume of paperwork contained in the papers and has agreed to meet with Dr Hellewell to discuss reducing the amount of papers for future meetings.	

	Cllr Brett highlighted the Drug Deaths report which was published in July Julie Paterson confirmed a report will be presented to the next Committee meeting. Cllr Brett reported there are a number of cases in the press around Adult Protection and Cllr Brett will continue to discuss with Julie Paterson whether there is a requirement to brief the Committee.	
2.	**DECLARATION OF MEMBERS' INTEREST**	
	There were no declarations of interest.	
3.	**APOLOGIES FOR ABSENCE**	
	Apologies were noted as above.	
4.	**MINUTES OF PREVIOUS MEETINGS**	
	The minutes of 24/5/19 and 18/6/19 were approved as a correct record.	
5.	**MATTERS ARISING – OUTSTANDING ACTIONS FROM ACTION LIST**	
	No issues under matters arising.	
6.	**GOVERNANCE**	
	6.1 CLINICAL QUALITY REPORT	
	Dr Helen Hellewell presented the report which gave assurance on the overall position in relation to themes, national and local identified priorities which are relevant to the Health and Social Care Partnership. The Committee discussed the following: 1. **Adverse Events** – Cllr Brett asked if the Committee will be given information on serious adverse events. Nicky Connor reported that when a review is undertaken a learning summary is generated which is presented to the Divisional Groups and also NHS Fife Adverse Events Review Group. It was agreed a summary of serious adverse events should be presented to the Committee for information. Cllr Brett asked for information on Comfort Rounds. Cathy Gilvear advised the purpose of Comfort Rounds is to support a systematic approach by staff to ensure that patient centred individualised comfort needs are met within a pre-determined regularity. 2. **HSMR** – Cllr Brett asked how the reduction in hospital mortality by a further 10% was achieved. Cathy Gilvear explained it is due to a collaboration of a large amount of improvement work over a long time of time. 3. **Falls** - Cllr Ross asked what the reasons are for the slight increase in Falls	**CG**

	in April 2019. Cathy Gilvear advised patients can fall due to a number of reasons including medication and blood pressure. Work is ongoing to try to understand why and where there are incidents so preventative measures can be put in place. Cllr Ross asked if every fall is treated as a separate event. Cathy Gilvear confirmed this is the case. Cllr Brett asked what the role of the Activity Care Co-ordinators. Cathy Gilvear explained the roles are an extension of the Health Care Support worker role. 4. **Pressure Ulcers** - Eugene Clarke asked if all staff are involved in the training and of those who have been trained,how will changes be monitored. Cathy Gilvear advised there is a plan in place to ensure all staff attend the training and attendance is being prioritised depending on where there is a higher rate of pressure ulcers. The results will be charted and monitored. In addition there is improvement and performance work which will ensure staff engage in the whole process. Eugene Clarke asked why the figures are from March/April and not more up to date. Cathy Gilvear reported there is more up to date data however this is currently being collated. Cllr Brett asked if work is happening on wards which are not included in the collaborative. Cathy Gilvear confirmed there are 5 wards within the collaborative however outcome data for other areas is monitored and action taken if required. 5 – **Medicines** – no issues. 6 – **Medication** – PGD – no issues. 7 – **Healthcare Associated Infection** – Cllr Wincott asked why there were graphs missing in part of the report. Cathy Gilvear reported there had been problems with the printing of the papers which ED will look into and resolve. Cllr Wincott also queried Page 97/98 which states VHK is not doing as well in terms of SAB and cDiff infections as other hospitals and asked what steps are being taken to improve these levels. Nicky Connor reported the governance for VHK is reported through NHS Fife's Clinical Governance process therefore are unable to comment at this meeting. 8 **– Mental Health** – Cllr Brett asked for an explanation on Safewards Interventions and Decider Skills training. Julie Paterson explained the Decider training is part of the mental health redesign and will ensure a	**ED**

	consistent approach to individuals who have historically attended A&E. These individuals will now be supported in a consistent way. Frances Baty added Decider is the name of package of skills and 140 staff have already been trained. Nicky Connor explained Safewards is evidence based around a range of intervention which support relationships between staff and patients and results in de-escalation, calmer environment and more peaceful places. Members were directed to Page 67 of the quality report which gives a full description of both Decider Skills Training and Safewards. Cllr Brett queried the number of ligature incidents and asked what work is being undertaken. Cathy Gilvear explained that there is collaborative improvement work being undertaken at the moment which is at an early stage to look at issues such as recording and reporting of incidents. Members were directed to page 70-71 of the quality report for further information. Cllr Wincott queried Chart 24 which reports an increase in the rates of incidents and asked if there is a reason for the restraints increasing and if there is any data available for patients post restraint. Julie Paterson was unable to give specific information on the figures but explained restraint and substance misuse are issues which are being discussed within the Divisional Clinical & Care Governance Group and papers will be escalated to the next Committee meeting. **9 – Patient experience** – Cllr Brett welcomed the positive comments however he would like to have information on anything that went wrong and any complaints received. Nicky Connor reported there were no negative care opinions which are within the reporting timeframe for this report. Cathy Gilvear added that work is ongoing to obtain quantitative data and this will be reported at the next meeting. Christina Cooper asked what the membership of the person centred steering group on page 29. Nicky Connor confirmed the group is directed by Helen Buchanan and chaired by Donna Hughes. Members agreed that the Quality Report was informative however felt that each meeting should focus on 2 or 3 of the 9 issues to allow more in-depth information and discussion to take place. The Committee: • **Noted** the Report • **Agreed** future reports should focus on 2/3 items to allow more indepth	**JP/CG** **CG**

	information and discussions to take place.	
	6.2 MENTAL HEALTH STRATEGY	
	Julie Paterson presented the new Mental Health Strategy for Fife (2019-2023) which takes account of the recommendations of the National Mental Health Strategy, which emphasises the need to build capacity within our local communities and reduce reliance on hospital beds. The new Strategy also takes full account of the extensive feedback gathered through engagement and consultation. The Strategy will be presented to the Integrated Joint Board on 25th October for approval and will then feed into the Voluntary Sector Review. Cllr Brett reported the NHS Fife Clinical Governance Committee have requested a presentation at their meeting on 4 September and Cllr Brett will ask the Chair if CCGC members can also attend. Cllr Ross felt it was a very good document and asked for an update on the creation of a Strategy for Suicide. Julie Paterson confirmed work is currently ongoing to develop a Suicide Prevention Strategy. Julie Paterson added it is difficult to identify people who are not known to the service who are taking their own lives however there is a model in Tayside which works closely with police which Fife are planning to replicate. A detailed report will be presented to the Committee at a future meeting. Eugene Clarke queried Commitment 5: Technology Enabled Care and asked what systems are in place. Julie Paterson reported there is currently a range of technologies such as self assessment and self referral tools and therapies websites. A Digital Strategy for HSCP is currently being developed. Eugene Clarke added that it is important to ensure there is enough staff to maintain and develop any new applications. In addition Eugene Clarke asked for assurance there is close integration around technology between HSCP and NHS Fife. Nicky Connor confirmed work has commenced in developing an Integrated Technology Strategy for the HSCP with representation on the Group from both organisations. Wilma Brown stated it was an excellent document however questioned whether the correct workforce will be in place and also queried the outcome of the Mental Health Nursing Recruitment Group. Nicky Connor confirmed there has been a Workforce Review done, Safe Staffing Legislation is coming into place and a review of how reports are put through governance structures is being undertaken. In addition work has been ongoing with Dundee University Fife Campus where 50 mental health training places have been agreed and will commence in September on a 3 year programme.	**TB** **JP/CG**

	Christina Cooper welcomed the document and was encouraged to see physical and mental health together and also areas such as anticipatory and preventative care across the sector. In relation to participation and engagement of people Christina Cooper was keen to see this continuing with co-production and co-design of the developments and queried how the mental health strategy would be linked to various other strategies within Fife including Drug & Alcohol and Suicide Prevention? Julie Paterson explained there is a draft Implementation Plan, Action Plan and Performance Framework which has been developed however it cannot be progressed until the Strategy has been signed off by the IJB. Christina Cooper asked for details of the Third Sector Review. Julie Paterson explained when the baseline assessment for the National Mental Health Strategy was undertaken it became clear a refresh of the Fife's Mental Health Strategy would have to be carried out first as this will inform the Voluntary Sector Review. Those involved with the Voluntary Sector Review will be kept updated on the timeline change. Eugene Clarke asked if recruitment can take into account individuals with neurological conditions and other conditions such as autism and establish how these people can be employed within the workplace in a productive way. Eugene Clarke agreed to send information which Nicky Connor will share with the team. Cllr Brett asked if there had been any concerns from various professional and key groups. Julie Paterson reported there has been a large amount of engagement and consultation. Frances Baty advised there had been positive support from clinicians in areas such as psychology, psychiatry and mental health nursing. Dr Hellewell added that clinical colleagues feel they have been consulted and are enthusiastic to take the Strategy forward. Also GPs are keen to see the early intervention which is echoed in the Strategy. The Committee: • Enthusiastically supported the Draft Strategy and **agreed** for submission to the IJB for approval.	**EC/NC**
	Julie O'Neill and Frances Baty left the meeting.	

	6.3 STRATEGIC PLAN	
	Alan Adamson presented the draft Strategic Plan 2019-2022 which sets out the vision and future direction of health and social care services in Fife, and it included some detail of the planned activities that will achieve this. Cllr Brett asked if any of the Strategic priorities had changed. Alan Adamson confirmed this Strategic Plan has 5 priorities compared to the previous Strategic Plan which had 4. The new priority is "Managing resources effectively while delivering quality outcomes" which was seen through the consultation and engagement to be a priority on its own. Nicky Connor added the feedback on the Strategy was to be specific and focused on what can be achieved over a timeframe. The key changes are around being more specific and clear on what can be done and where we want to be. Cllr Brett suggested the replacement of the Ladywalk Care Home be included in the Care Home development section within the "Working with communities, partners and our workforce to effectively transform, integrate and improve our services" section. David Heaney explained the business case for the two Care Homes mentioned in the report are signed off and work is still ongoing to identify a site for Ladywalk Care Home. David Heaney agreed to look into adding Ladywalk Care Home to the report. Wilma Brown stated that throughout the document it refers to numbers and percentages which is confusing and suggested consistency throughout the document. Alan Adamson agreed to amend the document accordingly. Also the period when the figures are for should be included throughout the document. Eugene Clarke highlighted Priority 5 – Managing resource effectively while delivering quality outcomes states "The health and Social Care Partnership will have a financial strategy in place which supported transformational change". Eugene Clarke suggested this should be the other way round as a strategy is required to ensure transformation change happens to deal with financial situation. Nicky Connor agreed to consider this suggestion. Cllr Wincott queried Priority 1, Children's Health Services states that children and young people will wait no longer than six months for a paediatric appointment and twelve months for a diagnosis of autism. Julie Paterson explained this is the current improvement target which Children's Services have in place. Cllr Wincott suggested "reducing from 18 months to ..." would be more acceptable. The Committee:	**DH** **NC** **AA**

	• **Supported** the Strategic Plan with the comments and changes recommended.	
	6.4 UPDATED TERMS OF REFERENCE, SKILLS MATRIX, COMMITTEE SELF-ASSURANCE QUESTIONNAIRE, ACTION PLAN	
	Norma Aitken presented the report which details governance arrangements surrounding the IJB and its committees. Members discussed and agreed it was helpful to have clinicians and other relevant staff join the Committee for specific items. Cllr Brett has suggested to Dr Bisset, Chair of NHS Fife Clinical Governance Committee that joint events be arranged with the two Committees. Members queried if a member of the public or carer should be on the Committee. NA agreed to consider this. Julie Paterson reported social work has not been included high on the agenda of the Committee. Members agreed Julie Paterson, Cllr Brett and Cathy Gilvear should meet to discuss improving Social Work involvement in the Committee. The Committee: • **Noted** the Report.	**NA** **TB/JP/ CG**
	6.5 GLENROTHES HOSPITAL UNANNOUNCED INSPECTION	
	Dr Helen Hellewell presented the report which provided an update on the three requirements from the inspection which took place on 19th and 20th March. Cllr Ross asked if it was a good/moderate/poor inspection report. Nicky Connor confirmed it was a balanced report and commended staff involved in addressing the three requirements so quickly. Cllr Brett queried if NHS Fife's mandatory infection prevention and control education requirements are monitored. David Heaney confirmed reports on the full range of mandatory training are submitted to Divisional Groups and 1:1 monitoring is also taking place between staff member and manager. The Committee: • **Noted** the contents of the report.	
	Wilma Brown left the meeting.	

7.	**ANNUAL REPORTS**	
	7.1 CHILD PROTECTION ANNUAL REPORT	
	Julie Paterson introduced the report which was presented to the NHS Fife Clinical Governance Committee in January 2019. It has been suggested the report come to this Committee on an annual basis at the same time as it is presented to NHS Fife Clinical Governance Committee. Cllr Brett agreed that the report can be added to the CCGC workplan. Members requested an introduction to child protection and glossary be included in the next report. The Committee: • **Noted** the report.	**CG/JP**
	7.2 HEALTH & SOCIAL CARE PARTNERSHIP ANNUAL REPORT 2018-19	
	Alan Adamson introduced the report which provided an overview of progress and performance within the Partnership for the period from 1st April 2018 to 31st March 2019. Cllr Brett felt the report was lengthy and asked whether the report can be condensed next year. Alan Adamson advised there is guidance which states the information which has to be included in the report. There is currently work being undertaken by a Group at the Scottish Government to look at the format of all HSCP reports across Scotland to determine if a standard format can be introduced. The Committee: • **Approved** the report.	
8.	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	8.1 EAST DIVISION CLINICAL & CARE GOVERNANCE COMMITTEE – 15/5/19	
	David Heaney highlighted to the Committee the high level risk in terms of medical cover at Cameron Hospital and Glenrothes Hospitals. Currently there is support from Geriatricians and GPs and Ward 1 have support from a practice in Glenrothes. The Hospital Services Manager is working with colleagues on a daily basis to ensure there is sufficient medical cover at Glenrothes Hospital and Cameron Hospital. It is anticipated the Community Hospital Redesign, which will be presented to the Committee and IJB will build a more stable and robust model. In the	

	meantime the risk is managed on a daily basis. Dr Hellewell gave assurance that the risk has been mitigated and by working together have ensured there is safe cover for both hospitals. The Committee: • **Noted** the Report.	
	8.2 WEST DIVISION CLINICAL & CARE GOVERNANCE COMMITTEE – 21/3/19	
	Cllr Brett congratulated the Diabetes Retinopathy Screening who won first prize in a poster competition at the British Assoication of Retinal Screeners Annual conference in Leeds. The Committee • **Noted** the minutes.	
	8.3 FIFE WIDE DIVISION CLINICAL & CARE GOVERNANCE COMMITTEE – 12/3/19 & 20/5/19	
	Julie Paterson highlighted an issue in relation to the temperature within dental surgeries. Dr Helen Hellewell has agreed to work with Julie Paterson to take forward the issue with Health and Safety and Estates. Minute of 12 March 2019 – It was agreed to escalate the following items to the Committee: – Illicit Drug Misuse – Paper will be brought to a future Committee meeting. – Mental Health Restraints – Paper will be brought to a future Committee meeting. – SUOMP (Safe Use of Medicines Policy Group) – This relates to children services and medications in schools. The Safe Use of Medicines Policy and procedures have been reviewed and concerns had been raised regarding the Administration of Medicines in Schools Policy. There has been engagement with Children Services to explore whether there is a requirement to change the NHS Fife Policies and Procedures to ensure the service is working within the Policy and Procedure Framework. Minute of 20 May 2019 – Cllr Brett asked for details regarding the three consultants short in Rheumatology. Dr Hellewell reported there is a national shortage of Rheumatology Consultants. Work is currently underway to look at service redesign to establish a multi disciplinary team approach with pharmacy and nurses. The Committee: • **Noted** the minutes.	

	8.4 FIFE DRUGS & THERAPEUTICS COMMITTEE – 19/6/19	
	Helen Hellewell presented the minutes by highlighting the work undertaken around the development of the Realistic Prescribing Strategy for NHS Fife which includes GPs and Pharmacists going into nursing homes and care homes to review medication jointly which has helped to improve safety and wellbeing in the homes. The Committee: • **Noted** the minutes.	
	8.5 INTEGRATED PROFESSIONAL ADVISORY GROUP (IPAG)	
	Helen Hellewell reported the role of IPAG is currently being reviewed. A meeting is scheduled to take place on 13 August 2019. An update will be presented at the next Committee meeting. The Committee: • **Noted** the update	**HH/CG**
9.	**FOR NOTING**	
	9.1 CLINICAL & CARE GOVERANCE WORKPLAN & ACTIVITY TRACKER	
	The Committee:- • **Noted** the CCGC workplan.	
10.	**ITEMS FOR ESCALATION**	
	• Mental Health Strategy. • Quality Report.	
11.	**DATE OF NEXT MEETING -** Friday 27TH September 2019, 10am, Conference Room 2, Ground Floor, Fife House	

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	**THE CLINICAL & CARE GOVERNANCE COMMITTEE HSCP**
Date of Group/Sub-committee Meeting:	FRIDAY 27TH SEPTEMBER 2019, 2.00PM
Release: draft/final minutes	Draft
Author/Accountable Person:	Dr Helen Hellewell

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
This should include good practice The clinical quality report was discussed. There was discussion around adverse events and looking at the process for this. It was acknowledged that further work needs to be done on HSMR and that this needs to link to the work NHS fife is doing. Assurance was given around falls prevention Scott Garden highlighted a positive in that NHS Fife Pharmacy were recently invited to the launch of the Royal Pharmaceutical Society and Royal College of Nursing standard for handling of medicines where SG was asked to present as NHS Fife Pharmacy are being held as a benchmark for NHS Scotland: NHS Fife are the only board in Scotland to have an Audit & Assurance programme around the safe & secure use of medicines and have become a learning board for others with a series of people due to visit to share this work. There was a discussion about Decider training which is aimed at helping support people in distress especially those with a diagnosis of personality disorder. There is planned to look at both self harm and hospital acquired infection at the next committee. There was a discussion about the transformation projects and the stage and gate process. The CAMHS report was highlighted and in particular the introduction of Primary Mental Health Worker roles to support CAMHS these workers see children that are referred to CAHMS in a timely manner and then often the child does not require to be referred on to the specialist service. The number of referrals to CAHMS has dropped since their introduction. The winter plan was discussed in particular the concern that there is pressure in the system already – there was a discussion of what was being done to mitigate this. The complaints system was discussed and the process was outlined to the committee.

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Agenda item no

The plans in preparation for brexit and fuel shortage were noted.
What are the concerns/issues/risks you want to bring to the attention of the committee?
Include any actions taken to date *The risk register was discussed at length and in particular there was assurance given that although the winter plan was at moderate this was because action was being taken to bring th pressure in the system down to pre winter levels and that this would be revised if this was not achieved.*

DRAFT MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE
FRIDAY 27TH SEPTEMBER 2019, 2.00PM
CONFERENCE ROOM 1, GROUND FLOOR, FIFE HOUSE

Present:
Councillor Tim Brett (Chair)
Christina Cooper, NHS Board Member
Councillor David J Ross
Councillor Jan Wincott
Margaret Wells, NHS Board Member (for Martin Black)

Attending:
Nicky Connor, Interim Director of Health & Social Care
Simon Fevre, Staff Side Representative
Cathy Gilvear, Quality Clinical & Care Governance Lead
Scott Garden, Director of Pharmacy
Carolyn McDonald, Associate Director of AHPs
Fiona McKay, Head of Strategic Planning, Performance & Commissioning
Paul Madill, Consultant in Public Health
Julie Paterson, Divisional General Manager (Fife Wide)
Lynn Barker, Interim Associate Director of Nursing

Apologies for absence:
Wilma Brown, NHS Board Member
Martin Black, NHS Board Member
Pauline Cumming, Risk Manager
David Heaney, Divisional General Manager (East)
Helen Woodburn, Head of Quality & Clinical Governance
Dr Helen Hellewell, Associate Medical Director

In attendance:
Lesley Gauld, Information Compliance Manager
Andrew Henry-Gray, PA (Minutes)

NO	HEADING	ACTION
1.	**CHAIRPERSON'S WELCOME & OPENING REMARKS**	
	Cllr Brett welcomed everyone to the meeting. It was noted that Elaine Dodds, the previous administrator for the Committee, has moved on to another post and the Chair sent thanks and best wishes to her on behalf of the Committee.	
2.	**DECLARATION OF MEMBERS' INTEREST**	
	There were no declarations of interest.	
3.	**APOLOGIES FOR ABSENCE**	

	Apologies were noted as above.	
4.	**MINUTES OF PREVIOUS MEETINGS**	
	The Committee discussed the minute of the C&CGC meeting of 09/08/2019 and the following points were raised: *[Page 2, Item 6.1, Section 2]* Correction: 'HMSR' should read 'HSMR'. *[Page 6, Item 6.2, Para 8, 2nd Sentence]* Amendment: Christina Cooper noted that she had asked 'How the mental health strategy would be linked to various other strategies within Fife including Drug & Alcohol and Suicide Prevention?' *[Page 6]* Correction: NC referred to the Committee decision for 'Item 6.2 Mental Health Strategy' and noted that the Committee 'enthusiastically supported the draft strategy' rather than 'approved the strategy' as approval would come later at the IJB. With these amendments the minutes of 09/08/2019 were accepted as a true and accurate record. The Committee: • **Approved** the minute of the C&CGC meeting of 09/08/2019.	
5.	**MATTERS ARISING – OUTSTANDING ACTIONS FROM ACTION LIST**	
	The Chair noted the action from 09/08/2019 [item 6.4] which was for him to meet with JP to discuss improving social work involvement in the CCGC. This is still to happen and AHG will follow this up to arrange.	**AHG**
6.	**GOVERNANCE**	
	6.1 CLINICAL QUALITY REPORT	
	Lynn Barker presented the report which gave assurance on the overall position in relation to themes, national and local identified priorities which are relevant to the Health and Social Care Partnership. The Committee discussed the following: 1. **Adverse Events** MW referred to page 35 *[Learning from Significant Adverse Event Reviews (SAER)]* and highlighted recent reporting about imprisonment of people who had offended against adults in protection. MW noted that she would appreciate greater clarification about the governance routes in relation to adult & child protection, the place of this committee in relation to this and its relationship to COPs; in particular to consider briefing options and when it would be appropriate to apply these at the highest level so that when a very significant adverse event occurs we are not reading about those things in the	

papers and then raising questions afterwards. The chair noted that recent discussions have been held between MW & JP and agreed that further discussion is due to take place with Helen Buchanan and so would expect a report back to clarify this.

2. **HSMR**
DR noted that QMH was significantly above the rate for mortality and queried if there is a reason for this. Lynn Barker confirmed that the rate is 1.24 (Scottish HSMR is 1.00) and this has been noted and discussions are ongoing with Claire Dobson and the clinical team there to recognise this and have further understanding. The Chair suggested adding this as an action to report back at the next meeting.

MW noted her role on the Clinical Governance Committee of the Health Board and advised that they look in great detail at incidences of mortality and HAIs that occur in hospital settings and suggested that there may be some duplication in this work. NC responded that the context of this report has been developed with Helen Buchanan and Chris McKenna to try and identify the partnership elements of this and that the data shows that with HSMR it is not enough to just look at community hospitals – this is still a work in progress and the report continues to be refined. The Chair suggested to MW that if the Health Board Clinical Governance Committee are looking into this issue then perhaps she could provide an update at some point. **LB**

3. **Falls**
DR asked for assurance that the good practice that is happening be shared across all wards to hopefully see sustained reduction in falls and falls with harm. LB agreed that the fundamentals of the collaborative are to identify where improvement work is necessary and once improved to share that learning. LB noted that the challenge is the sustainability and this work is ongoing across the collaborative and for all in clinical settings to maintain this. LB gave an explanation of what a collaborative is and how it works. **MW**

CC referred to the education sessions and the Strategy for Falls, thinking about anticipatory & preventative care, and queried if these sessions are included in the community for the care homes or other providers. LB responded that the updated falls toolkit has predominantly been for healthcare settings but they do engage with district nurses, who are not in collaboratives at the moment, and support them to educate when they are out in community settings with care providers.

4. **Pressure Ulcers**
No issues were raised.

5. **Medicines**
SG highlighted a positive in that NHS Fife Pharmacy were recently invited to the launch of the Royal Pharmaceutical Society and Royal College of Nursing standard for handling of medicines where SG was asked to present as NHS Fife Pharmacy are being held as a benchmark for NHS Scotland: NHS Fife are the only board in Scotland to have an Audit & Assurance programme around the safe & secure use of medicines and have become a learning board for others with a series of people due to visit to share this work. SG suggested that there is a model here that could be used in other parts of the organisation outwith medicines and could be extended

	further into all medication incidents. 6. **Healthcare Associated Infection** The Chair suggested having a more in-depth look at this item at the next C&CGC meeting. *7. [error in papers – no.7 omitted]* 8. **Mental Health** DR queried what 'decider training' is: JP responded that this is training that has been funded through Action 15 monies through action 15 of the Mental Health Strategy to reduce the burden crisis on A&Es, GPs and police. Decider Training is a toolkit for both people who use our services and all our multidisciplinary teams to work in a consistent and supportive way specifically aimed at those who are high-risk and have a diagnosis of personality disorder as these are the people who tend to be at A&E or come to the attention of the police. EC referred to page 26 where it states that *'three of the Older Adult wards accounted for 64% of the incidents'* in relation to self-harm and noted also that *'SCN's raised a number or areas for consideration, including environmental concerns, use of bank/agency staff, staff attending training and medical cover'* and queried if anything has been done about these issues. CG responded that this can be looked into and brought back in the next report. 9. **Patient experience** EC welcomed the insights into individual patient experience but queried if the quantitative data question has been answered. CG responded that challenges continue around this and they have been in contact with the Patient Relations team and work is ongoing. The Committee: • **Noted** the content of the report. • **Agreed** to have a more in-depth look at Healthcare Associated Infection at the next meeting.	**CG**
	6.2 TRANSFORMATION UPDATE – Verbal Report	
	NC presented an overview of the Stage & Gate approach in terms of the transformation programme and the development of a transformation board noting that it is still very much a work in progress. NC explained that the Stage & Gate approach is a whole-system way of looking at large scale transformation across an organisation. The Stage & Gate approach consists of 6 stages that major transformation goes through. It was recognised that across both acute services and H&SCP services there was already some transformation in progress. NC highlighted that a Stage & Gate event took place on Friday 20/09/2019 to look at the transformation currently in place and to discuss what stage each of these were at. This event was attended by LB, JP & Claire Dobson. LB explained that the event was led by Paul Hawkins and that further discussion is expected within the transformation board.	

	NC noted that next steps would be to work up a fuller paper to come back which hopefully will provide more clarity regarding how the board will work, how it will link to our governance structures and what that means in terms of our key pieces of transformation and how we are continuing to support that to progress. The Chair noted that a report would be helpful. SF referred to the Community Hospital Redesign and asked what stage that is in terms of the 6 stages. JP responded that the decision had been made to put it at stage 1 with a view to providing additional information with clarity and noted that the expectation is that it would move quickly through the process. SF expressed his disappointment given the amount of work that has taken place noting that they have communicated with staff that a decision would be expected at the IJB in October but now realises that this will not happen. SF noted that there is a requirement to go back out and speak to staff with a clear message about what that means within the next week. NC agreed to take an action to clarify what 'quickly through the process' means and what that means in terms of timescales as it was not clarified at the Stage & Gate meeting. SF expressed his concern that increased uncertainty may lead to staff voting with their feet and suggested that extra support may be required for certain ward areas over the winter period. LB agreed with that there are implications when staff feel unsettled in their workplace noting that there are internal processes to monitor the staffing levels and supplementary staffing is used to support when necessary but this has been noted. JP noted similar issues with mental health but reported that there was recognition of this at the meeting and the need to communicate with staff. The Committee: • **Noted** the content of the report.	**NC** **NC**
	6.3 CAMHS UPDATE	
	JP presented the CAMHS update which is brought to every 2nd meeting noting that it has already been to the NHS Fife Finance, Performance & Resource Committee. TB referred to page 102 and noted that the number of referrals has dropped slightly to the specialist service but suggested that the drop might have been greater given all of the other things that we are trying to put in place to provide support. JP responded by referring to page 104 which explains the role of Primary Mental Health Workers who are now based at GP surgeries to support people rather than automatic referral to CAMHS and noted the chart on page 105 which shows that there has been a drop in referrals to CAMHS following introduction of these posts. JP confirmed that the Primary Mental Health Workers are CAAPs (Clinical Associate in Applied Psychology). TB asked if we have any information on the outcomes for those who are not getting referred through to the specialist service. JP responded that there is quantitative data from the Primary Mental Health Workers and the feedback is positive and this data can be shared with the Committee. MW highlighted that one of the nurses from CAMHS had won an award at the recent NHS Fife Achievement Awards. MW asked about the impact of vacancies on the relatively small mental health team. JP responded that the service is historically a very small staff group and there is no	**JP**

	additional money for additional resources but did welcome the Action 15 funding which has helped to create more Primary Mental Health Worker roles to support CAMHS. JP clarified that the Action 15 funding was provided to aid the impact on A&Es, GPs and the police and not to prop up the service that already exists. SG highlighted a significant breakthrough with Shared Care Agreements between GPs and CAMHS in terms of repeat prescribing for this patient group which will allow prescribers/practitioners to focus on other parts of their service. CC referred to the table on page 104 and suggested that it may be beneficial to detail the reason for referral to allow follow up on this. The Committee: • **Noted** the content of the report.	
	6.4 DRAFT FIFE WINTER PLAN 2019-2020	
	NC presented the draft winter plan noting the requirement to submit a draft winter plan at this time then there is one month to work up the detail of this. NC highlighted that the plan states we are green in terms of capacity but this is not the current position noting significant pressure this month across acute services and additional beds have already been opened up within community hospitals and further extraordinary actions will be undertaken this week to support further discharge from hospital. JW referred to page 117 and queried the phrase 'Black Box testing'. NC advised that she would find out what this relates to and provide feedback. DR queried the effect on the budget of opening up extra beds and the cost of implementing the winter plan. NC explained that within the winter plan there are indicators and key headings which indicate that the system is starting to increase in pressure. Alongside this are action cards which indicate the actions that are required to be taken. NC agreed that this comes at an extra cost and noted that NHS Fife has been allocated £320-360k for the delivery of the winter plan though on average in previous years it has cost in the region of £2m. NC explained that a tracker has been in place over the past 3 years and this is now being analysed to look at the financials of implementation. DR queried how we are placed in terms of social care, particularly in West Fife, with community placements and care home placements. FM responded that there is a recognised challenge in the Dunfermline & West Fife due to the population growth and highlighted an event on 11/10/2019 in conjunction with Scottish Care to look at capacity and provide support. FM provided clarity about the STAR beds, which operate out of in-house care homes, and the STAR Implementation Board noting that an evaluation is due to be completed in October regarding a new model which works with the GPs and a report on this will be available on this soon. DR queried how the service prepares for a surge. NC responded that there are known times of surge such as the festive period and public holidays and also data from previous years indicate particular surge times so services are readied in anticipation for this. In terms of unexpected pressures from adverse weather events, a board is being	**NC**

	put in place with operational teams meeting weekly or even daily in times of particular pressure for whole-system working. SF highlighted the impact that surge planning has on staffing levels and suggested this is brought to the LPF for discussion. SF queried if there is a plan that goes beyond health staff and encompasses care staff when discussing surge planning. LB responded that she would be happy to bring something to the LPF and noted that there is surge capacity across East & West inpatient areas and noted that increase does not happen without approval from the senior charge nurse, lead nurse and head of nursing. NC provided clarity about what a discharge lounge is. TB referred to the table on page 115 and asked if the High Health Gain initiative is happening across the whole of Fife. NC responded that the initiative is being delivered across Fife and they are currently looking at how to expand this further by March 2020. NC provided an explanation of High Health Gain. JW asked if any work has been done about rolling out pre-vaccinations to a wider populace rather than just high-risk groups as a spend-to-save scenario. NC responded that the high-risk group covers those who are vulnerable as well as their carers. The winter plan includes plans for point-of-care testing at the front door which involves flu testing before admitting patients and identifying risk patients and isolating them from the other patients to avoid ward closures. Staff vaccination is also effective. Vaccination funding comes from the Chief Medical Officer for Scotland and is not a local decision. SG referred to page 125 and highlighted the escalation card noting that the service has been operating around sever pressure over the last 3 weeks. SG noted that the plans are live and constantly in use and suggested that the government view that winter is from January to March is not reflective of the pressures. SG highlighted that surge beds have not been closed in VHK since April this year. SG has suggested that an algorithm is necessary for the escalation card to remove the subjectivity of what level the service is at. The Committee: • **Noted** the content of the report.	**LB**
	6.5 COMPLAINTS UPDATE	
	FM presented the update noting that the Committee had requested more detail about the compliments and complaints across the partnership. Lesley Gauld had been invited along to answer questions on this item. JW highlighted that there was a complaint that she was aware of which had been upheld by the SPSO so she had expected to see it in this report but it was not listed. FM took an action to look into this. DR queried about timescales when complaints are referred to the ombudsman. LG responded that it depends on the complexity of the complaint: the SPSO will review every complaint but it can be anything from a month to a year depending on the nature of the complaint.	**FM**

	TB requested an update about all of the decisions in the next report. JM noted that we are just seeing a snapshot at the moment: what would be preferable would be to see all the ones that are currently open and how long it takes them to close and what decision was taken. FM agreed to take this as an action. TM requested some trend information to compare year-on-year data. FM agreed to take this as an action. The Committee: • **Noted** the content of the report.	**FM** **FM**
	6.6 RESILIENCE GROUP ANNUAL REPORT 2018/19	
	FM presented the Resilience Group Annual Report. TB referred to risk no. 25 on page 146 in relation to Brexit preparations. SG highlighted a meeting with government and the directors of pharmacy last week and advised that there was much more assurance in the system as to where we were a few months ago. TB referred to page 140 in relation to a fuel & power outages workshop and asked how ready we would be given an extended power outage. NC confirmed that hospital sites do have generator back up but was unsure about essential kit in people's own homes and suggested asking the resilience group about this. SF noted that any electrical equipment probably has battery backup. FM noted that cared under the Care at Home service has this flagged in the SWIFT system and in such an event they would be transported to a rest centre. The Committee: • **Noted** the content of the report.	
	6.7 FIFE FALLS STRATEGY 2018-2022 (UPDATE)	
	CM provided a verbal update on the Fife Falls Strategy. The Committee: • **Noted** the content of the report.	
	6.8 HSCP C&CG RISK REGISTER	
	FM presented the risk register and noted that the risks continue to be reviewed and a further risk around the delivery of the primary care improvement plan is being added along with Brexit. Work is ongoing in relation to development of the risk register which is being reported to the A&RC and once approved it will come to the C&CGC. DR referred to capacity and the winter plan and asked if this was on the risk register. FM responded that it comes under *'contractual and market capacity' [page 159]* and it was noted that it is at moderate risk. DR queried whether the Committee is content with	

	the moderate rating. NC responded that action is being taken to bring the pressures back down to pre-winter levels and if that does not come to fruition then the rating could be revisited. NC gave assurance that this is being closely monitored. TB referred to risk no. 23 on *[page 160]* in reference to the national formulary and asked if SG could expand on that. SG advised that this is a very live discussion which is ongoing with government. SG highlighted that a very good website has been developed which has been paid for by the Scottish Government. SG noted that there is concern that flexibility and agility would disappear by moving to a single national formulary but there is no change due in the short term. SG referred to risk no. 25 *[page 160; Brexit/Impact on Medicines]* and noted that there is a Brexit risk register being pulled together by Dona Milne. SG queried how these constantly evolving risks attached to Brexit are being pulled through to this and other risk registers. FM agreed that it is a fluid and tricky picture but assured the Committee that there are groups who are aware of this and who are looking into it. MW noted that Les Bisset chairs and Dona Milne is the lead for the NHS Brexit group. MW queried how the council plan fits into these discussions and suggested a need for clarification around how this all comes together. FM picked up an action to clarify how the Brexit risk discussions are being linked together currently and NC proposed bringing an update to this Committee about how we have been able to strengthen the connectivity between all the Brexit groups so that it is clear where decisions get made and how that feeds through the system. TB requested that the Committee is briefed on this subject prior to the next Committee meeting as Brexit is due to be implemented prior to that date. The Committee: • **Noted** the content of the report.	**FM/NC**
7.	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	7.1 WEST DIVISION CLINICAL & CARE GOVERNANCE COMMITTEE - 16/07/19	
	TB referred to item 5.4 Specialist Palliative Care and queried if the Committee get a report on that at some point in the year. NC explained that item 5.4 refers to an annual service review report that comes at a divisional level. NC noted that if the Committee wished to have a report on Specialist Palliative Care services then that would have to be timetabled in. TM suggested that there were previous discussions last year with Macmillan and queried how this is going. NC responded that this is an area of transformation that is being considered and explored but is separate from the annual service review plan. However, NC noted that she would be happy to bring an update on palliative care at a future meeting and will link with CD regarding the stage that is at in terms of timetabling that in for the appropriate meeting. The Committee • **Noted** the minutes. • Requested a future update on palliative care.	**NC/CD**

	7.2 FIFE WIDE DIVISION CLINICAL & CARE GOVERNANCE COMMITTEE - 09/08/19	
	JP referred to page 172 and highlighted the excellent work being done by Bayview Ward at Stratheden. JP highlighted that the Action 15 report had been to the F&PC and would be happy to bring it to the Committee for information. The Committee • **Noted** the minutes. • **Agreed** to have the Action 15 report added to a future agenda for noting.	
	7.3 UNCONFIRMED MINUTE OF THE FIFE DRUGS & THERAPEUTICS COMMITTEE - 21/08/19	
	SG presented the minutes and highlighted the positive progress with approval of the three Shared Care Protocols for ADHD and ongoing review of policy and procedures. SG noted that two policies have been approved: 'NHS Prescribing Following Private Consultation' and 'Introduction, Availability and Safe and Effective Use of Medicines, Including Newly Licensed Medicines'. SG noted that the revised flowchart for 'NHS Fife response to MHRA Drug Safety Alerts' has been approved. The Committee • **Noted** the minutes.	
	7.4 INTEGRATED PROFESSIONAL ADVISORY GROUP	
	CM noted that CD was down to speak against this item and, though no longer the chair of the Integrated Professional Advisory Group (IPAG), CM wished to highlight that none of the DGMs are a member of IPAG because it is a professional clinical and care advisory group and the terms of reference for IPAG state that the Integrated Professional Advisory Group should be reported by somebody who sits on that group. NC responded that CD has chaired the last two sessions recognising that there has been a challenge in terms of appointing a chair and vice-chair and they have been undertaking development sessions once of which took place last week. LB responded that it was a positive session and highlighted the value of it and where it sits within stage & gate in making sure that there is a clinical voice around the table. The need for a chair and vice-chair was going to be brought back to highlight the importance of this. JP clarified that as DGM she is also the lead for social work so potentially would attend that meeting because of her dual role. NC added that it is positive that the importance of the group has been recognised and that work is being done and proposed that an update about the direction of the Integrated Professional Advisory Group be brought to the January Committee meeting.	

	The Committee • **Noted** the minutes.	**HH/NC**
8.	**FOR NOTING**	
	8.1 MINUTE OF THE INFECTION CONTROL COMMITTEE – 05/06/19	
	The Committee:- • **Noted** the minutes.	
9.	**ITEMS FOR ESCALATION**	
	• Positive points to report from the Clinical Quality report. • Positive work to report within CAMHS.	
10.	**DATE OF NEXT MEETING** Friday 8th November 2019, 10am, Conference Room 2, Ground Floor, Fife House	

NHS Fife Clinical Governance Committee
6th November 2019

Agenda item no:

Title of Group/Sub-committee	NHS Fife Clinical Governance Oversight Group
Date of Group/Sub-committee Meeting:	11th September 2019
Release: draft/final minutes	Unconfirmed
Author/Accountable Person:	Dr C McKenna

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?

Tissue Viability

The group was informed that the Board Nurse Director had asked the Tissue Viability Steering Group to undertake a review of the current LAER reporting process, to look at the possibility to streamline, as it was acknowledged that the current process can be an arduous and time consuming. A short life working group acknowledged that there are different, often conflicting reporting mechanisms in place across the system and therefore came up with 2 scenarios for the Tissue Viability Steering Group to consider, both scenarios were present to the group. After discussions it was agreed for both the scenarios to be introduced in two stages.

Falls

A short life working group has reviewed and refreshed the falls toolkit for NHS Fife and has also developed significant new risk assessment, care plan and flowcharts for post falls assessment and the use of bed or chair alarms. An official launch of the falls toolkit took place on Tuesday 10th September 2019 within the Lecture Theatre at Victoria Hospital.

What are the concerns/issues/risks you want to bring to the attention of the committee?

There are no concerns, issues or risks that require the attention of the committee.

Unconfirmed Meeting Note of NHS Fife Clinical Governance Oversight Group
On Wednesday, 11th September 2019 at 09.30 in the Staff Club, Victoria Hospital, Kirkcaldy

Present

Lynn Barker (LB)	Interim Associate Director of Nursing – Fife
Helen Buchanan (HB)	Board Director of Nursing, NHS Fife **(Chair)**
Lynn Campbell (LC)	Associate Director of Nursing (Acute)
Pauline Cumming (PC)	Risk Manager, NHS Fife
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Elizabeth Muir (EM)	NHS Fife Clinical Effectiveness Coordinator
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance and Education & Training
Helen Woodburn (HW)	Head of Quality and Clinical Governance, NHS Fife

In Attendance

Gillian Boga (GB)	Clinical Governance Administrator (Admin Support)

Apologies:

Dr Sue Blair (SB)	Consultant in Occupational Health, NHS Fife
Andy Brown (AB)	Principal Auditor, NHS Fife
Dr Robert Cargill (RC)	Associate Medical Director, Acute Services Division (ASD)
Scott Garden (SG)	Director of Pharmacy, NHS Fife
Cathy Gilvear (CG)	Quality, Clinical & Care Governance Lead, HSCP
Dr Chris McKenna (CMcK)	Medical Director, NHS Fife
Donna Hughes (DH)	Patient Relations Manager, NHS Fife
Aileen Lawrie (AL)	Head of Midwifery/Nursing Women and Children's Directorate
Carolyn McDonald (CMcD)	Associate Director, AHPs, NHS Fife

Item		Action
1	**Apologies**	
	Apologies for absence were **noted** from the above named members.	
2	**Minutes of previous meeting held on Thursday, 18 July 2019 at 09.30 in the Staff Club, Victoria Hospital, Kirkcaldy**	
	Helen Buchanan referred to the note of the meeting from 18 July 2019 and asked members to check for accuracy. GS advised correction to section 9.4 could the initials be changed to read GSi to reflect Dr Gavin Simpson report Correction will be made and the note confirmed.	**GB**

3	**Action List**	
	3.1 Action List **Action No 16 Mortality & Morbidity** HW advised the group that the shared learning from the review of Addiction Services LAER's conducted had been shared now with HH. This action can now be closed. Discussion took place on the Adverse Events Management: NHS Board self – evaluation Report that was published yesterday by Healthcare Improvement Scotland (HIS). HB summarised the discussion with saying she would ask her PA to arrange a meeting to reflect on the HIS self evaluation review of adverse events. Attendees CMcK, HB, HW and PC. Feedback to be provided at the next meeting on 14/11/2019.	**HW** **HB**
4	**NHS Fife Integrated Performance & Quality Report**	
	Integrated Performance Report and Quality Report (IPQR) review was requested to bring the two reports together into one document. The August report has been carried forward to the 14 November 2019 meeting to allow the Director of Planning and Performance to come and speak to the new report format.	**SF**
5	**Health & Social Care Partnership Clinical Quality Report**	
	LB provided the group with a summary from NHS Fife Health & Social Care Partnership Clinical Quality Report. The key points noted: Learning from Addiction Services unexpected deaths are to be reviewed at a tabletop review, terminology of review to be confirmed. Compliance with the five day SBAR target for Executive decision making has demonstrated sustained improvement and since February 2019, (38) 97% of SBARs have met the target date of five days for submission. Comfort round education sessions have been carried out within the Falls and Pressure Ulcer collaborative wards within the partnership, 82% of staff that attended the training indicated that they would make changes to their practice as a result. Reduction in pressure ulcers; no grade 3 or 4 reported since November 2018. A meeting has been arranged to review Health Care Associated infections with Addiction services team as majority of SAB's are from people who inject drugs.	

6	**NHS Fife Tissue Viability Steering Group**	
6.1	**Tissue Viability Incident Reporting SBAR** LB advised the group that the Board Nurse Director had asked the Tissue Viability Steering Group to undertake a review of the current LAER reporting process, to look at possibilities to streamline, as it was acknowledged that the current process can be an arduous and time consuming. The Tissue Viability Steering Group met in January 2019 where this was discussed and a Task and Finish Group was established to look at the current process of what we are reporting and why and to discuss issues including where events are re-mapped. The Task and Finish Group acknowledged that there are different, often conflicting reporting mechanisms in place across the system and therefore came up with 2 scenarios for the Tissue Viability Steering Group to consider. **If the Pressure Ulcer is developed directly in NHS Care** (Inpatient ward, District Nursing etc) • Follow the adverse event policy • Complete an SBAR **Scenario 2: If the Pressure Ulcer is discovered on admission** • Establish if the patient was receiving NHS Care within the last week • Report in Datix that is a discovery on ward • Do not complete SBAR . The Group discussed the recommendations and noted that the review should introduced in two stages.	
6.2	**Tissue Viability Incident Flowchart** The group reviewed the flowchart developed by the Tissue Viability Steering Group to simplify the process. A number of suggestions were made to the flow chart, add caveat for Pressure Ulcers discovered on admission for patients admitted from Nursing Homes. HB commented Nursing Homes have responsibility to report pressure ulcers and when Nursing Homes are commissioned they should provide us this information. PC said she would ask other Health Boards what their reporting procedure is for pressure ulcers; do they report pressure ulcers discovered on admission HB said she would discuss with her Directors of Nursing colleagues in other boards their procedures for pressure ulcers. HB recommended LB reports back to the Tissue Viability Steering Group on phase 2 which has a 3 month lead in time.	**PC** **HB**

	Phase 2: Non reporting on pressure ulcers discovered on admission with caveat for patients admitted from Nursing Homes.	**LB**
	HB asked for a verbal update regarding Phase 2 Tissue Viability Reporting to be given at next CCOG meeting.	**LB**
	LC queried the sign off for Tissue Viability electronic SBAR's as currently 3 signatories are required. The group discussed and LC to discuss with acute colleagues (Head's of Nursing)	**LC**
6.3	**Tissue Viability Steering Group Terms of Reference SBAR** The terms of reference were noted by group.	
6.4	**Tissue Viability Steering Group Terms of Reference** LB advised the group that she would like to continue as chair on the group in her interim role as Associate Director of Nursing. LB's title to be amended on Tissue Viability Steering Group Terms of Reference.	**LB**
7	**Items for Information**	
7.1	**NHS Fife Activity Tracker** EM highlighted to the group the 2 consultations added to the activity tracker since the last meeting. • National Hub for reviewing and Learning from the Deaths of Children and Young People –Scoping Exercise. • Falls and Fracture Prevention Strategy for Scotland, 2019-2024 – Consultation.	
7.2	**NHS Fife Policy & Procedures Update** EM provided a summary; HB confirmed this update should be brought to CCOG meetings for information. There is 1 policy and 2 procedures past their review date. 95.8 **%** of all clinical policies and procedures are current and in date.	
7.3	**Clinical Effectiveness Register Audit update** EM provided overview of the Clinical Effectiveness Register. A new clinical effectiveness register was established on DATIX in January 2019 as the previous register was no longer fit for purpose. The new register enables staff to register local and national audits and service evaluations electronically in one place. Data on registered projects can be extracted and will be used to inform directorates/divisions of the work that is being carried out in their areas which should lead to improved reporting and governance. The group commented on the good presentation of the information.	

	PC commented it would be useful to see a breakdown of the projects; are any linked to SAER's EM agreed to bring a list of all projects on the clinical effectiveness register to the next meeting. HH asked if she could receive a list of all projects registered within NHS Fife Health & Social Care Partnership. HH asked to meet to discuss how we can capture GP cluster projects onto the register. EM agreed to arrange a meeting to demonstrate the register. LC commented not all projects are being reported however this is a good start. HW agreed the Clinical Effectiveness register does need to be promoted. EM will work with colleagues in our communication department to publicise the Clinical Effectiveness Register on the intranet banner and on dispatch	**EM** **EM** **EM** **EM**
8	**MINUTES FROM LINKED COMMITTEES/GROUPS**	
8.1	**NHS Fife Adverse Events and Duty of Candour Group of 6 August 2019** 06/08/2019 meeting was cancelled. A meeting was held on the 05/09/2019 and the note will be shared at next meeting.	
8.2	**NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group of 1 July 2019** NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group minutes were noted by the group. EM highlighted a procedure which is well past its review date: R2 – 1 - NHS Fife Wide Policy for the Response and Management of Cardiac Arrest or Acute Medical Emergency in our Community Health Partnership (30/06/2019) HH informed the group that she wasn't aware of the difficulties in getting this procedure approved. EM will send HH the procedure and correspondence for her to review.	**EM**
8.3	**NHS Fife Tissue Viability Working Group of 26 July 2019** The minutes of NHS Fife Tissue Viability Working Group were noted by the group.	
8.4	**NHS Fife Resuscitation Committee of 4 July 2019** The minutes of NHS Fife Resuscitation Committee were noted by the group.	

8.5	**NHS Fife Wide Inspection Oversight Group of 20 August 2019** LC provided and update and suggested the minute of this group is removed from the Clinical Governance Workplan, The group agreed.	**GB**
8.6	**NHS Fife In Patient Falls Steering Group of 21 August 2019** An official launch of the falls toolkit took place on Tuesday 10th September 2019 within the Lecture Theatre at Victoria Hospital. The minutes of the NHS Fife In Patient Falls Steering Group were noted by the group.	
8.7	**NHS Fife Point of Care Testing Committee of 4 September 2019** Carried forward to 14th November 2019 meeting.	
8.8	**NHS Fife Adverse Events and Duty of Candour Group of 5 September 2019** Carried forward to 14th November 2019 meeting.	
8.9	**Occupational Health Service, Clinical Governance Group Minutes** These meetings are held quarterly the next meeting is scheduled for 10 October 2019	
8.10	**NHS Fife Urinary Catheter Improvement Group of 24 June 2019** The minutes of the NHS Fife Urinary Catheter Improvement Group were noted.	
8.11	**NHS Fife Community Falls Group** The minutes of the NHS Falls Community Fall Group meeting were not received	
8.12	**NHS Fife Deteriorating Group, including DNACPR & HACP** The NHS Fife Deteriorating Group, including DNACPR & HACP have not met recently. A meeting is scheduled for 25 November 2019	
9	**Summary Points for the chair to Raise at NHS Fife Clinical Governance Committee**	
	Areas of Good Progress ➢ Launch of Falls toolkit	
10	**AOCB**	
	Workplan	

	The workplan for 2019 – 2020 was noted. The group agreed to remove the draft watermark HW suggested the Quality of Care(QoC)reviews are a standing item on the agenda of this group. HB agreed to that the QoC should be a standing item GB to update the workplan. HB asked for the Quality of Care Framework to be the main item for discussion at the November meeting. HB asked HW to present a presentation on where we are and how we can support the self assessment Quality of Care Framework to be added to Workplan	**GB** **GB** **HW** **GB**
11	**Date of Next Meeting: Wednesday, 14th November 2019 at 09.30 in the Staff Club, Victoria Hospital, Kirkcaldy.**	

NHS Fife Clinical Governance Committee
06th November 2019

Agenda item no 8

Title of Group/Sub-committee	Research Governance Group
Date of Group/Sub-committee Meeting:	12th September 2019
Release: draft/final minutes	Draft
Author/Accountable Person:	Dr Amanda Wood

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?

1) R&D Annual Report 2018/2019 & R&D Strategy & Strategic Priorities 2019/2020 – These demonstrate activities in increasing culture to include research as part of role and to build research capacity and delivery against 2019/2020 strategic priorities.

2) MHRA Inspection Plan – The MHRA study inspection will take place on 21st and 22nd October. Weekly preparation meetings have been organised in order to prepare. Mock interviews have also been held with colleagues from other Boards.

3) Pharmacy update – Cost avoidance figures will now be provided for discussion at the R&D Operational Group.

4) Cancer Pain study – Following a re-classification by the MHRA from IIb to I/IIb it was agreed by the group that NHS Fife should no longer consider participating in this study at this early stage since it fell outside the current Phase II pilot.

5) SHARE - Total registrations are 266k with Fife being second highest recruiting region in Scotland.

6) Fife Community Advisory Group – Excellent Lay involvement and input continues. Next meeting takes place on 10th October at VHK.

7) R&D Annual review by Chief Scientist Office (CSO) – Feedback will be circulated once received and all Boards had been visited by the CSO.

8) Awareness Raising – Assistant R&D Director and Lead Nurse have been visiting clinical areas to raise awareness and discuss support opportunities available via R&D to participate in research. Most of the Service Managers have now been visited.

NHS Fife Clinical Governance Committee
06th November 2019

Agenda item no 8

This should include good practice

1. Expansion of public involvement in research via Primary Care Fife Community Research Advisory Group with 13 additional members.

2. 2nd Highest board to recruitment to SHARE - The NHS Research Scotland initiative created to establish a register of people interested in participating in health research and who agree to allow SHARE to use the coded data in their various NHS computer records to check whether they might be suitable for health research studies. Fife now has 13.7% of its eligible population signed up.

What are the concerns/issues/risks you want to bring to the attention of the committee?

Include any actions taken to date

Issue to be highlighted to NHSF CGC –

MHRA Statutory Inspection visit to NHS Fife on 21st/22nd October. Inspection involves the GaPP2 research study and will take place in the Clinical Research Facility at VHK. R&D Director, Medical Director and Chief Executive are aware.

Action taken –

Review of all study documentation. Weekly meetings with the study team and study Sponsor.

Other identified risks –

Current capacity within Oncology Pharmacy with regards to chemo care.

FIFE RESEARCH GOVERNANCE GROUP MEETING
MINUTES
LH2, EDUCATION CENTRE,
QUEEN MARGARET HOSPITAL, DUNFERMLINE

	12 SEP 2019	**ACTION**
	Present: Dr Chris McKenna, Medical Director (CMcK) Dr Frances Elliot, Interim Director of R&D (FE) Dr Amanda Wood, Assistant R&D Director (AW) Scott Garden, Director of Pharmacy (SG) Gwen Stenhouse, Management Accountant (GS) Dr Fay Crawford, R&D Senior Research Advisor (FC) Julie Aitken, R&D Trials Facilitator (JA) Tara Graham, Research & Development Psychologist (TG) Bannin Jansen, Scientific Officer, East of Scotland Research Ethics Service (BJ) Anne Haddow, Lay Advisor (AH) In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** Dr Mckenna welcomed all and everyone introduced themselves. **Apologies;** Prof. Alex Baldacchino, R&D Director Dr Richard Malham, Research Policy Officer, University of St. Andrews Tamara Lawson, Research Policy Officer, University of St. Andrews Dr Chris McGuigan, Consultant in Public Health Prof. Frank Sullivan, Director of Research, University of St. Andrews	
2.0	**MINUTES OF THE LAST MEETING** The minutes were accepted as an accurate record. Actions were discussed and the action list updated. It was agreed that "Innovation" would be added to the agenda as a standing item.	
	STANDING ITEMS	
3.0	**OVERSIGHT OF R&D OPERATIONAL GROUP (OPS) MINUTE** This was reviewed and accepted.	
	RESEARCH GOVERNANCE	
4.1	**RESEARCH WITHIN GOVERNANCE FRAMEWORK**	
4.1.1	NHS FIFE R&D ANNUAL REPORT 2018-2019 AW advised that the report was open to comment from the group before being submitted to the Clinical Governance Committee. AW also advised that there had been issues with trying to obtain information from the Clinical Academics for this report, which will be discussed further with Prof. Sullivan.	**AW/FE**
4.1.2	R&D STRATEGY & STRATEGIC PRIORITIES 2019-2020 AW advised the group of the purpose of this document, increasing culture to include research as part of role, to build research capacity and governance structures with academic institutions. Governance review and update in preparation for MHRA inspections and the ongoing improvement with of	

	communication.	
4.1.3	R&D POLICY, SOP AND WI UPDATES & APPROVALS JA updated from her report that had been attached to the agenda, advising that there are no new documents in production due to preparations for the forthcoming MHRA visit.	
4.1.4	EAST OF SCOTLAND RESEARCH ETHICS SERVICE UPDATE BJ read from her report that had been attached to the agenda, advising of new processes that have been introduced by the Health Research Authority designed to improve the quality of applications submitted.	
4.1.5	RISK BASED PROGRAMME OF MONITORING There has been no further monitoring activity since the last meeting although the delegation log and Annual Progress Report to REC for 17-081 - SaIR - Staphylococcus aureus infection reduction has been recieved. The following actions are outstanding from previous monitoring visits: 18-046 - The burden of M.abscessus and M.avium complex in Fife & Tayside – MAAFT. Awaiting copy of completed delegation log and Annual Progress Report to REC.	**JA**
4.1.6	MHRA INSPECTION AW updated the group regarding the ongoing preparations for the visit on 21st and 22nd October. Weekly meetings continue to take place and mock interviews for the study team have also been held with colleagues from other Boards.	
4.1.7	PHARMACY UPDATE & COST AVOIDANCE 2018-19 12 MONTH REPORT It was agreed that the cost avoidance figures will now be discussed at the Operational Group and will be removed from the agenda at this group. The Pharmacy report will be tested in the new format at the next RGG in December.	
4.1.8	CANCER PAIN STUDY/PHASE II REVIEWS 2019 JA advised that there had been no new Phase II studies added since the last meeting. Cancer Pain Study - NHS Fife was approached by a commercial Sponsor about the possibility of NHS Fife taking part in a Phase IIb study in patients with Cancer Pain having expressed an interest. However at the recent site selection visit the Sponsor clarified that as there was limited clinical data available for this formulation of the IMP, the MHRA had asked for the study to be reclassified as a Phase I/IIb study. Although the Sponsor explained that there has been no changes to the study protocol requested and no changes to the risk assessment, the Assistant R&D Director felt that this study was no longer covered by the agreement from the Research Governance Group to undertake a limited number of Phase II studies and NHS Fife should therefore consider not being involved in this trial. The group agreed that following its re-classification this study should now be rejected.	**JA**
4.1.9	RESEARCH POLICIES FOR REVIEW The Management of Intellectual Property and Research Fraud and Misconduct policies are due for review. They had previously been out for review by the Assistant R&D Director, Quality and Performance Lead, Commercial Research Manager, Scottish Health Innovation Ltd Innovation Manager and Senior Research Advisor. Comments had already been	

	received from the R&D Director.	
4.1.10	RESEARCH GOVERNANCE ROLE & REMIT A discussion took place with regards to core membership of this group. Although the group has been without representation from AHPs for some time, a member has now been found. It was also agreed that there would be no need for representation from Acute Services.	
4.2	**PUBLIC PARTNERSHIP WORKING**	
4.2.1	SHARE AW advised that the total registrations are now 266k, with recruitment of patients from Fife is the second highest in Scotland.	
4.2.2	R&D/FIFE COMMUNITY ADVISORY GROUP AH advised that there had been no meetings since the last Research Governance Group and that the next meeting is due to take place on 10th October. She also advised that the "Sir James Mackenzie Institute for Early Diagnosis" would be opening on Monday 23rd September.	
4.3	**FINANCIAL SUPPORT / RESOURCES**	
4.3.1	R&D BURSARIES/INNOVATION GRANT UPDATES FC advised that five bursaries were awarded in March 2019 and requests for the first progress reports will be issued from the primary recipient during September 2019. Three older bursaries are in the final stages and 2 reports are expected in the next month; one report continues to be sought.	**FC**
4.3.2	R&D ANNUAL REVIEW BY CSO AW advised that this review took place on 20th May. Official feedback will be received once the CSO has met with all the other Boards. AW will provide their report to the next meeting.	**AW**
5.0	**CAPACITY BUILDING**	
5.1	**CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AS PART OF ROUTINE PRACTICE**	
5.1.1	COMMUNICATION The R&D bulletin was attached to the agenda and is now being issued every 2 months.	
5.2	**COLLABORATION WITH ACADEMIC/COMMUNITY PARTNERS**	
5.2.1	ANY ACADEMIC/NHS/OTHER PARTNERSHIP UPDATES FE advised that she would again try and arrange a meeting with Prof. Chouliara at Abertay University to request her to join this group.	**FE**
5.3	**DEVELOPING RESEARCH KNOWLEDGE/SKILLS OF STAFF**	
5.3.1	R&D EDUCATION PROGRAMME FC advised that there had been 110 attendees to the NHS Fife training courses so far this year.	
5.4	**AWARENESS RAISING** CMcK discussed Board Development sessions taking place in 2020 and advised we contact Gillian MacIntosh (Board Secretary) to request R&D be added to the agenda.	**RH/AW**
6.0	**AOCB**	

	CMcK discussed his attendance at the recent East Region Innovation Oversight Committee meeting and queried why AW was not part of this group. This CSO funded group which consisted of members from NHS Lothian, NHS Borders, NHS Fife (although he was the only Fife member), CMcK also noted that some projects were already underway and Fife has not been asked to become involved / nor offered any opportunity to take part. It was agreed that AW would contact the group to discuss further appropriate representation from Fife.	**AW**
7.0	**DATE AND TIME OF NEXT MEETING** Thursday 12th December, 10.00 – 12.00, Lecture Hall 2, Education Centre, QMH	

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	**Information Governance & Security (IG&S) Group**
Date of Group/Sub-committee Meeting:	**29/08/19**
Release: draft/final minutes	**Draft**
Author/Accountable Person:	**Carol Potter, Senior Information Risk Owner**

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?

The IG&S Group have started to implement some of the actions compiled within the B31-32/19 Information Governance and eHealth Audit Report; papers presented to the Group now arrive in SBAR format or with an accompanying SBAR.

Staff from within the IG&S Team now attend Staff Induction to capture new starts and provide an information leaflet that contains a Confidentiality, Integrity and Availability overview to staff. A proposal will be produced for EDG recommending that Information Governance mandatory training is increased from a 3 yearly requirement to 2 yearly.

NHS Fife and H&SCP provided the IG&S Group their individual statistical FOI reports which detail requests received and adherence to legislative timescales. It was agreed that the Group will receive a joint report going forward.

The IG&S Group were updated on the NHS Fife GP Data Protection Project, which commenced April 2019. Fife are currently the only Health Board to have commenced this Project after instruction in November 2018 that NHS Boards were to provide Data Protection support to GP colleagues.

Subject Access Request figures were provided to the Group, with an increase in compliance to legislative timescales from 84% to 92%.

An Information Governance Compliance Working Group has been initiated, to sit under the IG&S Group and membership consists of a range of staff who are non-Managerial and who will be “champions” of Information Governance within their respective areas; the IG Compliance Working Group members contributed and provided feedback and comment on the information leaflet given out at Staff Inductions.

What are the concerns/issues/risks you want to bring to the attention of the committee?

The IG&S Group regularly review all Information Governance and Security Risks. There are currently 6 HIGH risks outstanding.

ID	Title	Risk Level	Management Actions	Next Review
537	Failure of Local Area Network causing loss of access to IT systems	High	20/2/19 Implementation of the new Core Network is now complete and further configuration will take place in order to maximise the resilience. A Network health assessment will take place in 2019 as part of the preparations for O365, there will also be an independent IP Telephony assessment carried out.	01/03/2020
529	Cyber Security and IT Hardware	High	15/07/2019 The risk remains high NHS Fife is still unable to comply with Cyber Essentials Plus and ISO27001 framework has not been deployed for the entire organisation as required DL(2015)17. The Governance tasks contained in DL(2015)17 are completed therefore this risk resides with the IT Operations section of eHealth. Due to the upcoming audit the review date has been changed to monthly.	15/08/2019
1338	End of support lifecycle for Microsoft Office 2007	High	01/05/2019 [AY] NHS Scotland has now committed nationally to O365 licensing and this will allow NHS Fife to begin a programme of business transformation to upgrade to O365. Anticipated completion for this work is March 2021, and in the meantime reasonable endeavours will continue in order to minimise the risk through providing 'defence in depth' security measures.	01/10/2019
1393	Patch Management Risk	High	[05/04/2019] The current patch management strategy is constantly under review and updated to reflect the current situation. Continuous improvements are being made to Microsoft patching scope and schedule.	30/09/2020
1422	Unable to meet Cyber Essentials compliance	High	SBAR papers were submitted to eHealth strategy board in December 2017 and February 2018 to provide initial brief and outline the costs associated with meeting and maintaining the standards. A SLWG will be set up to maximise the resources available in order to fully understand the shortfalls and efforts / funding required to resolve. Review in 6 months.	01/10/2019
1424	End of support lifecycle for Microsoft Server Products	High	07/06/19 - The replacement programme has been progressing slowly, but lack of resource is preventing any real traction. A VMF has been agreed so that we can bring resource in to focus on the 40 Server 2003 and 258 2008R2 servers requiring attention. 21/02/19 - The replacement programme has now upgraded all of the GP Servers to a supported level and work continues to manage the rest down to zero.	01/03/2020

Fife NHS Board

UNCONFIRMED MINUTE OF THE INFORMATION GOVERNANCE & SECURITY GROUP MEETING HELD ON THURSDAY 29TH AUGUST 2019, SEMINAR ROOM 4, EDUCATION CENTRE, VHK

Present:

Carol Potter	**Director of Finance (Chair)**
Bruce Anderson	Head of Partnership (f*or Barbara Nelson)*
Fay Crawford	Senior Research Advisor *(for Amanda Wood)*
Heather Fernie	Business Manager, H&SC Partnership
Lesley Gauld	Information Compliance Manager, IJB *(for Nicky Connor)*
Lizzie Gray	Patient Relations Officer *(for Donna Hughes)*
Margaret Guthrie	Information Governance and Security Manager
Kirsty MacGregor	Head of Communications
Gillian Mackintosh	Head of Corporate Governance
Amy McCulloch	Health Records Supervisor *(for Gail Watt)*
Karen Pearson	Data Protection & Information Policy Specialist *(for Martin Kotlewski)*
Andrew Rattrie	Laboratory IT Administrator *(for Stephen McGlashan)*
Torfinn Thorbjornsen	Information Services Manager
Allan Young	eHealth Head of Operations (***also*** *for Lesly Donovan)*

In Attendance:

Andy Brown	Principal Auditor
Michelle Campbell	Information Governance & Security Advisor
Yvonne Chapman	Risk Management Co-ordinator
Alison Johnston	Information Governance & Security Advisor
Jane Mercer	Legal Services Manager
Claire Neal	Personal Assistant to General Manager – eHealth & IMT (Minute)
Garry Taylor	Information Security Manager

Apologies:

David Gowans	Primary Care IM&T Manager *(For Joyce Kelly)*
Helen Hellewell	Associate Medical Director
Dona Milne	Director of Public Health
Dr Chris McKenna	Medical Director and Caldicott Guardian
Kathleen Norris	Radiology IM&T Systems Manager
Janette Owens	Associate Director of Nursing (*for Helen Wright)*
Ellen Ryabov	Chief Operating Officer
Michelle Smith	Medical Records Manager, Mental Health Service

1. CHAIRPERSON'S WELCOME AND OPENING REMARKS

C Potter opened the meeting by welcoming everyone in the room and thanked them for attending**.**

2. APOLOGIES

Apologies noted for the group**.**

3. MINUTES OF PREVIOUS MEETING HELD 28/05/19

Minutes from previous meeting reviewed and confirmed with the following amendments below.

C Potter asked for the attendees from St Andrews University to be added.
Item no 11, action amended from C Potter to M Guthrie.

4. ACTION LIST

Action were discussed and Action log update accordingly.

5. INFORMATION GOVERNANCE & SECURITY PLAN UPDATE

5.1 B31-32/19 Information Governance and eHealth Audit Report

Audit report presented to the group for information only. A Brown raised with group the quality of assurance and papers being presented to group outwith the agreed time, with no explanation for the delay.

M Guthrie confirmed with group that actions are starting to be addressed. SBAR's now implemented and workplan complete.

No comments raised by group.

6. IG TRAINING UPDATE

M Guthrie provided a brief explanation to paper and expressed they are content with progress. C Potter queried Information Governance training and M Guthrie confirmed this not part of core training any more, however Information Governance now attend Induction Training every 2nd Monday to provide an overview and information leaflet to new staff.

M Guthrie informed the Group that Information Governance training within NHS Fife is every 3 years and would like to change to every 2 years. B Anderson mentioned that the issue with this would likely be staffing / resource. C Potter queried if Information Governance was to reduce to 2 years what would the process be to implement, B Anderson advised that such a proposal would require to be submitted to EDG.

Action – M Guthrie and B Anderson to create a proposal for EDG around increasing mandatory IG Training from a 3 yearly requirement to 2 yearly. **MG&BA**

7. INFORMATION REQUESTS

7.1 FOI Figures – NHS Fife

L Gauld presented paper for information only. L Gauld confirmed that at present FOI's are reported separately NHS Fife and IJB but these are going to be combined. G MacKintosh advised that a spreadsheet has been created to capture the FOI's.

Action – L Gauld and S Fraser will compile a joint report for the next meeting and will report on the same data. **LG&SF**

7.2 FOI Figures – IJB

As discussed above.

8. DATA PROTECTION UPDATE(S)

8.1 DPIA / ISA / Caldicott Register, SBAR & Report

A Johnston provided an update on DPIA's and informed the group, these are now being responded to within 2 weeks, which is a big improvement. A Brown queried if any systems have been implemented without a DPIA. M Guthrie confirmed that as far as they are aware, none have been but cannot guarantee this. M Guthrie advised they are communicating with Procurement. A brief discussion took place within group regarding where it was noted that only 3 departments could procure systems; Capital, Procurement and eHealth.

Action - M Guthrie to speak with Procurement Management regarding system purchases and when to involve the IG&S Team**.** **MG**

A Brown asked for clarity around Information Sharing Agreements; the overall numbers in place and if any had breached their review dates.

A Johnston reported that this was a piece of work she was currently undertaking and will provide these figures at the next meeting.

Action – A Johnston to provide the figures for any lapsed Information Sharing Agreements at the next meeting. **AJ**

8.2 GP Data Protection Update SBAR

M Campbell provided a brief update to the Group regarding the GP Data Protection Project.

M Campbell reported that a nationally drafted Memorandum of Understanding (MoU) had been discussed at the NHS Fife GP Sub Committee on 20th August 2019, who approved the document in principle. M Campbell said she would circulate the MoU to the Group, for information. This document will be sent out for signature once Practice visits have taken place.

Action – M Campbell to circulate the GP Data Protection Memorandum of Understanding to the group. **MC**

9. INFORMATION POLICIES UPDATE

9.1 – Information Policies, SBAR & Report.

G Taylor informed the Group that there are 20 policies to review and that he would be dedicating one a day per week to review these policies and clear the backlog.

10. INFORMATION AND SECURITY RISKS / INCIDENTS

10.1 IG&S Incidents SBAR & Report

M Campbell presented the papers to the group, updating that there were three incidents reported to ICO in the last quarter but no further action has taken against NHS Fife.

A Brown queried why the incidents had been reported as the Report highlighted that no incidents were MAJOR for the period.

This was because there were 2 GP Practice breaches and they are not yet captured onto Datix and the other breach was captured onto Cherwell the eHealth Service Desk system.

10.2 Information Governance & Security Risks, SBAR & Report

G Taylor provided an update on Information Governance and Security Risks. The Group discussed the Reports and it was queried whether or not Risk 529 should should be owned by ICT or Information Governance.

A further conversation was suggested to take place offline with A Young and M Guthrie.

Action – M Guthrie and A Young to arrange a meeting to discuss Risk No. 529. **MG&AY**

G Taylor raised with group NIS assessment and a brief discussion was held.

Action – G Taylor, A Young and A Brown to discuss further. **GT/AY&AB**

10.3 Information Security Incidents, SBAR & Report

G Taylor presented the Information Security Incident Report to the group. There were no issues to escalate and the Group **noted** the documents.

11. SUBJECT ACCESS REQUESTS

M Guthrie provided an update on SAR requests and reported that 639 SARS were completed with a 92% compliance rate, which is greatly improved from 84%.

M Guthrie confirmed that training for the new SAR System, AXLR8 will take place prior to implementation.

12. APPROVALS

12.1 IG&S Terms of Reference & SBAR

M Guthrie presented the IG&S Group ToR to the group for approval. No comments were raised within group, happy with content and approved the document ready to go to the Clinical Governance Committee.

ToR **approved**.

12.2 NHS Fife GP/A4 Acceptable Use Policy & SBAR

G Taylor presented the updated Acceptable Use Policy, seeking approval from the Group. C Potter asked if there were any major changes within the document to note, however G Taylor reported that there were none and that it was mostly language and inclusion / update of legislation. .

The GP/A4 Acceptable Use Policy was **approved** by the group.

13. UPDATES FROM OTHER MEETINGS

13.1 IG Compliance Working Group – Decision Log & SBAR

M Campbell presented the IG Compliance Working Group Decision Log to the Group and informed them that the Compliance Group had helped draft and finalise an internal document regarding Data Protection which will be handed out to staff at Induction and core training. A Data Protection Leaflet for patients is being drafted.

14. AOCB

14.1 IG&S Group Meeting Dates

M Campbell asked if the Group meeting dates could align with the financial reporting period as the meetings currently run May, August, November and February meaning that separate reports had to be generated for this Group to ensure that up to date information was provided. This was **agreed**.

M Guthrie asked for it to be noted that if meetings required to be cancelled then this has to be in agreement with C Potter and M Guthrie. The Group **noted**.

15. DATE OF NEXT MEETING

12th November 2019, 1530 hours within Training Room 1 at VHK.

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	Integration Joint Board
Date of Group/Sub-committee Meeting:	6 September 2019
Release: draft/final minutes	Unconfirmed
Author/Accountable Person:	Wendy Anderson

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
Nothing to raise.
What are the concerns/issues/risks you want to bring to the attention of the committee?
Nothing to raise.

UNCONFIRMED

MINUTE OF THE FIFE HEALTH AND SOCIAL CARE – INTEGRATION JOINT BOARD HELD ON FRIDAY 6 SEPTEMBER 2019 AT 10.00 AM IN COMMITTEE ROOMS 1 AND 2, 5TH FLOOR, FIFE HOUSE, NORTH STREET, GLENROTHES, KY7 5LT

Present	Councillor Rosemary Liewald (Chair) Christina Cooper (Vice Chair) Non-Executive Members – Dr Les Bisset, Martin Black, Eugene Clarke, Paul Hawkins, Chief Executive, NHS Fife Helen Buchanan, Nurse Director, NHS Fife Councillors David Alexander, Tim Brett, David Graham, Fiona Grant, David J Ross, Tony Miklinski and Jan Wincott - Fife Council Carolyn McDonald, Associate Director, Allied Health Professionals Ian Dall, Chair of Public Engagement Network Kenny Murphy, Third Sector Representative Morna Fleming, Carer Representative Paul Dundas, Independent Sector Representative Simon Fevre, Staff Representative, NHS Fife
Professional Advisers	Nicky Connor, Interim Director of Health and Social Care/Chief Officer Audrey Valente, Chief Finance Officer Katherine Paramore, Medical Representative Lynn Barker, Interim Associate Director of Nursing
Attending	Claire Dobson, Divisional General Manager (West) David Heaney, Divisional General Manager (East) Julie Paterson, Divisional General Manager (Fife Wide) Helen Hellewell, Associate Medical Director, NHS Fife Scott Garden, Director of Pharmacy & Medicine, NHS Fife Fiona McKay, Head of Strategic Planning, Performance & Commissioning Andrew Henry-Gray (Minute)

NO HEADING **ACTION**

1 PERSON STORY

The Chair welcomed all who were attending to present and share the Person Story with the Integration Joint Board.

Carolyn McDonald introduced Caoimhe's story and the benefits technology has offered to support independent and inclusive play using the Drive Deck. This story was presented by Caoimhe, her mother Katie MacMillian and Allied Health Professionals Pippa Oglivie and Hazel Golon. The presentation was supported by a video demonstrating the involvement of partners and person-centred approach to this initiative. This was followed by discussion with the Board.

The Chair thanked all involved in presenting todays person story.

2 CHAIR'S WELCOME AND OPENING REMARKS

The Chair welcomed everyone to the Health & Social Care Partnership (H&SCP) Integration Joint Board (the Partnership Board) and also welcomed Nicky Connor and Lynn Barker to their first meetings in their new roles.

The **Diabetic Retinopathy Service** won first prize in the Poster Exhibition at the British Association of Retinal Screeners Annual Conference in Leeds recently.

Elaine Siggers, Unit Manager at Ostlers House, Kirkcaldy was nominated in the Leading for Impact category of the Scottish Social Services Council Awards 2019. Congratulations on her nomination.

The Chair congratulated the **Children and Young Peoples' Continence Team** who have been awarded this year's Bladder and Bowel UK Enuresis Award. The team will receive their award at a ceremony in Manchester later this year

The Chair congratulated the **Occupational Therapy Mental Health Service** who work in partnership with **Contact Point**, a mental health charity, who have received Kingdom FM's Local Hero award for the Roads to Success initiative. They were nominated for the award by Provost Jim Leishman. The initiative works with people to support mental health through arts & crafts. The artwork is then exhibited at Lochore Centre. This partnership has been successful for over 20 years and it is great to see their work being recognised.

The Chair advised members that a recording pen was in use at the meeting to assist with Minute taking.

The Chair noted that from today there will be a verbal Chief Officer's Report included as part of the IJB agenda and handed over to Nicky Connor to provide the first of those reports to the Board.

CHIEF OFFICER'S REPORT

Nicky Connor had proposed the introduction of a Chief Officer's report on the agenda to ensure that the Board remains sighted and kept updated on key priorities and emerging issues.

Key issues:

- Submission of self-assessment and action plan to the Ministerial Steering Group.
- Transformation Programme – Redesign (Mental Health & Community Hospital).
- Winter Plan.

CHIEF OFFICERS REPORT (Cont)

Nicky Connor responded to questions from the Board on the following issues:

Morna Fleming sought assurance that Board Members will be involved in informing and developing the Ministerial Steering Group (MSG) Action Plan in future years submissions. Nicky confirmed that work on the MSG Action Plan will be inclusive in future years. Tony Miklinski enquired about when the plan was submitted and what processes will be put in place to monitor delivery and support governance. Nicky Connor confirmed that the MSG Action Plan was submitted on 23 August 2019 and there will be further feedback and information provided moving forward which could be considered at a Board Development Session.

David Ross asked for an update on the delay in both Mental Health and Community Hospital Redesign Transformation being reported to the Integration Joint Board. Nicky Connor confirmed that a Transformation Board is being developed in partnership with Fife Health and Social Care Partnership, NHS Fife and Fife Council. This will provide opportunity to support whole system working for future priorities. The current transformation change programme including Community Hospital and Mental Health Redesign will be considered through the Transformation Board. An update will be brought to the relevant Committees following the first Transformation Board meeting.

3 DECLARATION OF MEMBERS' INTERESTS

Nil.

4 APOLOGIES FOR ABSENCE

Apologies had been received from Margaret Wells, Steve Grimmond, Kathy Henwood, Eileen Rowand, Debbie Thomson, Wilma Brown, Chris McKenna and Eleanor Haggett.

5 MINUTE OF PREVIOUS MEETINGS

The Minute of the meeting held on 21 June 2019 was discussed and a typo had been noted (*page 7, item 8.2, para 1, 2nd last sentence*): should read 'phlebotomy', not 'lobotomy'.

With this correction the minute was agreed as an accurate record.

6 MATTERS ARISING

Les Bisset raised a matter that that was not on the action list *[item 8.1 of previous minutes: Out of Hours Urgent Care Review]* noting that when the proposal was agreed in June there was an understanding that there was still work to be done in relation to the detail of the model for NE Fife and St

MATTERS ARISING (Cont)

Andrews including engagement with the Community Council and other community groups. Les Bisset queried how this work is going, if any issues had arisen and, if there are issues, how they are being taken forward.

Nicky Connor responded that the Health & Social Care Partnership (H&SCP) are committed to engagement and HSCP representatives had met with the Royal Burgh of St Andrews Community Council in August of this year. Representatives of the Community Council were invited to join the communications sub-group of the Urgent Care Transformation Board and the invitation was accepted with meetings due to be held in September. These representatives will also have the opportunity to meet with officers from the H&SCP. There have been meetings to discuss urgent care and a series of meetings with the locality group in Fife have been arranged. Communication and engagement has taken place with St Andrews University. Urgent care staff will attend and support matriculation and fresher's week supporting students who are new to the area. Following the resignation of the chair of the Glenrothes Area Residents' Forum, numerous attempts have been made to contact and engage with the Glenrothes Area Residents Forum and this will continue. The HSCP has recruited 8 members of the public to join the communications group which includes people from across Fife as well as a young carers' representative. Significant work has been done over the summer to engage with staff. A briefing on the implementation of the urgent care proposals will be issued to the IJB and to elected members next week.

Action Note **CD**

The Action Note from the meeting held on 21 June 2019 had been circulated previously and was agreed as accurate.

David Heaney updated that, of the additional 50 START posts that were to be recruited, 43 have now completed training with 7 remaining posts having had to go back to advert due to recruits pulling out of training.

Information was sought regarding the Out-of-Hours plans for Glenrothes and it was queried whether the Out-of-Hours service has ceased. Claire Dobson updated that services continue for the time being and this will be included in the briefing which will be issued to IJB members at the beginning of next week.

7 PERFORMANCE

7.1 Finance Report

Audrey Valente presented this report which was for information advising that there are no financial monitors on the agenda today but that a full set will be brought to the IJB meeting on 24 September 2019.

7.1 Finance Report (Cont)

Tim Brett enquired if it would be possible to get an indication of the longer - term financial situation for the Council and NHS Fife. Audrey Valente undertook to bring that to the IJB meeting on 24 September 2019. It was also agreed that there will also be an update brought to that meeting and a Financial Monitoring report would also be presented, **AV**

Discussion took place around budget and savings proposals for the next financial year and these will be presented to the Board prior to the end of the calendar year. The Senior Leadership Team are looking at both in-year savings and a medium-term financial strategy is also being developed to assist with financial planning and this will be discussed at the Development Session on 13 November 2019. **AV**

Les Bisset asked for information in relation to ADP funding which will be discussed at the next Finance & Performance Committee.

Eugene Clarke asked about the risk share arrangements. Nicky Connor updated that this is an area that will be explored through the Ministerial Steering Group Action Plan at the agreed future Development Session.

7.2 Revision of the Performance Framework

Fiona McKay presented this report and highlighted that the previously arranged Finance & Performance Committee Development Session did not go ahead as a number of people were unable to attend. This will be rescheduled and the revised framework, when complete, will be brought back to the IJB committee.

Discussion took place around the contents of the Report and how to ensure that the Finance & Performance Committee receives appropriate information.

The Board:-

- **Noted** the current position and provided further comments for consideration in the review of the Integrated Performance Framework.
- **Agreed** that a further development session be arranged for members of the Finance and Performance Committee.

8 STRATEGY

8.1 Strategic Plan for Fife 2019-2022

Fiona McKay presented this report. Tim Brett advised that the Clinical and Care Governance Committee had spent time looking over this and making small changes, which have been incorporated into the final report.

8.1 Strategic Plan for Fife 2019-2022 (Cont)

Discussion took place around the Plan and the priorities within it. Fiona advised that once the Plan has been signed off then a delivery plan will be developed covering the next three years.

The Board:-

- The Board **agreed** to approve the Strategic Plan.

8.2 Mental Health Strategy (Progress Update)

Julie Paterson gave an update on the Mental Health Strategy which was for information.

It was noted that the original intention was to bring the Mental Health Strategy to the IJB in October 2019. However, as referred to in the Chief Officers Report this will now be considered within the Transformation Board in the first instance. The review of the voluntary sector is linked to strategy completion therefore this timescale will require to be reviewed once the Strategy is complete.

Discussion took place around the Strategy and its links to other strategies in Fife.

9 GOVERNANCE

9.1 H&SC Annual Report 2018-2019

Fiona McKay presented this report and following discussion the Board approved the Annual Report for 2018-19.

9.2 Governance Manual

Audrey Valente presented this report which has been to the Audit & Risk Committee. Following discussion, it was felt it should go to the other two Governance Committees as well before coming back to the IJB for approval.

A Development Session is to be arranged to discuss this document, Governance and also the Ministerial Steering Group Action Plan. **NC**

Manual has been deferred until after the Development Session has taken place.

NO HEADING **ACTION**

10 MINUTES FROM OTHER COMMITTEES AND ITEMS FOR ESCALATION

10.1 Audit & Risk Committee (Unconfirmed Minute from 5 July 2019)

The Chair asked Eugene Clarke to highlight any items for escalation to the IJB.

EC raised 3 points not for escalation but for noting by the IJB

1. Norma Aitken has previously sent out an invite to members to join the A&RC committee and EC repeated this invite today. Members to contact NA.
2. EC highlighted that the A&RC had had concerns around the number and frequency of changes to IJB board and committee meetings and the impact on governance. A report has been requested for the next A&RC meeting on 20/09/2019.
3. Consultant's report was issued in November 2018: A&RC took the view that it should be made aware of what was happening with that report. Assurances were given by members of the F&PC that an action plan was created and was being modified and that the A&RC would be updated. EC wished it noted that this has not happened and that an update is still expected.

Nicky Connor advised that discussions had been held with the Chair and Vice-Chair around the governance of the IJB and Committees, which is of the upmost priority. Discussions to take place at Development Session around future governance arrangements.

10.2 Clinical & Care Governance Committee (Confirmed Minutes from 24 May 2019 & 18 June 2019 and unconfirmed minutes from 08 August 2019)

The Chair asked Tim Brett to highlight any items for escalation to the IJB.

Tim Brett referred to the May minutes which listed items for escalation at that time:

- Dr McCallum to inform the IJB of the review of Tayside Mental Health Reports – Julie Paterson to look and highlight any issues that we should be considering to the Clinical Governance Committee.
- Primary Care Improvement Plan – positive work, in some respects ahead of some other areas in Scotland.
- Children's Inspection Report to be taken to the full IJB. It was noted that this action is complete.
- Safe Staffing and Excellence will come to a future Clinical & Care Governance Committee.

10.2 Clinical & Care Governance Committee (Cont)

The meeting in June was a special meeting specifically dealing with the Out-of-Hours matter which has since been to the IJB.

The August minute lists items for escalation:

- report on drug deaths;
- mental health restraints;
- safe use of medicines report;
- shortage of rheumatologists.

10.3 Finance & Performance Committee (Unconfirmed Minute from 26 June 2019)

The Chair asked David Graham to highlight any items for escalation to the IJB.

DG reported that all items had been part of today's agenda. The Consultant report has been discussed in great length at the Finance & Performance Committee with a more detailed action plan requested and this remains a standing item moving forward.

Tim Brett referred to an item within the minute *[page 145, item 11: Cabinet Secretary –Financial Position]* and asked if there was any further information about the meetings with the cabinet secretary.

David Graham, Paul Hawkins and Les Bisset responded that there was nothing more to add at this time.

10.4 Local Partnership Forum (Unconfirmed Minute from 26 June 2019)

The Chair asked Simon Fevre to highlight any items for escalation to the IJB. No items were raised and no questions were asked.

11 AOCB

Nothing raised.

12 DATES OF FUTURE MEETINGS

IJB DEVELOPMENT SESSION – Tuesday 17 September 2019 at 1.30 pm in Committee Rooms 1 & 2, Fifth Floor, Fife House, North Street, Glenrothes, Fife, KY7 5LT.

IJB MEETING (ANNUAL ACCOUNTS) – Tuesday 24 September 2019 at 10.00 am in Conference Rooms 2 and 3, Ground Floor, Fife House, North Street, Glenrothes, Fife, KY7 5LT.

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	Integration Joint Board
Date of Group/Sub-committee Meeting:	24 September 2019
Release: draft/final minutes	Unconfirmed
Author/Accountable Person:	Wendy Anderson

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
Nothing to raise.
What are the concerns/issues/risks you want to bring to the attention of the committee?
Nothing to raise.

UNCONFIRMED

MINUTE OF THE FIFE HEALTH AND SOCIAL CARE – INTEGRATION JOINT BOARD HELD ON TUESDAY 24 SEPTEMBER 2019 AT 10.00 AM IN CONFERENCE ROOMS 2 AND 3, GROUND FLOOR, FIFE HOUSE, NORTH STREET, GLENROTHES, KY7 5LT

Present	Councillor Rosemary Liewald (Chair) NHS Fife, Non-Executive Members – Dr Les Bisset, Martin Black, Eugene Clarke and Margaret Wells, Helen Buchanan, Nurse Director, NHS Fife Dr Chris McKenna, Medical Director, NHS Fife Fife Council - Councillors David Alexander, Tim Brett**,** David Graham, Fiona Grant, David J Ross, Tony Miklinski and Jan Wincott Ian Dall, Chair of Public Engagement Network
Professional Advisers	Nicky Connor, Interim Director of Health and Social Care/Chief Officer Audrey Valente, Chief Finance Officer Lynn Barker, Interim Associate Nurse Director
Attending	Claire Dobson, Divisional General Manager (West) Julie Paterson, Divisional General Manager (Fife Wide) Fiona McKay, Head of Strategic Planning, Performance & Commissioning Norma Aitken, Head of Corporate Services Wendy Anderson (Minute)

NO	HEADING	ACTION

1 CHAIR'S WELCOME AND OPENING REMARKS

The Chair welcomed everyone to the Health & Social Care Partnership (H&SCP) Integration Joint Board (the Partnership Board).

The Chair advised members that a recording pen was in use at the meeting to assist with Minute taking.

2 DECLARATION OF MEMBERS' INTERESTS

Nil.

3 APOLOGIES FOR ABSENCE

Apologies had been received from Christina Cooper, Wilma Brown, Morna Fleming, Helen Hellewell, Scott Garden, Katherine Paramore, Simon Fevre Paul Dundas, Paul Hawkins, Dona Milne, David Graham and David Heaney.

4 4.1 2018/19 Annual Audit Report

Audrey Valente presented this report which consisted of three elements – Annual Accounts 2018/19, External Annual Audit Report and the Independent Audit Report (last two for information only).

NO	HEADING	ACTION
4	**4.1 2018/19 Annual Audit Report (Cont)**	

Audrey advised that two small changes were being made to the Annual Accounts, on Page 19 remove the word voting in relation to the Nursing Director and Associate Medical Director. Page 20 replace the word elected with appointed, in relation to Fife Council Internal Audit Team.

Eugene Clarke confirmed that this report had been scrutinised by the Audit & Risk Committee on 20 September 2019 and no issues had been raised.

Tony Miklinski raised questions about eligibility criteria and selection process which are used to allocate adult care packages, Julie Paterson will share information on the criteria which have been published It was also agreed to have an item at a future Development Session on Adult Care Packages. **JP**

Discussion and questions took place around the content of the three reports including value for money, transformation proposals and ongoing actions from previous report. Nicky Connor confirmed that transformation proposals are under consideration by officers. It was agreed that a clear plan and timescales for these actions will be taken to the Finance & Performance Committee on 7 November 2019. **AV**

Tim Brett asked if the issues relating to the set aside budget raised in the Ministerial Steering Group Action Plan would be part of the Development Session. Nicky Connor confirmed that this was the case.

Martin Black reiterated that he was still concerned that the previous actions had not been concluded. An action plan will be drawn up and taken to the Audit & Risk Committee on 15 November 2019. **NA**

The Board approved the Annual Accounts for signature.

4.2 Finance Report as at 30 June 2019

Audrey Valente presented this report which gave the financial position as at 30 June 2019. Audrey outlined several of the main areas of overspend and additional funding which is still to be allocated as well as updating on savings for this financial year. This will be updated at a future Board meeting.

Discussion took place around financial pressures, spending of allocated funds, achievement of savings and the introduction of Total Mobile to external care at home providers.

NO	HEADING	ACTION

4.2 Finance Report as at 30 June 2019 (Cont)

Eugene Clarke asked about the grip and control / financial monitoring measures which were to be introduced. Audrey advised that Financial Efficiency meetings take place on a weekly basis and are being reviewed to include Service Change Plans. Audrey will get information on the £7.7m overspend and recurrent additional funding and will circulate to Board members. **AV**

Advised that packages we do not support are referred to voluntary and third sector partners or can involve Self Directed Support. It was agreed to bring this to a future Development Session to allow Board members a greater understanding of these issues. **NC/JP**

Audrey will bring a Financial Recovery Report to the Finance & Performance Committee on 7 November 2019, verbally update the Development Session on 11 November 2019 and then bring the report to the IJB meeting on 6 December 2019. **AV**

The Board:-

- Noted the financial position as reported at 30 June 2019.
- Noted and discussed the next steps and key actions.

4.3 Savings Tracker

Audrey Valente presented this new report and advised she was happy to take onboard comments about the format and content. Questions were asked about several sections of the report. Nicky Connor advised that she is working with Ellen Ryabov, Chief Operating Officer at NHS Fife to set up meetings to support joint working.

The Board considered the information, discussed and agreed the next steps.

4.4 Internal Audit Annual Assurance Statement

Audrey Valente presented this report which was written by Avril Cunningham, Chief Internal Auditor at Fife Council and was for noting and information. Discussion took place around corporate governance and internal controls within the IJB. The Board noted the report.

5 AOCB

Nothing raised.

NO	HEADING	ACTION

6 DATES OF FUTURE MEETINGS

INTEGRATION JOINT BOARD – Friday 25 October 2019 at 10.00 am in Conference Rooms 2 and 3, Ground Floor, Fife House, North Street, Glenrothes, Fife, KY7 5LT.

IJB DEVELOPMENT SESSION – Wednesday 13 November 2019 at 10.00 am in Conference Rooms 2 and 3, Ground Floor, Fife House, North Street, Glenrothes, Fife, KY7 5LT.

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	Infection Control Committee
Date of Group/Sub-committee Meeting:	2.10.2019
Release: draft/final minutes	Draft
Author/Accountable Person:	Helen Buchanan Margaret Selbie

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?

1. SAB: continues to be a problem with PWID
2. C-Section SSI, Q2 2019 saw a significant reduction in SSI rate (from 6.5% to 2%)
3. *Clostridioides difficile* (CDI) in par with last year's rate which continues to be at a low level for NHS Fife
4. National Guidance
5. Systems Control Risk Built Environment (SCRIBE) remains on the risk register
6. MERS_COv table top exercise
7. Safe and Clean Audit roll out
8. IP&C Study Day `Back to the Future'

What are the concerns/issues/risks you want to bring to the attention of the committee?

1. NHS Fife continue to work towards reducing the SAB, IPC are working closely with addictions services to prevent infections and early detection to reduce the amount of SABs in people who inject drugs (PWID). Working Group set up to will produce driver diagram highlighting actions and prevention. Ward 44 continues with their QI programme to reduce their SAB incidents.
2. IP&C team are working closely with Maternity. There is a new surveillance methodology being rolled out from the 1st October
3. CDI staff across Fife to continue the good work that is being performed across Fife regarding Anti Microbial Stewardship, disinfection cleaning and completion of CDI bundles. Continued enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
4. Respiratory Protection Equipment (RPE) for High Consequence Infectious Disease – Event 27th September was attended by Senior Nurse JCook, further meetings to be arranged with the IP&C team and Health and Safety
5. HAI-SCRIBE which is intended mainly for new builds, refurbishments and reconfiguration of healthcare facilities requires contributions from various disciplines. A meeting with Head of Estates and estates managers have been arranged, education has been delivered to estates staff emphasising the need for the process which was well attended.
6. This table top exercise was a combined Public Health and Infection Prevention exercise, which was well attended by numerous disciplines and felt to have been a great success.

7. Safe and clean roll out programme is complete and many wards now completing their monthly audits.
8. IP&C Study Session 13th September was a great success, numerous disciplines attending and excellent feedback.

(UNCONFIRMED) MINUTE OF NHS FIFE INFECTION CONTROL COMMITTEE
2ND OCTOBER 2019 AT 2PM
WITHIN TRAINING ROOM 2, DINING ROOM, VHK

Present	
Helen Buchanan	Director of Nursing NHS Fife (Chair)
Julia Cook	Senior Infection Prevention and Control Nurse
Margaret Selbie	Acting Lead Infection Prevention and Control Nurse
Suzanne Watson	Infection Control Surveillance Nurse
Andy Fairgrieve	Director Estates & Facilities
Lynn Burnett	Health Protection Nurse Specialist
Helen Shaw	Public Health Registrar
Norma Beveridge	Head of Nursing (deputising for Lynn Campbell)
Cathy Gilvear	HSCP Quality, Clinical and Care Governance Lead
Keith Morris	Consultant Microbiologist, Infection Control Doctor Associate
Aileen Lawrie	Head of Midwifery/Nursing, Women & Children
Apologies	
Lynn Barker	Associate Director of Nursing, HSCP
Lynn Campbell	Associate Director of Nursing, Acute
Pauline Cumming	Risk Manager
Hilda Johnston	Public Representative
Priya Venkatesh	Consultant Microbiologist
Fiona Bellamy	Health Protection Nurse
In Attendance	
Lori Clark	Minute Taker

1	**APOLOGIES** HB welcomed the committee and started introductions around the table. Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – 7th August 2019** Keith Morris would like the following amendment noted. Original in minute 3: 4.4 National Guidance: Neo-natal screening programme Sits with clinical teams to agree whether taking part in this project. KM highlighted this is not mandatory, does not attract funding and not a problem in Fife. If surveillance picks this up we can review but there are systems in place and content mitigating risk at present. In other Boards it has been a maternity decision With Correction 3: 4.4 National Guidance: Neo-natal screening programme This project sits with clinical teams to agree whether to take part in the project. KM highlighted this is not mandatory, does not attract funding and the laboratory monitors the neonatal unit does for "alert" pathogens. The neonatal unit does not have an issue with MRSA or CPO cases or cross transmission. If monitoring of laboratory reports identifies an increase in MRSA or CPO cases the decision to clinical risk assess (CRA) and screen can be reviewed but there are systems in place and content mitigating risk at present. In other Boards it has been a maternity decision The remainder of the document agreed to be an accurate minute.	
3	**ACTION LIST (7th August 2019)**	
	3 (4.4) - National Guidance: Neo-natal screening programme HB to speak with AL regarding this.	H

	Action to be carried forward	Buchanan
	3 (4.8) – Infection Prevention & Control Audit Programme: HB to speak with NC **Action to be carried forward**	H Buchanan
	3 (7.1) – Waste Management Posters for changes have been rolled out and the information has been cascaded. Possibility of having a dedicated Waste Manager being looked at. **Action Complete**	
	4.1d – ECB Surveillance Report The 3 urinary catheter groups have been amalgamated into 2 groups and these are working well. **Action Complete**	
	4.1e – HAI Update HB has fed back to the Clinical Governance Group. There is an improvement plan in place which HB is to send to the committee for viewing. **Action Complete**	H Buchanan
	4.2 – NHSS national Cleaning Services Specification JR contacted contractor and procedures are fine **Action Complete**	
	4.3 – Risk Register Group agreed this action should be closed as the risk register is a standing item on the agenda so will be checked regularly and actions taken when required. **Action Complete**	
	5.3 – ICC Terms of Reference Document Document in agenda for review and approval. **Action Complete**	
	7.2 – Elective Orthopaedic Centre As resource from the IPCT has been asked for, when the business case is put out it should have a section in it for the cost of the time of the IPCT. If a dedicated person was to go to the team the cost would need covered. HB can take any issues brought up in this committee to the board. **Action Complete**	
4	**STANDING ITEMS**	
4.1	4.1a <u>HAIRT Board Report</u> JC gave an overview of the HAIRT Board report within agenda. Achievements: The IPCT held a great study day which received some very positive feedback. The day focused on going back to basics and having good	

	cleaning and hygiene to prevent infection. IPCT also supported HPS MERS-CoV Tabletop exercise which was a successful event. Challenges: C-Section exception report, team are working closely with Maternity. There is a new methodology being rolled out on 1st Oct. SABs: Increased incidence rate in PWID however IPC are working with additions to catch the problems earlier in the community and lower the rate. ECBs: Community numbers are below average, however healthcare numbers are above average. CDI: Rate on par with last year this time. Large Bowel: IPC Surveillance Nurse working closely with theatres to improve surveillance form returns. Visits are being made before theatre starts to inform and remind about the form and the importance of returning it. Theatre Manger is supporting the push on form returns. Group discussed if HAIRT report was needed at Clinical Governance when the data is in the quality report in a different format. Group suggested HAIRT should be publicly available. Members **noted** the report.	
	4.1b HAI LDP Update – SABs Reports Data is complete to the end of August. The end of August numbers are lower than the previous 2 years however there are still a lot of vascular access device related SABs. • 6 PVC related SABs • 5 Urinary Catheter related SABs • 1 Dialysis line There are an extra 6 for this month but this is still relatively low compared to previous years. NB aired an observation she has made to the group, this being that she has noticed a link between haematology and dermatological conditions with CVC/hicman line infections – Labs are aware NHS Fife are below the National Comparator for Q2. Members **noted** the update.	
	4.1c HAI LDP Update – CDIs Reports Numbers are roughly the same at this point as last year. There has been one CDI death which has DATIXed. Patient presented in the community with loose stools and was not checked for CDI. A SAER has been requested. There has been a number of episodes relating to 1 chronic CDI case this year. Members **noted** the update.	
	4.1d ECB Surveillance Report	

	Numbers are running slightly lower than last year. Community numbers are below average, however healthcare are above average. There are still too many urinary catheter related infections however the urinary catheter group continue to work to find ways to reduce the numbers. Morse is being used in the community to track catheters and Patient Trak is being used in Acute. Members **noted** the update.	
	4.1e HAI Update – C Section SSI Reports Q2 4 SSI's - 2% incidence rate which is down for Q1 There is a new surveillance form for diagnosing clinicians being rolled out from 1st Oct and to be reviewed monthly to quality assure. The new form has all HPS diagnosing SSI criteria. Lynsey Delaney has been carrying out training and education to support on the new process. Members **noted** the update.	
	4.1f HAI Update – Orthopaedic SSI Reports Q2 1 SSI – Emergency Hip Replacement, incidence rate 0.8%. The Scottish incidence rate is 0.4%. Members **noted** the update.	
	4.1g Colorectal SSI Surveillance Report Q2 10 SSI's out of 99 operations – incidence rate of 10%. 7 of the 99 operations performed with dirty wound classes which are excluded in National reporting so incidence rate is 11% Members **noted** the update.	
	4.1h CPE Surveillance Q2 continued to improve 83% compliance up from 64% May improve further when EiC tool is launched. Members **noted** the update.	
	4.1i Outbreaks, Incidents and Triggers QMH ward 6, 1 bay closed for 2 days, the 2 patients presented with loose stools, both CDI positive, bay reopened once both patients were isolated. IPCT were contacted as soon as loose stools started, delay in isolating 1 patient. Ward 34 VHK has 2 cases of VRE colonisation, essentially indistinguishable, suggestive of cross transmission. Members **noted** the update.	
4.2	NHSS National Cleaning Services Specification For **noting** only - Members **noted** the update.	
4.3	Risk Register	

	Risk 637 – SAB Heat Target – HB advised this should stay on register and the score will stay the same. Group Agreed Risk 1558 – Estates Services & HAI Repairs – AF reviewed the risk and it remains the same Risk 1117 – Patient Equipment Refurbishment / Decontamination issues – HB to ask Claire Dobson to review risk and look into ICAS Risk 1299 – Bed frames and bed rails – Risk is too lengthy and needs to be reduced. MS updated group that Domestics and nursing staff will have new schedules for cleaning which so exactly what they are required to do. NB to look into this risk. Risk 1427 – Dermatology VHK Risk of Infection to Patients and Staff – Work not started yet as it is out for tender. The risk will reduce when the work is complete. Risk 1443 – Clinitex Detergent Wipes – This can be removed from register and risk has been removed. HB to update register Risk 552 – Non Compliant Wash Hand Basins – Risk to stay on register as is. Risk 646 – CDI Local Delivery Standard Target. JC advised group there is no LDP standard. JC to look at risk and if not required can be removed. Risk 1457 - Changes to occupational health clearance arrangements for Doctors in Training under lead employer model from August 2018 – LB has staff lists and has found that most need vaccinated so will let OSHAS know its everyone instead of the select names originally thought. Thought is to start vaccinations after the flu vaccinations. Also Doctors in training are all employed by Lothian. LB to assess if this should be a separate risk. Risk 1472 – Immunoglobulin Supply Crisis – This risk is ongoing and will be reviewed after Brexit. Members **noted** the update	H Buchanan N Beveridge H Buchanan J Cook L Burnett
4.4	National Guidance RPE for High Consequence Infectious Disease – Event 27th September Review of PPE, HPS to do SBAR. JC meeting with Craig Webster Health and Safety, 3rd week in October to discuss. FFP3 masks will be included in this. JC to bring back to group if any actions are required. The clinical risk assessment for use in neonatal settings has now been finalised after being piloted by NHS Boards. HPS are currently working towards delivery of comprehensive evidence based guidance which will form Chapter 4 of the National Infection Prevention and Control Manual on the built environment and decontamination. Norovirus season preparation – only 1 month to go. A reminder of guidance and information has been sent out in the HPS HAI Digest. Members **noted** the update	J Cook

4.5	HEI Inspections Healthcare Improvement Scotland are changing the way audits are carried out focusing more on patient experience and workforce tools. A letter has been sent out with a list of contacts on it for any queries. The new tool should be released soon. Members **noted** the update.	
4.6	NHS Fife Fife-Wide Inspection Co-ordinating Group – Update No update, nothing to highlight.	
4.7	Quality Improvement Programmes For information only: UCIG – great work from this group which is ongoing. PWID – Working closely with addictions to try catch infections earlier before hospital admissions. Working with the idea of having wound cards, training staff in the community what to look out for and how to take wound swabs, therefore catching any issues to prevent infections. LB to link up with Janice Barnes to discuss cross over between works and share information. PVC associated SAB W44 – IPCT and Clinical Effectiveness supporting QI programme in V44. Ongoing work with hand hygiene, PVC auditing, observations of care, real time feedback etc. Ward V44 to be congratulated as they have achieved first aim of over 30 days without a PVC associated SAB and last week achieved 100% compliance with removal of PVC before 72 hours. NB will feedback to V44. Members **noted** the update.	L Burnett
4.8	Infection Prevention & Control Audit Programme On target, will review 6 monthly Audit – HEI aide memoire for all wards (IPCT currently developing and trialling an outpatient tool). The aim is to audit 3 acute and 3 community areas per month.	
4.9	Infection Control Manual Update Ongoing work, updating yearly.	
4.10	Staff Education Update The winter training programme is now complete. Findings were that some areas are struggling to release staff to attend the sessions so there may be a few more additional short sessions at ward level. There are currently facilitating sessions for domestic/facilities satff. Estates training arranged for SIPCs and HAI-SCRIBE. IPCT facilitating 4 days at Dundee University with the nursing students. Opportunities have been given for pre registration students to shadow IPCT. The 1st Education planning meeting for 20202 has been successful with some good ideas for the year to come. NB asked about a “1 Stop Toolkit” for education. JC advised that there is a matrix being created so that it shows in one place what training is available and where. JC to look into the status of this matrix and have it ready for the next ICC meeting to share.	J Cook

4.11	Prevention and Control of Infection Work Programme 2019-2020 (for noting) For **noting** only - Members **noted** the update.	
5.	**NEW BUSINESS**	
5.1	Excellence in Care JC and Marie Paterson have met with Janette Owens to discuss. 18th – Friday Slide at VHK Safety Huddle to raise awarness 22nd Oct – Attending Leading Better Care training to present new tool, also have speaker from IPC team attending (Winter preparedness). IPCT shall provide short sharp sessions at ward level to support staff that shall be utilising the CRA. JC, Catherine McCullough and Marie Paterson met with Arlene saunderson to discuss a separate 1 page document/sticker for pre-assessment. Members **noted** the update	
5.3	ICC Terms of Reference (annual review) HB asked group to comment on the Terms of Reference. Only change is there is no consultant nurse so this must be taken out of the document and an interim arrangement to be put in place. Group **approved** document except for above change.	J Cook
5.4	Safe and Clean Audit The audit went live on all sites in September. There has been some confusion when to start using this audit so an update has gone into dispatches to let everyone know to start using the tool now. An email also went out to all the HoN to raise awareness that wards/departments can start auditing. Staff have also been advised that Ken Marshall can provide IT support for this and the IPC team can offer support on their weekly visits. Additional training has been organised for QMH, VHK and Stratheden for week commencing 7th Oct. Members **noted** the update	
5.5	HAI Education, Training and Development Strategy JC will have document ready to present at next ICC	J Cook
5.6	IPC Implementation Framework For **noting** only	
5.7	IPC Annual Report For **noting** only	
5.8	Winter Planning HB asked the committee to read through this document as an action to all.	ALL
6	**NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS**	
6.1	Infection Prevention & Control Team Nothing to highlight - Members **noted** the notes of the meeting	
6.2	NHS Fife Decontamination Steering Group Nothing to highlight - Members **noted** the notes of the meeting.	

6.3	NHS Fife Antimicrobial Management Team Nothing to highlight - Members **noted** the notes of the meeting.	
6.4	NHS Fife Water Safety Management Group Paul Bishop is now lead on this, nothing else to highlight Members **noted** the notes of the Meeting.	
6.5	NHS Fife HAI Education and Training Group Nothing to highlight. Members **noted** the notes of the meeting.	
6.6	NHS Fife CJD Sub Group Nothing to highlight- Members **noted** the notes of the meeting.	
6.7	Quality Reports HB advised that these reports have been well scrutinised at other platforms.	
7	**ANY OTHER BUSINESS** Letter to Chief Executives – For information Cleaning Sanitary Fittings – Guidance is that all fittings are to be cleaned with TitanChlor Plus (hypochlorite solution 1,000ppm av cl.). However some staff are having severe reactions to the solution. Following discussions it was decided that non-patient areas will go back to cleaning as before with titan sanitiser and any staff having reactions in patient areas can be relocated. Keith Morris made the group aware that the microbiologists and ICPT would like to have more single rooms in the new orthopaedic centre. Members **noted** updates.	
7.1	**AOB** Care Home Discharges – Lynn Burnett updated on the topic of care home discharges and opened a discussion in the group asking if hospitalised patients can go back to their closed care homes. That the Health protection Team would have some from if a risk assessment to be carried out and precautions taken. LB raised depending on the care home, some areas may only be partially closed or only staff have been affected. Some in group agreed this would be a suitable process and suggested that during flu season the patient may not be any safer in a hospital environment than they would in the care home. MS objected and stated that HPS guidance is that patients shouldn't go back to care homes unless a terminal clean has been carried out, as this would expose vulnerable patients to vomiting and diarrhoea putting them at risk. Cases where a patient has been admitted to hospital from a closed home with flu, the patient can go back to the care home as they have had treatment/already been exposed. All comments on SBAR to be returned by Friday 11th of October.	ALL
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held on 4th December 2019 in Training Room 2, Dining Room, Victoria Hospital, Kirkcaldy.	

NHS Fife Clinical Governance Committee
Xxx 2019

Agenda item no

Title of Group/Sub-committee	NHS Fife Resilience Forum
Date of Group/Sub-committee Meeting:	19 September 2019
Release: draft/final minutes	
Author/Accountable Person:	Dona Milne, Director of Public Health

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
1. Review of major Incident Plan guidance from Scottish Government against NHS Fife plan. Agreed to continue with NHS Fife plan as working document until after Major Incident Plan workshop in November. 2. EU Exit risk register reviewed and updated. 3. Review process for Business Continuity Plans agreed.
What are the concerns/issues/risks you want to bring to the attention of the committee?
None at present.

MINUTES OF THE MEETING OF THE NHS FIFE RESILIENCE FORUM HELD ON 19 SEPTEMBER 2019 AT 1PM IN THE GARDEN ROOM, WARD 7, CAMERON HOSPITAL

Present:

Dona Milne (DM)	**Director of Public Health, NHS Fife (Chair)**
Donna Baillie (DB)	Resilience Team, Scottish Ambulance Service
Paul Bishop (PB)	Head of Estates, NHS Fife
George Brown (GB)	Emergency Planning Officer, NHS Fife
Wilma Brown (WB)	Employee Director, NHS Fife
Hazel Close (HC)	Public Health Pharmacist, NHS Fife
Lesly Donovan (LD)	General Manager eHealth & IM&T, NHS Fife
Kirsty Macgregor (KM)	Head of Communications, NHS Fife
Dr Chris McKenna (CMcK)	Medical Director, NHS Fife
Ian Orr (IO)	Business Continuity Manager, NHS Fife
Euan Reid (ERe)	Pharmacist, NHS Fife (for Scott Garden)
Ellen Ryabov (ER)	Chief Operating Officer, Acute Services, NHS Fife
Avril Sweeney (AS)	Manager - Risk Compliance, Health and Social Care Partnership

In Attendance:

Shona Lumsden (SL)	Personal Secretary, Dept of Public Health

ACTION

1. WELCOME & INTRODUCTIONS

DM welcomed everyone to the meeting. Round the table introductions followed.

2. APOLOGIES

Apologies were received from

3. MINUTES OF PREVIOUS MEETING HELD ON 30 APRIL 2019

Subject to a minor change to the list of apologies the minutes of the previous meeting were accepted as an accurate record.

4. MATTERS ARISING

- Call out Exercise

  IO/GB to liaise with LD to discuss system options **IO/GB/LD**

  It was agreed to hold a small call out test before our Major Incident Plan workshop in November.

- Business Continuity Plans

  It was agreed that all Business Continuity Plans be updated ahead of winter and a list maintained with a review date identified. It was agreed that all plans be updated annually at the end of September in future. A deadline for responses to be set and shared widely with all departments. **ALL** **IO**

ACTION

Scottish Government update their contacts list twice yearly. NHS Fife staff contact list also requires to be updated. It was recommended that HR send a reminder to staff asking them to ensure their details are up to date. **IO**

ACTION

It was noted there is a requirement in the Major Incident Plan to have a Corporate Business Continuity Plan. IO confirmed he will bring the first draft to the next meeting. **IO**

5. BREXIT

5.1 Brexit Assurance – current assessment of risks on register

It was noted that although risks have been updated it would appear that the review date remains unchanged. DM reminded everyone to update the review date once the risk has been updated. These should be updated one week prior to each Resilience Forum meeting **ALL**

5.2 EU Exit Scottish Planning & Assumption and operational readiness return

Self assessment return has been submitted. In terms of H&SC, reassurance has been given from external agencies that things are in place.

5.3 LRP EU Exit Planning

Reporting from LRPs to commence during October and will be coordinated through EDG. George Brown will lead this.

6. MAJOR INCIDENT PLAN

6.1 New Major Incident and Mass Casualties Plan from Scottish Government and actions needed SBAR

IO provided a brief update on the workshop held in June. It was noted that the Scottish Government plan was issued without wider consultation and that there are some concerns around this which are highlighted in the Appendix 1 of the SBAR. GB reported that the EPO (Emergency Planning Officers) group is looking to take these concerns forward. DM reported she will provide an update on this to the Chief Executive.

Scottish Ambulance Service (SAS) noted their concerns around private ambulance providers.

IO explained he will be attending Exercise 'Inhale' in October which will look at testing the casualty bureau.

DM recommended that our Major Incident Plan remain a working draft but it should go onto the NHS Fife Intranet now on this basis. The draft plan will be tested on 22 November with adjustments subsequently being made thereafter.

It was noted that Mike Healy from Scottish Government Health Resilience Scotland is planning a visit to Fife w/c 30 September. An invitation to be extended to him to attend our table top exercise. **IO/GB**

7. Primary Care Resilience

CMcK provided a brief update on the current situation in primary care. It was noted there will be a total of 5 GP practices under board control by January 2020. The main concerns are around workforce issues and rise in population numbers. DM agreed to liaise with Keith Winter, Fife Council to determine which planning considerations are taken into account when new build sites are submitted for approval.

AS advised she has spoken to Dr Helen Hellewell who will take concerns forward to the GP group for discussion. AS agreed to feedback any further discussions she has with Dr Hellewell.

A new governance structure is being developed for Primary Care. The Primary Care Resilience group is also being reinstated. The Primary Care Governance Board will oversee all activity around resilience. It was noted that it will be well into 2020 before this is established.

ACTION

8. Organisational Resilience Standards Action Plan SBAR

GB provided a brief update on the paper tabled for discussion. It was noted that named leads have been identified for each standard and the action plan updated. Named leads to respond by the end of the month with any changes. Responses to be sent directly to IO/GB. **ALL**

It was recommended and agreed that this document be updated every 6 months with the first update being available at the ahead of the next meeting in February.

9. Feedback from local and national meetings

National Resilience Forum

GB provided a report on the recent meeting held in August:

- National CBRN Recovery Group being set up – role and remit still to be established
- EU-Exit - Boards are receiving quite a number of FOI requests
- Radiation Monitoring Units – PHE giving a presentation at Glasgow Royal on the 24th October (13:00 – 16:00) – likely to be focussed on local authorities (who are responsible for identifying and setting up the RMUs). More information to follow.
- Brief discussion on the RPA (Risk Preparedness Assessment)
  - Rather than individual boards providing input to the process it would be better to provide a single response from the National Forum
  - Some concern at the lack of input from national agencies notably HPS
- NHS D & G – have concerns about unplanned events (mainly raves) in their area, mostly being attended by folk from outside the area so difficult to control. A number of full sized helium cylinders found at a number of locations after the events
- A short presentation from NHS Borders on their new business continuity system ("Cloud" based)
  - Allows users to produce and easily update BC plans based upon a standard template and these are then stored in the "cloud"
    - Used by SAS
    - They were not forthcoming about the cost of the system
    - Need more information to decide if of any use
- A further presentation given on Climate Change & Sustainability in NHSScotland – NSS in conjunction with the University of Manchester have developed a GIS mapping tool which includes all NHS sites and facilities and how they might be affected in various climate change scenarios. Currently being tested in NHS Highland but the tool should be available to all Boards later this year.

- ER reported on the Scottish Government Shortage Review group she attended recently where guidance was given around managing shortages in Primary Care and Secondary Care.

- Pharmacy Brexit PAG is due to meet on 1 October.

10. Report to Clinical Governance Committee and Brexit Assurance Group

- The Brexit Assurance Group (BAG) is due to meet on 25 September with monthly meetings planned thereafter.

ACTION

- We have considered risks for Brexit and the risk register will be updated by the end of this week.
- Major Incident workshop planned for 22 November 2019.

11. AOCB

GB reported on the exercise planned for Wednesday, 25 September which will involve the erection of the decontamination tent at A&E VHK. GB/IO to provide a briefing for KM as the exercise will be held at the same time as the Board meeting.

12. Date of future meetings

Friday, 1 November 2019 at 10am in MR1 CH
Friday, 13 December 2019 at 10am in MR1 CH
Wed, 15 January 2020 at 2pm in MR1 CH
Wed, 5 February 2020 at 10am in MR1 CH
Wed, 13 May 2020 at 10 am in MR1 CH
Wed, 19 August 2020 at 10am in MR1 CH
Wed, 18 November 2020 at 10am in MR1 CH