NHS Fife Clinical Governance Committee

Fri 30 April 2021, 09:30 - 12:00

Via MS Teams

Agenda

09:30 - 09:30
0 min

1. APOLOGIES FOR ABSENCE

Dr Cargill, Nicky Connor, Rona Laing, Carol Potter

09:30 - 09:30
0 min

2. DECLARATION OF MEMBERS' INTERESTS

09:30 - 09:30
0 min

3. MINUTES OF LAST MEETING HELD ON 11 MARCH 2021

(enclosed)

Item 3 - Unconfirmed Notes 11 March 2021 V2.pdf (8 pages)

3.1. Public Engagement & Consultation

(enclosed) *Janette Owens*

Item 3.1 - 20210430 CGC Participation Update.pdf (5 pages)

09:30 - 09:30
0 min

4. ACTION LIST

(enclosed)

Item 4 - Action List 30 April 2021.pdf (3 pages)

09:30 - 09:30
0 min

5. MATTERS ARISING

09:30 - 09:30
0 min

6. COVID19 - UPDATE

6.1. Covid-19 Vaccination Programme Update

(Verbal) *Scott Garden*

6.2. Expansion of Covid-19 Testing

(verbal) *Dona Milne*

09:30 - 09:30
0 min

7. REMOBILISATION OF CLINICAL SERVICES

7.1. No Paper

09:30 - 09:30
0 min

8. GOVERNANCE

8.1. Board Assurance Framework - Quality & Safety

(enclosed) *Chris McKenna/Janette Owens*

Item 8.1 - SBAR Quality & Safety BAF to NHS Fife Clinical Governance Committee on 300421 V 1.0.pdf (3 pages)
Item 8.1 - Appendix 1, NHS Fife Board Assurance Framework (BAF) Quality & Safety to NHS Fife CGC 300421 V1.0.pdf (2 pages)
Item 8.1 - Appendix 2, BAF Risks - Quality & Safety - Linked Operational Risks to NHS Fife CGC300421 V1.0.pdf (15 pages)

8.2. Board Assurance Framework - Strategic Planning

(enclosed) *Chris McKenna*

Item 8.2 - SBAR CGC BAF 5 300421.pdf (3 pages)
Item 8.2 - 5. NHS Fife Board Assurance Framework (BAF) v25.0 300421 - Strategic Planning.pdf (2 pages)

8.3. Board Assurance Framework - Digital & Information

(enclosed) *Chris McKenna*

Item 8.3 - BAF DI to Clinical Governance Committee V1.1.pdf (3 pages)
Item 8.3 - 7d. NHS Fife Board Assurance Framework (BAF) v12.0 220421 - Digital Information.pdf (3 pages)
Item 8.3 - Appendix 1 BAF - Digital Information 210422.pdf (2 pages)
Item 8.3 - Appendix 2 - Digital Information - Linked Operational Risks as at 210422.pdf (4 pages)
Item 8.3 - Appendix 2 - Digital Information - Linked Operational Risks as at 210422.pdf (4 pages)

8.4. Clinical Governance Self Assessment Report

(enclosed) *Gillian MacIntosh*

Item 8.4 - SBAR Committee Self-Assessment CG.pdf (11 pages)

8.5. Annual Assurance Statements/Reports from Sub Committees/Groups

(enclosed) *Gillian MacIntosh*

Item 8.5 - CGC Sub Groups Annual Reports & Assurance Statements.pdf (27 pages)

8.5.1. Draft Clinical & Care Governance Committee Assurance Statement

8.5.2. Draft Digital & Information Annual Report & Assurance Statement

8.5.3. Draft Health & Safety Sub-Committee Annual Report & Assurance Statement

8.5.4. Draft Information Governance & Security Annual Report & Assurance Statement

8.6. Draft Assurance Statement for the Clinical Governance Committee

(enclosed) *Gillian MacIntosh*

Item 8.6 - SBAR CGC Annual Report.pdf (3 pages)
Item 8.6 - DRAFT Clinical Gov Annual Assurance Statement 202021.pdf (18 pages)

8.7. Annual Workplan

(enclosed) *Gillian MacIntosh*

Item 8.7 - Clinical Governance Committee_Annual Workplan_2122_May 21.pdf (3 pages)

09:30 - 09:30
0 min

9. REQUESTED PAPERS

9.1. Guidance On Deceased Organ And Tissue Donation In Scotland: Authorisation Requirements For Donation And Pre-Death Procedures

(enclosed) *Janette Owens*

- Item 9.1 - Board Paper Organ Donation 04-21.pdf (3 pages)

9.2. Improvement of Healthcare & Forensic Medical Services for Adults, Children and Young People who have experienced Rape, Sexual Assault or Child Sexual Abuse

(enclosed) *Janette Owens*

- Item 9.2 - NHS Clinical Governance Committee.pdf (7 pages)
- Item 9.2 - Appendix 1.pdf (3 pages)
- Item 9.2 - Appendix 2.pdf (2 pages)
- Item 9.2 - Appendix 3.pdf (3 pages)
- Item 9.2 - Appendix 4.pdf (9 pages)
- Item 9.2 - NHS Clinical Governance Committee appendix.pdf (21 pages)

09:30 - 09:30
0 min

10. SAFETY, QUALITY & PERFORMANCE

10.1. Integrated Performance & Quality Report

(enclosed) *Chris McKenna*

- Item 10.1 - SBAR CG Committee.pdf (3 pages)
- Item 10.1 - 01 Apr 2021 IPQR.pdf (46 pages)

10.2. Winter Performance Report

(enclosed) *Janette Owens*

- Item 10.2 - SBAR CGC Winter Performance Report v1.0.pdf (4 pages)
- Item 10.2 - Winter Planning Performance Summary Mar 2021 v1.0.pdf (20 pages)

10.3. HAIRT Report

(enclosed) *Janette Owens*

- Item 10.3 - HAIRT Report April 2021.pdf (19 pages)

10.4. Healthcare Improvement Scotland – Unannounced Inspection Glenrothes Hospital Report

(enclosed) *Janette Owens*

- Item 10.4 - 20210430 CGC HIS Inspection Glenrothes Hospital.pdf (3 pages)
- Item 10.4 - HIS Improvement Action Plan Glenrothes Hospital 7-9 July 2020 - Master Draft @23.11.20 v0.6.pdf (13 pages)

10.5. Healthcare Improvement Scotland - Unannounced Inspection Adamson Hospital Report

(enclosed) *Janette Owens*

- Item 10.5 - 20210430 CGC HIS Inspection Adamson Hospital.pdf (3 pages)
- Item 10.5 - Working HIS Tar Action PLan March 2021 Update 0.3.pdf (13 pages)

09:30 - 09:30
0 min

11. STRATEGIC PLANNING & TRANSFORMATION

11.1. Corporate Objectives

(verbal) *Margo Mcgurk*

11.2. Strategy Development

(verbal) *Margo Mcgurk*

09:30 - 09:30
0 min

12. PUBLIC ENGAGEMENT & CONSULTATION

12.1. Planning & People SBAR

(verbal) *Janette Owens*

09:30 - 09:30
0 min

13. DIGITAL & INFORMATION

13.1. Information Governance & Security Group - Terms of Reference

(enclosed) *Chris McKenna*

Item 13.1 - Final Confirmed IGS Steering Group ToR V1.pdf (6 pages)

09:30 - 09:30
0 min

14. ANNUAL REPORTS

14.1. Medical Education Report

(enclosed) *Chris McKenna*

Item 14.1 - Med Ed Item 6 - SBAR Med Ed Report to CG.pdf (13 pages)

14.2. Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework

(enclosed) *Janette Owens*

Item 14.2 - 20210430 CGC PAF Survey November 2020.pdf (20 pages)

09:30 - 09:30
0 min

15. LINKED COMMITTEE MINUTES

15.1. Acute Services Division Clinical Governance Committee - 17/03/2021

(enclosed) *Robert Cargill*

Item 15.1 - NHSF CGC Board Template 190421.pdf (2 pages)
Item 15.1 - ASD CGC Minute - UNCONFIRMED 170321.pdf (24 pages)

15.2. Fife Drugs & Therapeutics Committee - 03/02/2021

(enclosed) *Chris McKenna*

Item 15.2 - FIFE DTC UNCONFIRMED MINUTES 3 February 2021.pdf (6 pages)

15.3. Fife HSCP Clinical and Care Governance Committee - 26/02/2021

(enclosed) *Nicky Connor*

Item 15.3 - CONFIRMED Minute C&CG 260221.pdf (8 pages)

15.4. NHS Fife Clinical Governance Oversight Group - 25/02/2021

(enclosed) *Chris McKenna*

Item 15.4 - Unconfirmed Meeting Note of NHS Fife Clinical Governance Oversight Group 25 02 2021.pdf (6 pages)

15.5. Research Governance Group - 25/03/2021

(enclosed) *Chris McKenna*

Item 15.5 - RGG Minutes.pdf (6 pages)

15.6. Health & Safety Sub Committee

(enclosed)

Item 15.6 - 2021-03-12 Draft minutes Mar meeting.pdf (4 pages)

15.7. Integration Joint Board (IJB) - 19/02/2021

(enclosed) *Nicky Connor*

Item 15.7 - Final Minute of IJB Meeting 190221.pdf (6 pages)

15.8. Digital & Information Board - 16/02/2021

(enclosed) *Chris McKenna*

Item 15.8 - D&I Board Minutes 160221.pdf (7 pages)

15.9. Infection Control Committee - 03/02/2021

(enclosed) *Janette Owens*

Item 15.9 - ICCNotes 03 02 2021.pdf (7 pages)

15.10. Public Health Assurance Group - 25/02/2021

(enclosed) *Dona Milne*

Item 15.10 - PHAC Minutes 250221 DM EC.pdf (7 pages)

09:30 - 09:30
0 min

16. ITEMS FOR NOTING

09:30 - 09:30
0 min

17. ISSUES TO BE ESCALATED

09:30 - 09:30
0 min

18. ANY OTHER BUSINESS

09:30 - 09:30
0 min

19. DATE OF NEXT MEETING: Wednesday 7 July 2021 at 2pm

09:30 - 09:30
0 min

20. PRIVATE SESSION

20.1. Remobilisation Plan 2021/22 Update

(enclosed) *Margo Mcgurk*

Fife NHS Board

UNCONFIRMED

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON 11 MARCH 2021 VIA MS TEAMS

Present:

Dr Les Bisset, Chair
Rona Laing, Non-Executive Member
Aileen Lawrie, ACF Representative
Dona Milne, Director of Public Health
Janette Owens, Nurse Director
Martin Black, Non-Executive Member
Margaret Wells, Non-Executive Member
Chris McKenna, Medical Director
Carol Potter, Chief Executive
John Stobbs, Patient Representative

In Attendance:

Dr Rob Cargill, AMD ASD
Gemma Couser, Interim Head of Quality & Clinical Governance
Linda Douglas, Director of Workforce
Gillian MacIntosh, Board Secretary
Elizabeth Muir, Clinical Effectiveness Co-ordinator
Catriona Dziech, Note Taker
Nicky Connor, Director of Health & Social Care
Claire Dobson, Director of Acute Services
Scott Garden, Director of Pharmacy & Medicines
John Morrice, AMD, Women & Children Services
Margo McGurk, Director of Finance
Dr Gaener Rodger, Non-Executive Director & Chair of NHS Highland Clinical Governance Committee

Dr Bisset opened the meeting by welcoming Janette Owens in her new role as Director of Nursing; Aileen Lawrie, Associate Director of Midwifery, in her new role as ACF Representative; Gemma Couser in her new role as Interim Head of Quality & Clinical Governance; Dr John Morrice in his new role as Associate Medical Director for Women & Children's Services; Linda Douglas, Director of Workforce, attending as part of her professional development; and Dr Gaener Rodger, Non-Executive Director & Chair of NHS Highland Clinical Governance Committee, who was attending the meeting as an observer.

Dr Bisset advised that, due to the pressures of Covid, the agenda has been shortened and contains items of high importance or require decision by the Committee. Dr Bisset advised that he was confident the governance requirements remain robust and any other items missed from this meeting will be brought forward to future meetings.

On behalf of the Committee Dr Bisset recorded warm thanks to all staff for their ongoing resilience in response to the pandemic and the pressures that this bring upon them. It is a very difficult time for them, whether they are working in their own role or in in other roles unfamiliar to them.

1. Apologies for Absence

Apologies were noted from members Sinead Braiden, Wilma Brown and David Graham and regular attendees Lynn Campbell, Susan Fraser and Helen Hellewell.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the Meeting held on 10 January 2021

The note of the meeting held on 10 January 2021 was formally approved.

4. Action List / Matters Arising

All outstanding actions were discussed and will be updated on the separate rolling Action List.

Margaret Wells queried why there was no specific lead for Fife in Terms of Child Protection (Page 12, para 4 of minutes) and asked if this was something that would be covered in the Child Protection Annual Report. Dr McKenna advised that the current lead was off on bereavement leave and interim arrangements had been made to cover this. Dr Morrice confirmed this situation was ongoing and, in the meantime, contingencies were being made and Lothian had been helpful in covering. Two new consultants were due to start in the next month or two that may help to mitigate any risk in regard to the Child Protection Lead. There is also a very experienced Specialty Doctor taking up some of the work being undertaken by the Clinical Lead. Dr Morrice advised he felt there was no significant risk that required any further action at the moment. The Committee noted the update.

5 COVID-19 UPDATE

5.1 Covid-19 Vaccination Programme Update

Scott Garden advised that, at close of play on 10 March 2021, 135,000 doses of Covid-19 vaccine have been administered to Fife citizens. 3,500 of these are second doses from the second dose programme, which started at the beginning of March.

The availability of vaccine is a limiting step to the pace of the programme. There has been a slowing down in supply for both AstraZeneca and Pfizer vaccines. There has been direction from Government around the Pfizer vaccine that, from week of 22 February 2021, stocks had to be reserved for second doses and for 16-17-year olds, for which AstraZeneca is not licenced for. This has been planned for and is working well. There has been an increase in the supply of the AstraZeneca vaccine, and this will allow the number of doses to be increased to 24,000 (on average) appointments a week, based on the overall vaccine supplies. This will allow us to complete cohorts 1 – 9 by mid-April, in line with Government direction and targets.

Looking forward, confirmation has been received from JCVI that interim advice has been published and accepted in Scotland. A CMO letter has supported this. The programme will continue with the rest of the population within the 18 – 49 years cohort and plans are in place to support this. Three larger venues have been

secured that will increase a throughput of patients and allow consolidation of the resources workforce as we move through the programme. The thirteen community venues will continue to operate meantime and people who have received their first dose within one of these venues will get their second dose in the same clinic. Our EQIA has been updated to support these changes.

A series of subgroups has been set up to manage some of the nuances of the programme. This has involved a lot of thinking about how this fits with the current governance structure, as set out in detail within the paper. The functions of planning and delivery have also been considered. This mirrors some the changes within the national Seasonal Flu / Covid vaccine programme and will be played into the external review currently being undertaken by Carol Bebbington. This should be available towards the end of the April 2021, which will allow us to put a more medium to longer term infrastructure for immunisation in Fife. Risks continue to be reviewed and considered on a weekly basis. Links continue with Military colleagues around planning.

Dr Bisset thanked Scott Garden for his comprehensive report. In taking comments it was noted there was no dedicated reserve list for spare vaccines, but mechanisms are in place to pull in people through the leadership structure we have.

The Committee noted the paper and took assurance from the progress noted. Dr Bisset said he felt Scott Garden was underplaying the challenges being faced, which were considerable. The fact the programme is running smoothly is a team effort but special thanks should be recorded to Scott Garden and Ben Hannan for their leadership.

5.2 Expansion of Covid-19 Testing

Dona Milne advised that this report provides an update to the Committee on proposed and existing testing policy and activity within Fife. It provides an additional summary of proposals to augment testing carried out across Fife and summarises the main areas of risk and mitigation actions in place.

Dona Milne highlighted that one of the main developments since the paper was the opening of the Regional Drive through testing facility at Bankhead. The asymptomatic testing centres at the Maxwell Centre, Cowdenbeath, Glebe Centre and Chapel Level in Kirkcaldy are providing excellent services to support people with isolation. This includes giving food supplies to people to prevent them going shopping. Further centres will open at Savoy in Methil and Kincardine. Centres will pop up and down as required, based on prevalence of disease.

In relation to asymptomatic testing, there have been 1,417 lateral flow devices and 153 PCR tests completed between 11 February – 8 March 2021. 33 cases have been identified and we have also provided support to people to isolate. It is still very early days and this was in response to a proposal from SGHD where new ways of testing were to be identified. The information from the models of delivery have been gathered and the SGHD have now confirmed they will continue funding for a further six months with a bigger pot of money available to us. A paper will be taken to EDG with a proposal for the next six months. The model is constantly reviewed to ensure

it is as successful as possible. There have also been engagement events with community leaders in different areas to encourage and promote testing in the local facilities.

Dr Bisset thanked Dona Milne for her detailed report, which shows the complexity around this piece of work, and asked that thanks be passed to her and her team for their dedication and perseverance to getting this right.

The Committee noted the contents of the paper and the new developments as part of the ongoing expansion of Covid-19 testing programmes.

6 REMOBILISATION OF CLINICAL SERVICES

6.1 Update on Remobilisation Plan

Dr McKenna highlighted that the Remobilisation Plan document will be discussed in detail at the Private Session of the Committee. This sets out strategic detail on how we intend to recover NHS Fife services over the next year.

We are currently in a more positive situation, with activity in the Acute Hospital in relation to Covid reducing. Within the last two weeks the numbers presenting with a Covid illness requiring hospital admission has fallen dramatically. This has resulted in shrinking back the areas of the hospital dedicated to looking after patients with Covid, to a smaller area, like the levels last summer.

In the last three weeks parts of the routine elective programme has been restarted. This includes major orthopaedic surgery and remobilising routine surgery at QMH. It also means the green pathways have been reinstituted across the Acute hospital to deliver services. The process has also restarted for outpatient cases.

Dr McKenna advised the Committee that during the whole of the pandemic we have been able to deliver cancer urgent surgery on all but a few occasions.

Dr Bisset thanked Dr McKenna for his verbal update.

6.2 Redesign of Urgent Care – Flow and Navigation Update

Dr McKenna noted that this paper sets out the work to date, undertaken by key stakeholders, to design and delivery the Flow Navigation Hub (FNH), thus meeting the requirements set out by the Scottish Government for the launch of the programme on the 1 December 2020, including development, initial implementation and ongoing delivery.

The strategic vision for the programme is to support the public to access the right care, at the right place, at the right time, first time. This is being assisted by a National Single Point of Access (SPoA) through NHS24/111, available 24/7 for urgent care and applying a digital first approach.

The Committee noted:

- the proactive approach to effective communication internally and externally to support launch of the programme, with a commitment to ongoing public engagement;
- the content of the report and the significant input clinically, operationally and digitally to design and deliver a Fife flow and navigation hub as part of the wider redesign of urgent care; and
- the ongoing commitment of all teams involved to support the ongoing implementation plan in line with national and local strategic direction to continue to provide safe and effective person-centred care with the right person, right place, right time, first time.

In taking comments it was noted that the Unscheduled Care pathway is broader than just A&E and it was noted that support would need to be in place for people to be navigated timeously. There would be the need to gather evidence to show the workstreams provide the required levels of care and support patient satisfaction, as well as meet overall service needs. A clear analysis of data would be important going forward and development of the EQIA should continue to ensure the patient voice is heard. It was noted the initial phase had shown this was the right direction of travel but it requires time to bed in.

Margo McGurk advised that this is a major change in terms of pathways for patients, which every Board in Scotland has had to respond to very quickly. One of the key pieces of work taking place at the moment is a formal evaluation of how this first phase has gone. This includes the effectiveness of the patient pathway, experience and all the aspects you would expect to see in a new service evaluation. The SGHD have indicated we will not progress to next phase - which would be extending the types of connection through this new service - until we know how first phase has gone. SGHD are holding off on allocating the resource until 2021/22 until the evaluation has been considered.

Janette Owens agreed to check with Donna Hughes for any feedback garnered from Public Engagement.

Action: JO

Dr McKenna clarified that the “exemplar” word is used around the collaborative working across different systems within NHS Fife. It describes the exemplar work across the H&SCP and Acute Services as a way of collaborative working with the clinical oversight. We are not describing an exemplar service; we are describing as exemplar the way that we have put together the piece of work and the design of the workstream.

Carol Potter personally acknowledged and commended the teams involved in this piece of work. Not only were these staff working at the frontline during a pandemic, but they have also redesigned and transformed a service through a project directed, and supported, by SGHD.

Dr Bisset agreed this was a huge piece of work, with major changes in delivery. The report and its content were noted and the working together with front line staff in order to deliver it as effectively and efficiently as possible was commended. It was agreed an updated report be brought to the next meeting setting out further evidence

and data as it is gathered around communicating with the public. The national evaluation, highlighted by Margo McGurk, would also be considered at the next meeting.

Action: CMcK / MMcG

7 GOVERNANCE

7.1 Review of Committee Terms of Reference

Gillian MacIntosh advised that the updated draft of the Committee's Terms of Reference was presented for consideration, with suggested changes tracked for ease. Proposed amendments largely relate to clarifying routine attendees at the Committee and reflecting the new terminology now in use for Digital and Information.

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

The Committee approved the proposed changes and approved a final version for further consideration by the Board.

Dr Bisset thanked Gillian MacIntosh for her work on this.

8 QUALITY, PLANNING AND PERFORMANCE

8.1 Integrated Performance & Quality Report

Janette Owens highlighted that it was hoped to bring complaints performance up to 65%, but the second wave of the pandemic has resulted in this not being achieved. Janette Owens will be meeting with the complaints team to look as setting new targets for the complaints process.

SABs – MRSA blood stream infections have been eliminated in 2020. This is the lowest blood stream infections on record, along with the lowest number of vascular associated device infections.

ECB – work continues looking at data to optimise communication with the clinical teams, looking at urinary tract infections and catheter associated infections. The ECB Strategy Group is looking at improvement work around hydration and the prevention of UTIs within the elderly population within the community.

CDiff – doing well within the targets. To reduce recurrence of CDI infection, two treatments are utilised in Fife.

Dr McKenna highlighted that monitoring in-patient falls with harm have increased. This is in part due to the change in layout of the Acute hospital, where we have had to cohort patients by their Covid infection status rather than what their needs are. This means patients who would routinely be looked after on Care of the Elderly

wards are treated on a Covid ward, which is reflected in these increases in the number of falls with harm.

SABs – closely monitoring increases in SABs in December. It is thought this is related to a very small cluster and will keep under close review.

Although not in the Clinical Governance section of the IPQR, Dr Mckenna highlighted that diagnostic waiting times are good, as are Cancer Waiting Times, despite the operational challenges linked to Covid.

In taking comments it was noted that although complaints remain an issue, Janette Owens advised she would be meeting with the Team to look at how to improve the service going forward. It was also noted that although it is important to respond to complaints within the timeframe, a quick response does not always give an adequate response. Some complaints are very complex, and it is important to get it right. Carol Potter echoed this. It was agreed Janette Owens will bring back an in-depth report for the Committee.

Action: JO

The Committee noted the report.

9 ITEMS FOR NOTING

9.1 HAIRT Report

The Committee noted the report.

10 ANNUAL REPORTS

10.1 Integrated Screening Annual Report

Dona Milne advised that this report provides a single integrated report of the key learning, achievements and challenges from the six National screening programmes in NHS Fife. This report was considered by the Public Health Assurance Group on 25 February 2021.

The main area of concern is the inequalities aspects around the uptake of the programmes. Additional resource has been added to the established screening team to increase support for screening programmes. The focus for the coming year will be to continue to work with the screening programme groups across Fife and Lothian and further work will also be undertaken to understand non-attendance and how this can be improved. Work has begun on sexual health and further activities are planned jointly with mental health to look at how to support people coming forward.

The Committee noted the content of the report. Dr Bisset said it was very helpful to see a consolidated report and thanked Dona Milne for the report.

11 LINKED COMMITTEE MINUTES AND ANNUAL REPORTS – FOR INFORMATION

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

11.1 Fife HSCP Clinical & care Governance Committee 29.01.2021
11.2 Integration Joint Board (IJB) 04.12.2020
11.3 Infection Control Committee 02.12.2020

11.4 Public Health Assurance Committee 20/01/2021
Item 4.1 – Interagency Referral Discussion

Margaret Wells commended the actions taken by the Community testing team, which led to an adult concern issue being raised.

12 ISSUES TO BE ESCALATED

There were no items for escalation. Dr Bisset would liaise with Dr McKenna about any
further items of escalation.

13 AOCB

There was no other competent business.

14 DATE OF NEXT MEETING

Thursday 6 May 2021 at 2pm via MS Teams

Item 3.1

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting Date:	**30 April 2021**
Title:	**Public Engagement & Consultation Update**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Donna Hughes, Head of Person-centred Care**

1. Purpose

This is presented to the Clinical Governance Committee for:

- Awareness

This report relates to an:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambitions:

- Safe
- Effective
- Person Centred

2. Report Summary

2.1 Situation

This report has been prepared to update the Clinical Governance Committee on the public engagement and consultation work, including urgent care redesign, undertaken in the last year.

2.2 Background

"Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change"
(The National Standards for Community Engagement, Scottish Community Development Centre)
Over last 18 months a model for participation and engagement has been designed and tested with National Standards for Community Engagement as the basis, in the anticipation for the replacement of CEL 4 2010.

The Participation & Engagement Advisory Group (PEAG) was established and is made up of professional staff who acts as a single point of contact for services seeking public participation across Acute Services, HSCP Services, Corporate Services and Localities.

2.3 Assessment

Over the last year there has been 24 requests to the PEAG for support (see Appendix 1) Most notable are the large pieces of work such as the development of the Lochgelly and Kincardine health and wellbeing centres, the mental health strategy and urgent care redesign.

Urgent Care Redesign.
The level of engagement for the urgent care redesign has been to **inform**. This was the appropriate and only available response from NHS Fife given this was a Scottish Government directive. Local communication therefore has been controlled in line with national direction and has been around the sharing of this information.

However, stage one and two EQIA's have been completed with full participation from a wide variety of community and voluntary sector representatives. Over 40 participants were involved, providing a broad range of references to health access, inequalities and possible recommendations. This is stage 1 of our public involvement.

The intention is to, as part of the move toward phase two of urgent care, do the following:

- Discussion with the Lead for Urgent Care to discuss the EQIA, and create a sub group to address issues that require a specific response.
- The new sub group (possibly to be called 'inequalities sub group') will consider the involvement of the public. The focus for the involvement of the public will be to support us to understand, respond and address outstanding inequalities for urgent care that have been highlighted as part of the EQIA, rather than to replicate what was in place with the public before or indeed to offer a 'consultation' element of their inclusion; as this is not appropriate at this time due to the mandate for the change.

2.3.1 Quality / Patient Care

As highlighted in the Feeley Report, "Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room"

2.3.2 Workforce

Public participation and engaement supports our workforce to consider how to continually improve the ways in which people and communities can become involved in developing services that meet their needs.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland

2.3.5 Equality and Diversity, including health inequalities

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People‘s rights are respected, protected and fulfilled
- Providers of care clearly inform people of their rights and entitlements
- People are supported to be fully involved in decisions that affect them
- Providers of care and support respect, protect and fulfil people‘s rights and are accountable for doing this
- People do not experience discrimination in any form
- People are clear about how they can seek redress if they believe their rights are being infringed or denied

2.4 Recommendation

The Clinical Governance Committee is asked to note this update

3. List of Appendices

Participation and Engagement Activity Report

Report Contact: Donna Hughes
Email donna.hughes@nhs.scot

Participation & Engagement Activity 1 April 2021 – 31 March 2021

	Project Title	Request	Distribution	Outcome
1.	Website Consultation	Consultation re website		Not taken forward at this point
2.	Public-facing Website	Tests		Not taken forward at this point
3.	Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
4.	Letter and leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
5.	Leaflets	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
6.	Questions re Pandemic, Acute, GP, Other	Feedback re questions posed	P&E Directory / External Agencies Group contacts	Feedback collated and shared with Lead for action
7.	Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
8.	Inpatient Services East Division	Representative to sit on working group		Not taken forward at this point
9.	NHS Fife Urgent Care Redesign - Flow and Navigation Hub	Inform wider networks		Service liaised directly with those involved and directed them to the P&E directory
10.	Questions re Signage (COVID)	Feedback re questions posed	P&E Directory / External Agencies Group contacts	Feedback collated and shared with Lead for action
11.	Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
12.	Kincardine & Lochgelly Communication H&W Centred	Stakeholder involvement		Participants advised of proposals directly

	Project Title	Request	Distribution	Outcome
13.	Eqaulity & HRSG	Public member to sit on group	P&E Directory / External Agencies	Not taken forward at this point
14.	Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
15.	Mental Health Redesign	Information / Consultation		Not taken forward at this point
16.	Radiology Survey	Survey	P&E Directory	N/A (respond directly)
17.	Palliative Care Patient & Carer Information Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
18.	Whistleblowing Policy	Circulate for information / interest	P&E Directory	N/A (respond directly)
19.	Eating Disorders	Circulate for information / interest	P&E Directory	N/A (respond directly)
20.	Dalteparin Leaflet	Readability & Format	P&E Leaflet Review Group	Comments collated and shared with Service Lead. Thank email sent to participants
21.	Accessible Communication Group	Request for Group Representation	P&E Directory / External Agencies Group contacts	Names collated and shared with service lead, await further contact.
22.	Digital and Information	Request for Group Representation		Awaiting comments re application.
23.	Prehabilitation Leaflet	Readability & Format	P&E Leaflet Review Group	closing date for responses 21/04/2021
24.	Factsheets	Readability & Format	P&E Leaflet Review Group	closing date for responses 16/04/2021

TABLE OF ACTIONS FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE
UPDATED ON 11 MARCH 2021
FOR DISCUSSION ON 30 APRIL 2021

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
Situation report for combining of key plans and programmes	7.9.2020	Executive Directors' overview, when completed, to be brought back to the Committee to understand how things will be managed across the Health Board & H&CP.	SF	~~November 2020~~	4.11.2020 & 11.03.2021 To remain on Action List until Pandemic settles.
Seasonal Flu Programme 2020 Review	14.1.2021	It was noted a number of actions have been dealt with and are now in place. There are also clear mechanisms for closing the rest. Will be brought back to the next meeting, to close off from the agenda.	DM	~~March 2021~~ May 2021	11.03.2021 Confident issues completed. For Governance purposes to remain on Action List and B/f to next meeting for final sign off.
IPQR	14.1.2021	Thanks to be passed to Keith Morris and his team for the work around reducing SABs.	HB	March 2021	11.03.2021 JO confirmed thanks were passed on.
Public Engagement & Consultation	14.1.2021	Donna Hughes to bring a report on the work undertaken in the last year.	HB	~~March 2021~~ May 2021	11.03.2021 B/f to next meeting.
BAF – Quality & Safety	14.1.2021	Risk to be added around the Community Paediatric Service.	HB	March 2021	11.03.2021 MW confirmed risk on register.

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
BAF – eHealth	4.11.2020	CMcK to check if Assurance Mapping Exercise being carried out by the Risk Manager and Internal Audit should be considered by the Committee.	CMcK	~~January 2021~~ ~~March 2021~~ May 2021	14.1.2020 CMcK advised no update at present. 11.03.2021 CMcK confirmed still work in progress. Update will be available at next meeting.
R& D Annual Report 2019-2020 – St Andrews University	4.11.2020	CMcK to update the Committee on the status of the Board as a teaching health Board.	CMcK	May 2021	
Equality Outcomes 2021-25	14.1.2021	HB and RL will meet to consider and expand on the rationale behind the outcomes given therein before the report is taken to the Board.	LB	March 2021	11.03.2021 Complete
Information Governance & Security Group Terms of Reference	14.1.2021	Update will follow in due course.	CMcK	~~March 2021~~ May 2021	11.03.2021 B/f to next meeting.
Fife Child Protection Annual Report 2019-20	14.1.2021	HB agreed to take back to the Child Protection Team the issues of what is not known at the moment and how we make this as safe a service as it can be in the current times and how the clinical governance element can address this. A further report to be brought back to the Committee.	HB	~~March 2021~~ May 2021	11.03.2021 To remain on Action List.
Redesign of Urgent Care – Flow & Navigation Update	11.3.2021	JO to check with Donna Hughes for any feedback garnered from Public Engagement.	JO	May 2021	
	11.3.2021	Update report setting out further evidence and data as it is gathered around communicating with the public. The National evaluation to be considered.	CMcK MMcG	May 2021 May 2021	

MINUTE REFERENCE	DATE OF MTG	ACTION	LEAD	TIMESCALE	PROGRESS
IPQR	11.3.2021	JO to provide in depth report on how to improve complaints following her meeting with the Team.	JO	May 201	

Item 8.1

NHS Fife

Meeting:	**NHS Fife Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Update on NHS Fife Board Assurance Framework (BAF) Quality & Safety**
Responsible Executive:	**Dr Chris McKenna, Medical Director & Janette Owens, Director of Nursing**
Report Author:	**Pauline Cumming**

1 Purpose

This is presented to EDG for:

- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide 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 necessary, the chair should seek further information. The Committee is required 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?

This report provides the Committee with an update on the Quality & Safety BAF since the last report on14 January 2021.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions. Details are contained in Appendix 1 and 2.

2.3 Assessment

The committee can be assured there are systems and processes in place to monitor quality and safety, and that work relating to managing related risks continues.

Changes since the last report to the Committee:

Risk Ownership:

Risk ID 1652 - Community Paediatric Staffing - lack of Medical Capacity. The owner has changed from Gemma Couser, General Manager, Women, Children and Clinical Services, to Claire Dobson, Director of Acute Services, NHS Fife.

Risk ID 1296 - Emergency Evacuation, Victoria Hospital, Phase 2, Tower Block. The owner has changed from Andrew Fairgrieve, Director of Estates, Facilities & Capital Services, to Neil McCormick, Director of Property and Asset Management, NHS Fife.

Linked Operational Risks:

Following review, 2 linked operational risks have been closed:

Risk ID 1667 - Infusion pumps, volumisers and syringe drivers in Paediatrics and Neonatal Units

Risk ID1514 - Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices

The previously reported review of all high level risks is ongoing. Pending the outcome of same, and following consideration by the Medical Director and the Director of Nursing, there are currently no changes to the existing linked operational risks.

2.3.1 Quality/ Patient Care

Highlighting relevant high risks to the committee, ensures there is appropriate scrutiny and monitoring of the highest level of risks in the organisation which impact or potentially impact on the quality and safety of services and patient care delivery.

2.3.2 Workforce

No change

2.3.3 Financial
No change

2.3.4 Risk Assessment/Management
The risks associated with this BAF are assessed and managed at an operational level.

2.3.5 Equality and Diversity, including health inequalities
Equality and diversity are considered and managed operationally, and there are no assessments associated with this BAF.

2.3.6 Other impact
N/A

2.3.7 Communication, involvement, engagement and consultation
N/A

2.3.8 Route to the Meeting
This paper has been considered by the Head of Quality and Clinical Governance, the Medical Director and the Director of Nursing.

2.4 Recommendation

- **Discussion** – the content and current position of the Quality & Safety BAF

3 List of appendices
Appendix 1, NHS Fife Board Assurance Framework (BAF) Quality & Safety to NHS Fife CGC 300421 V1.0
Appendix 2, BAF Risks - Quality & Safety - Linked Operational Risks to NHS Fife CGC 300421V1.0

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

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?	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
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	30/12/2020	30/04/21	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 Risk	3 – Possible – May occur occasionally – reasonable chance	5 – Extreme	15	High Risk	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.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*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 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan for clinical services These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Patient Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts	1.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. 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level. 4.Risk Management Framework has been updated but to be rolled out.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 4..Review the coverage of mortality & morbidity meetings in line with national developments and best practice guidance 5. 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. 6. Review annually, all technology & IT systems that support clinical governance e.g. Datix, Formic Fusion Pro. 7. Review our position against the Quality of Care Framework and understand our state of readiness. 8. Further develop the culture of person centred approach to care. 9. Only Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives'.	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 e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs. 7. External agency reports e.g. GMC 8. 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 11. Specific National reporting	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.We require additional assurances that there is a system in place for oversight of actions from a variety of sources e.g. audit, adverse events, SPSO. 3.We require additional assurances that there are systems in place for oversight of operational risks.	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 – Not expected to happen – potential exists	5 – Extreme	10	Moderate Risk	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	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	McCormick, Neil
43	Vascular access for haematology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
521	Capacity Planning	Active Risk	High Risk	16	Watts, Miriam
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Active Risk	High Risk	16	Shepherd, Angie
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Active Risk	High Risk	15	Anderson, Jane
1670	Temperature within fluid storage room within critical care.	Active Risk	High Risk	15	Watts, Miriam

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk			
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk			
356	Clinical Pharmacy Input	Closed Risk			
528	Pandemic Flu Planning	Active Risk	Moderate	12	Milne, Dona
637	SAB LDP standard	Active Risk	Moderate	9	Cook, Julia
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			
1502	3D Temperature Monitoring System (South Lab)	Closed Risk			
1524	Oxygen Driven Suction	Closed Risk			

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
1652	Acute Services - Women Children and Clinical Services - Obstetrics, Gynae and Paeds Risk Register	12.11.2019	Lack of Medical Capacity in Community Paediatric Service	The Community Paediatric Service staffing has reduced from 14wte in 2014 to 4.25 wte substantive general community paediatricians now in 2020. This is due to the service being unable to fill vacancies following retirals. Permanence and Child Protection specialist posts are delivered by 1.7 wte. The service is unable to meet demand both in terms of new patient and review patient caseloads. There is a risk that care will be compromised and patient safety impacted. Complaints are significant in number and many have been received from MSP's and local councillors.	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25
1296	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register	22.08.2016	Emergency Evacuation, VHK Phase 2 Tower Block	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20

43	Acute Services - EMERGENCY CARE & MEDICINE DIRECTORATE RISK REGISTER	24.03.2012	Vascular access for haematology/Oncology	A lack of a vascular access service and access to timely Hickman line insertion poses a risk to the timely initiation of chemotherapy to Haematology/Oncology patients.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20
521	Acute Services - EMERGENCY CARE & MEDICINE DIRECTORATE RISK REGISTER	02.10.2012	Capacity Planning	Capacity Planning: There is a risk of a mismatch between capacity and demand for elective and emergency activity which will lead to delays to admit emergency patients high levels of boarding, failure to meet 4 hour A&E target and failure to meet waiting time standards including the 12 week legally binding guarantee	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16

529	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register	02.10.2012	Information Security Risk	There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, affect essential services, loss theft or misuse of paper based records during transportation, clinical processes or storage. This risk relates to the Networking and Information Systems(NIS)Regulations.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15
1287	Acute Services - EMERGENCY CARE & MEDICINE DIRECTORATE RISK REGISTER	18.08.2016	Overcapacity in AU1 Assessment Unit	There is a risk to clinical care and patient/staff safety when there is overcrowding within AU1 assessment area.	4 - Likely - Strong possibility this could occur	2 - Minor	Moderate Risk	8

1365	Acute Services - ACUTE SERVICES DIVISION RISK REGISTER, NHSFBD - Cancer Services Risk Register, NHSFBD – COVID-19 Risk Register
15.06.2017	
Cancer Waiting Times Access Standards	There is a risk that NHS Fife will be unable to deliver and sustain Cancer Waiting Times Access Standards which will result in delays to patient appointments, investigations and treatment.
5 - Almost Certain - Expected to occur frequently - more likely than not	
3 - Moderate	
High Risk	
15	

1515	NHSFBD - Brexit Risk Register
04.10.2018	
Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Brexit could limit our access to nuclear medicine supplies. Subject to the final withdrawal agreement, resources used within diagnostic and treatment service(s) could be impacted by supply chain difficulties, thereby impacting on our ability to maintain these services.
3 - Possible - May occur occasionally - reasonable chance	
5 - Extreme	
High Risk	
15	

1670	Acute Services - EMERGENCY CARE & MEDICINE DIRECTORATE RISK REGISTER	11.12.2019	Temperature within fluid storage room within critical care.	The temperature within the fluids storage room must be kept at 25degrees to maintain safe storage of IV fluids and Hemofiltration fluids. The temperature within this area continues to be at a level of 28 degrees which is not acceptable to reduce the temperature the clinical area is requiring to wedge open the door which allows the temperature to reduce to 26degrees. This presents a further risk that a fire door remains open.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15

Current Management Actions	Likelihood (current)
Conversations regarding ADHD Service taking place with Divisional Manager Fife wide HSCP regarding governance and improvement actions required across HSCP and Community Paediatrics Interviews were held on 7/9/2020 for Consultant and Specialty Doctor - both posts appointed to and likely to start in the new year. Caseload review continues across the different areas.	5 - Almost Certain - Expected to occur frequently - more likely than not
JR - 04/11/2020 - The current management actions/position for this risk are: two tone fire alarm system to allow identification of zone of fire and progression of patients to a safe zone. :Fire response team in place all wit their own pagers, responding to a fire alert automatically. :Clinical coordinators/fire response team trained. :Fire wardens for the site trained.	4 - Likely - Strong possibility this could occur

03/01/2021 Risk remains unchanged we are liaising closely with the vascular service within Ninewells to mitigate the risk but due to the inability to recruit to interventional radiology.	5 - Almost Certain - Expected to occur frequently - more likely than not
10/09/20: We continue to manage the beds differently due to COVID and the requirement for Red and green capacity there are weekly reviews of this at present. 23/12/2019 Capacity remains difficult due to increased numbers of admissions and patients who are medically fit for discharge to other care providers but there is no capacity within there services . his increases the numbers of patients boarding within planned care wards. Ongoing work to reduce this and improve capacity including daily discharge planning improvement work.	4 - Likely - Strong possibility this could occur

This risk remains high. NHS Fife is taking steps to identify and risk assess data assets using the DPIA Template, but this involve significant effort to retrospectively complete, this is work in progress. There is ongoing discussion between the CSM and ISM as to the formulation of a work flow for DPIA's to progress through to streamline the process, this will be raised within the IG&S Ops meeting. The NIS regulations audit has been carried out and we await the report, this report will be used to build an action plan of progression towards addressing the information security objectives. CSM and ISM are in process of developing a framework of baseline acceptable standards and documentary requirements that will address information security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks:220,225, 226,230,537,538,540,1410,1569.	4 - Likely - Strong possibility this could occur
03/01/2021 There remains capacity concerns within AU1 although due to COVID the process and pathways have been changed into red and Amber areas. There remains overcrowding for periods within AU1 and this is managed by Capacity team and senior management teams on a day by day hour by hour basis depending on assessment of risk .	4 - Likely - Strong possibility this could occur

24/02/21 PTL meetings continue to ensure robust escalations for patients that are not moving through their pathways. National discussions have taken place to ensure up to date and appropriate waiting times adjustments are applied. A Cancer Strategy Group has been formed to oversee performance within NHS Fife and take forward the recently published Cancer Recovery Plan. A continuing issue is the number of necessary steps in the pathways that occur without significant delay a national review of pathways will be undertaken as part of the Cancer Recovery Plan.	5 - Almost Certain - Expected to occur frequently - more likely than not
(Update: 16/2/21) In the opinion of the MPE this needs to remain on the risk register – although we have obviously exited the EU now, potential issues remain, including disruption of supply due to delay at the borders. I am hopeful that the transport of radioactive materials across frontiers will be in a much better position in 12 months time, but at present other sites nationally have reported issues related to Brexit.MPE unaware of any problems. All seems to be running smoothly. Advice from MPE Lothian - Given that the negotiations don't seem to be going well, I think we should keep Brexit as a risk to radiopharmaceutical supply at the turn of 2020/21. At end Jan 2020 (UK entering transition phase) we had some delays to radiopharmaceutical deliveries. Things got back to normal within a few weeks, and most Nuclear Medicine departments prepared by reducing workloads over that period. What happens at the end of the transition phase is unclear but depends on whether we get a trade deal. If not there could be an immediate impact on supplies, but it's pointless to speculate at the moment so please retain this risk over the Jan 2021 period. The cutover to a Netherlands supply took place with no adverse effects. Fife will be informed of any future changes. 01/07/2019 We have as yet not been notified of any anticipated problems 04/02/2020.	3 - Possible - May occur occasionally - reasonable chance

03/01/2021 No further changes I regards to this risk awaiting Engie to provide cost via external contractor.	5 - Almost Certain - Expected to occur frequently - more likely than not

5 - Extreme	5 - Extreme	Consequence (current)
High Risk	High Risk	Risk level (current)
20	25	Rating (current)
1 - Remote - Can't believe this event would happen	3 - Possible - May occur occasionally - reasonable chance	Likelihood (Target)
5 - Extreme	4 - Major	Consequence (Target)
Low Risk	Moderate Risk	Risk level (Target)
5	12	Rating (Target)
McCormick, Neil	Dobson, Claire	Risk Owner
Ramsay, Jimmy	Couser, Gemma	Handler
26.03.2021	21.12.2020	Previous Review Date
30.06.2021	30.06.2021	Next Review

4 - Major	4 - Major
High Risk	High Risk
16	20
2 - Unlikely - Not expected to happen - potential exists	3 - Possible - May occur occasionally - reasonable chance
4 - Major	4 - Major
Moderate Risk	Moderate Risk
8	12
Watts, Miriam	Savage, Shirley-Anne
Watts, Miriam	Davidson, Dr Kerri
30.12.2020	03.01.2021
31.05.2021	30.06.2021

4 - Major	4 - Major
High Risk	High Risk
16	16
3 - Possible - May occur occasionally - reasonable chance	1 - Remote - Can't believe this event would happen
2 - Minor	4 - Major
Low Risk	Low Risk
6	4
Shepherd, Angie	McGurk, Margo
Hutchison, Wendy	Irving, Kevin
03.01.2021	20.04.2021
30.04.2021	20.07.2021

5 - Extreme	3 - Moderate
High Risk	High Risk
15	15
2 - Unlikely - Not expected to happen - potential exists	3 - Possible - May occur occasionally - reasonable chance
5 - Extreme	3 - Moderate
Moderate Risk	Moderate Risk
10	9
Anderson, Jane	Couser, Gemma
Anderson, Jane	Nicoll, Kathleen
31.01.2021	24.02.2021
30.04.2021	24.09.2021

3 - Moderate
High Risk
15
2 - Unlikely - Not expected to happen - potential exists
3 - Moderate
Low Risk
6
Watts, Miriam
Shepherd, Angie
03.01.2021
30.04.2021

Item 8.2

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**NHS Fife Board Assurance Framework (BAF) Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 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 5 on 30.4.21.

2.2 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.

2.3 Assessment

There has been a revision of this BAF to reflect the changes that have happened over the COVID period and the strategic planning for the new Population Health and Wellbeing Strategy for NHS Fife.

The risk associated with this BAF has been reviewed and renewed. The previous risk which has been in place since 2017 was:

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.

This no longer reflects that current position of strategic planning, the development of the strategy and associated changes. The proposed risk is:

There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

The BAF and risk also describes how the Corporate Objectives have been derived from the Strategic Planning and Resource Allocation (SPRA) process and the Strategic Priorities form part of the strategic planning direction going forward for NHS Fife.

2.3.1 Quality/ Patient Care

Quality of Patient Care is part of the work of the Strategic Planning and Resource Allocation (SPRA) process.

2.3.2 Workforce

No change.

2.3.3 Financial

Financial implications are part of the work of the Strategic Planning and Resource Allocation (SPRA) process.

2.3.4 Risk Assessment/Management

Risk Assessment is part of the work of the Strategic Planning and Resource Allocation (SPRA) process.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is part of the work of the Strategic Planning and Resource Allocation (SPRA) process.

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Chief Executive, 23 April 2021

2.4 Recommendation

The Committee is invited to:

- **Discuss and Agree** the change in the risk associated with the BAF for Strategic Planning.

Report Contact
Susan Fraser
Associate Director of Planning and Performance
Email susan.fraser3@nhs.scot

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?	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
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	03/03/2021	1 July 2021	Proposed New Risk There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Remove Historic Risk(s) There is a risk that NHS Fife will not deliver the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost with the consequence that the Clinical Strategy does not reflect current priorities. 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 transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	Likely	Major	16	High risk	Unlikely	Major	12	Medium risk	The Board remains under the direction of Scottish Government will clear priorities established for 2021/22. The RMP3 sets out those priorities and is likely to be reviewed in September 2021.	Margo McGurk Director of Finance	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 20/4/21 1. NHS Fife has commenced the development of an approach and timeline to deliver a new Population Health and Wellbeing Strategy by 31 March 2022. 2. Investment in redesigning our programme management capacity and capability and governance has been prioritised through the Strategic Planning Resource Allocation (SPRA) process. 3. Development of corporate objectives is ongoing and has been informed through the 2021/22 SPRA process.	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	EDG will engage in monthly sessions to ensure the ongoing development of the new strategy. The NHS Fife Board and Governance Committees will be fully engaged in this process throughout 2021/22 and will be responsbile for approval of the emerging strategy. Work is ongoing to develop clarity on the system-wide governance arrangements in terms of the developing strategy. Joint sesssion planned with NHS Fife and Fife Council Executive Teams for May 2021. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance Committeee scrutiny and reporting.	Governance of new arrangements will be agreed to deliver the required assurance.	Work is ongoing to agree the corporate objectives through SPRA process and the development of the Population Health and Wellbeing Strategy. This will be supported by the corporate PMO.	Unlikely	Moderate	9	Low risk	-

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

Item 8.3

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Update on NHS Fife Board Assurance Framework (BAF) - Digital and Information (D&I)**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham – Associate Director of Digital and Information**

1 Purpose

This is presented for:

- Discussion

This report relates to a:

- Local Policy

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide 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
- NHS Fife Digital & Information Strategy 2019 - 24

The Committee has a key role in scrutinising the risk and where necessary, the chair should seek further information. The Committee is required 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?

This report provides the Committee with an update on NHS Fife BAF in relation to Digital & Information (D&I) as at 20 April 2020.

2.2 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 Committee and associated risks, legislation & standing orders or opportunities

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor D&I performance and continue to work on the risks as and when resource/funding becomes available.

The high-level risk is as set out in the BAF, together with the current risk assessment and the mitigating actions. The committee is asked to note the rewording of the Risk Description, following discussion and review with Internal Audit.

Changes since the last report to the Committee:-

Risk Ownership:

Linked Operational Risk ID 226: Ownership changed from Lesly Donovan, General Manager Digital & Information to Alistair Graham, Associate Director of Digital & Information.

As reported previously, Internal Audit continues to undertake an assurance mapping exercise and the BAF chosen as a pilot is the D&I BAF. This activity is ongoing.

The BAF current risk level has been assessed at High with the target score remaining Moderate.

2.3.1 Quality/ Patient Care

No negative impact on quality of care (and services).

2.3.2 Workforce

No change

2.3.3 Financial

D&I continue to work within the agreed budget with a focus on high risk/priorities.

2.3.4 Risk Assessment/Management

Please see attached risks and BAF.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

External stakeholders are engaged where appropriate:

2.3.8 Route to the Meeting

The BAF reflects the consideration and activities from the:-

Digital & Information Board

Information Governance & Security Steering Group

2.4 Recommendation

- **Discussion** – the content and current assessment of the Digital & Information BAF

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - BAF Digital & Information
- Appendix 2 - Digital & Information linked operational risks

Report Contact
Alistair Graham
Associate Director of Digital & Information
Email alistair.graham@nhs.scot

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?	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
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	20/04/2021	3 June 2021	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and enable transformation across Heath and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	Likely	Extreme	20	High risk	Possible	Extreme	15	High risk	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.	CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Strategic Framework and Clinical Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with ongoing review 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning 6. Operational governance lead through SLT focussing on operation controls, lifecycle management, policy/procedure implementation and adherence 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance. 9. FOI, records management, DPA 10. Senior Management Team consideration of policy and procedure impact and associated implementation 11. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 12. Performance Review 13. Participation in national and local audit e.g. NISD Audit 14. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and co-ordination protocols. 15 Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 16. Business Case development to include costed resilience by design and ongoing support activities. 17. Enhancing monitoring of our digital systems.	Lack of long term financial, lifecycle and workforce planning - plan to address is in development (Target October 2021) Lack of systems to maintain ongoing monitoring of compliance with the key controls: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target June 2021) NIS Directive - Improvements to be planned following April 2021 Audit feedback Cyber Essentials Plus - Incorporated in NIS D Audit Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021 Governance and procedures do not fully follow ITIL professional standards - Await Internal Audit Findings	1. Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment 2. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Target October 2021) 3. Ensure existing systems are considered first prior to new systems introduced without sufficient skilled resources to maintain on an ongoing basis. The continual use of business case development and governance of digital request by D&I Board will support this mitigation 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 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. Update to Assessment following June 2019-Digital Maturity Assessment	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and 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. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now being progressed - target completion July 2021 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. Assurance reports are consistently provided to D&I SLT monthly and development of data reports to Governance Groups continue to be developed. 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). 3. As the requirements are defined the reporting is developed accordingly and then undergoes consistent review. 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. 4. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 5. Output from national Digital maturity is	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving 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. 5. Engagement with EDG in relation to FOI compliance (February 2021) 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	Unlikely	Extreme	10	Moderate risk	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.

considered as part of the D&I Strategy development and associated delivery plan

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	Young, Allan
1338	End of support lifecycle for Microsoft Office 2007	Active Risk	High Risk	16	Young, Allan
1424	End of support lifecycle for Microsoft Server Products	Active Risk	High Risk	16	Young, Allan
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1934	Loss of Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1746	O365 May Cause Disruptive Network Overhead	Active Risk	High Risk	16	Young, Allan
1393	Patch Management Risk	Active Risk	High Risk	16	Young, Allan
1576	Risk of not meeting SaMD full compliance	Active Risk	High Risk	16	McKenna, Christopher
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1927	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Active Risk	High Risk	16	Fowles, Malcolm
1932	T4 - User error (including those supporting system)	Active Risk	High Risk	16	Fowles, Malcolm

537	Failure of Local Area Network causing loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
913	MIDIS replacement	Closed Risk			
1928	T2 - Deliberate unauthorised access or misuse by outsiders (e.g. hackers)	Active Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk			

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?	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
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CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Strategic Framework and Clinical Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with ongoing review 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning 6. Operational governance lead through SLT focussing on operation controls, lifecycle management, policy/procedure implementation and adherence 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance. 9. FOI, records management, DPA 10. Senior Management Team consideration of policy and procedure impact and associated implementation 11. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 12. Performance Review 13. Participation in national and local audit e.g. NISD Audit 14. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 15 Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 16. Business Case development to include costed resilience by design and ongoing support activities. 17. Enhancing monitoring of our digital systems.	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Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 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. Update to Assessment following June 2019-Digital Maturity Assessment	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and 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. 6. 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Linked Operational Risk(s)

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1929	T7 - Inadequate or absent audit trail	Closed Risk			

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
1504	NHSFBD - Prescribing & Medicines Management Risk Register	14/12/2018	Lack of a central IT location to store guidance documents	Currently there is a lack of a central IT repository for NHS Fife guidance documents. Particularly in the acute setting leading to potential risk to the patients in delay of treatment or use of guidance documents from other areas which have not been through our medicines governance process. - Currently documents that go through MSDTC and are approved have no official place to be positioned where they can be easily accessed. - As we have no central repository the risk of old versions of documents still being in circulation is high	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	03/02/21 - awaiting meeting with Digital & Information to progress implementation plan for Microguide.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	1 - Remote - Can't believe this event would happen	4 - Major	Low Risk	4	McKenna, Christopher Reid, Euan	03/02/2021	30/06/2021
1422	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	19/02/2018	Unable to meet NIS & Cyber Essentials compliance	There is a risk that not enough resource or funding will be available to implement requirements for the full NIS and Cyber Essentials legislation and standards.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	March 2021 - NIS audit has been conducted, awaiting outcome with view to update plan. Dec 2020 - No change from previous update	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	4 - Major	Moderate Risk	8	Young, Allan	Davies, John	17/03/2021	13/09/2021
1338	NHSFBD - Digital and Information Directorate Risk Register	23/02/2017	End of support lifecycle for Microsoft Office 2007	There is a risk that NHS Fife is victim of a targeted cyber intrusion from adversaries, because Microsoft has stopped supporting all Office 2007 products, this effectively ends the lifecycle of this product and sub-products including: MS Word 2007, MS Excel 2007, MS Powerpoint 2007, MS Publisher 2007, MS Access 2007 (Also lighter MS Office 2007 products like Picturemaker, Groove, One Note and InfoPath), although these products will continue to function after this date, organisations will no longer receive patches for security vulnerabilities identified in these products, resulting in a successful cyber attach and data breach.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	02/03/2021 Time frame is now possibly by 31st March 2022. Earlier time frame estimates were based on just migration of NHSmail to O365, and whilst that is now complete, with users now either accessing email via Outlook Online (web) or Outlook for O365 (E3) or Outlook 2016 where applications don't support O365, although Office 2007 could now be removed from clients, the rest of Office 2007 needs to remain until H: and S: drive data has been moved to OneDrive & SharePoint. This part of the project is now underway, but only at an early stage. There are a number of dependencies such as data cleanse, business classification scheme, endpoint management, conditional access etc that need to be resolved/implemented first.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Young, Allan	Faichney, Brian	02/03/2021	10/01/2022
1424	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	14/07/2015	End of support lifecycle for Microsoft Server Products	There is a risk that NHS Fife is victim of a targeted cyber intrusion due to Microsoft Servers falling out of support lifecycle, but still remaining in Production. Microsoft stopped supporting all Server 2003 products from July 14th 2015 and Server 2008R2 from January 14th 2020. Although these products will continue to function after this date, organisations will no longer receive patches for security vulnerabilities identified in these products, resulting in a successful cyber attack and data breach. There is also a risk that running legacy versions will cause legislative issues under NIS.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	09/03/2021 - The replacement programme continues to progress slowly due to resourcing issues, some vendors being slow to align products with MS support lifecycles, and lack of funding for upgrades which need new licensing or professional services to progress. NHS Scotland is now subject to ongoing NIS Legislation Audit, which may help to attract funding. This risk is also tracked on the IT Operations Monthly Highlight Report. Current numbers = 20 SRV2003 & 149 SRV2008/R2.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Young, Allan	Fowles, Malcolm	09/03/2021	01/03/2022

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529	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register	02/10/2012	Information Security Risk	There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, affect essential services, loss theft or misuse of paper based records during transportation, clinical processes or storage. This risk relates to the Networking and Information Systems(NIS)Regulations.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	This risk remains high. NHS Fife is taking steps to identify and risk assess data assets using the DPIA Template, but this involve significant effort to retrospectively complete, this is work in progress. There is ongoing discussion between the CSM and ISM as to the formulation of a work flow for DPIA's to progress through to streamline the process, this will be raised within the IG&S Ops meeting. The NIS regulations audit has been carried out and we await the report, this report will be used to build an action plan of progression towards addressing the information security objectives. CSM and ISM are in process of developing a framework of baseline acceptable standards and documentary requirements that will address information security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks:220,225, 226,230,537,538,540,1410,1569.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	1 - Remote - Can't believe this event would happen	4 - Major	Low Risk	4	McGurk, Margo	Irving, Kevin	20/04/2021	20/07/2021
1934	NHSFBD - Digital and Information - Information Technology Risk Register	08/09/2020	Loss of Email & Collaboration Services	There is a risk that NHS Fife users and services could be prevented from using Email and Collaboration solutions (such as Teams) due to a loss of connectivity to the Internet or Microsoft Azure Infrastructure, resulting in a negative impact upon services, collaboration and communication.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Dec 2020 - Initial work has begun to design and cost secondary connections to the Internet using resilient design and auto failover.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Young, Allan	Fowles, Malcolm		01/07/2021
1746	NHSFBD - Digital and Information - Information Services Risk Register, NHSFBD - Digital and Information Directorate Risk Register	25/02/2020	O365 May Cause Disruptive Network Overhead	There is a risk that the introduction of O365 alongside other Cloud solutions, will cause disruptive levels of Network traffic overhead. This is especially likely on branch sites with lower bandwidth and no local breakout to the Internet. Based in current plans, O365 is due to be delivered in stages between July-Dec 2020. Problems could manifest instantly when O365 is applied at any given site (which can be managed through testing) or through gradual degradation over time.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	05/11/2020 We have replaced the firewalls at QMH and have also started sending more data from VHK. We have also split most teams traffic away from our VPN and also allowed teams traffic to go direct from each site rather than forcing it to come back to central sites. Still monitoring on an ongoing basis.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	Young, Allan	Fowles, Malcolm	05/11/2020	13/04/2021

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1393	NHSFBD - Digital and Information - Information Technology Risk Register	30/10/2017	Patch Management Risk	There is a risk that software, hardware and firmware patches are not applied correctly because of: • Patching not being applied consistently, especially non-Microsoft • Patches may not be rolled out on legacy servers due to their fragility, high availability requirements or lapsed support lifecycle • Some third party suppliers of IT services or systems will not support the patching of their infrastructure due to insufficient support contracts • Limited test environments to test patches • Inability to fully test all patches due to the number of systems maintained by the D&I department • Third parties deploying patches without applying the change management process • Servers using operating systems/applications that are no longer supported by the vendor i.e. no longer providing patches resulting in NHS Fife's software, hardware and firmware having reduced functionality and exposure to security vulnerabilities.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	[Dec 2020] 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.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	1 - Remote - Can't believe this event would happen	3 - Moderate	Very Low Risk	3	Young, Allan	Fowles, Malcolm	01/12/2020	01/07/2021
1576	NHSFBD - Digital and Information - Information Services Risk Register, NHSFBD - Digital and Information Directorate Risk Register	03/07/2019	Risk of not meeting SaMD full compliance	There is a risk that NHS Fife will not be able to comply with Software as Medical Device (SaMD) regulations before the Medical Device Regulations (MDR) come into full effect on 26th May 2020.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	July 2019 - Acknowledgement that there is currently no programme or resources allocated to carrying out the identification and assessment of software to determine whether it is a Medical Device; then to determine classification based on the MDR criterion.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	McKenna, Christopher	McKenna, Christopher		06/01/2020
226	NHSFBD - Digital and Information Directorate Risk Register	28/11/2007	Security of data being transferred off/on site	There is a risk that confidential or Personal Data may be lost or accidentally disclosed because it is lost in transit or if removable media is not handled securely e.g. data being transferred off/on site in paper or un-encrypted media, like laptops, USB, cd, DVD, PDA etc etc., resulting in a possible breach of data protection	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	31/03/2021 [KI]: The status of this risk has remained the same. The mitigations in place are: a) Encryption and device control of laptops, tablets, mobile phones and memory sticks as per GP/D6 Data Encryption Policy. b) Computer group policies that restrict the what memory storage devices can be connected to the NHS Fife network via computers/tablets. This does not apply to Windows 10 computers, Data Loss Protection(DLP) has not been implemented for this operating system. c) staff training & guidance on information governance, data protection and security - stronger training campaign and more specific training added in compliance with the NHS Scotland Information Security framework i.e. Networks and Information Systems Regulations. d) Discuss with eHealth Support team guidelines to be included as part of staff IG training with regards to how staff can check themselves if their equipment is or not encrypted. e) A patching policy for operating systems of endpoints (computers, mobile devices, tablets) has been developed and rolled out. This is still to implemented for servers. Windows Server 2003 & 2008 is no longer supported by Microsoft. f) The introduction of the SWAN Secure File Transfer (SFT), reduces the need to create DVD & CD due to the size and amount of data that can be transferred in a secure manner i.e. encrypted. This service allows none NHS email addresses to be used.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	3 - Moderate	Low Risk	6	Graham, Alistair	Irving, Kevin	31/03/2021	30/09/2021

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1927	NHSFBD - Digital and Information - Information Technology Risk Register	08/09/2020	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Personal and special data will be processed via emails sent using the O365 Email service. There is a risk disgruntled staff, contractors, volunteers etc. may attempt to access other users email accounts to access information they are not entitled to read.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Use of secret authentication information (ISO 27002: A.9.3.1) This control is managed by the GP/P2 Password Policy and GP/I5 Information Security Policy. These policies will need to be reviewed to ensure that they are in sync with the O365 Email service and training reviewed to ensure that staff understand them. This control would be implemented by Microsoft as part of its ISO 27001 certification as well as implementing the 14 NCSC cloud security principals which includes identity and authentication for O365 Email software. Access control policy (ISO: A.9.1.1) (CAF: B2.d) The GP/D3-2 Access Controls for Information Systems and the GP/I5 Information Security Policy address this control. Access to networks and network services (ISO 27002: A.9.1.2) (CAF: B2.d) IT access to networks and network services requires an IT login account, which is covered by the following policies: GP/D3-13 System Access Provisioning Procedure; GP/D3 Data Protection and Confidentiality Policy - Appendix 2 NHS Fife IG structure, roles and responsibilities; GP/I5 Information Security Policy; FairWarning monitors inappropriate access. Termination or change of employment responsibilities (ISO: A.7.3.1) The NHS Fife Confidentiality Statement for Employees & Contractors needs to be updated to cover non-disclosure of information security measures and vulnerabilities after leaving its employment. Leavers and Movers form Outstanding Mitigations: Staff require protected training time around the safe use of email. Also the implementation of MFA or agreed conditional access to reduce the dependency on staff awareness to prevent information security incidents. There is the concern that enterprise management security (EMS) has not been procured as a risk mitigation for mobile devices.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Fowles, Malcolm	Fowles, Malcolm		15/10/2020
1932	NHSFBD - Digital and Information - Information Technology Risk Register	08/09/2020	T4 - User error (including those supporting system)	There is a risk that users may send emails with personal data to incorrect email addresses, because of out of date demographics or human error, resulting in a data breach.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Classification of information (ISO 27002: A.8.2.1) (CAF: B3.a) : NHS Fife has adopted the Scottish Government Mobile Data Standard (CEL 25, 2012), which is reference in GP/E6 Email Policy, Appendix 1. Information transfer policies and procedures (ISO 27002: A.13.2.1) (CAF: B3.b) GP/M4 Media Handling Policy; GP/M5 Mobile Device Management Policy GP/E6 Email Policy; SWAN SFT service;	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Fowles, Malcolm	Callaghan, Sarah		15/10/2020
537	NHSFBD - Digital and Information Directorate Risk Register	02/05/2006	Failure of Local Area Network causing loss of access to IT systems	There is a risk of localised or widespread extensive and persistent IT network failure caused by failure of any of Local Area Networks within NHS Fife. Thus resulting in clinicians / admin staff being unable to access data which is pertinent to patient care and administrative services being significantly hindered.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	09/03/2021 - Some investment has been made in the LAN switches throughout Fife and replacement of any end of life appliances is planned. There will also be work ongoing to virtually segregate the LAN in order to make it more modular.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	1 - Remote - Can't believe this event would happen	5 - Extreme	Low Risk	5	Young, Allan	Fowles, Malcolm	09/03/2021	01/03/2022

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1504	NHSFBD - Prescribing & Medicines Management Risk Register	14.12.2018	Lack of a central IT location to store guidance documents	Currently there is a lack of a central IT repository for NHS Fife guidance documents. Particularly in the acute setting leading to potential risk to the patients in delay of treatment or use of guidance documents from other areas which have not been through our medicines governance process. - Currently documents that go through MSDTC and are approved have no official place to be positioned where they can be easily accessed. - As we have no central repository the risk of old versions of documents still being in circulation is high	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	03/02/21 - awaiting meeting with Digital & Information to progress implementation plan for Microguide.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	1 - Remote - Can't believe this event would happen	4 - Major	Low Risk	4	McKenna, Christopher	Reid, Euan	03.02.2021	30.06.2021
1422	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	19.02.2018	Unable to meet NIS & Cyber Essentials compliance	There is a risk that not enough resource or funding will be available to implement requirements for the full NIS and Cyber Essentials legislation and standards.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	March 2021 - NIS audit has been conducted, awaiting outcome with view to update plan. Dec 2020 - No change from previous update	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	4 - Major	Moderate Risk	8	Young, Allan	Davies, John	17.03.2021	13.09.2021
1338	NHSFBD - Digital and Information Directorate Risk Register	23.02.2017	End of support lifecycle for Microsoft Office 2007	There is a risk that NHS Fife is victim of a targeted cyber intrusion from adversaries, because Microsoft has stopped supporting all Office 2007 products, this effectively ends the lifecycle of this product and sub-products including: MS Word 2007, MS Excel 2007, MS Powerpoint 2007, MS Publisher 2007, MS Access 2007 (Also lighter MS Office 2007 products like Picturemaker, Groove, One Note and InfoPath), although these products will continue to function after this date, organisations will no longer receive patches for security vulnerabilities identified in these products, resulting in a successful cyber attach and data breach.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	02/03/2021 Time frame is now possibly by 31st March 2022. Earlier time frame estimates were based on just migration of NHSmail to O365, and whilst that is now complete, with users now either accessing email via Outlook Online (web) or Outlook for O365 (E3) or Outlook 2016 where applications don't support O365, although Office 2007 could now be removed from clients, the rest of Office 2007 needs to remain until H: and S: drive data has been moved to OneDrive & SharePoint. This part of the project is now underway, but only at an early stage. There are a number of dependencies such as data cleanse, business classification scheme, endpoint management, conditional access etc that need to be resolved/implemented first.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Young, Allan	Faichney, Brian	02.03.2021	10.01.2022
1424	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	14.07.2015	End of support lifecycle for Microsoft Server Products	There is a risk that NHS Fife is victim of a targeted cyber intrusion due to Microsoft Servers falling out of support lifecycle, but still remaining in Production. Microsoft stopped supporting all Server 2003 products from July 14th 2015 and Server 2008R2 from January 14th 2020. Although these products will continue to function after this date, organisations will no longer receive patches for security vulnerabilities identified in these products, resulting in a successful cyber attack and data breach. There is also a risk that running legacy versions will cause legislative issues under NIS.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	09/03/2021 - The replacement programme continues to progress slowly due to resourcing issues, some vendors being slow to align products with MS support lifecycles, and lack of funding for upgrades which need new licensing or professional services to progress. NHS Scotland is now subject to ongoing NIS Legislation Audit, which may help to attract funding. This risk is also tracked on the IT Operations Monthly Highlight Report. Current numbers = 20 SRV2003 & 149 SRV2008/R2.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Young, Allan	Fowles, Malcolm	09.03.2021	01.03.2022

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529	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register	02.10.2012	Information Security Risk	There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, affect essential services, loss theft or misuse of paper based records during transportation, clinical processes or storage. This risk relates to the Networking and Information Systems(NIS)Regulations.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	This risk remains high. NHS Fife is taking steps to identify and risk assess data assets using the DPIA Template, but this involve significant effort to retrospectively complete, this is work in progress. There is ongoing discussion between the CSM and ISM as to the formulation of a work flow for DPIA's to progress through to streamline the process, this will be raised within the IG&S Ops meeting. The NIS regulations audit has been carried out and we await the report, this report will be used to build an action plan of progression towards addressing the information security objectives. CSM and ISM are in process of developing a framework of baseline acceptable standards and documentary requirements that will address information security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks:220,225, 226,230,537,538,540,1410,1569.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	1 - Remote - Can't believe this event would happen	4 - Major	Low Risk	4	McGurk, Margo	Irving, Kevin	20.04.2021	20.07.2021
1934	NHSFBD - Digital and Information - Information Technology Risk Register	08.09.2020	Loss of Email & Collaboration Services	There is a risk that NHS Fife users and services could be prevented from using Email and Collaboration solutions (such as Teams) due to a loss of connectivity to the Internet or Microsoft Azure Infrastructure, resulting in a negative impact upon services, collaboration and communication.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Dec 2020 - Initial work has begun to design and cost secondary connections to the Internet using resilient design and auto failover.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Young, Allan	Fowles, Malcolm		01.07.2021
1746	NHSFBD - Digital and Information - Information Services Risk Register, NHSFBD - Digital and Information Directorate Risk Register	25.02.2020	O365 May Cause Disruptive Network Overhead	There is a risk that the introduction of O365 alongside other Cloud solutions, will cause disruptive levels of Network traffic overhead. This is especially likely on branch sites with lower bandwidth and no local breakout to the Internet. Based in current plans, O365 is due to be delivered in stages between July-Dec 2020. Problems could manifest instantly when O365 is applied at any given site (which can be managed through testing) or through gradual degradation over time.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	05/11/2020 We have replaced the firewalls at QMH and have also started sending more data from VHK. We have also split most teams traffic away from our VPN and also allowed teams traffic to go direct from each site rather than forcing it to come back to central sites. Still monitoring on an ongoing basis.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	Young, Allan	Fowles, Malcolm	05.11.2020	13.04.2021

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226	NHSFBD - Digital and Information Directorate Risk Register	28.11.2007	Security of data being transferred off/on site	There is a risk that confidential or Personal Data may be lost or accidentally disclosed because it is lost in transit or if removable media is not handled securely e.g. data being transferred off/on site in paper or un-encrypted media, like laptops, USB, cd, DVD, PDA etc etc., resulting in a possible breach of data protection	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	31/03/2021 [KI]: The status of this risk has remained the same. The mitigations in place are: a) Encryption and device control of laptops, tablets, mobile phones and memory sticks as per GP/D6 Data Encryption Policy. b) Computer group policies that restrict the what memory storage devices can be connected to the NHS Fife network via computers/tablets. This does not apply to Windows 10 computers, Data Loss Protection(DLP) has not been implemented for this operating system. c) staff training & guidance on information governance, data protection and security - stronger training campaign and more specific training added in compliance with the NHS Scotland Information Security framework i.e. Networks and Information Systems Regulations. d) Discuss with eHealth Support team guidelines to be included as part of staff IG training with regards to how staff can check themselves if their equipment is or not encrypted. e) A patching policy for operating systems of endpoints (computers, mobile devices, tablets) has been developed and rolled out. This is still to implemented for servers. Windows Server 2003 & 2008 is no longer supported by Microsoft. f) The introduction of the SWAN Secure File Transfer (SFT), reduces the need to create DVD & CD due to the size and amount of data that can be transferred in a secure manner i.e. encrypted. This service allows none NHS email addresses to be used.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	3 - Moderate	Low Risk	6	Graham, Alistair	Irving, Kevin	31.03.2021	30.09.2021

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
1927	NHSFBD - Digital and Information - Information Technology Risk Register	08.09.2020	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Personal and special data will be processed via emails sent using the O365 Email service. There is a risk disgruntled staff, contractors, volunteers etc. may attempt to access other users email accounts to access information they are not entitled to read.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Use of secret authentication information (ISO 27002: A.9.3.1) This control is managed by the GP/P2 Password Policy and GP/I5 Information Security Policy. These policies will need to be reviewed to ensure that they are in sync with the O365 Email service and training reviewed to ensure that staff understand them. This control would be implemented by Microsoft as part of its ISO 27001 certification as well as implementing the 14 NCSC cloud security principals which includes identity and authentication for O365 Email software. Access control policy (ISO: A.9.1.1) (CAF: B2.d) The GP/D3-2 Access Controls for Information Systems and the GP/I5 Information Security Policy address this control. Access to networks and network services (ISO 27002: A.9.1.2) (CAF: B2.d) IT access to networks and network services requires an IT login account, which is covered by the following policies: GP/D3-13 System Access Provisioning Procedure; GP/D3 Data Protection and Confidentiality Policy - Appendix 2 NHS Fife IG structure, roles and responsibilities; GP/I5 Information Security Policy; FairWarning monitors inappropriate access. Termination or change of employment responsibilities (ISO: A.7.3.1) The NHS Fife Confidentiality Statement for Employees & Contractors needs to be updated to cover non-disclosure of information security measures and vulnerabilities after leaving its employment. Leavers and Movers form Outstanding Mitigations: Staff require protected training time around the safe use of email. Also the implementation of MFA or agreed conditional access to reduce the dependency on staff awareness to prevent information security incidents. There is the concern that enterprise management security (EMS) has not been procured as a risk mitigation for mobile devices.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Fowles, Malcolm	Fowles, Malcolm		15.10.2020
1932	NHSFBD - Digital and Information - Information Technology Risk Register	08.09.2020	T4 - User error (including those supporting system)	There is a risk that users may send emails with personal data to incorrect email addresses, because of out of date demographics or human error, resulting in a data breach.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Classification of information (ISO 27002: A.8.2.1) (CAF: B3.a) : NHS Fife has adopted the Scottish Government Mobile Data Standard (CEL 25, 2012), which is reference in GP/E6 Email Policy, Appendix 1. Information transfer policies and procedures (ISO 27002: A.13.2.1) (CAF: B3.b) GP/M4 Media Handling Policy; GP/M5 Mobile Device Management Policy GP/E6 Email Policy; SWAN SFT service;	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	Fowles, Malcolm	Callaghan, Sarah		15.10.2020
537	NHSFBD - Digital and Information Directorate Risk Register	02.05.2006	Failure of Local Area Network causing loss of access to IT systems	There is a risk of localised or widespread extensive and persistent IT network failure caused by failure of any of Local Area Networks within NHS Fife. Thus resulting in clinicians / admin staff being unable to access data which is pertinent to patient care and administrative services being significantly hindered.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	09/03/2021 - Some investment has been made in the LAN switches throughout Fife and replacement of any end of life appliances is planned. There will also be work ongoing to virtually segregate the LAN in order to make it more modular.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15	1 - Remote - Can't believe this event would happen	5 - Extreme	Low Risk	5	Young, Allan	Fowles, Malcolm	09.03.2021	01.03.2022

Item 8.4

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Committee Self-Assessment Report 2020-21**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Clinical Governance Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

2.2 Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

Following the comprehensive review undertaken in 2019 of the format and range of self-assessment questions previously used, a more light-touch review of the question set was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the questionnaire. Board Committee Chairs each approved a revised set of questions for their respective committee.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in early February 2021. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness. Given the events of the past year, an additional question was added to capture any comments related to the Committee's operation during the pandemic period.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite responses for the Clinical Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference and no matters of concern were raised.

Self-Assessment questionnaire (completed by members and attendees)

In total, 8 members (excluding the Chair) and 3 regular attendees completed the questionnaire. 4 members did not complete the questionnaire, likely due to ongoing Covid pressures on staff time, meaning this is a reduced level of response than seen in previous years. In general, the Committee's current mode of operation received a positive assessment from its members and attendees who participated. It was noted that Committee members were clear about their role, scrutinised effectively and participated appropriately in discussion, aided by an effective Chair. The operation of the Committee due the pandemic was praised, with respondents noting that it had been effective in scrutinising priority items and maintaining an appropriate level of challenge and oversight of the NHS Fife response. The quality of the minutes and follow up of the action list was also commended.

Some areas for improvement were highlighted. Initial comments identified for further discussion include:

- further work being required on agenda management, to focus the Committee on key matters and balancing the amount of operation detail provided given the Committee's governance role;
- improving the sign-posting on papers and reducing the provision of excessive data / appendices, to clearly identify what the Committee's input is expected to be; and
- reducing the number of late papers and improving the timeliness of information presented (noting, however, the particular impact of Covid on the Committee's operation this year).

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for:

- **Discussion** – what actions members would wish to see implemented to address those areas identified for improvement.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Outcome of Committee's self-assessment exercise

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics							
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	6 (55%)	5 (45%)	-	-	-	A very effective Committee that uses its membership, resources and authority fully. The Committee in my opinion is well resourced, has sufficient membership & authority to be effective.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	5 (45%)	6 (55%)	-	-	-	Should the HSCP Associate Director of Nursing also be part of the group as this would mirror the representation from Acute Services? Key stakeholders are present at the Committee with a very clear clinical voice from across the organisation. It would be good to have a more active public representative.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	3 (27%)	8 (73%)	-	-	-	Members of the Committee appear clear about their role - where this is still in development the Chair supports. Role is clearly laid out with good balance of participation / contributions. Some Committee members are not always constructive in their comments and sometimes bring personal issues to the table, which doesn't feel appropriate
A4.	Committee members are able to express their opinions openly and constructively.	6 (55%)	5 (45%)	-	-	-	Due to the lengthy agendas, participants are encouraged to take any issues that cannot be resolved outside of the meeting. This seems like a reasonable solution. Meetings are chaired effectively and opinions and views are sought. This Committee is well structured and has pathway for individuals to have free dialogue and scrutinise subject matter.

A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	3 (27%)	8 (73%)	-	-	-	Members are not discouraged from raising critical or sensitive issues, although a respectful and constructive approach is encouraged. Effective scrutiny and challenge are in place. This also supports the development of the Committee. I would agree that the members of this Committee are free to challenge any matter before them - and regularly do.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	2 (18%)	7 (64%)	2 (18%)	-	-	It is difficult to know what individual training needs are in relation to CGG unless members themselves raise something as an issue. The Committee receives briefings in the meetings and via board development sessions. The support from officials on this committee must be commended. The training given is both informative and helpful. As the age of digital moves with time it maybe that training can be given through this medium in the not so distant future, which would help the carbon footprint of the Committee.
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	3 (27%)	8 (73%)	-	-	-	There is broad representation from members who have experience across health and social care. There is good opportunity for in-depth discussion and consideration of specific topics e.g. SAB infection management. The Chair is very skilled in supporting all members to understand issues. This is enhanced via board development sessions. Members have the backup and support to call on additional support for clarity and understanding if so required and this helps ensure no grey areas exist. This support gives members reassurance when any issues arise.
B. Committee meetings, support and information							
B1.	The Committee receives timely information on performance concerns as appropriate.	2 (18%)	7 (64%)	2 (18%)	-	-	This has been difficult in the last 12 months due to the fast-paced and continually changing nature of the required response to COVID-19. There have been a number of late papers but personally I see this as having been unavoidable and understandable given the circumstances. It would only be a concern if late papers become the norm in less pressing times. As all NHS Boards are currently under direction due to the Covid pandemic, some aspects of performance monitoring are given greater focus than others.

							Regular scrutiny of the IPQR. Data and information on the whole are timely, with a few instances within the calendar year seeing data / information being untimely with new deadlines being given.....
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	4 (36%)	7 (64%)	-	-	-	Issues are raised in a timely way and exception reports shared.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	5 (45%)	6 (55%)	-	-	-	No issues.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	3 (27%)	6 (55%)	1 (9%)	1 (9%)	-	Papers attached as appendices to papers can be excessive. The inclusion of the accompanying SBAR gives direction as to what is being asked of members i.e. for noting or decision etc, which is helpful. This means less time is spent trawling through documentation that will not be discussed in any great depth or detail, with the focus on the papers that have been brought to the Committee for decision. Papers are of good quality and usually hit the mark in terms of level and detail. The data presented from time to time needs further explanation in that the figures on graphs do not tie up or to reach an appropriate conclusion needs the fog cleared a bit. Too much information can sometimes muddy the waters and leads to more questions being asked than the report answers. Presenting a subject is sometimes shorter than reading the report. Audio reporting on large subject matter would save trees.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	2 (18%)	7 (64%)	2 (18%)	-	-	As noted above, the need to priorities the clinical demands of the Executive group due to Covid has led to more verbal reports than usual. As far as possible in view of the pandemic and operational pressures. The individuals who receive meeting papers via (post) face delays that cut down the effectiveness. This is due to the inefficiency of the postal system currently. Access to digital papers would be better as would also suit individuals with sight issues etc.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	6 (55%)	5 (45%)	-	-	-	Agendas are very full but good discussion throughout. On occasions where the discussion is bigger, then alternatives are given to suit circumstance. i.e. further meeting to expand if time allows etc.

B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	6 (55%)	5 (45%)	-	-	-	Minutes are clear and concise and helpful when preparing for the Committee. Effective, clear and prompt with accuracy due to the excellent note taking at this committee.
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	6 (55%)	5 (45%)	-	-	-	Action list useful in this respect. The action list is clear and helpful. Some actions continue over to the next meeting and this doesn't always feel necessary.
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	7 (64%)	4 (36%)	-	-	-	High level of scrutiny supports assurance to Board.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub-groups) is operating effectively as part of the overall governance framework.	5 (45%)	6 (55%)	-	-	-	Committee is very effective and operates effectively.
C. The Role and Work of the Committee							
C1.	The Committee reports regularly to the Board verbally and through minutes and makes clear recommendations on areas under its remit when necessary.	7 (64%)	4 (36%)	-	-	-	Chair reports at every Board.
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	5 (45%)	6 (55%)	-	-	-	The Committee is very focussed and effective. This is correct level is due to the diligence of its members and the officials under direction of the Chair. Perhaps too much operational detail on occasion

C3.	The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered.	7 (64%)	3 (27%)	-	1 (9%)	-	I would also add that in the past year Covid related topics are prioritised. Agendas are full but issues are current. Too lengthy. Very well manged agenda and excellent structured approach ensures all TOR is covered well.
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	7 (64%)	4 (36%)	-	-	-	Meetings are well chaired and structured. Decision making is focussed with a high level of scrutiny. Very well managed approach and the public can be assured with confidence of the Committee's workings.
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	None. Issues highlighted in the recent review of the flu vaccination programme set out aspects of governance to be strengthened. Happy with working practice. No issues to flag. Perhaps discussion with Committee members of their role and how to conduct their interactions? Travel being drastically reduced would be a prime benefit to the committee and its members and better for the Planet. Giving clinicians time to manage their time better using digital input to when we have round-the-table meetings. Looking at ways to reduce the paper used in reporting is the way forward for all committees i.e. audio files, recordings etc. Being able to gives individuals / attendees time slots if only one presentation, as regularly Clinicians have to sit through long meetings to present one paper. Digital being the way forward cutting down on Travel, C02 emissions, Time, Heating and Power for meeting rooms, Allocation of meeting rooms less of an issue. Using digital technology and link ups screens for presentations cutting down the time that the presenter has to travel / attend.					

C6.	Particularly in reference to the challenges faced during the ongoing Covid pandemic, are you content with the Committee's input and oversight of areas of NHS Fife's response relevant to the Committee's particular remit? Please provide comments.	Yes, I am content I am satisfied that challenges have been covered regularly and thoroughly within the parameters of national programmes and emergency measures. It has been a challenging time for all. However, the Chair in particular has ensured due diligence on this committee Yes, even when committees were stood down during the first wave of the pandemic, special meetings and regular updates and papers were received and distributed through the CGC. As previously noted, the Committee agenda has given priority to Covid related issues and this has enabled members to have the necessary input and oversight of the response from NHS Fife. Yes, very - committee has requested sight of escalation plans and has provided scrutiny over winter plans. Yes. Happy with the way in which this particular committee adapts and carries out due diligence with all the challenges that face all of our NHS staff. Yes.					
D. Clinical Governance Committee specific questions							
D1.	The Committee is provided with appropriate assurance that the corporate risks related to the specific governance areas under its remit (i.e. those related to either Clinical, Finance and Performance, Remuneration, or Staff) are being managed to a tolerable level.	4 (36%)	7 (64%)	-	-	-	Assurance is given that corporate risk is has been managed adequately.
D2.	The performance information and data presented to the Committee allows for easy identification of deviations from acceptable performance (both negative and positive).	4 (36%)	7 (64%)	-	-	-	The formats i.e. IPQR, HAIRT report etc are consistent in their data presentation. The presentation of negative / positive performance is / has been highlighted adequately.

D3.	Where there is a negative deviation from acceptable performance, the Committee receives adequate information to provide assurance that appropriate action is being taken to address the issues.	6 (55%)	5 (45%)	-	-	-	Assurance given is / has been adequate where there has been a negative deviation.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Annual Assurance Statements & Reports from Sub-Committees & Groups**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. In order for the Clinical Governance Committee to finalise its own report, it first requires to consider the annual statements of assurance from its formal sub-groups, including the Clinical & Care Governance Committee of the IJB.

2.2 Background

The Clinical Governance Committee's sub-groups are: the Digital & Information Board; Health & Safety Sub-Committee; and the Information Governance & Security Steering Group. For assurance purposes, the minutes and an annual report of the Clinical & Care Governance Committee of the IJB are also part of the Committee's workplan of business.

2.3 Assessment

The four separate reports are given as annexes to this paper. Each report should indicate the span of business considered by each group over the course of the last financial year and draw out any areas of concern to be highlighted to the Committee. These are then covered within the Clinical Governance Committee's own annual report (given in full in a following agenda item).

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

Each of the Committee's sub-groups have considered their annual statements of assurance at recent meetings and each are formally approved by the respective Chair.

2.4 Recommendation

The paper is provided for:

- **Awareness** – For Members' assurance and information

3 List of appendices

The following appendices are included with this report:

- Clinical & Care Governance Committee Assurance Statement
- Digital & Information Annual Report & Assurance Statement
- Health & Safety Sub-Committee Annual Report & Assurance Statement
- Information Governance & Security Steering Group Annual Report & Assurance Statement

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

Fife Health & Social Care Partnership

Supporting the people of Fife together

CLINICAL AND CARE GOVERNANCE COMMITTEE

ANNUAL ASSURANCE STATEMENT 2020-2021

1 PURPOSE

1.1 To provide the Integration Joint Board (IJB), and through the IJB, the NHS Fife Governance Committees and the Fife Council Scrutiny Committee with the assurance that Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership (HSCP) and systems exist to make these effective throughout the whole of the areas responsibilities, including health improvement activities.

2 MEMBERSHIP

2.1 During the financial year to 31 March 2021 membership of the group comprised: -

Tim Brett (Chair)	Councillor from Fife Council
David J Ross	Councillor from Fife Council
Jan Wincott	Councillor from Fife Council
Wilma Brown	Non-Executive Director from NHS Fife
Christina Cooper	Non-Executive Director from NHS Fife
Martin Black	Non-Executive Director from NHS Fife

2.2 The Committee may invite individuals to attend the Committee meetings but normally in attendance would be:

Nicky Connor	Director of Health & Social Care Partnership
Dr Helen Hellewell	Associate Medical Director
Cathy Gilvear	Partnership Quality Clinical & Care Governance Lead
Lynn Barker	Associate Director of Nursing
Kathy Henwood	Chief Social Work Officer
Scott Garden	Director of Pharmacy

David Heaney	Divisional General Manager – East (until Nov 2020)
Julie Paterson	Divisional General Manager – Fife Wide (until Nov 2020)
Claire Dobson	Divisional General Manager – West (until Aug 2020)
James Crichton	Divisional General Manager – Fife Wide (from Oct 2020)
Lynne Garvey	Divisional General Manager – West (from Jan 2021)
Fiona McKay	Head of Strategic Planning, Performance and Commissioning (until Nov 2020) then as Interim Divisional General Manager - East (from Jan 2021)
Simon Fevre	Staff Side Representative
Paul Madill	Consultant Public Health
Helen Woodburn	Head of Quality & Clinical Governance
Chris McKenna	Medical Director & Responsible Officer for NHS
Helen Buchanan	Nurse Director NHS Fife

2.3 The IJB Chair and the Director of the Health & Social Care Partnership have the right to attend the Clinical & Care Governance Committee.

3 MEETINGS

3.1 The Committee meets bi-monthly (between IJB meetings) to fulfil its remit but not less than four times per year. The Committee may meet more frequently if deemed necessary by the Chair. The Group met on 5 occasions during the year (1 April 2020 to 31 March 2021) on the undernoted dates: -

3.2 The attendance schedule is attached at Appendix 1.

4 BUSINESS

4.1 Details of the substantive business items considered are attached as Appendix 2.

4.2 Minutes of the meetings of the Clinical & Care Governance Committee have been timeously submitted to the IJB for its information.

4.3 The range of business covered at the meetings and the additional papers submitted to the Board demonstrates that the full range of matters identified in Clinical & Care Governance Committee's remit is being addressed.

4.4 Adequate and effective Clinical & Care Governance arrangements were in place throughout year 2020 - 2021.

5 BEST VALUE

5.1 Reliance is placed on the value for money arrangements within the partner organisations. The IJB has issued directions to the partnership organisations with regard to finance. The IJB Audit & Risk Committee approved the Governance Framework Action Plan on 6 July 2018 and work continues to progress this.

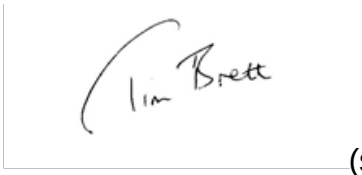
6 RISK MANAGEMENT

6.1 The Risk Management Strategy was approved by the IJB on 7 April 2016. This includes the reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities and monitoring risk management activity and performance. The Committee has considered risk through a range of reports and scrutiny. Progress and appropriate actions were noted.

7 CONCLUSION

7.1 As Chair of the Clinical & Care Governance Committee during financial year 2020 - 2021, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at the meetings has allowed us to fulfill our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective Clinical & Care Governance arrangements were in place across all Divisions of the Fife Health & Social Care Partnership during the year.

7.2 I would thank all those members of staff who have prepared reports and attended meetings of the Committee and express my sincere thanks to all staff for their excellent support of the Committee.



(signed) 16 April 2021 (date)

Councillor Tim Brett
CHAIRPERSON 2020-2021
On behalf of Fife Health & Social Care Partnership Clinical & Care Governance Committee

Appendix 1

FIFE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL & CARE GOVERNANCE COMMITTEE ATTENDANCE
1 APRIL 2020 TO 31 MARCH 2021

	07 Aug	02 Oct	13 Nov	29 Jan	26 Feb
Cllr Tim Brett (Chair)	√	√	√	√	√
Christina Cooper	√	√	√	√	√
Cllr David J Ross	√	√	√	√	√
Councillor Jan Wincott	√	√	√	√	√
Martin Black	√	√	√	√	√
Wilma Brown	Apol	√	√	√	Apol

Appendix 2

FIFE HEALTH & SOCIAL CARE PARTNERSHIP
CLINICAL & CARE GOVERNANCE COMMITTEE
SCHEDULE OF BUSINESS CONSIDERED 2020-2021

07 August 2020

Remobilisation Plan
Care Homes (Progress Report) / CNO Letter
COVID-19 Risk Register
Post COVID Inspection Visits
Clinical Quality Report
Winter Plan Review / Winter Planning 2020-2021
CAMHS
Joining Up Care / Urgent Care Review
Clinical and Care Governance Annual Statement of Assurance / Review of Workplan
Complaints Update
C&CGC and Pharmaceutical Care Services Annual Report 2019/20

02 October 2020

Clinical Quality Report
Mental Health Strategy : Restraints & Ligature Deep Dive
Joint Fife HSCP Fife Flu & COVID-19 Vaccination Oversight Group Paper
Urgent Care
Care Homes Assurance
Care Inspectorate Report
Winter Plan Update
Primary Care Improvement Plan
Mental Health Strategy Implementation Plan and Suicide Prevention Plan
HSCP Annual Performance Report for Governance

13 November 2020

Clinical Quality
Mental Welfare Commission Inspection Visit Update
Alcohol and Drug Partnership Annual Report / Strategy
Winter Readiness
CAMHS
Urgent Care
Professional Assurance Framework Report
The Keys to Life

29 January 2021

Clinical Quality Report
Winter Position
COVID Vaccination Programme Update
Mental Health Strategy Implementation Plan
PC Improvement Plan (SG Letter)
Child Protection Committee Annual Report

Children's Services Inspection Action Plan
NHS Children's Services : Child Protection Report
SBAR Overview : Clinical & Care Governance / COVID-19

26 February 2021

COVID-19 Position Update
Lateral Flow Testing
Winter Update
Pharmaceutical Care Services Report 2020/21
Care Home Update
NHS / HSCP Inspection Visits – Hollyview Stratheden / Tarvit / Glenrothes
Mental Welfare Commission End of Year Meeting
RM Annual Report

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE DIGITAL & INFORMATION BOARD FOR FOR 2020-2021

1. Purpose

1.1 The purpose of the Digital & Information Board is to develop and monitor the Digital & Information Strategy and resulting delivery plan on an annual and long term basis in line with the National Digital Health & Care Strategy and to support the delivery of the NHS Fife Annual Operational Plan, clinical strategies and policies.

2. Membership

2.1 During the financial year to 31st March 2021, membership of the Digital & Information Board comprised:

Dr Chris McKenna	**Chair** - Medical Director
Lesly Donovan	General Manager – Digital & Information
Dr Philip Duthie	General Practitioner
Dr Helen Hellewell	Associate Medical Director, H&SC Partnership
Andy Mackay	Deputy Chief Operating Officer (until October 2020)
Dr John Chalmers	Digital & Information Clinical Lead
Margo McGurk	Director of Finance & Strategy - **SIRO**
Mr Scott Garden	Director of Pharmacy & Medicines
Miriam Watts	General Manager – Emergency Care
Amanda Wong	Interim Associate Director, AHPs
Claire Dobson	General Manager H&SCP (from October 2020, Director of Acute Services)
Josie Murray	Consultant in Public Health
Janette Owens	Associate Director of Nursing (from March 2021 Director of Nursing)
Lee Cowie	General Manager, Mental Health & Disability Service
Nicky Connor	Director of Health & Social Care
Lynn Barker	Associate Director of Nursing

2.2 The Digital & Information Board may invite individuals to attend meetings for particular agenda items, but the list of attendees detailed in 2.1 will normally be in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting and their attendance is included in Appendix 1.

2.3 The membership and attendance of the group were sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the Group's annual workplan.

3. Meetings

3.1 The Digital & Information Board met on three occasions during the financial year to 31 March 2021, on the undernoted dates:

- 21st April 2020 - This meeting cancelled due to COVID 19
- 15th July 2020

- 6th October 2020
- 19th January 2021

3.2 The attendance schedule is attached in Appendix 1.

4. Business

4.1 The Group has developed the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital Strategy and associated delivery plan. This work included consideration of the Internal Audit findings within reports B31, B32, B06 and B08.

4.2 Minutes of the meetings of the Digital & Information Board have been timeously submitted to the Clinical Governance Committee (CGC) for its information.

4.3 The Digital and Information Strategy 2019 – 2024 was presented to the NHS Fife Board and approved on 30 September 2020.

4.4 The necessity to support the COVID-19 pandemic response has impacted the planned activities of the group and the delivery plan associated with the Strategy. The Board's consideration of the impact was outlined in a report submitted to CGC on 7 September 2020. The group noted there had been considerable benefits to digital adoption in many key areas during this time, supported by key financial investment decisions. The Board recognised that the lessons learnt through this year should be considered for the work of the Board in future years.

4.5 The range of business covered at the meeting demonstrates that the full range of matters identified in the Digital & Information Board's remit. Reporting to the Digital & Information Board has been evolving but it has been recognised that there needs to be more explicit detail regarding large projects.

In line with its Terms of Reference, the Digital & Information Board has considered the undernoted aspects:

- The development of NHS Fife Digital & Information Strategy 2019 – 2024
- Progress with implementing new systems;
- Support available to develop new initiatives;
- Operational Performance and improvements;
- Digital & Information Requests; and
- Compliance with National Digital Health & Care Strategy

4.6 Significant activity considered:

- Six Business Cases (at varying stages, Initial Agreement, Outline and Final Business cases) were brought to the Digital & Information Board. Of note was the Outline Business Case for HEPMA which was approved for onward consideration and sign off by the NHS Fife Board due to cost and impact.
- Oversight and guidance provided by the Board to the national initiatives mandated including, the adoption of Near Me and the accelerated adoption of Office 365 applications including MS Teams, Mail Migration and Microsoft Identity Management.
- Several initiatives that incorporated enhanced engagement with our patients were considered including the adoption of Near Me in support of remote consultation

capacity, Digital Hub for the presentation of electronic letters to patients (ongoing) and Self Booking to allow patients an opportunity to self-book for community services.

- Two Quarterly performance reports were presented and scrutinised. No items of concern were noted and no items require to be highlighted to the Clinical Governance Committee.
- Individual large scale programme highlight reports were reviewed for National, Regional and Local activities, many of which are aligned to NHS Fife strategic priorities.

4.7 The Board continues to give careful consideration to the Digital Readiness of our staff and patients. Recognising the opportunity to maximise the digital enablement and ensure equality of access to services this work will be critical to supporting a digitally enabled health and care system.

5. Risk Management

5.1 The Digital & Information Board has considered all relevant risks identified as Digital & Information within the corporate and project risk registers, at every meeting. Progress and appropriate action were noted.

5.2 The Associate Director of Digital & Information has initiated a full risk audit within the areas of Digital & Information, with particular attention being given to the correct ownership of the risks within the organisation and being able to evidence the mitigation actions being planned and taken. An early focus is a financial assessment of the Digital and Information Strategy to ensure affordability can be matched with expectation and ambition.

5.3 The Digital & Information Board Assurance Framework (BAF) continues to be maintained and presented to relevant standing committees. The BAF is being piloted to apply assurance mapping and work is ongoing with the support of Internal Audit.

6. Conclusion

6.1 As Chair of the Digital & Information during the financial year 2020 - 2021, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Digital & Information has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

6.2 I can confirm that there were no significant control weaknesses or issues at the year-end which the Digital & Information considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

6.3 I would pay tribute to the dedication and commitment of fellow members of the Digital & Information and all attendees. I would thank all those members of staff who have prepared reports and attended meetings and would wish to extend my thanks to all the Digital and Information Teams for their outstanding and significant effort during the COVID-19 Pandemic response.

Signed:  Date: 21 April 2021

Dr Chris McKenna, Chair
On behalf of the Digital & Information Board

APPENDIX 1

NHS Fife Digital & Information Board Attendance Record
1st April 2020 to 31st March 2021

	21/04/20 Meeting cancelled due to COVID 19	15/07/20	06/10/20	16/02/21
Members				
Chair Dr Chris McKenna	x	√	√	√
Mrs Lesly Donovan	x	√	√	√
Dr Philip Duthie	x	√	√	√
Andy Mackay	x	√		
Dr John Chalmers	x	√	√	√
Scott Garden	x	√	√	√
Amanda Wong	x	√	√	√
Josie Murray	x	x	x	√
Ms Janette Owens	x	√	√	x
Lee Cowie / Jillian Torrens*	x	√	√	√
Miriam Watts	x	√	x	√
Claire Dobson	x	√	√	x
Margo McGurk	x	√	√	√
Nicky Connor	x	x	x	x
Lynn Barker	x	x	√	x
Helen Hellewell	x	x	x	x
In attendance				
Mr Andy Brown	x	√	x	√
Ms Claire Neal	x	√	√	√
Ms Eileen Duncan	x	x	x	√
Mr Allan Young	x	√	x	√
Ms Marie Richmond	x	√	√	√
Mr Torfinn Thorbjornsen	x	x	√	x
Ms Margaret Guthrie	x	√	x	√
Mr Alistair Graham				√

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE HEALTH & SAFETY SUB COMMITTEE

1. Purpose

1.1 The purpose of the Health and Safety Sub-Committee is to ensure that Fife NHS Board provides a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations with regards to Health and Safety.

2. Membership

2.1 During the financial year to 31 March 2021, membership of the sub-committee comprised:

Name	***Role / Designation***
Mr Andrew Fairgrieve	Director of Estates, Facilities and Capital Services (Chair) [until February 2021]
Mr Neil McCormick	Director of Property and Asset Management [from March 2021]
Dr Christopher McKenna	Medical Director
Ms Linda Douglas	Director of Workforce (Vice- Chair)
Mr Conn Gillespie	Staff Side H&S Representative
Mr Craig Webster	H&S Manager (Lead officer)

2.2 The Sub-Committee may invite individuals to attend meetings for particular agenda items, but Mr David Young (H&S admin support) will normally be in attendance at meetings for purposes of minute taking. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

3. Meetings

3.1 The sub-committee met on four occasions via Teams during the financial year to 31 March 2021, on the undernoted dates:

- 12 June 2020
- 11 September 2020
- 11 December 2020
- 12 March 2021

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 Unsurprisingly the business of the Health & Safety Sub-Committee has been dominated by issues relating to the COVID Pandemic. The 2019 – 2021 Workplan was ratified at the June 2020 meeting, as were the Terms of Reference for the Sub-Committee. Whilst some aspects of the workplan were affected, the policy and procedure reviews scheduled for the year were completed.

4.2 Discussions at the June 2020 meeting reviewed the approach to the pandemic during what turned out to be the first wave. The group noted that the Board approach at all levels had been robust and that safety measures had been properly implemented. There was discussion regarding face-fit testing for staff and issues with regards to ongoing supply of particular FFP3 respiratory protection.

4.3 There was also discussion relating to a complaint received by the Health & Safety Executive (HSE) regarding COVID management issues in the North Laboratory. There was disappointment that the issue seemed to have been escalated directly to HSE rather than through line management or staff side colleagues. At the time of the meeting, the Health & Safety manager was liaising with laboratory and HSE staff regarding the complaint. Updates on a number of policies and procedures were received by the sub-committee.

4.4 Discussions regarding COVID issues were raised at the September 2020 meeting, but no significant concerns were raised as the national situation seemed to be improving. The H&S Manager noted that the complaint regarding the laboratories had been resolved with no site visit or further follow up from HSE inspector. However, the sub-committee was again disappointed that a second complaint to HSE regarding the Laundry had been made by staff. Again, this had been escalated directly to HSE. The H&S Manager was able to advise the sub-committee that this complaint too had been closed with no site visit from HSE inspectors. Updates on a number of policies and procedures were received by the sub-committee. The sub-committee was also informed at this meeting that the Internal Audit service would be conducting a review of Sharps Management issues in NHS Fife and that the H&S manager was liaising with the service to support this.

4.5 In November 2020, NHS Fife received a COVID Management 'spot check' visit from two HSE inspectors. This visit was conducted on the VHK site only. The visit resulted in a 'Notice of Contravention' being issued to the organisation with a requirement for actions to be taken. The December 2020 sub-committee meeting was therefore given over to discussion on the detail of the Notice to ensure that actions were being addressed and that appropriate managers and staff were involved in this work. The H&S manager was able to advise that a number of actions identified had already been actioned and that support was being received from the Deputy Chief Operating Officer, Hospital Control Team and relevant departments. The issues raised by the HSE centred mainly on application of physical distancing (especially in rest / break areas), records management and training with regards to face fit testing and fit testers and concerns with changing and locker facilities. Detail of this discussion as noted in the meeting minutes is included as Appendix 2. The sub-committee was also updated on the outcome of the audit conducted on sharps management, with indication that full discussion would be made at the March 2021 meeting.

4.6 The March 2021 meeting was still dominated by discussions around COVID and the HSE action plan. However, with the retirement of Mr Andrew Fairgrieve, this was also the first meeting to be chaired by Mr Neil McCormick. There was therefore discussion around the future plans for the sub-committee, including the Terms of Reference and membership of the group. The agreement for the time being was to refresh and update the Terms of Reference and workplan for 2021 – 2023 but no significant changes to membership or frequency of meetings at this time.

5. Risk Management

5.1 The COVID Pandemic and HSE interventions dominated the H&S agenda for 2020 – 2021 resulting in significant reactive work for the H&S Team. Despite this, the team

were able to continue with 'business as usual' support for the organisation as well as managing HSE visits, action plans, meeting support and delivery of fit testing 'clinics' up to three days per week. This reactive work represented key risks for the organisation and the work undertaken on behalf of the sub-committee aligned with the remit to ensure that Fife NHS Board provides a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations with regards to Health and Safety.

5.2 During the pandemic however, routine face-to-face training for manual handling and aggression management has been suspended. This has resulted in a back-log of personnel, including new starts who will require training support and updates in 2021 – 2022. This will be a key focus for the H&S Manager and sub-committee.

5.3 The Sharps Management Audit raised particular concern regarding difficulties with clinical / nursing attendance at the NHS Fife Sharps Strategy Group, which has hampered efforts for wider implementation of sharps management and training across NHS Fife. Again this, alongside recommendations from the internal audit report, will be a key focus point for the H&S Sub-committee in 2021 – 2022.

6. Conclusion

6.1 This annual report has been jointly agreed by Mr Andrew Fairgrieve (as previous Chair) and by Mr Neil McCormick as current Chair of the H&S Sub Committee in discussion with sub-committee members. The following paragraphs were agreed by Mr Fairgrieve prior to his retirement.

6.2 As Chair of the Health & Safety Sub-Committee during financial year 2020-2021, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

6.3 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Health & Safety Sub-Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

6.4 I would pay tribute to the dedication and commitment of fellow members of the Health & Safety Sub-Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

6.5 I would also note that, with my retirement, the Chair of the Sub-Committee will pass to Mr Neil McCormick, Director of Property and Asset Management.

Signed:  Date: 24 March 2021

Neil McCormick, Chair
On behalf of the Health & Safety Sub-Committee

Appendix 1 – Attendance Schedule
Appendix 2 – December meeting discussions on HSE Notice of Contravention

APPENDIX 1

NHS Fife Health & Safety Sub-Committee Attendance Record
1st April 2020 to 31st March 2021

	12 June 2020	11 September 2020	11 December 2020	12 March 2021
Members				
Mr Andrew Fairgrieve	✓	✓	✓	
Mr Neil McCormick				✓
Dr Christopher McKenna	×	×	✓	×
Ms Linda Douglas	×	×	✓	✓
Mr Conn Gillespie	✓	✓	✓	✓
Mr Craig Webster	✓	✓	✓	✓
In attendance				
Mr David Young	✓	✓	✓	✓
Ms Rhona Waugh (for Ms Linda Douglas)	✓	✓		

HSE Notice of Contravention Discussion
[Extract from minutes of December 2020 Sub-Committee Meeting]

NOTICE OF CONTRAVENTION

Endoscopy units undertaking AGPs
CW pointed out to the group that a response regarding Endoscopy Unit Risk Assessment on the AGPs needs to be sent to HSE by 16th January 2021. [ADDENDUM: This was achieved. Inspector came back with further questions and requests for information. This too was provided on time.]

CW informed the group that information does exist in various documents but needs to be pulled together. AF advised that CW should contact Paul Bishop to obtain information from ENGIE.

CW has most of the information which he is currently pulling together CW will contact Ann Haythorne for clinical support and input.

Main Staff Locker Room
CW stated that an existing risk assessment can be adapted. CW will take lead. AF commented that issues could be difficult to resolve due to logistics and space.

LD added that physical issues could perhaps be considered, amending shift rosters for example. AF agreed stating that all issues should be explored.

CM commented that he had advised Junior Doctors to use the locker room as a safe place and asked if this was correct. The group agreed this was correct advice.

CG asked if it would be possible to audit the number of staff who are using the changing rooms. AF stated that the access system for the changing rooms should be able to provide this information but unfortunately, the system is currently faulty. If the system is repaired, it will make it possible to monitor the number of staff using the changing rooms. [ADDENDUM-system was repaired. Level of access low with busiest period around 07:00 – 09:00 with approximately 60 staff entering the area over this period]

CW informed the group that all necessary sinks and cubicles within the main staff locker rooms have been taken out of action.

There was some discussion regarding screens and the amount of protection they provided. CW suggested that the HSE seemed to be pushing for screens to be installed. LD highlighted the need to be mindful regarding an organisationally balanced response to meet HSE requirements. AF agreed, suggesting that all actions should be run past EDG. CW raised concerns regarding screens stating that Health and Safety Team, Infection Prevention and Control Team, Occupational Health Team and Microbiology all agree that screens may not provide adequate protection and face masks, in this instance, offer better protection.

CW told the group that posters and tape are now in place.

LD asked if this will be carried through into other areas. CW confirmed that this will happen.

Theatres locker rooms
CG confirmed that space in the theatre locker rooms is tight. CG also suggested that Claire Lee was the best person to contact.

CW asked if CG would be able to take charge of the assessment. CG agreed and will contact Claire to arrange this

CG told the group that the existing lockers are small and there may be some difficulty storing jackets etc. There may be some housekeeping issues.

AF stated that a review may be required for all staff changing facilities and there may be a need for additional spaces.

AF said that solutions may be available to make use of existing spaces within the Hospital for welfare/ communal areas.

CG noted that staff will take masks off when using communal areas for example to eat and asked if the group had any ideas. AF stated that physical distancing should be used along with the removal of un-necessary tables and chairs.

Alongside social distancing LD noted that restrooms have a function as a restful place for staff to relax and that should be considered when making any changes.

Health records Filing, The 'Queen Margaret Room'
CW indicated that issues identified by HSE had been addressed.

Clinical Areas - welfare and communal areas
There was some discussion by the group. CW suggested that staff should be encouraged to clean areas before and after use. LD stated that safety huddles could be used to reinforce the message.

There was some discussion by the group regarding how the organisation can implement COVID management training for Staff. LD asked if this could be added to the return to work training. CW to contact Kirsty Berchtenbreiter to discuss.

Laundry
CW stated that the installation of screens may be required. CW conducting site visit with Paul Bishop 14 December to review. [ADDENDUM: Screens installed early January and inspector notified.] Otherwise all issues identified by HSE had been addressed.

Kitchen/ Dining Room
CW indicated that issues identified by HSE had been addressed.

Face Fit Testing
CW stated that he is confident in the competence of staff carrying out face fit testing. However, he informed the group that the staff carrying out the testing have no formal accredited training. CW is making arrangements for bespoke training session to provide formal accreditation for the H&S team fit testers.

CW said that local fit testers will require refresher training and competency updates. CW exploring possibility of being able to provide ‘in-house’ Fit2Fit accreditation.

AF thanked CW and the Health and Safety team and asked if help was required to achieve HSE timescales. CW thanked AF and indicated that help was not needed at present. AF said that CW should not hesitate to escalate any issues

AF advised CW that once the draft has been completed, it should be sent to the Sub Committee and also to Carol Potter for discussion at EDG.

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE INFORMATION GOVERNANCE & SECURITY STEERING GROUP

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement that relates to the effectiveness of the structures, policies and practice in place to ensure the confidentiality, availability and integrity of the information processed by or on behalf of NHS Fife, including patient records and all corporate records which are pertinent to regulations, and to enable the ethical and safe use of them for the benefit of individual patients and the public good.

2. Membership

2.1 During the financial year to 31 March 2021, membership of the Information Governance & Steering Group comprised: -

Membership	
Margo McGurk	**Chair/SIRO** - Director of Finance & Strategy
Bruce Anderson (until November 2020)	Head of Staff Governance (on behalf of the Director of Workforce)
Linda Douglas (from December 2020)	Director of Workforce
Dr Chris McKenna	Medical Director - **Caldicott Guardian**
Helen Hellewell	Associate Medical Director, H&SCP
Janette Owens	Associate Director of Nursing (to December 2020) Director of Nursing (from January 2021)
Philip Duthie	General Practitioner
Frances Quirk	Assistant Research & Development Director
Claire Dobson	Director of Acute Services
Jim Crichton	Interim General Manager, Health and Social Care Partnership (on behalf of Director of Health & Social Care)
Lesly Donovan (until March 2021)	General Manager, Digital & Information
Alistair Graham (from February 2021)	Associate Director, Digital & Information
Susan Fraser	Associate Director of Planning and Performance
Scott Garden	Director of Pharmacy & Medicines

Attendance	
Andy Brown	Principal Auditor
Lizzie Gray	Patient Relations Officer *(on behalf of Head of Person Centred Care)*
Kirsty MacGregor	Head of Communications
Gillian MacIntosh	Head of Corporate Governance
Allan Young	Head of Digital Operations

2.2 The Information Governance & Security (IG&S) Steering Group invited individuals to attend meetings for particular agenda items and the list of attendees detailed in

2.1 have been in regular attendance at meetings. Other attendees, deputies and guests have been recorded in the individual minutes of each meeting.

2.3 The membership and attendance of the group was sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the Group's annual workplan.

3. Meetings

3.1 The Information Governance & Steering Group met on three occasions during the financial year to 31 March 2021, with one meeting cancelled, on the undernoted dates:

- 15 October 2020
- 8 December 2020 – Meeting cancelled as not quorate
- 13 January 2021
- 23 March 2021

3.2 The attendance schedule is attached in Appendix 1.

4. Business

4.1 The IG&S Steering Group reformed in October 2020, following the transfer of Senior Information Risk Owner responsibilities to the Director of Finance & Strategy. The group delayed its first meeting in the 2020-21 period till October to allow the revised governance arrangements of the IG&S Operational Group and IG&S Steering Group to be established and due to the work pressures associated with the COVID-19 pandemic.

4.2 The Group has developed the governance, process and control framework arrangements necessary to assure the organisation about the confidentiality, availability and integrity of patient, corporate and staff information held across the organisation. This work included consideration of the Internal Audit findings within reports B31, B32, B06 and B08.

4.3 The Group has developed Terms of Reference for the IG&S Steering and Operational Groups. The Group also gave careful consideration to membership to reflect the importance and corporate nature of the Group's remit.

4.4 As detailed in section 5, Risk Management has been a consistent feature of the Groups work to date.

4.5 The Group has taken time to consider and provide guidance on the appropriate presentation of information to provide an accurate baseline of compliance within the IG&S domains, and the presentation of work plan activities and objectives within a timeline plan for the coming year. Consideration and support to the availability of a summary dashboard that supports the work of the Operational and Steering Groups was agreed at its meeting on 15 October 2020 and is now under development. The consideration and guidance given covered the necessary areas of:-

- Data Protection & GDPR
- Freedom of Information Requests
- Public Records

- NHS Scotland Information Security Policy Framework
- NHS Fife Information Governance & Security Policies
- Information Governance & Security Incident Reports

4.6 Within the detailed work plans, now being created, the Group sought the inclusion of communication, training and education activities to ensure that staff and key members can support and affect improvement in IG&S compliance and assurance received a clear understanding of their responsibilities. The Group noted the benefit of the Freedom of Information paper presented to the Executive Directors' Group (EDG) on 18 February 2021, which detailed a sustained improvement in performance in answering requests within the statutory timeline.

4.7 The Group reviewed an assurance report detailing the current baseline of performance and controls within the remit of the IG&S activities. The Group recognised that while compliance and assurance in some areas were effective, in others improvement is necessary to ensure the consistent confidentiality, availability and integrity of patient, corporate and staff information. From the report, the Group specifically noted:

- that Subject Access Requests (Acute) achieved an average 96.6% compliance between April 2020 and March 2021 against a 100% target of responding within one month.
- the presentation of registers relating to Data Protection Impact Assessments; Data and Information Sharing Agreements; Caldicott Requests and Information Assets.
- that Freedom of Information requests had achieved the required standard of response time in 8 out of 12 months (April 2020 – March 2021), and consistently for each of the last 6 months (October 2020 – March 2021). The response standard is that 85% of requests are provided within the 30-day timeframe. The group recognised the improvement in performance in this area and will continue to monitor.
- a revised Records Management Plan had been approved by the Chief Executive and had been submitted, in February 2021, to the Keeper at the National Records for Scotland. We await formal feedback from the Keeper to inform the action plan.
- that a national external audit relating to Network and Information Systems Directive (NISD) compliance was conducted in March 2021 (findings report expected in April 2021). The Group noted the implementation of controls specifically the 12 high priority items from the previous audit and tactical progress across medium and low priority items. The controls required across the NISD domain remain dynamic given the nature of external threat and benchmarking across NHS Scotland helps to identify areas for action.
- that of the 17 active policies within the IG&S Domain, 8 are up to date and active, 6 have been reviewed and await approval and 3 are currently under review with targeted completion by May 2021.
- the positive in-year continuation of monthly reporting or direct representation to the SIRO, for alerting, complying and actioning any events considered to be a breach of data protection regulations including near misses.
- that during the financial year 2020 to 2021, 11 incidents were reported to the Information Commissioner's Office (ICO), with no further action required for 9 of the incidents. The ICO is still to report on 2 incidents reported in March 2021. This is a reduction from the 13 incidents reported to the ICO during 2019 to 2020 financial year.

A summary report on performance across the year is in Appendix 2.

4.8 The Group recognised the requirement to further enhance and develop suitable controls in some areas and are meeting regularly to progress.

5. Risk Management

5.1 In line with the Board's agreed risk management arrangements, the IG&S Steering Group has given careful consideration to the risk management processes currently adopted in this area, work that is also extending across Digital & Information teams.

5.2 To support the clarity on governance responsibility, the SIRO has requested that a full risk review is conducted by the Associate Director of Digital & Information. Within this review, to be completed by May 2021, careful consideration should be given to the correct alignment of risks between the Information Governance and Security Steering Groups and the Digital and Information Board governance routes. This should include the assignment of the correct risk owner and handler, evidence of regular risk review, details of planned and completed mitigations and their impact on the risk level.

5.3 The Digital & Information Board Assurance Framework (BAF) continues to be maintained and presented to relevant standing committees. The Digital & Information BAF is being piloted to apply assurance mapping and work is ongoing with the support of Internal Audit.

6. Conclusion

6.1 As Chair of the Information Governance & Security Steering Group, I am satisfied that the focussed improvement approach, being developed at pace, the frequency of meetings, the breadth of the business undertaken and the range of appropriate attendees at meetings will enable successful delivery of the remit of the group.

6.2 In parallel with the development of the appropriate governance and controls, we have commenced the design of a reporting mechanism that will deliver the required evidence to demonstrate the effectiveness of the new controls in place across all areas of IG&S.

The following statement summarises the assurance that can be given on the controls operating in relation to IG&S across the organisation:

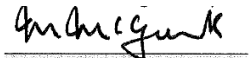
As a result of the work undertaken during the period from October 2020, I can confirm that we have established effective governance arrangements, and introduced the necessary processes and controls to provide a baseline of consistent and reliable assurance for IG&S.

Reporting on compliance with the controls framework has been developed and will be embedded in practice during 2021/22.

There were no material deteriorations in levels of compliance against controls during 2020/21, indeed several areas noted improved performance, however a number of areas require further work to ensure consistent improvement.

Focus has been established on targeting improvements in compliance where that is required and this will be continuously monitored during 2021/22.

6.3 I would pay tribute to the dedication and commitment of fellow members of the Group and to all attendees, who have supported the rapid development of governance and controls. I would thank all those members of staff who have prepared reports and attended meetings.

Signed:  Date: 21 April 2021

Margo McGurk
On behalf of the Information Governance & Security Steering Group

Appendix 1 – Attendance Schedule
Appendix 2 – Summary IG&S performance report

NHS Fife Information Governance & Security Steering Group
Attendance Record 1st April 2020 to 31st March 2021

	15/10/20	08/12/21 Cancelled as not quorate	13/01/21	23/03/21
Members				
Margo McGurk	✓		✓	✓
Claire Dobson	✓		✓	x
Lesly Donovan	✓		✓	
Linda Douglas (Kirsty Berchtenbreiter attending as Deputy)	x		✓	✓
Philip Duthie	✓		✓	x
Susan Fraser	✓		✓	✓
Scott Garden	✓		x	x
Dr Helen Hellewell	x		x	x
Dr Christopher McKenna	✓		x	x
Janette Owens (Doreen Young attending as Deputy)	✓		x	x
Nicky Connor (Jim Crichton attending as Deputy)	x		x	✓
Frances Quirk	✓		✓	✓
Bruce Anderson	✓			
Alistair Graham				✓
In attendance				
Elizabeth Gray	x		x	x
Margaret Guthrie	✓		✓	✓
Kirsty MacGregor	x		✓	x
Gillian MacIntosh	x		x	✓
Allan Young	x		x	✓
Andy Brown	x		✓	✓

Summary IG&S Performance Report

	Information Governance & Security Performance Summary	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Performance Indication	Trend
Operational Performance	Cyber Security - Exposure Score*	25%	68	57	35	36	37	40	41	64	42	48	41	38		
	FOI's - Responses within target	85%	100.0%	81.8%	72.7%	72.0%	93.3%	81.1%	96.8%	87.5%	93.5%	93.6%	91.1%	100.0%		
	SARs Received (% responded to timeously)		9 (100%)	10 (90%)	20 (95%)	35 (100%)	28 (100%)	25 (100%)	19 (100%)	19 (100%)	18 (100%)	28(85.71%)	25(96%)	43(93%)		
	Information Governance Incidents		47	50	59	57	68	61	95	102	82	123	82	81	N/A	
	Incidents Reported to ICO		1	0	0	0	2	0	3	0	1	1	1	2	N/A	
	Follow up required by ICO		0	0	0	0	0	0	0	0	0	0	0	0	N/A	

* Scored out of 100; Low 0-29, Med 30-69, High 70-100

Item 8.6

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Draft Clinical Governance Committee Annual Statement of Assurance 2020-21**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. The Clinical Governance Committee is invited to review the draft of this year's report and comment on its content, with a view to approving a final paper for onward submission.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. Given the extended timeframe for approval of the accounts this year (September), amendments can be discussed and recommended and a final version brought back to the next Committee meeting, if so required.

2.3 Assessment

The annual reports from the Committee's sub-groups are included in a previous agenda item and their content has been considered in the drafting of this report. In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2020-21, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and Executive Lead and takes account of any initial comments thus received.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2020/21

1. Purpose

1.1 To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities, including health improvement activities.

2. Membership

2.1 During the financial year to 31 March 2021, membership of the Clinical Governance Committee comprised: -

Dr Leslie Bisset	Chair / Non-Executive Member
Martin Black	Non-Executive Member
Sinead Braiden	Non-Executive Member
Wilma Brown	Area Partnership Forum Representative
Helen Buchanan	Director of Nursing (to February 2021)
Cllr David Graham	Non-Executive Member
Rona Laing	Non-Executive Member
Aileen Lawrie	Area Clinical Forum Representative (from March 2021)
Dr Christopher McKenna	Medical Director
Dona Milne	Director of Public Health
Janette Owens	Area Clinical Forum Representative / Director of Nursing (from March 2021)
Carol Potter	Chief Executive
John Stobbs	Patient Representative
Margaret Wells	Non-Executive Member

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Health & Social Care, Director of Pharmacy & Medicines, Associate Medical Director (Acute Services Division), Associate Medical Director (Fife Health & Social Care Partnership), Head of Quality & Clinical Governance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2021, on the undernoted dates:

- 15 June 2020
- 8 July 2020
- 7 September 2020
- 4 November 2020
- 18 November 2020
- 14 January 2021
- 11 March 2021

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs in late March 2020 (the NHS in Scotland has remained on an Emergency Footing continually since that date). At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

4.2 Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. Committee meetings largely resumed on their regular schedule from July 2020 onwards. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan has however been reviewed to ensure that new items related to Covid-19 are covered appropriately and that the required assurances can still be provided to the Board as part of the year-end process. Each Committee has also actively considered a governance checklist, prepared initially by Internal Audit, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The Clinical Governance Committee's first meeting of the 2020-21 reporting year took place in June 2020, where a briefing was given on the changes made to the Board's usual governance arrangements and structures in consequence of Covid-19. The report included detail on the Gold / Silver / Bronze Command groups set up to manage the day-to-day response to the pandemic, including how this structure enhanced agile operational decision-making to support a rapid response to the increase in clinical activity, and detailing also the reporting routes to established groups that provide formal assurance to the Board.

4.4 At the June 2020 meeting, the Committee also received individual updates from the respective Directors on: the shielding of vulnerable patients from Covid-19; community testing arrangements (including Test & Protect work); care home support and changes to the professional responsibilities of Nurse Directors in relation to this area; learning from outbreaks of Covid within the hospital setting; ensuring PPE and Medicines availability; and plans for the gradual remobilisation of services, as the first wave of Covid reduced from its initial peak. At the Committee's request, many of the reports given to members were delivered verbally or via a presentation, to ensure that the Committee had the most up-to-date information on what was a fast-developing and rapidly changing situation.

4.5 At its scheduled July 2020 meeting, the Committee's agenda was prioritised to review further updates on the organisation's ongoing response to Covid-19 and also governance-related items linked to the 2019-20 year-end process. Written briefings on testing policy and delivery arrangements for Covid-19 in Fife, care home support arrangements and a Lessons Learned

report on hospital onset coronavirus infections were carefully scrutinised by the Committee. In relation to the latter report, the complex network of potential transmission of infection in a hospital setting was highlighted, and key learning was outlined in the areas of atypical presentation of coronavirus symptoms, movement of staff and patients, social distancing, cleaning protocols, and the reduction of the bed base, to increase spacing, particularly in the community setting.

4.6 The new responsibility placed on the Board around nursing leadership and infection control arrangements in support of care homes also received detailed scrutiny, with the Committee congratulating the work done in partnership with colleagues in the social care sector aimed at protecting vulnerable residents in the care home setting. All 76 individual care homes in Fife received an assurance visit, where a supportive and collaborative approach was undertaken to provide advice and guidance around Covid-19 prevention. A Specialist Nursing Support team was put in place to give assistance to those homes identified with areas to improve, again taken forward in a collaborative manner. The Committee received the required assurance that the Board's new responsibilities in this area have been met in a robust and thorough way, in accordance with the Cabinet Secretary's instruction.

4.7 A draft of the remobilisation plan for restarting clinical services, formally agreed with the Scottish Government in June 2020, was reviewed by the Committee at its meeting in July. The Plan detailed the adopted methodology around the planning for resumption of normal services, based around a 'Respond, Recover and Renew' approach. To ensure governance around the restart of clinical services, the Remobilisation Oversight Group was initially established to oversee the restarting of health and care services in Fife during this phase. This group was intended to drive the reintroduction of clinical services in a safe, measured and Covid-19 sensitive way, with a wide representation of clinical leaders, and it has overseen the whole system restart to improve integrated pathways from primary care, community, social care and secondary care, adhering to our routine governance arrangements and with learning from our Covid-19 response.

4.8 Also discussed in July 2020 was the Joint Health Protection Plan 2020-22, as developed between Fife Council Environmental Health and NHS Fife Public Health departments, which provided an overview of health protection priorities, provision and preparedness for the NHS Fife Board area. Although drafted before the full impact of the coronavirus pandemic became clear, the greater priority of public health-related measures in light of society's response to Covid has been appropriately reflected in the Committee's schedule of business, with appropriate consideration of reports such as this.

4.9 In relation to Seasonal Flu Immunisation, the Committee considered at its September 2020 meeting the delivery plan and governance around this year's programme, noting that the campaign was expected to be more challenging that previous years, due to the ongoing restrictions of the pandemic, and with a different model of delivery from the previous GP-led clinics. On the programme's launch in mid-September, the increased demand for flu vaccinations quickly overwhelmed the planned delivery model and communications hub, resulting in a less than satisfactory patient experience and reputational damage to the Board. An independent review into the seasonal flu programme was commissioned in October 2020 and a Lessons Learned report considered in depth by the Committee at its meeting in early November. The report made a number of important recommendations in the areas of governance, reporting routes and clarity of roles and responsibilities; planning and project management support; workforce; communications; and IT support. A related Action Plan has been developed, and regular reporting on addressing these individual improvement actions has continued to the Committee. In addition, an external review has since been commissioned to consider how the Board delivers immunisation programmes in general (noting the additional activity due to Covid), and in particular clarifying the respective responsibilities for Public

Health and colleagues in the Partnership. The outcome and recommendations from this will be considered at a future meeting of the Committee.

4.10 An Extraordinary Meeting of the Committee was held on 18 November 2020, for members to specifically consider the arrangements for the imminent launch and delivery of the Covid-19 vaccination programme, the single largest public health intervention in modern times. Members discussed issues ranging from the availability of vaccine, the prioritisation of cohorts, the governance, risk and project management arrangements for the roll-out of the programme, planning for venues, scheduling and appointing mechanisms, and the likely workforce and financial implications. Noting the vital importance of learning from the challenges faced with the delivery of the 2020 seasonal flu vaccination, and in particular the recommendations of the independent review into that programme considered in depth at the Committee's previous meeting on 4 November, the Committee took assurance from the risk-focused approach of planning for the Covid programme, and in particular the enhanced support offered by a dedicated Programme Management Office. Meetings of the Committee since the Covid vaccination launch have continued to focus attention on the effective delivery of the vaccine to the people of Fife, in a person-centred, responsive manner. The strong performance of the Board when compared with other nationally has given the appropriate assurance that the planning and implementation of the large-scale programme has taken due cognisance of the lessons learned from the review of seasonal flu immunisation, in addition to benefitting from the expertise, dedication and knowledge of staff from across a range of services, including many volunteer vaccinators.

4.11 A presentation by the Medical Director on the Redesign of Urgent Care was delivered to members in November 2020, with a further update given in January 2021. Noting the challenges of making these service changes as Covid-related activity increased with the second wave of widespread infection, the planned 'hard' launch of the service was postponed, due to challenges with the resilience of NHS24 services. A soft launch of the programme, however, gave the opportunity to test the model and ensure local readiness. In March 2021, the Committee considered a further report on the design and operation of the Flow & Navigation Hub within the Urgent Care Service, following Scottish Government guidance for all Boards to establish a local hub to ensure patients are directed to the appropriate point of care. This continues to operate successfully, helping ensure A&E attendances are managed and patients are directed to the right forms of support for their own individual needs.

4.12 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events, via the Integrated Performance & Quality Report. Specific scrutiny has been given in recent meetings to the rate of Staphylococcus aureus Bacteraemia (SABs), with members receiving an update at its July 2020 meeting on community C.Diff cases, with detail on how an increase in cases pre-Covid was being addressed and monitored. Despite the challenges of the pandemic, the Board has had the lowest number of SABs since 2005, with no MRSA case within the 2020 calendar year. Staff were congratulated for their successful work aimed at reducing cases to a minimal level.

4.13 The preparation of a robust plan for dealing with Winter demand was covered by the Committee at their meeting in November 2020, and regular performance reports have followed since. Despite the operational challenges of dealing with increased demand due to coronavirus activity, the delay position in general has been an improving one, recognising the close partnership working across health and social care.

4.14 Papers were provided to the Committee on various capital projects, including, in November 2020, the full business case for large-scale Elective Orthopaedic Centre to be established at Victoria Hospital and the full business case for the implementation of Hospital Electronic

Prescribing & Medicines Administration (HEPMA). Both projects were recommended for approval by the Committee to the Board, noting the potential transformational nature of both initiatives for patient care in Fife.

4.15 Annual reports were received on the subjects of the work of the Clinical Advisory Panel, Equality Outcomes, Fife Child Protection, Integrated Screening, Radiation Protection, Medical Revalidation, Prevention & Control of Infection, Organisational Duty of Candour, Research & Development Strategy & Annual Review, and any relevant Internal Audit reports that fall under the Committee's remit, such as that on Adverse Events Management (in which the Committee commissioned a separate update on progress made in addressing the various action points). Updates were also provided on public engagement matters, including, in January 2021, dedicated reports on Equality Outcomes and Mainstreaming Equality across the organisation.

4.16 The Committee has received minutes and assurance reports from its three sub-groups, namely the Digital & Information Board, Health & Safety Sub-Committee, and the Information Governance & Security Steering Group, detailing their business during the reporting year. Updates to Terms of Reference and workplans for these groups have also been considered when necessary. As agreed last year, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's May 2021 meeting.

4.17 In reference to the Health & Safety Sub-Committee, their work has been detailed in their annual report to the Committee. Whilst Covid has dominated their proceedings, including HSE visits to check compliance, the policy and procedure reviews scheduled for this year have been completed. In November 2020, NHS Fife received a Covid Management 'spot check' visit to the Victoria Hospital site from HSE inspectors. The visit resulted in a 'Notice of Contravention' being issued to the organisation with a requirement for actions to be taken. The December 2020 sub-committee meeting was therefore given over to discussion on the detail of the Notice to ensure that actions were being addressed and that appropriate managers and staff were involved in this work, and updates on the delivery of this action plan were given to the sub-committee in March, with progress noted in the implementation of the HSE's recommendations.

4.18 Over the past year, the Digital & Information Board has developed the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital Strategy and associated delivery plan, as outlined in a report submitted in July 2020 on the eHealth Governance Review. This work has included consideration of a number of significant and outstanding Internal Audit findings given in previous reports, as well as the action points from the NIS audit carried out in March 2020. The Digital & Information Strategy 2019-2024 was presented to the NHS Fife Board and approved on 30 September 2020. The necessity to support the Covid-19 pandemic response has impacted the planned activities of the group and the delivery plan associated with implementing the Strategy, as outlined in a report submitted to the Clinical Governance Committee in September 2020. The group noted there had been considerable benefits to digital adoption in many key areas during this time, supported by key financial investment decisions. The Board recognised that the lessons learnt through this year should have significant impact on Digital delivery going forward.

4.19 In relation to Digital enhancements, the Committee has received updates on the hospital electronic prescribing and medicines administration system (HEPMA) being introduced in Fife. In September 2020 the Committee noted progress and approved a revised timeframe for submission of the business case. The full business case was considered and approved in November 2020. The Digital & Information Board's annual report has also detailed areas of significant activity across the organisation, particularly those in support of enabling

enhancements for remote working / patient consultation and in implementing O365 roll-out etc. The Committee has noted that the new Associate Director of Digital & Information has initiated a full risk audit within the areas of Digital & Information, with particular attention being given to the correct ownership of the risks within the organisation and being able to evidence the mitigation actions being planned and taken. An early focus is a financial assessment of the Digital and Information Strategy, to ensure affordability can be matched with expectation and ambition. It is also anticipated that this work will ensure the completion of a number of outstanding internal audit recommendations, to enhance the overall control environment and governance structures of this key directorate. Reporting arrangements to the Clinical Governance Committee will also be part of this work, to ensure appropriate scrutiny and oversight.

4.20 The Clinical Governance Committee has also considered the annual report from the Information Governance & Security Steering Group, which has been restructured during the reporting year. The newly refreshed Group first met in October 2020 and has developed appropriate Terms of Reference for itself and its supporting operational groups. The Group has reviewed a report detailing the current baseline of performance and controls within the remit of the Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. Whilst the appropriate governance structures and controls are now in place, the production of evidence to the Steering Group on all matters under its remit remains a work in process. Therefore, the Clinical Governance Committee notes that the assurance the Steering Group is in a position to provide this year is necessarily partial, though there are no significant issues that would otherwise merit a disclosure in the Governance Statement.

4.21 An annual statement of assurance has also been received and considered from the Clinical & Care Governance Committee of the Integration Joint Board, detailing how Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility. Updates have also been given to the Committee on the ongoing review of the Fife Integration Scheme, which has been delayed from its original timeline due to Covid-related pressures. The new Scheme will seek to further clarify clinical governance assurance mechanisms and reporting routes and will reflect input from the Board's internal auditors and Central Legal Office, in addition to recommendations made from the Council side.

4.22 Minutes of Clinical Governance Committee meetings have been subsequently approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2020/21.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of

reports and scrutiny, including oversight on the detail of the Board Assurance Framework in the areas of Quality & Safety, Strategic Planning and Digital & Information. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to Covid have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care, service delivery and vaccination.

6.2 During the year, in relation to Quality & Safety, the Committee has specifically considered the risk of lack of medical capacity in both the Community Paediatrics and Child Protection services. In relation to the former, an update was given on potential collaborative approaches with other Boards and the resilience that could be offered by utilising hospital-based paediatricians. The absence of the Board's Clinical Lead for Child Protection has resulted in help and support being sought from a neighbouring Board, to improve capacity. Members took assurance from the mitigating actions and supported the planned programme of service improvement work going forward.

6.3 The Committee recognises that, as mentioned above, further work is required around the reporting of Digital and Information Governance & Security risks and also those related to transformation programmes, noting that the ongoing strategy review will bring an overall focus and direction to a number of hitherto individual strands of work. Updates have been given to the Committee on the new Strategic Planning & Resource Allocation process, which has linkages to the overall Remobilisation planning, and the Committee looks forward to being a central part of the development of the new Health & Well-Being Strategy currently under preparation. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its May 2021 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As current Chair of the Clinical Governance Committee, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed: …… Date: …….

Christina Cooper, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS Fife Clinical Governance Committee Attendance Record
1st April 2020 to 31st March 2021

	15.06.20	08.07.20	07.09.20	04.11.20	18.11.20 (private)	14.01.21	11.03.21
Dr L Bisset (Chair)	√	√	√	√	√	√	√
Mr M Black	√	√	√	√	√	√	√
Ms S Braiden	√	√	√	√	x	√	x
W Brown	√	√	√	√	√	√	x
H Buchanan	√	√	√	x	√	√	x
Cllr D Graham	√	x	√	√	√	√	x
R Laing	√	√	√	√	√	√	√
A Lawrie							√
Dr C McKenna	√	√	x	√	x	√	√
D Milne	x	√	√	√	√	√	√
J Owens	√	√	√	√	√	√	√
C Potter	√	√	√	x	√	√	√
J Stobbs	√	√	√	√	√	√	√
M Wells	√	√	√	√	√	√	√

In attendance

N Connor, Director of H&SC	√	x	√	√	√	√	√
C Dobson, Director of Acute Services				√	√	√	√
L Douglas, Director of Workforce							√
S Garden, Director of Pharmacy & Medicines	√	x	√	√		√	√
Dr R Cargill, AMD, ASD			√	√		√	√
Dr L Campbell, ADN, ASD		√	x	√		x	x
Dr H Hellewell, AMD, H&SCP		√	√			x	x
J Morrice, AMD, Women & Children's Services							√
A Mackay, Deputy Chief Operating Officer	√	√	√				
S Fraser, Ass. Director of Planning & Performance		√	√	x	√		x

APPENDIX 1

	15.06.20	08.07.20	07.09.20	04.11.20	18.11.20 (private)	14.01.21	11.03.21
In attendance (cont.)							
M McGurk, Director of Finance & Strategy		√					√
Dr E Curnock, Deputy Director of Public Health	√	√					
Dr G MacIntosh, Board Secretary	√	√	√	√	√	√	√
H Woodburn, Head of Quality & Clinical Governance	√	√	√	√		√	
G Couser, Head of Quality & Clinical Governance							√
A Ballantyne, Clinical Lead				√			
L Barker, AND, H&SCP		√		√			
J Crichton, Interim Director, Project Management Office		√					
L Donovan, eHealth General Manager		√	√				
B Hannan, Chief Pharmacist					√		
B Johnston, Project Manager				√			
E Muir, Clinical Effectiveness Coordinator						√	√
BA Nelson, Independent Reviewer				√			
G Smith, Lead Pharmacist, Medicine Governance & Education		√					

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan review NHS Fife Clinical Governance Workplan is approved annually and kept up-to-date on a rolling basis Minutes from Linked Committees e.g. • NHS Fife Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • NHS Fife Infection Control Committee • NHS Fife H&SCP Care & Clinical Governance Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates considered regularly Via the NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Update on Participation & Engagement processes and groups undertaken during the reporting year NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife's activities.	Information & Security Governance Steering Group Annual Report Digital & Information Board Annual Report Digital & Information Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports
NHS Fife understands and exploits the value of the data and information it holds.	Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting Particular review of performance in relation to SSIs and community-based SABs undertaken in current year

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Operational Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes from Linked Committees e.g. • Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • Digital & Information Board • Infection Control Committee • Information Governance & Security Steering Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format undertaken in reporting year

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meetings Minutes of Linked Committees are reported at every meeting
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with adverse events
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes of Linked Committees • Area Clinical Forum • Acute Services Division, Clinical Governance Committee • Area Drugs & Therapeutics Committee • Fife Resilience Forum

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates regularly considered Digital & Information Strategy reviewed in current year All strategies have a completed EQIA
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates regularly considered Digital & Information Strategy reviewed in current year All strategies have a completed EQIA
NHS Fife's policies, functions and service planning overtly consider the different	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
current and future needs and access requirements of groups within the community.	access requirements of the groups within the community.			when uploaded onto the website
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	Update on Participation & Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users

NHS FIFE CLINICAL GOVERNANCE COMMITTEE – ANNUAL WORKPLAN 2021/2022

	Lead	May	July	September	November	January	March
General							
Minutes of Previous Meeting	Chair	✓	✓	✓	✓	✓	✓
Action list	Chair	✓	✓	✓	✓	✓	✓
Covid-19 Update							
Testing	DoPH	✓	✓	✓	✓	✓	✓
Vaccination Programme	DoPh	✓	✓	✓	✓	✓	✓
Strategy/ Remobilisation							
Remobilisation Plan	DoF&S/ADPP		✓	✓	✓	✓	✓
Population Health and Wellbeing Strategy Development	DoF&S/ADPP		✓	✓	✓	✓	✓
Corporate Objectives	DoF&S/ADPP	TBC					
Cancer Strategy	MD	TBC					
Clinical Governance Strategy	MD/ Head of Q&CG				✓		
Quality and Performance							
Integrated Performance and Quality Report	DoF&S/ADPP	✓	✓	✓	✓	✓	✓
Winter Plan and Performance	DoN	✓			✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	DoN	✓	✓	✓	✓	✓	✓
Digital and Information							
Digital and Information Strategy Update	MD		✓				
Strategy delivery update	MD			✓			✓
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	MD			✓			✓
Person Centred Care, Participation and Engagement							
Complaints Report	DoN			✓			
Volunteering Report	DoN				✓		
Equalities Outcome Report	DoN					✓	
Governance and Assurance							
Board Assurance Framework - Quality and Safety	MD/DoN	✓	✓	✓	✓	✓	✓
Board Assurance Framework - Strategic Planning	DoF&S/ADPP	✓	✓	✓	✓	✓	✓
Board Assurance Framework - Digital and Information	MD	✓	✓	✓	✓	✓	✓
Committee Self-Assessment Report	Board Secretary						✓

Updated 21/04/2021

	Lead	May	July	September	November	January	March
Corporate Calendar / Committee Dates	Board Secretary			✓			
Annual Workplan	Head of Q&CG	✓					✓
Annual Assurance Statement (inc. best value report)	Board Secretary	✓					
Annual Assurance Statements from sub-committees	Board Secretary	✓					
Review of Terms of Reference	Board Secretary						✓
Annual Reports							
NHS Fife Equality Outcomes Progress Report	DoN	✓					
Area Radiation Protection Annual Report	MD	✓					
Public Health Annual Report	DoPH					✓	
Integrated Screening Report	DoPH			✓			
Annual Immunisation Report	DoPH		✓				
Clinical Advisory Panel Annual Report	MD		✓				
Digital and Information Annual Report	MD	✓					
Medical Education Report	MD		✓				
Medical Revalidation	MD				✓		
R& D Annual Report	MD				✓		
R&D Strategy Review	MD				✓		
Fife Child Protection Annual Report	DoN					✓	
Adult Support and Protection Annual Report	DoN					✓	
Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework	DoN						✓
Prevention and Control of Infection Annual Report	DoN		✓				
Organisational Duty of Candour Annual Report	MD				✓		
Flu Report	DoPH		✓				
Quality Framework for Participation and Engagement Self Evaluation	DoN					✓	
Linked Committee Minutes							
Acute Services Division Clinical Governance Committee	ASD AMD	✓	✓	✓	✓	✓	✓
Area Clinical Forum	Chair	✓	✓	✓	✓	✓	✓
Fife Drugs and Therapeutic Committee	MD	✓	✓	✓	✓	✓	✓
Area Radiation Protection Committee	MD	✓					
Fife IJB Clinical and Care Governance Committee	AMD	✓	✓	✓	✓	✓	✓
NHS Fife Clinical Governance Oversight Group	MD	✓	✓	✓	✓	✓	
Digital and Information Board	MD	✓		✓	✓		
Research Governance Committee	MD	✓	✓		✓	✓	✓
Health and Safety Sub-Committee	Chair	✓	✓		✓	✓	✓
Information Governance and Security Group	MD	✓		✓	✓	✓	✓
Infection Control Committee	DoN	✓	✓	✓	✓	✓	✓
Public Health Assurance Group	DoPH	✓	✓	✓		✓	

Updated 21/04/2021

	Lead	May	July	September	November	January	March
Ionising Radiation Medical Examination Regulations Board (IRMER)	MD		✓				
Information Governance and Security Steering Group	DoF&S		✓		✓	✓	
Area Medical Committee	MD			✓	✓	✓	✓

Updated 21/04/2021

Item 9.1

NHS Fife

Meeting:

Meeting date:

Title: **Response to the Human Tissue (Scotland) Act – 2019 Amendment.**

Responsible Executive:

Report Author: **Dr Robert Thompson**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government Policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

Deceased organ and tissue donation is a unique act of generosity which has the potential to greatly enhance or save the life of a person receiving a transplant. The donation system relies on public trust and confidence in order for it to function and provide the life-saving and life-enhancing transplants it has the potential to. Key to this is the lawful fulfilment of the donor's decision, but also sensitive support of the donor's family who are involved as part of end of life care.

A core principle in current good practice, enshrined in the new duty to inquire under the Human Tissue (Authorisation) (Scotland) Act 2019, is that health workers should make every effort to establish the decision or views of the potential donor, and then to support their decision being fulfilled. Secondly, the 2019 Act moves towards a default position of deemed authorisation where the decision of the person to be an organ donor upon death is unknown: proceeding to authorisation should only occur following a discussion with the person's next of kin to ensure that donation does not take places against their wishes. Thirdly, the 2019 Act provides a new statutory framework for pre-death procedures, which is tailored to the practical and ethical issues relating to donation.

2.2 Background

In practice, organ donation can only proceed when a person dies whilst or after receiving advanced respiratory organ support (i.e. mechanical ventilation) and when death occurs in a controlled and predictable manner. Most commonly the cause of death is a brain injury that has resulted from haemorrhage, trauma or cardiac arrest. Intensive Care Medicine Consultants approach the person's next of kin to communicate that unfortunately death has occurred or will do when organ supporting treatment is stopped and that end of life options require to be considered. During this conversation, in appropriate cases, the potential for organ and tissue donation is discussed with the assistance of a specialist requestor or specialist nurse in organ donation. Screening is then performed over the next twelve hours or so to confirm whether organ donation and successful transplantation would be feasible. When confirmed and authorised, a surgical retrieval team is then mobilised to attend the operating theatre adjacent to the intensive care unit where the person is. In NHS Fife, organ retrieval is performed approximately eight to ten times per annum.

2.3 Assessment

- The duty to inquire clause now mandates that a healthcare worker has a discussion about donation with the person's next of kin when end of life care plans are being made. This should be carried out in most cases by a specialist requestor or specialist nurse in organ donation.
- Whilst deemed authorisation now shifts the default position to be one of presumed agreement to become a donor, the necessity to speak to the person's next of kin for the purposes of authorisation remains in place.
- Detailing a framework for acceptable pre-death procedures will result in a change of practice in some scenarios for clinical staff when continuing to care for the person where donation authorisation has been confirmed but organ supportive therapies are still being administered.

It is expected that the change in legislation will increase the number of people who proceed to be a donor at the end of their life: in practice this will mean up to fifteen people per annum in NHS Fife. This will result in a small increase in the number of Intensive Care Unit bed days and operating theatre work.

Intensive Care Medicine Consultants in NHS Fife have attended a seminar detailing the changes to practice that the 2019 Act will introduce, as well as having the opportunity to complete an online module about the new legislation.

2.3.1 Quality/ Patient Care

This should not affect the standard of patient care delivered.

2.3.2 Workforce

No change- additional specialist requestors and specialist nurses in organ donation have been employed by NHS Blood and Transplant to meet additional demand.

2.3.3 Financial

More donation activity will mean increased spend in Critical Care and Theatres. However, NHS Blood and Transplant pay a set tariff to each Health Board for every donor who proceeds to organ retrieval which reimburses the incurred costs for such additional work.

It is foreseeable that an increase in the number of organ transplantations performed will result in cost savings for each Health Board, particularly in the delivery of kidney dialysis services.

2.3.4 Risk Assessment/Management

Nothing identified.

2.3.5 Equality and Diversity, including health inequalities

Whilst the introduction of this Act is unlikely to impact Equality and Diversity, it is worth highlighting that the length of time spent waiting on an organ transplant is longer for people of Asian, Black and Arab ethnicity. This is probably due to the number of donors from these ethnic groups being proportionally less.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

This has been completed by Scottish Government on a national level via various forms of communication.

2.3.8 Route to the Meeting

Report requested by Dr Christopher McKenna, Medical Director.

2.4 Recommendation

NHS Fife Board members and senior managers should be aware of the three noteworthy changes that the 2019 Act introduces (as detailed above), and provide the support required to ensure that a high quality organ donation service is maintained.

Report Contact
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Item 9.2

NHS Fife

Meeting:	Clinical Governance Committee
Meeting date:	**30th April 2021**
Title:	Update on the implementation of HIS standards for Healthcare and forensic medical services for people who have experienced rape, sexual assault, or child sexual abuse: Children, young people, and adults
Responsible Executive:	**Janette Owens**
Report Author:	Heather Bett, Interim Senior Manager

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- National Health & Well-Being Outcomes

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

- Person Centred

2 Report summary

2.1 Situation

The aim of this report is to advise the Committee of the progress made within Fife to meet the Health Improvement Scotland Standards for the provision of Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: Children, young people and adults published in 2017 and the preparation being made for the enactment of the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill which was passed by Parliament in December 2020 .

This report provides an overview of the progress to date and the upcoming challenges for the service around FME service developments.

2.2 Background

In 2017 the Chief Medical officer created a national Taskforce to provide leadership for the improvement of healthcare and forensic medical examination (FME) for adults, children and young people who have experienced rape, sexual assault, or child sexual abuse.

The vision of the Taskforce was the delivery of consistent person centred, trauma informed health care and forensic medical services and access to recovery for anyone who has experienced rape or sexual assault in Scotland.

- The Task force commissioned HIS to produce a set of standards which covered
- Leadership and governance
- Person-centred and trauma-informed care
- Facilities for forensic examinations
- Educational, training, and clinical requirements, and
- Consistent documentation and data collection.

Subsequently the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill was introduced in the Scottish Parliament on the 26th November 2019 by the Cabinet Secretary for Health and Sport, Jeane Freeman MSP.

The Bill places duties on health boards regarding forensic medical services for victims of sexual offences (and harmful sexual behaviour by children under the age of 12) and provides a statutory basis for health boards to provide forensic medical examinations for victims of sexual crime.

It will also establish a legal framework for consistent access to “self-referral”. This will mean that a person can access healthcare and request a FME without first making a report to the police. The Bill has unanimously been passed by the Parliament on 10 December 2020.
Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill

2.3 Assessment

Services for Adults

Prior to 2017, the responsibility for the provision of FME rested with Police Scotland and within Fife, forensic medical examinations were carried out at Police Headquarters. The focus of the pathway was the collection of the physical evidence necessary to pursue a criminal investigation. Service users were supported by the Police Sexual Offences Liaison Officer (SOLO) and often supported by Fife Rape and Sexual Assault Centre (FRASAC); however, they were left to navigate health services by themselves.

Within Fife the FME was undertaken by colleagues from NHS Lothian as part of the Service Level Agreement (SLA) for Healthcare in Police custody.

With the publication of the HIS standards and the actions set out by the Task force, the service offered to victims of rape and sexual assault were significantly redesigned to place a focus on the healthcare needs of the individuals as well as the collection of forensic evidence.

The key elements of the standards that were addressed were

- **Each NHS board ensures that people who have experienced rape, sexual assault or child sexual abuse receive person-centred and trauma-informed care.**

To address this standard, the Gender Based Violence (GBV) Service developed a care coordinator role to offer support to the service user following their medical examination. The support they offer follows the five primary guiding principles of trauma informed care, to achieve the best-informed outcome for the individual:

- safety
- choice
- collaboration
- trustworthiness and transparency
- mutuality and empowerment

Pathways has been developed and embedded to provide high-quality person-centered health care and support to individuals who have been referred to the service by Police or FME services. These pathways ensure that all individuals receive appropriate Sexual Health screening, diagnosis and treatment, and designated support and counseling for up to 12 weeks from the GBV service. Onward referral to 3rd sector agency partners, if required, is also facilitated by the team.

The development of a psychological wellbeing *Safety and Stabilisation Assessment* in collaboration with Psychology has been completed and is helping to support this process. This ensures formal assessment is completed and any required actions are completely integrated into the individual's care.

Throughout the 12-week support offered by the GBV team, individuals can require daily support whilst they try to understand and acknowledge their trauma. This is often resource intensive with the initial stages of care requiring the supporting nurse to incorporate many aspects of the safety and stabilization framework.

The GBV team Annual report contained in Appendix 1 provides positive feedback from users of the service.

- **Each NHS board ensures that the facilities and equipment for forensic examinations are appropriate, safe, and effectively managed**.

A key part of the work to meet the standards was the establishment of a suitable facility on a health care setting rather than at police headquarters. The Fife Suite at Queen Margaret Hospital was officially opened on the 1st April 2019, providing a dedicated suite where victims can be supported through their examination by a female health chaperone. The suite also allows a domestic space for the police interview to begin.

- **Each NHS board ensures that forensic examinations of people who have experienced rape, sexual assault or child sexual abuse are recorded using consistent documentation and data collection.**

In addition to the HIS Standards, the CMO Taskforce has developed indicators which are reviewed and reported on a quarterly basis and the NHS Fife GBV data relating to these indicators shows a high level of performance. Recognition of this performance is also noted by the Scottish Government, with the National Coordinator recently commending our achievement, and indicating that NHS Fife are forerunners in the

delivery of quality specialised GBV and FME care. The indicators are included in the annual report in Appendix 1.

A national tool for documentation and the collection of these indicators has been developed nationally and will be rolled out in 2021.

There are some aspects of the standards which are more difficult to achieve

- **People have the opportunity to request the gender of the forensic examiner who will be involved in their care**

Due to the low number of women who undertake the role of forensic medical examiner this standard has been difficult to achieve. NHS Fife is working closely with NHS Lothian to try to maximize the availability of female examiners. In addition, NES are currently offering training for Nurse examiners and work is under way through the task force to ensure that their evidence is suitable for court proceedings.

Female chaperones have been introduced to offer support to Victims during the examination

- **For young people and adults, the forensic examination is undertaken within three hours of request**

As the provision of FME is a regional service, it can be challenging to meet the three-hour window, and this is monitored closely.

- **Each NHS board has a care pathway for adults which supports:**

a) **easy access and self-presentation to healthcare, and**
b) **forensic medical examinations, subject to appropriate and agreed national collection and retention policies for storage of forensic medical samples.**

The newly passed Bill will allow for self-referral which means that any individual can refer themselves to the FME service without Police involvement. This should allow victims to access healthcare and support without the need to report a crime and will allow forensic evidence to be collected at the time for a potential criminal prosecution in the next 2 years.

The GBV team is currently undertaking service improvement to ensure this can be delivered, though the challenge is to understand the potential activity generated by this. This will be supported by a national telephony provision delivered through NHS 24, and work is underway to develop a responsive pathway.

Services for Children

The responsibility for the delivery of the standards in relation to children and young people sits with the Child protection team and their clinical lead. However, the East region MCN for child protection provides oversight and drives improvement for services to children and young people and their families. This includes improving services for children and families who have been affected by neglect, physical, emotional, and sexual abuse.

The MCN represents the east region in the work of the CMOs task force and is involved in the subgroups developing the Children and Young People pathway along with the establishment of therapeutic services for children who have experiences sexual assault.

The MCN is also part of a Children and Young Peoples Expert Group, convened by the CMO Taskforce. The expert group provide national oversight and clinical expertise to focus specifically on supporting NHS Boards to make improvements to services for children and young people.

A key aspect of the work taken forward is to ensure that Each **NHS board ensures that people who have experienced rape, sexual assault or child sexual abuse receive person-centred and trauma-informed care.** The MCN expert group put forward a proposal to the CMO Taskforce Steering Group in December 2019. This set out initial recommendations for the development of a new advocacy role, known as a Child Family Support Worker, as the first stage of addressing much needed support as families negotiate the child protection process. The recommendations have been well received by families, the Third Sector and service providers.

Fife has welcomed the opportunity to work with a dedicated Child Family Support Worker and Fife Child Protection Social Work team is currently in the process of reaching an agreement for the Family Support Worker to engage directly with victims of child abuse and act as their advocate as well as provide rich learning regarding children's own experience of our service delivery.

Each NHS board ensures that the facilities and equipment for forensic examinations are appropriate, safe, and effectively managed.

When the Fife Suite was established for the provision of adult examinations the decision was taking to continue to offer examinations for children and young people within the paediatric ambulatory care unit. Although this area is a not forensic suite it is decontaminated before a forensic examination as per the decontamination protocol from the CMO Taskforce.

The Service was provided with a colposcope which allows for electronic image capture and work is underway to establish a national storage solution for such images

NHS Fife offers a Child Sexual Abuse (CSA) service within working hours and arrangements are in place for NHS Lothian to support NHS Fife if there is no CSA trained paediatrican available.

A regional out of hours (OOH) rota for CSA examinations is coordinated by NHS Lothian Children's Services. A standard operating procedure is in place to support appropriate follow-up locally of children from NHS Fife who are examined within NHS Lothian.

Within NHS Fife seven (23%) acute cases were seen by NHS Lothian CSA trained paediatricians from January to December 2019.

People have the opportunity to request the gender of the forensic examiner who will be involved in their care

As with adults providing a choice of examiner is difficult. Children and young people may be able to request the gender of their examiner but due to the limited staff their request may not be possible. The paediatricians trained to do CSA examinations in the

Fife are female. In joint examinations where there is a female paediatrician and a male Forensic Practitioner young people can be given the option of a single doctor of their gender choice.

For young people and adults, the forensic examination is undertaken within three hours of request

The timing of the examination will be in the best interests of the child and considering the clinical/forensic needs. Any acute CSAs are attended to swiftly, which may require the child to be seen in Lothian if out of hours, whilst the majority are provided for by NHS Fife.

2.3.1 Quality/ Patient Care

The development of this service has significantly improved services for patients and by adopting a trauma informed approach will result in long term benefits

2.3.2 Workforce

Scottish Government funding supported an increase in staffing for this project for 3 years. (£55,368)

2.3.3 Financial

The capital costs of developing the Fife Suite were met by the CMO task force (£27,500) as well as the above funding for staffing.

2.3.4 Risk Assessment/Management

Describe relevant risk assessment/mitigations.

- The risks relating to the provision of CSE examination are managed as part of the arrangement with NHS Lothian for out of hours support as detailed above
- The risk in relation to meeting the clinical indicators are managed by regular review with colleagues from NHS Lothian and through a SEAT oversight group

2.3.5 Equality and Diversity, including health inequalities

The service is open to citizen currently who report to the police regardless of gender. It also accepts patients referred through Sexual health Fife Services.

With the introduction of the self-referral pathway, the service will be available to all citizens, the uptake of the service will be monitored to ensure that no group is disadvantaged or under represented and appropriate actions taken to address this .

Patients are supported to access support services by both Health staff and third sector staff

An impact assessment will be completed for the self referral pathway.

2.3.6 Other impact

Describe other relevant impact.

2.3.7

Communication, involvement, engagement and consultation

A a regular oversight group was established which includes police , Fife rape and sexual assault service , representatives of NHS Lothian and Fife Violence against Women Partnership .

Meetings are held quarterly to monitor performance against the clinical indicators and to address issues.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

Not applicable

2.4 Recommendation

- **Awareness** – For Members' information only. The Clinical Governance Group is asked to note the information presented within this update in particular the significant steps being undertaken to sustain, improve and develop the services delivered.

3 List of appendices

The following appendices are included with this report:

- Gender Based Violence Nurse Advisory Service Report 2019/2020

Report Contact
Heather Bett
Interim Senior Manager
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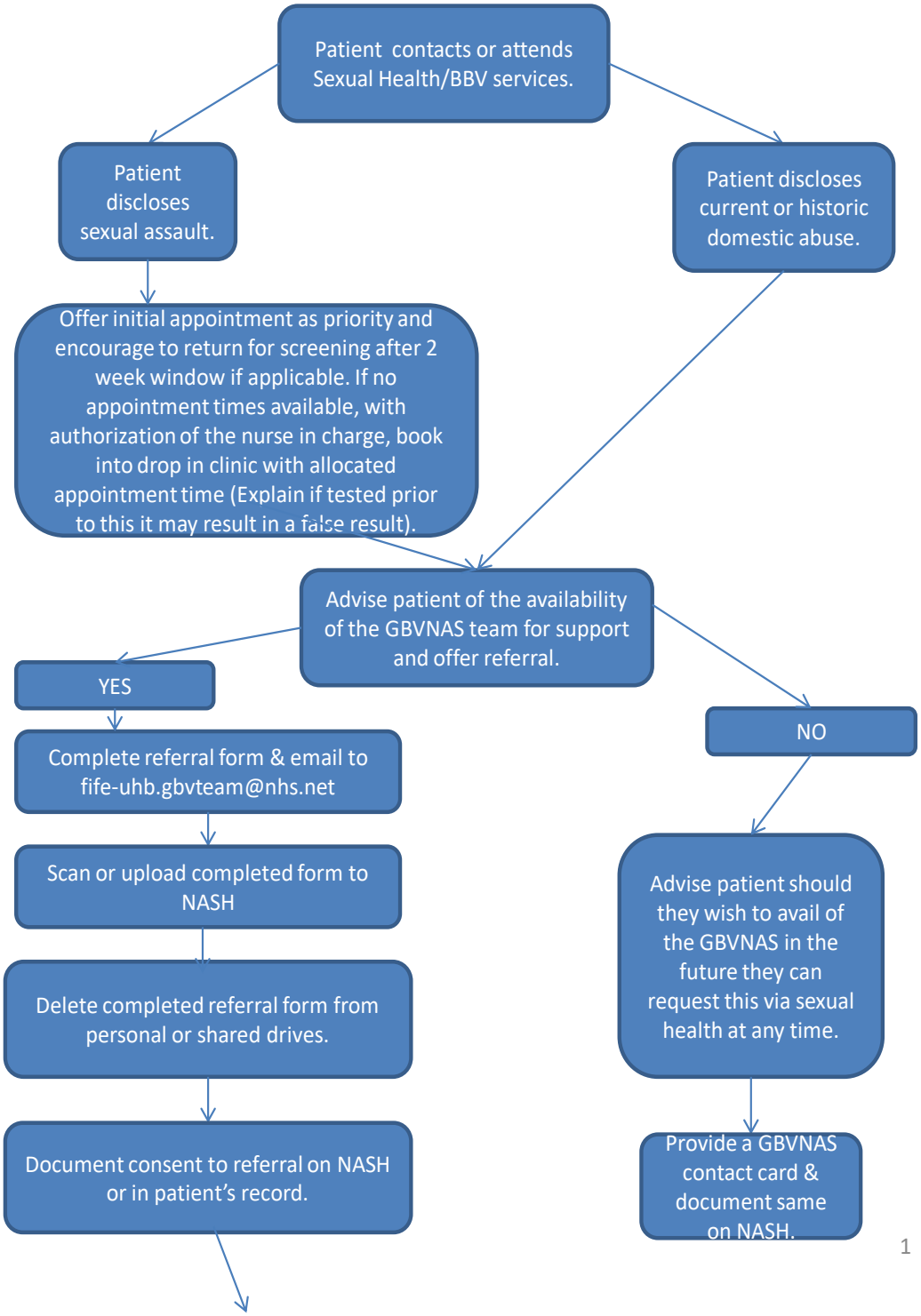
Appendix 1. Gender Based Violence referral Pathway

Gender Based Violence Nurse Advisory Service (GBVNAS) referral pathway following disclosure of sexual assault, current or historic domestic abuse to Sexual Health/BBV services



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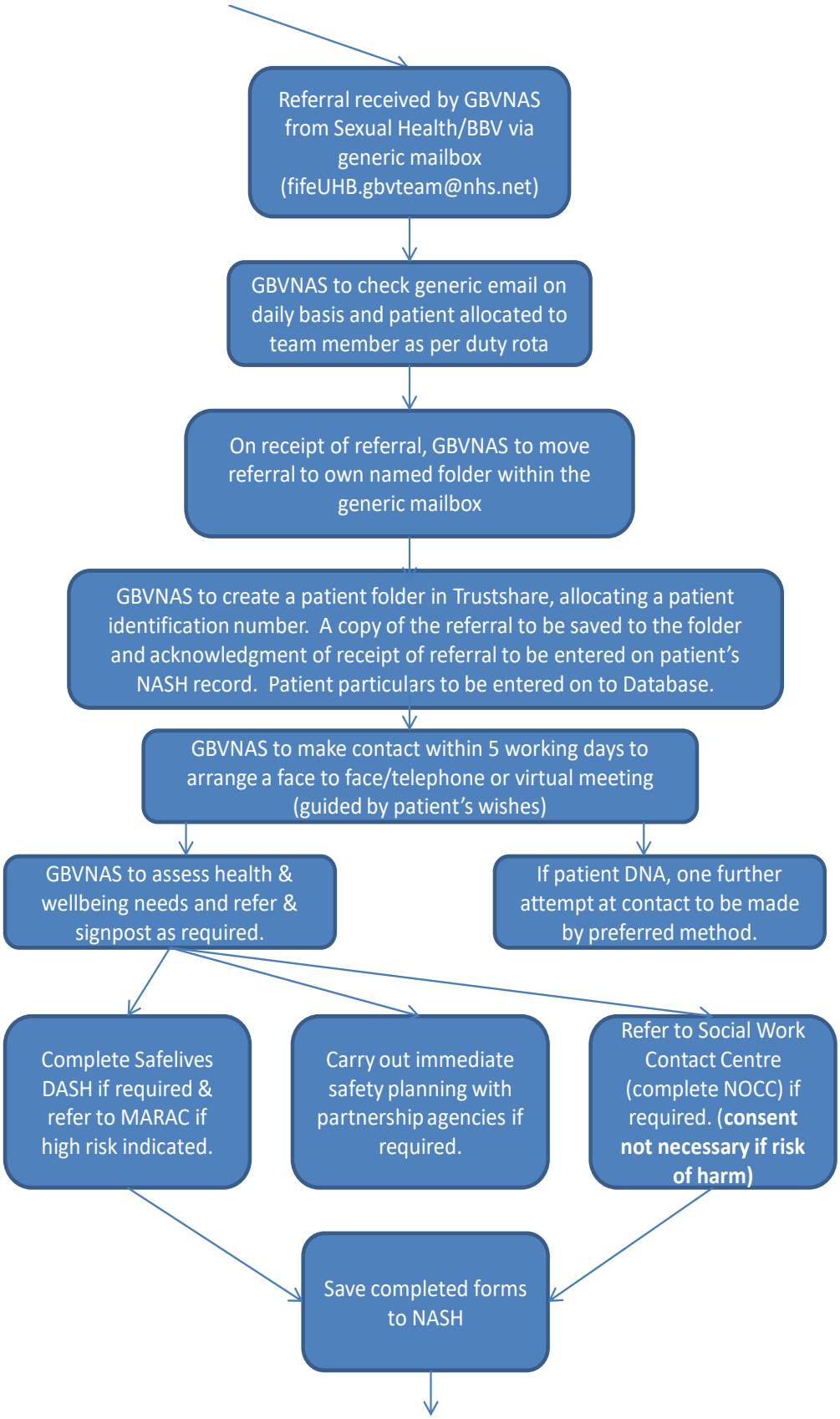
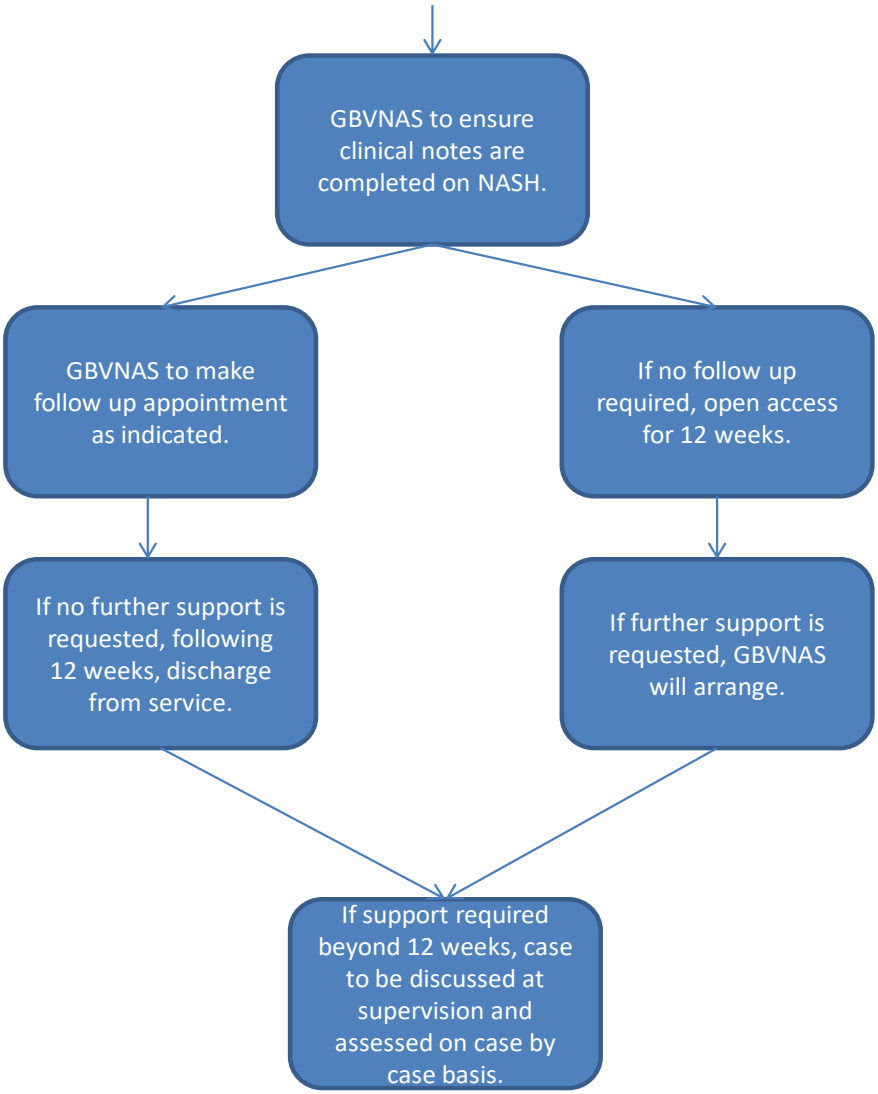
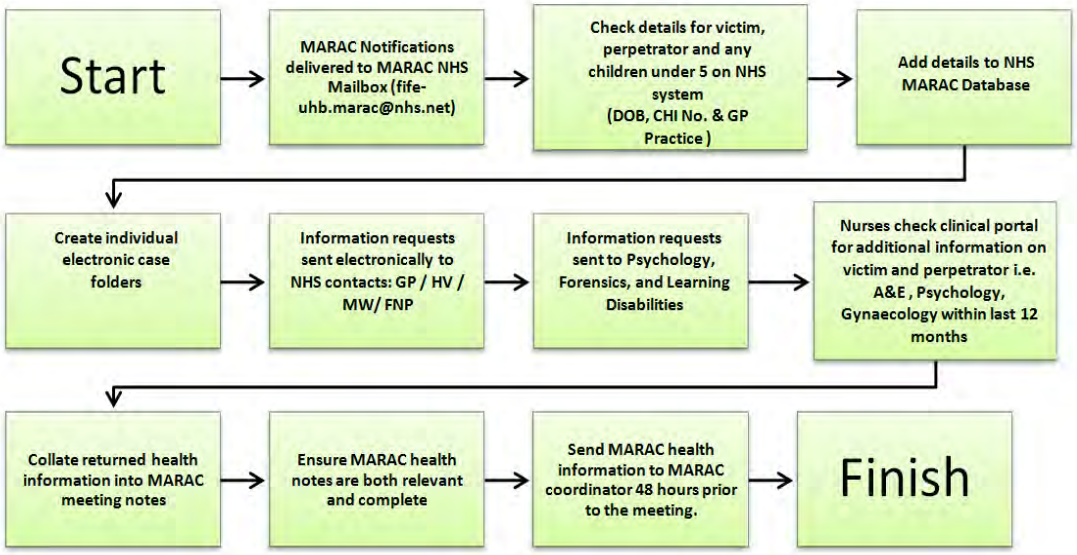

Referral received by GBVNAS from Sexual Health/BBV via generic mailbox (fifeUHB.gbvteam@nhs.net)
GBVNAS to check generic email on daily basis and patient allocated to team member as per duty rota
On receipt of referral, GBVNAS to move referral to own named folder within the generic mailbox
GBVNAS to create a patient folder in Trustshare, allocating a patient identification number. A copy of the referral to be saved to the folder and acknowledgment of receipt of referral to be entered on patient's NASH record. Patient particulars to be entered on to Database.
GBVNAS to make contact within 5 working days to arrange a face to face/telephone or virtual meeting (guided by patient's wishes)
GBVNAS to assess health & wellbeing needs and refer & signpost as required.
If patient DNA, one further attempt at contact to be made by preferred method.
Complete Safelives DASH if required & refer to MARAC if high risk indicated.
Carry out immediate safety planning with partnership agencies if required.
Refer to Social Work Contact Centre (complete NOCC) if required. (consent not necessary if risk of harm)
Save completed forms to NASH

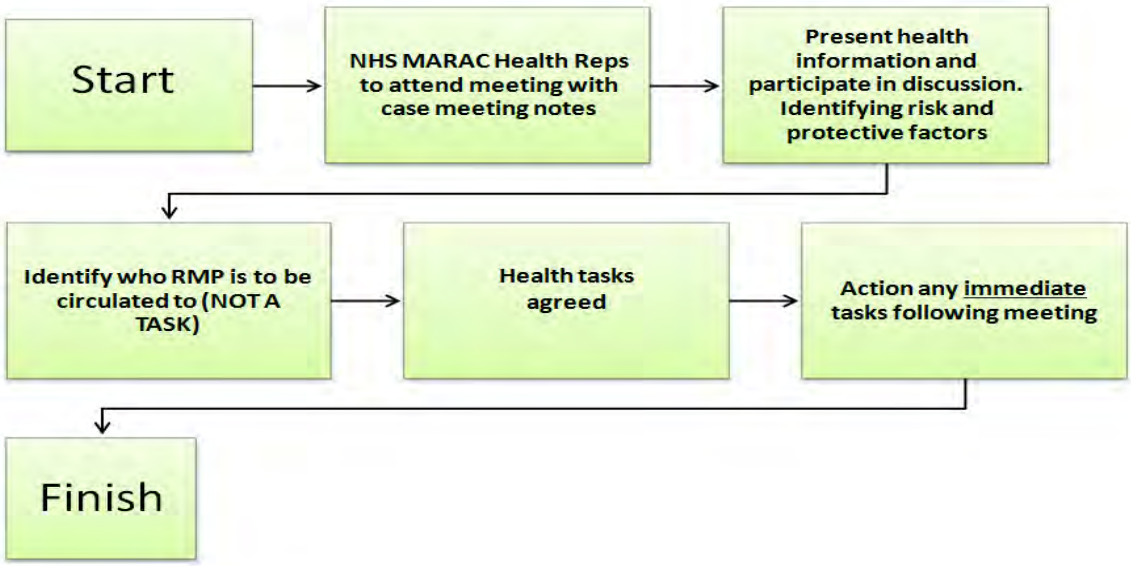

GBVNAS to ensure clinical notes are completed on NASH.
GBVNAS to make follow up appointment as indicated.
If no follow up required, open access for 12 weeks.
If no further support is requested, following 12 weeks, discharge from service.
If further support is requested, GBVNAS will arrange.
If support required beyond 12 weeks, case to be discussed at supervision and assessed on case by case basis.

*Appendix 2- **NHS Fife MARAC Process***

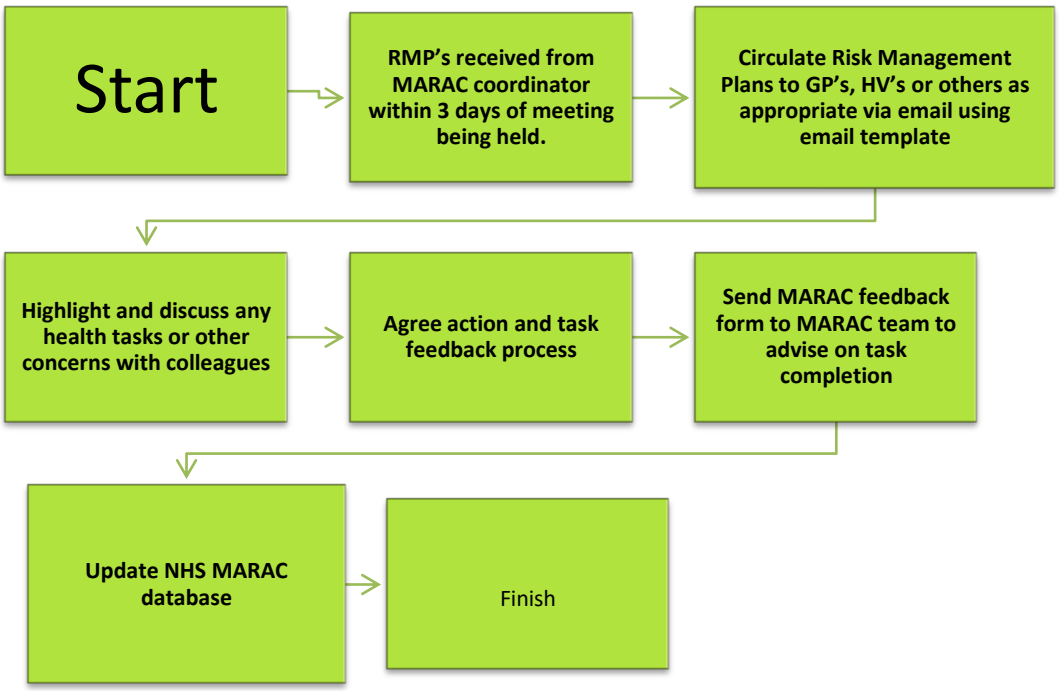
Pre-Meeting Process



MARAC Meeting Process

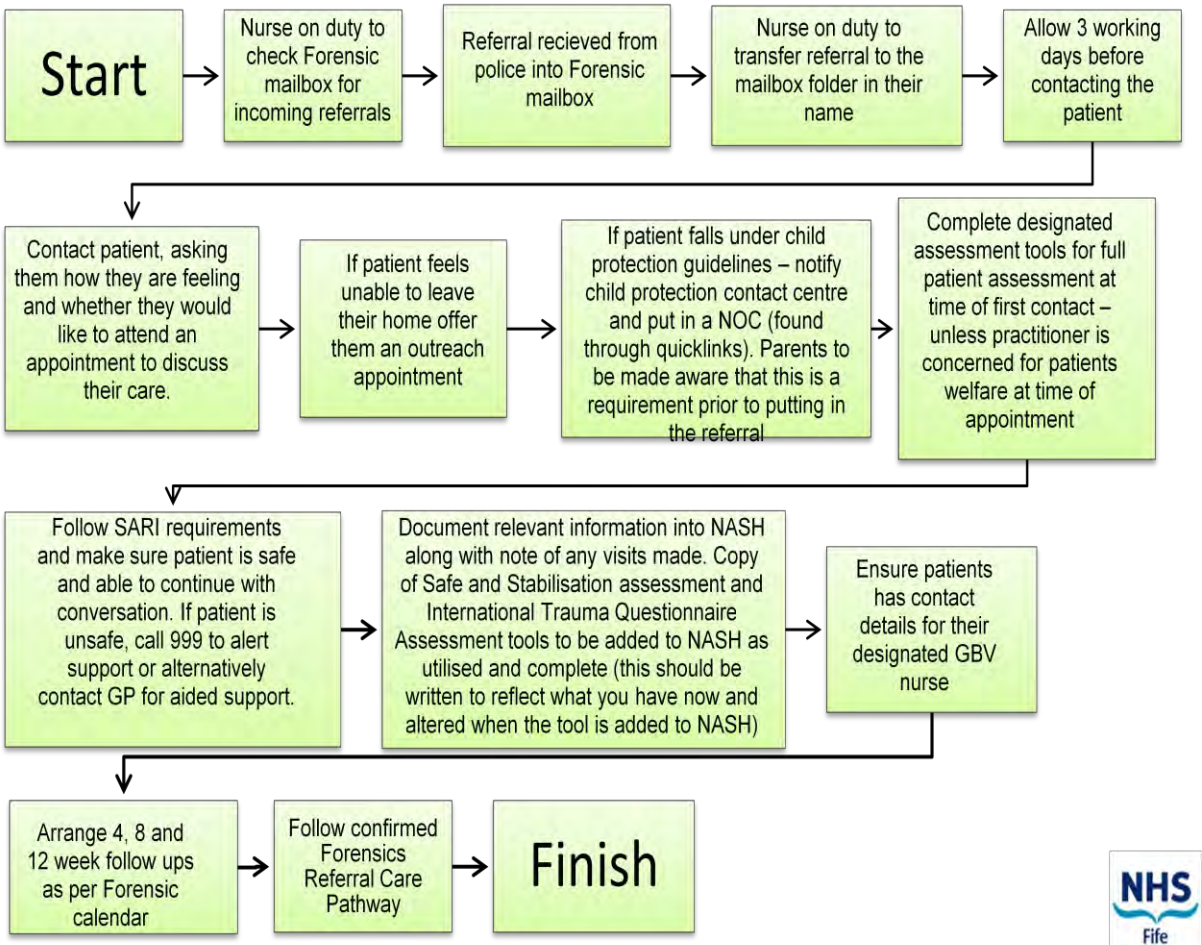


Post-Meeting Process



Appendix 3-NHS SAST Team Process

NHS SAST Team Process



Appendix 3 continued

Sexual Assault Support Team – Psychological Assessment and Support Pathway

GBV Nurses – Initial Assessment and Support

1. Explain the assessment and support pathway, including follow-ups (up to 3x, at 4, 8 and 12 weeks*)
2. Discuss confidentiality, limits, information sharing (including communication to GP if suicidal or complex mental health needs). Obtain signed consent if possible.

Assess:

3. Trauma symptoms
4. Coping strategies and supports
5. Suicidality
6. Wider needs
7. Outcome measures – ITQ & PHQ4 (can be deferred to 4 week follow-up at discretion of nurse, e.g. if extreme distress – *document if deferred*)

Support:

- **If actively suicidal or has complex mental health needs, refer to GP/UCAT/CMHT.** Inform GP (if suicidal or if have referred to CMHT due to complex mental health)

8. Psychoeducation
9. Advise re local supports and discuss how the person feels about self-referral (preferable) or referral. If not interested at this point advise can self-refer at any point in the future.
10. Give support pack (including relevant Rape Crisis Scotland booklets and leaflet regarding services in Fife).

4- and 8-week follow-up

Contact from GBV Nurse (using preferred method of patient, e.g. text, call face-to-face)

Final follow-up from GBV Nurses (Normally 12-weeks*)

Reassess:

1. Trauma symptoms
2. Coping strategies and supports
3. Suicidality
4. Wider needs
5. Repeat outcome measures

Support:

- **If actively suicidal or complex mental health needs, refer to GP/UCAT/CMHT**
- If does not meet CMHT criteria, but has significant needs, then refer or encourage self-referral to appropriate agency.
- **Discharge** with advice regarding coping and options for support if required in future. Give support pack again if required. Add additional materials to pack if required, e.g. due to needs that have emerged since initial assessment.
- If previously contacted GP, inform GP of discharge from SAST (also inform CMHT if referred to CMHT due to complex mental health)

* This Pathway is intended to promote consistency of care. The timing of follow-up appointments does not have to be followed rigidly if this would not benefit patients. Some may not need interim follow-up appointments and some may be discharged before 12 weeks, however, all should receive an initial assessment and a final review.

Appendix 4-Safety and Stabilisation Assessment

Fife Sexual Assault Support Team - Psychological Assessment & Support Pathway

Safety and Stabilisation Assessment

Section 1: Environmental Safety

Section 2: Substance and Alcohol Use Safety

Section 3: Body/Health Safety

Section 4: Emotional Safety

Please consider your patient's needs in each area by working through each section.

If physical safety needs (Sections 1-3) are not addressed first, then patients are less likely to benefit from emotional safety work

Patient Name	
Date of Assessment	
Assessor	

Patient informed of confidentiality limits? YES/NO Patient gave signed consent? YES/NO

Section 1: Environmental safety

Is the patient safe at home? YES/NO Is the patient safe outside the home? YES/NO

Are there any children in the home? YES/NO Are the children safe at home? YES/NO/NA Are the children safe outside the home? YES/NO/NA

NOCC required? YES/NO SafeLives checklist used to screen for risk of domestic violence? YES/NO/NA

Notes re risks to patient and children:

If not safe consider the following:

- Referral to Fife Women's Aid: 0808 802 5555 (for women experiencing domestic abuse)
- Referral to Safe, Secure and Supported at Home (home security review www.fife.gov.uk/sssh)
- Referral to FRASAC 01592 642336 (rape and sexual assault)
- Domestic Abuse and Forced Marriage Helpline 0800 027 1234
- Scottish Rape Crisis 08088 01 03 02 https://www.rapecrisisscotland.org.uk/
- Scottish Government Domestic Abuse Information and Support https://safer.scot/
- Supporting the patient to contact the police: 101

NB: Any change of address or serious suicidal risk must be communicated to Police

Does the patient have access to:	**Y/N**	**Who can help?** **During Covid Restrictions –** Community Help and Assistance
Safe accommodation		Fife Council Customer Services and Contact Centre are a first point of contact, they can provide a range of information • online Fife Direct Portal www.fifehousingregister.org.uk/options • Contact Centre 03451 55 00 33 Emergency Homeless / Fife Council Housing Service 0800 028 6231 Violence Against Women Housing Options Practitioner's Guide
Fuel (heating, hot water, electricity)		Cosy Kingdom: 01592 807930

Furniture / White goods		Scottish Welfare Fund: 0300 555 0265, Frontline Fife: 01592 800430, Castle Furniture Project: Cupar – 01334 65444, Glenrothes – 01592 773790 (domestic appliances) Furniture Plus: Dysart - 01592 654546, Dunfermline – 01383 720131 Cowdenbeath – 01383 515222 *please note furniture and white goods from castle furniture and furniture plus are not free but are heavily discounted.
Foodbanks		Referrals to foodbanks can be made by: • Fife Council's Welfare Fund team (tel. 0300 555 0265), • Social Work, • Citizens Advice & Rights Fife • *Some GPs and health visitors can also refer.* https://www.fife.gov.uk/kb/docs/articles/benefits-and-money-advice/food-banks
Money		Welfare fund: One off crisis grants for emergencies - **0300 555 0265 (**Monday to Friday: 9.30am to 4.30pm) Citizens Advice and Rights (CARF) Fife: 0845 140 0095 Department of Work and Pensions https://www.gov.uk/government/organisations/department-for-work-pensions Benefits and Grants https://www.mygov.scot/benefits/

Section 2: Substance and Alcohol Use Safety

2.1 Dependent Opiate, Benzodiazepine or Alcohol use:

Does the patient appear to be dependent on one or more illicit substances (opiates and/or benzodiazepines) or alcohol? YES/NO

- The patient may be dependent if they are using the substance very regularly (daily or most days) and are experiencing symptoms of withdrawal when they stop using the substance (nausea, shakes, sweating, headaches etc)

If yes: The patient should be referred to NHS Fife Addiction Services: 01592 716446. If refuses referral (or to acknowledge dependence), then notify GP due to risk.

2.2 Problematic Illicit Drug use:

Is the patient experiencing problems with work, relationships, health or social functioning as a result of their use of alcohol and/or one or more illicit substances? YES/NO. Is the patient aware of times when they may have overdosed? YES/NO. If yes, can they describe what that felt like (warning signs)? YES/NO. Explain what Naloxone is, and ask if there is anyone who could help them use it if required – document this.

Does the patient acknowledge that they have an alcohol and/or illicit substance use problem? YES/NO

If yes: Consider a referral to one of the following services:

Service	Description	Contact
Addaction Scotland	Supports people to make positive behavioural changes and improve their lives, whether that's with alcohol, drugs, or mental health and well-being	Freephone: 0800 9179211. Phone: 01592 619090 Email fife@addaction.org.uk
FIRST	Community rehabilitation Service	http://www.firstforfife.co.uk/ 01592 585960
DAPL	Counselling for drug and alcohol use	http://www.dapl.net/home/ 01333 422277
FASS	Counselling for alcohol use	https://www.fassaction.org.uk/ 01592 206200
Clued Up	Substance Use support and Information for under 25's	http://www.cluedup-project.org.uk/ 01592 858248

Section 3: Body/Health Safety

Does the patient have difficulties with:	Y/N	Comment	First Line of Support	Potential Areas for Intervention
Physical health - any significant health issues or concerns which are not being adequately treated?			GP	Health anxiety Planning and problem solving
Dental health - untreated dental problems?			NHS Dental Service	Dental anxiety Planning and problem solving
Sexual health - concerns about possible or diagnosed sexual health problems?			Sexual Health Fife: 01592 647979 Relationships Scotland: http://www.relationships-scotland.org.uk/	Anxiety management Planning and problem solving
Self harming - engaging in self harming			Penumbra http://www.penumbra.org.uk/how-can-	Risk management Interventions for Self

behaviour? Suicidal ideation? History of suicide attempts?			we-help/service-locations/fife/self-harm-project-fife/ GP	Harm Treatment of Associated Conditions

Section 4: Emotional Safety

For interventions to increase emotional safety, consider:

1. Most people will experience some trauma symptoms and emotional dysregulation following a sexual assault. For a significant proportion of people, these symptoms will naturally diminish over time. Therefore, risk management, attention to the safety needs identified above, and watchful waiting may be sufficient.
2. People who are experiencing more significant acute symptoms should be directed to FRASAC or Women's Aid.
3. Where significant risk of suicide is identified, the patient's GP should be informed.
4. People with complex trauma (significant difficulties under the headings below and a history of multiple traumatic experiences in childhood and / or as an adult) *with acute difficulties* should be managed as described above (interventions 1. – 3.), or via referral to the CMHT if there is significant risk / mental health issues. Patients with complex trauma, *who are not in acute crisis and want to work on longer standing difficulties,* can be referred to KASP, Safe Space, or the Fife Complex Trauma Pathway through their CMHT.
5. Patients with mild-moderate residual difficulties, who are not in acute crisis, can be directed to Access Therapies Fife for help with anxiety, mood, etc.
6. If unsure, discuss with colleagues or in supervision.

Does the patient have difficulties with:	Y/N	Description	Comment – Including Intervention Plan
Trauma symptoms		Re-experiencing symptoms Avoidance Symptoms Arousal Symptoms Low mood/Negative Cognitions.	
Emotional Dysregulation		Difficulty with controlling or regulating emotional responses – the individual experiences emotional responses to internal or external stimuli which would not be considered to fall with the normal range of emotions	

Relationships		Problems with relationships with others, including isolation, distrust, difficulty with healthy boundaries, history of abusive relationships, tendency to form intense relationships very quickly, tendency to reject others etc.	
Self-concept/Identity		Difficulties may include a sense of helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings.	
Attention and concentration		Impaired ability to maintain attention and concentrate e.g. on conversations, tv, books etc. Easily distracted.	
Dissociation		Symptoms include Amnesia, Depersonalisation, Derealisation, and confused/altered identity.	

Appendix 1

GENDER BASED VIOLENCE NURSE ADVISORY SERVICE REPORT

2019/2020

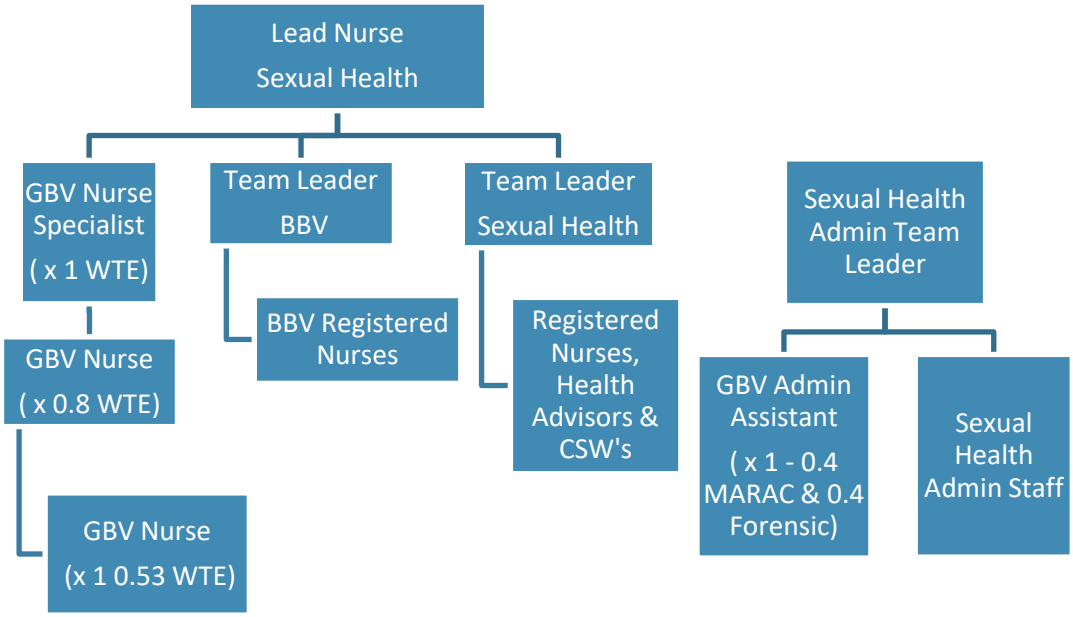
Contents

1. Introduction – Overview of NHS Fife Gender Based Violence Service Provision 2019/2020

This is the Gender Based Violence Nurse Advisory annual report for the year 2019/2020. The team are co located within Sexual Health Services in Fife. The Sexual Health Service provides optimum access to sexual and reproductive health care to male and female clients of all ages.

In the year 2019/2020, the Gender Based Violence Nurse Advisory team consisted of one WTE Gender Based Violence Nurse Specialist, one 0.53 WTE Gender Based Violence Support Nurse and one 0.4 WTE Administration Assistant. With the introduction of the Forensic Medical Examination Service on the 1st April 2019, additional funding secured one Gender Based Violence Nurse x 0.8WTE and one 0.4WTE Administrative Assistant. Due to Covid-19, the team has been delayed in recruiting into these posts as quickly as previously possible.

Figure 1. Organisational Structure



2. Breakdown of referrals to NHS Fife Gender Based Violence Nurse Advisory Service

Following the introduction of the GBV Nurse Advisory Service Referral pathway in October 2018, patient's attending NHS Fife Sexual Health clinics can be referred directly by their sexual health nurse or sexual health Doctor to the GBVNAS if consent is given and they are seeking further support. ***See appendix 1.***

The gender based violence pathway has resulted in **35** individuals (**31 Females and 4 males**) receiving support from the GBV Nurse Advisory service between April 2019 and March 2020. The table below (Figure.2) shows the age distribution for individuals who were referred to the GBV Nurse Advisory service via Sexual Health Fife.

Figure 2. Age of referrals to Gender Based Violence Nurse Advisory Service from Sexual Health
Figure 3. Break down Gender Based violence referrals pertaining to age group.

Figure 2.

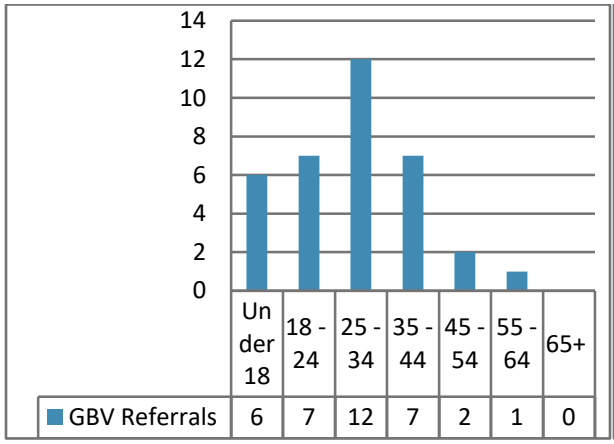
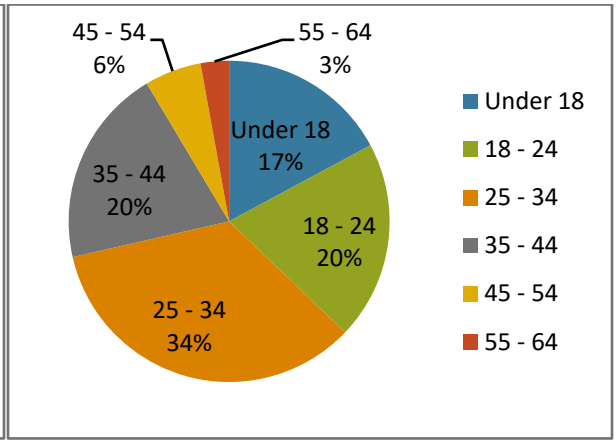


Figure 3.



The Gender Based Violence Nurse Advisory Service also provides support to young people of less than 18 years of age. Between April 2019 and March 2020, The Gender Based Violence Nurse Advisory Service supported 6 individuals under 18 years of age, and 29 individuals who were over the age of 18. The chart above *(Figure 3.)* shows the percentage breakdown of Gender Based Violence referrals from Sexual Health pertaining to their age group.

Reason for Referral

Gender Based Violence is identified by Public Health Scotland (2020) as a major public health, equality and human rights issue. It covers a spectrum of violence and abuse, committed primarily but not exclusively against women by men. This includes, but is not limited to:

- Domestic abuse
- Coercive control
- Rape and sexual assault
- Childhood sexual abuse
- Stalking and harassment

- Financial control
- Commercial sexual exploitation
- Harmful practices - such as female genital mutilation, forced marriage and so-called 'honour' based violence."

(Public Health Scotland, 2020)

Referrals received by the NHS Fife GBV Nurse Advisory Service can include current or historic abuse, of all the aforementioned types. For the year 2019/2020, 8% of the referrals were for childhood sexual abuse, 29% for Domestic Violence, 9% for Domestic Violence and Sexual Assault and 54% for Sexual Assault. A breakdown is shown below in *Figures 4 & 5.*

Figure 4. Reason for Referral to Gender based Violence Nurse Advisory Service
Figure 5. Reason for Referral to Gender based Violence

Figure 4.

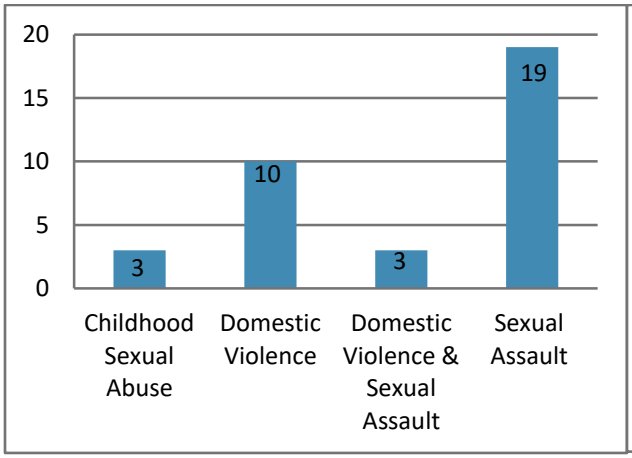
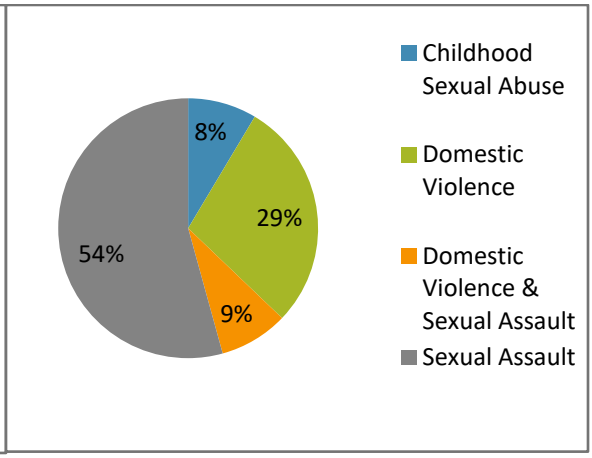


Figure 5.



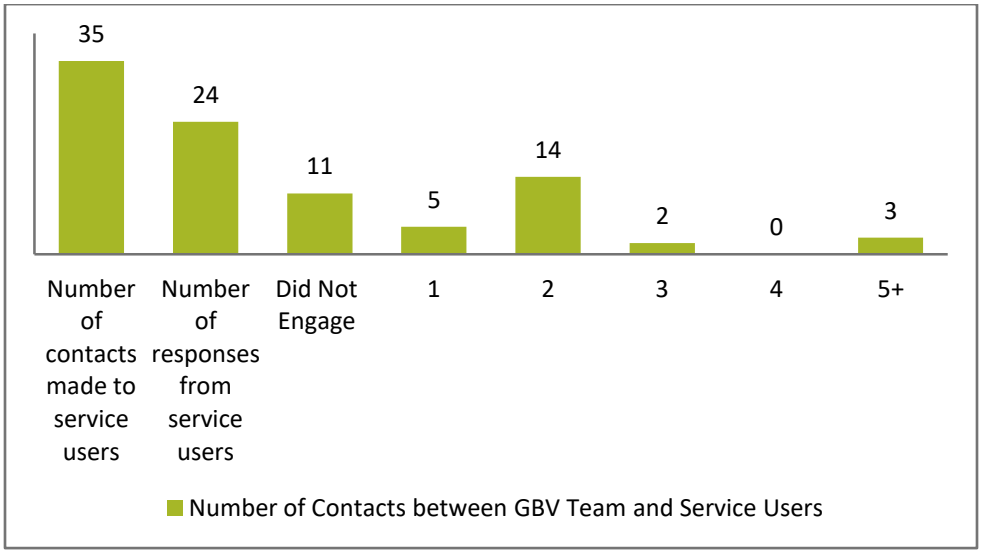
Service Engagement

Individuals who are referred to the Gender Based Violence Nurse Advisory Service continue to be offered up to 12 weeks support, or more if required. Out of the 35 referrals received by the Gender Based Violence Nurse Advisory Service from Sexual Health Fife, 18 individuals did not fully engage for the full 12 weeks or did not engage at all with the service despite initially consenting to contact from the team. It is difficult to ascertain the reasons for non-engagement, however some information through SMS texts indicated that it was felt to be too soon for support and they may contact the service later. Contact via text message has been initiated to allow individuals to respond by either telephone or SMS text at a time preferred by them.

Between April 2019 and March 2020, the Gender Based Violence Nurse Advisory Service contacted service users a total number of 35 times and received a total number of 24 responses. The table below (*Figure.6.1)* shows the number of contacts made to service users, the number of responses from service users, the number of service users that did not engage and the number of appointments that were required by service users accessing the Gender Based Violence Service.

Figure 6.1. Number of contacts required by service users

Figure 6.1

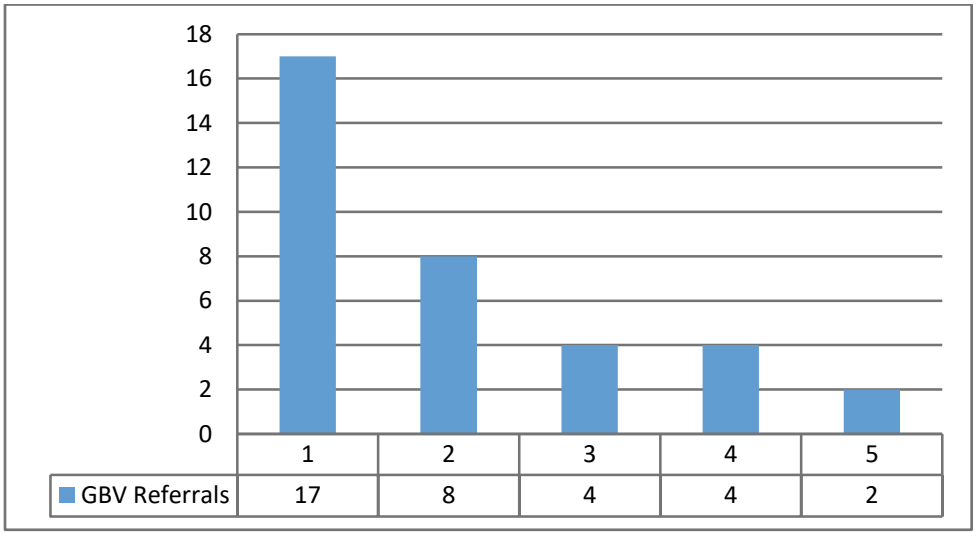


Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) has been used to identify the deprivation status of individuals who were supported by the Gender Based Violence Nurse Advisory Service in 2019/2020 (*See Figure 6.2*). Using postcode analysis, the SIMD ranks small areas from most deprived (ranked 1) to least deprived (ranked 5). The most common SIMD ranking for individuals supported by the Gender based Violence Nurse Advisory Service was **1**, suggesting that the majority of those supported by the Gender Based Violence Nurse Advisory Service lived in the most deprived areas in Fife. This can often leave the individual feeling chaotic and challenged within many areas of their lives.

F*igure 6.2. Deprivation status (SIMD)*

Figure 6.2



Client Feedback

The Gender Based Violence Nurse Advisory team continue to collate valuable client feedback.

Comments received include:

“Thank you very much for sorting that out and all your support”.

“I have felt so isolated, thank you for helping me”.

“Thank you very much for finding me help, you have been a star”.

“Thank you; I don’t know what I would have done without you”.

“Thanks so much for everything”.

“I can’t thank you enough for the support. Thanks again.

3. NHS Fife Partnership with MARAC (Multi-Agency Risk Assessment Conferencing)

MARAC (Multi-Agency Risk Assessment Conferencing) identifies the highest risk victims of domestic abuse and aims to reduce the risk of further victimisation. MARAC is a process that involves:

- Appropriate sharing of information across agencies.
- Producing multi-agency safety plans to reduce the risk to victims and any children.
- Sharing an awareness of risk posed by the perpetrator to the victim or third party.

NHS Fife is a core MARAC partner. Within NHS Fife, the Gender based Violence Nurse Advisory Service act as MARAC representatives. As MARAC representatives, the Gender based Violence Nurse Advisory Service collate and share information with partner agencies to assess and develop an individualised Risk Management Plan. This enables NHS Fife to help reduce risk to known victims.

NHS Fife MARAC process maps can be seen in *Appendix 2*

NHS Fife MARAC Tasking - MARAC health tasks by NHS discipline

In 2019/2020, at time of this report accurate data from Police Scotland was not available relating to figures of domestic abuse incidents however there have been:

- **437** case discussions at MARAC for the highest risk domestic abuse cases.
- **421** of those were female victims and **16** male victims.
- **451** children were discussed. Of the cases discussed, **400** were first time referrals with **37** repeat referrals - where the same victim and perpetrator have been referred.

At the MARAC meeting, NHS Fife MARAC representatives share proportionate and appropriate health information about the victim, any children and third parties and identify how NHS Fife can contribute towards reducing further risk of harm to the victim.

NHS Fife identified **344** tasks in the year 2019/2020, some relating to more than one individual (adult victim, perpetrator and/or children). Of the **344** tasks generated, **296** of these were share the RMP with the health professionals involved, and **48** were deemed 'other' health related tasks (*Figure 7)*. Moving forward in 2019/2020, sharing of RMP to core health professionals (GP's, Health Visitors, FNP nurses, Psychology, Psychiatry and Midwifery) already involved will become procedural and will not be taken as individual tasks. This initially made it difficult to ascertain the amount of tasking completed and it is thought that the tasking figures are greater. The database has now been developed to capture these figures and will be available for any future reports.

Figure 7. Percentage of health tasks which were routine Sharing of RMP

Figure 8. MARAC health tasks by NHS discipline 2019/2020

Figure 7.

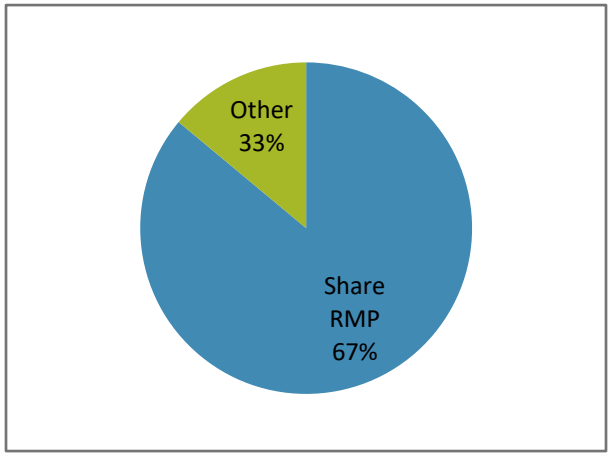
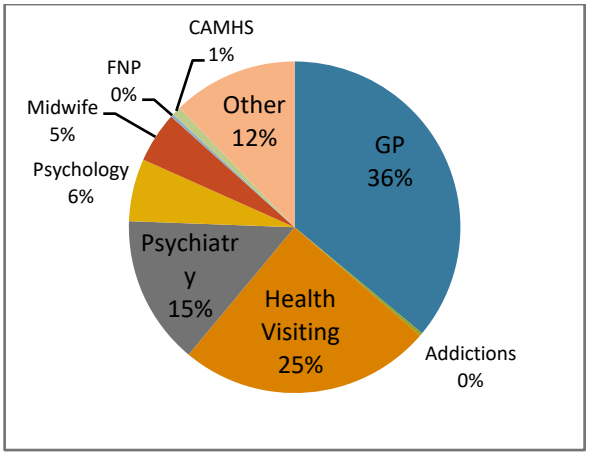


Figure 8.



The table above (*Figures 8*) shows a breakdown of which services within NHS Fife, these tasks involved.

MARAC health tasks in relation to children

In the year 2019/2020, **451** children were discussed at MARAC. An additional **18** MARAC victims were identified as pregnant *(MARAC Fife Annual Update, 2019/2020).* Therefore, many of the health tasks taken by NHS Fife tend to involve NHS Children's Services. In 2019/2020, of the **451** health tasks that were identified by NHS Fife, 110 of these tasks were in relation to children and involved NHS Fife children's services (*see Figure 9.*).

Children's services include Health Visiting, Midwifery services, School Nursing and Child and Adolescent Mental Health (CAMHS).

Figure 9. Percentage of MARAC health tasks which were in relation to children.
Figure 10. Provides a further breakdown of which of these children's services MARAC health tasks involved.

Figure 9.

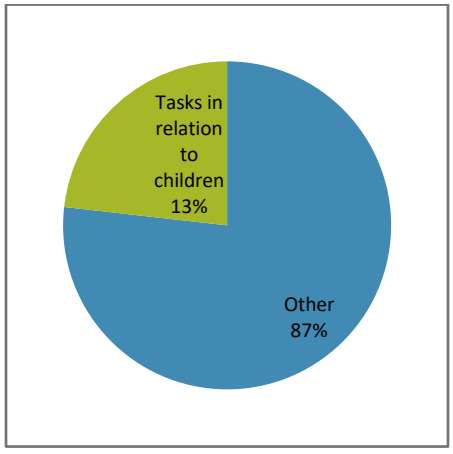
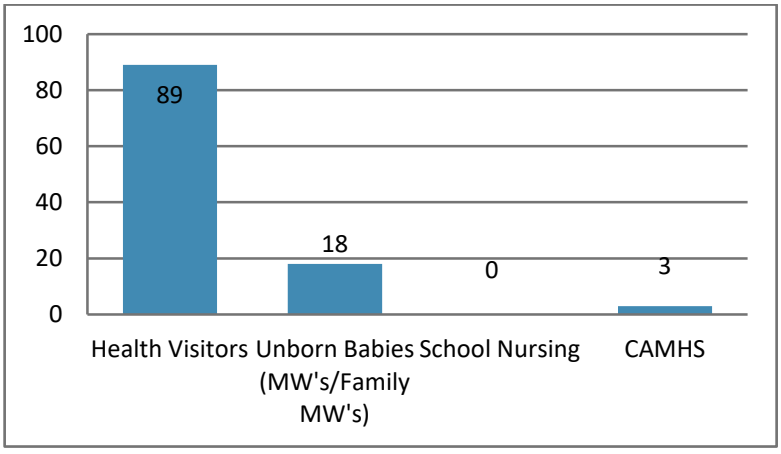


Figure 10.



Of the 110 tasks which were in relation to children, 61 of them were routine sharing the RMP and 49 of them were 'Other' including helping secure early years placements, reviewing health visiting plans, considering convening wellbeing meetings and behavioural management (*see Figure 11*).

Figure 11. No. of health tasks in relation to children which solely involved sharing the RMP.
Figure 12. Percentage of tasks for repeat cases, which were routine Sharing of the RMP

Figure 11.

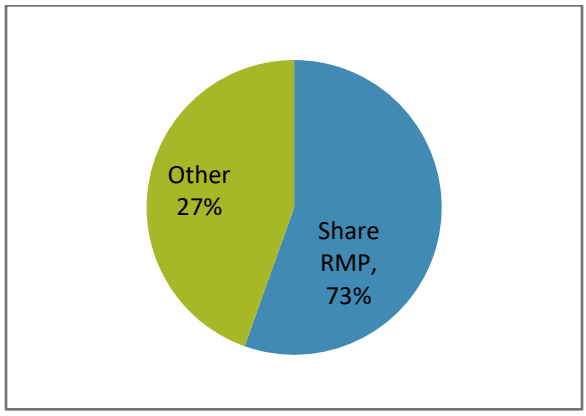
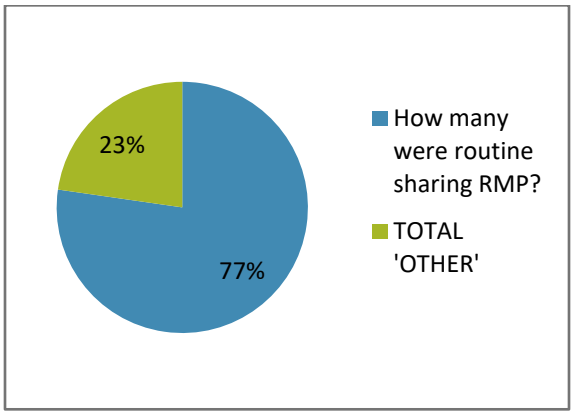


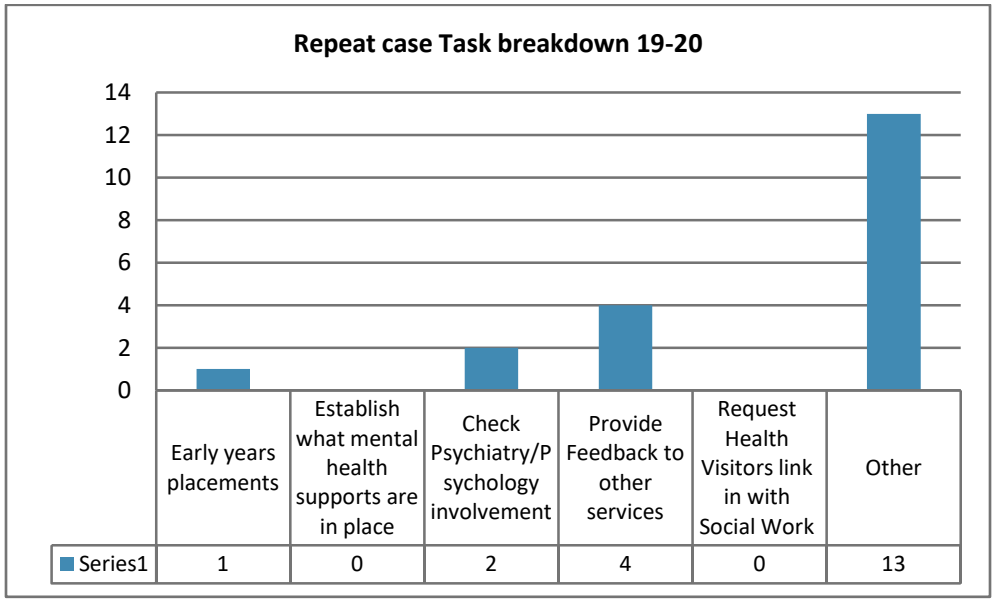
Figure 12.



MARAC health tasks for repeat cases

- There were **37** repeat cases discussed at MARAC, generating **108** health tasks.
- Of the **108** health tasks generated, **88** were routine Sharing of the RMP with health professionals and **20** tasks were deemed 'Other' (*Figure 12*. above), those 'other' tasks are further broken down in *(Figure 13*. below)

Figure 13. Repeat case task breakdown



MARAC GP Locations 2019/2020

Within NHS Fife, there are **58** GP Practices. There are **21** GP Practices within the Dunfermline and West Fife area, **19** in Glenrothes and North East Fife and **18** across Kirkcaldy and Levenmouth. The table below (*Figure 14.*) shows the number of victims and perpetrators registered to a GP Practice within each GP cluster in 2019/2020. Dunfermline and West Fife appear to have the highest number of both MARAC victims and perpetrators followed closely by Kirkcaldy and Levenmouth.

Figure 14. Number of MARAC victims and perpetrators registered to a GP Practice within each area in 2019/2020.

Figure 14

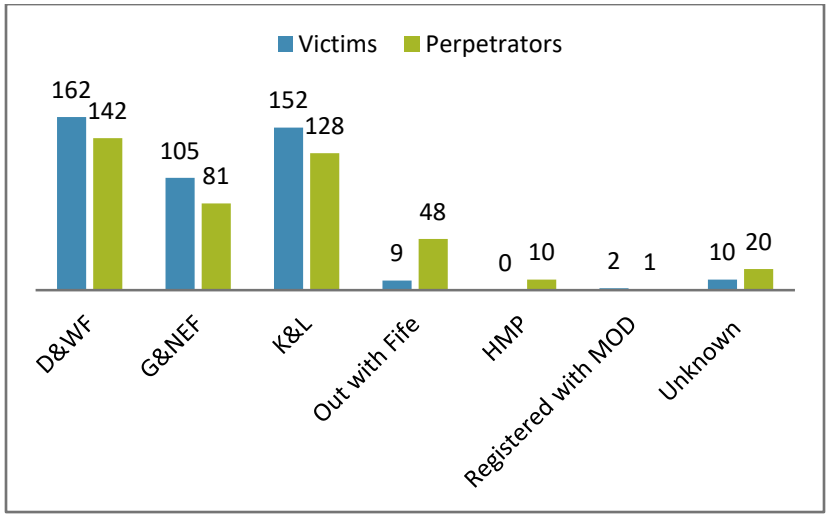


Figure 15. Shows the percentage of MARAC victims registered to a GP practice within each area in 2019/2020.

Figure 15. Percentage of MARAC victims registered to a GP practice within each area in 2019/2020.
Figure 16. Percentage of MARAC perpetrators registered to a GP practice within each area in 2019/2020.

Figure 15.

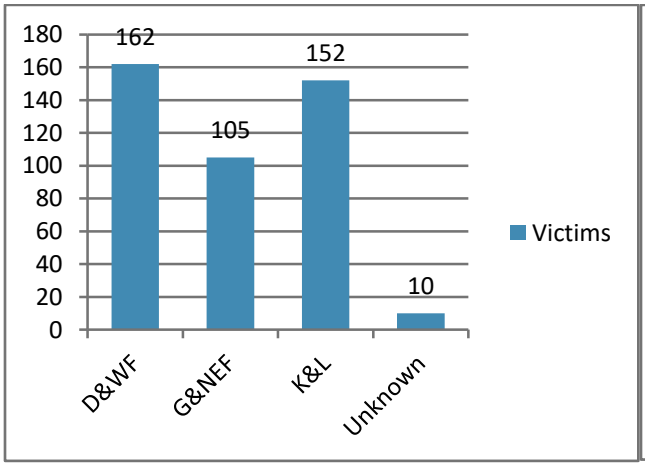


Figure 16.

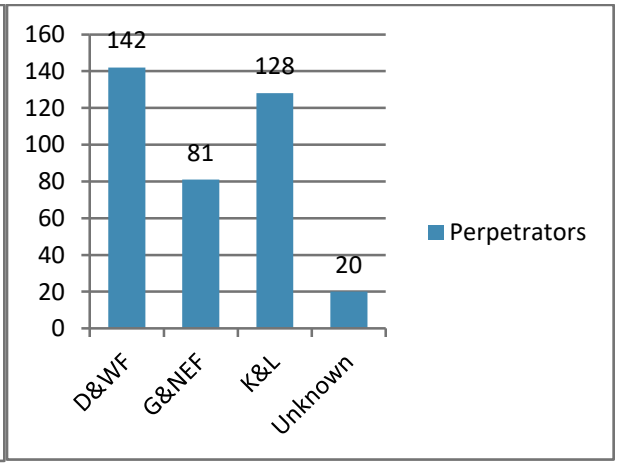


Figure 17.1 & 17.2 Victims SIMD status 2019/2020

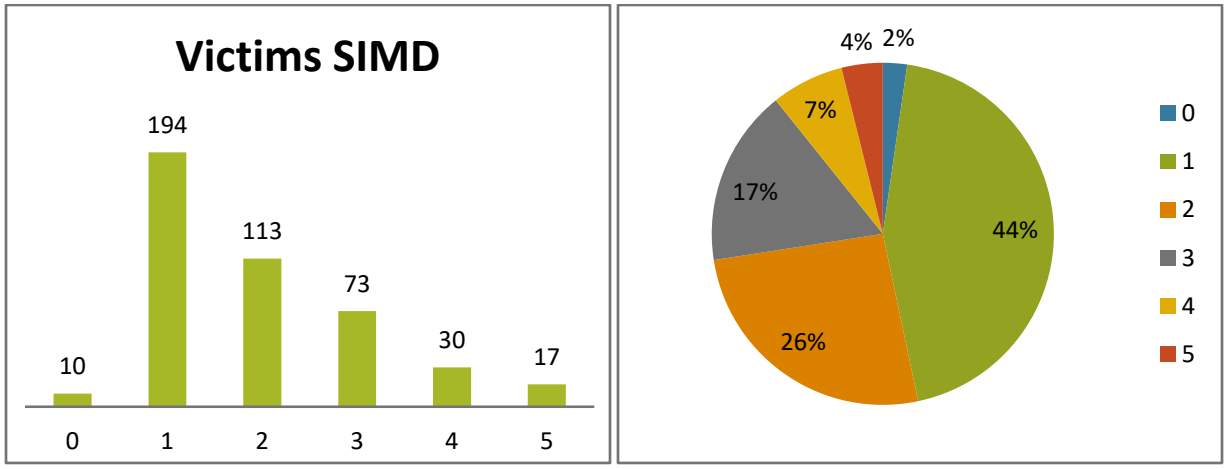
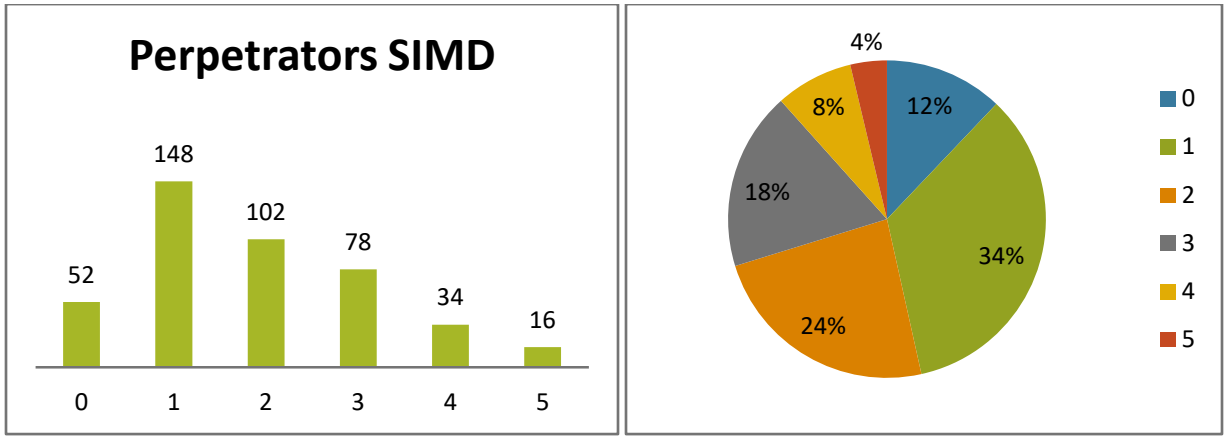


Figure 18.1 & 18.2 Perpetrators SIMD status 2019/2020



This is clearly reflective of previous linkage of increased Gender Based Violence areas of high deprivation and poverty.

4. Gender Based Violence Nurse Advisory service for individuals who have experienced sexual assault

A pathway has been developed and embedded to provide standardised support to individuals who have experienced sexual assault and who have been referred to the service by Police or FME services. The implementation of these pathways ensure that all individuals receive appropriate sexual health follow up and designated support and counselling for 12 weeks from the GBVNAS and from our 3rd party agency partners if required (Appendix 3). The development of a psychological wellbeing Safety and Stabilisation Assessment in collaboration with Psychology has been completed and is concluded to become fully functional to support this process. This ensures formal assessment is completed and any actions are completely integrated (Appendix 4).

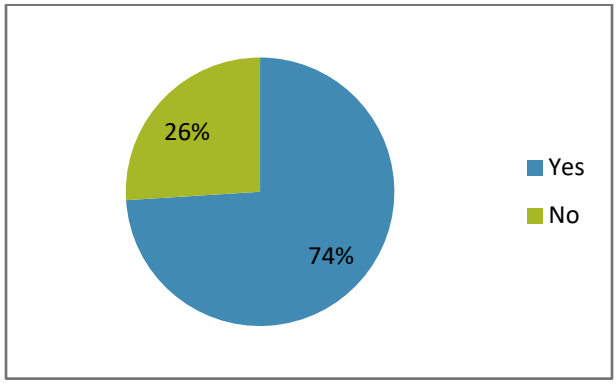
The Fife Suite was officially opened on the 1st April 2019.

The CMO Taskforce have developed specific indicators for all Boards to adhere to. These indicators of care are reviewed and reported on quarterly and the GBVNAS have produced and submitted a report to provide data relating to these indicators. These are shown below. New indicators were implemented from January 2020. The final assessment indicators are now in place as seen below.

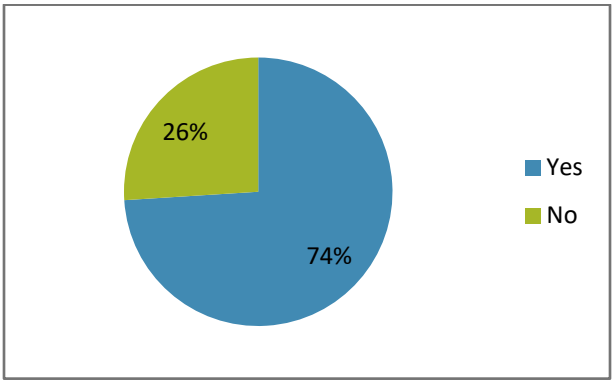
NHS Fife Forensic Indicators 2019/2020

4.1a Proportion of people who underwent a psychosocial risk assessment, which included risk of suicide
4.1b Proportion of people who underwent a psychosocial assessment, which included risk of domestic abuse

Indicator 4.1a



Indicator 4.1b

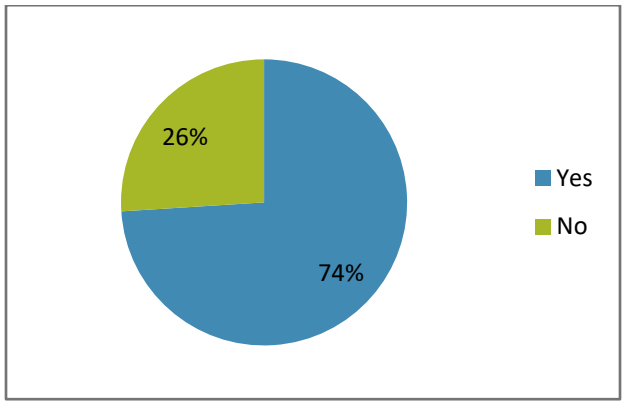


Despite lack of engagement, the 14 individuals who represent the 26% above were appropriately assessed to ensure their safety and wellbeing including safety planning and signposting.

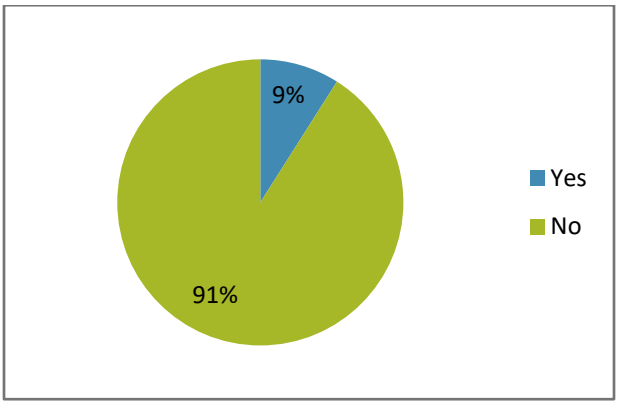
Full psychological assessments were concluded and safety planning implemented if required to those who engaged with services. No incidences of suicidal ideation were disclosed.

4.1c Proportion of people who underwent a psychosocial risk assessment which included risk of harmful coping strategies
4.2a Proportion of people who, if required, were referred to child protection

Indicator 4.1c



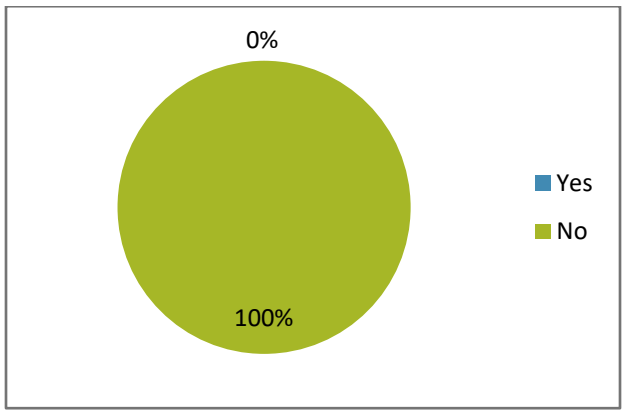
Indicator 4.2a



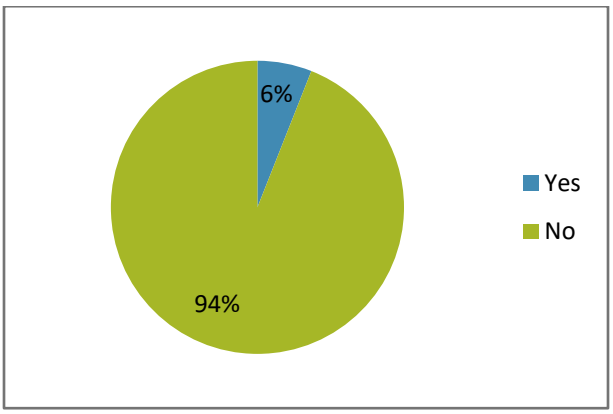
All children who attended the suite had a Notification of Child Concern (NOCC) as part of the mandatory guidance within our service and all relevant discussions held as part of the statutory processes within the service. 5 were required and 5 referrals sent.

4.2b Proportion of people who, if required were referred to advocacy
4.2c Proportion of people who, if required, were referred to housing

Indicator 4.2b



Indicator 4.2c

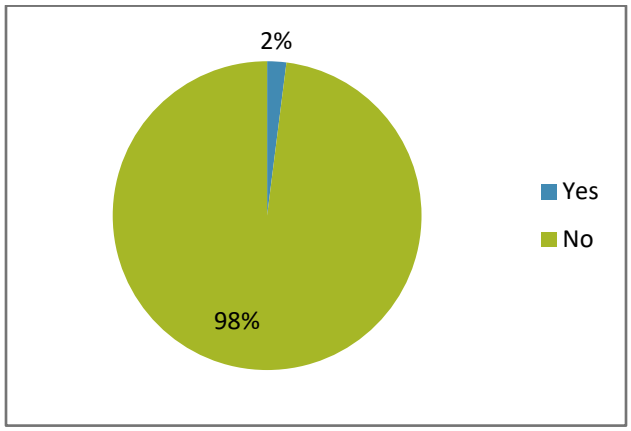


Any individual who requires advocacy support has this arranged. No referrals were required.

The 3 individuals who required housing found it difficult to remain within their home due to re traumatisation. The sexual assault was not always the reason they required support but had been a catalyst in their ability to remain within the property.

4.2d Proportion of people who, if required, were referred to crisis support

Indicator 4.2d

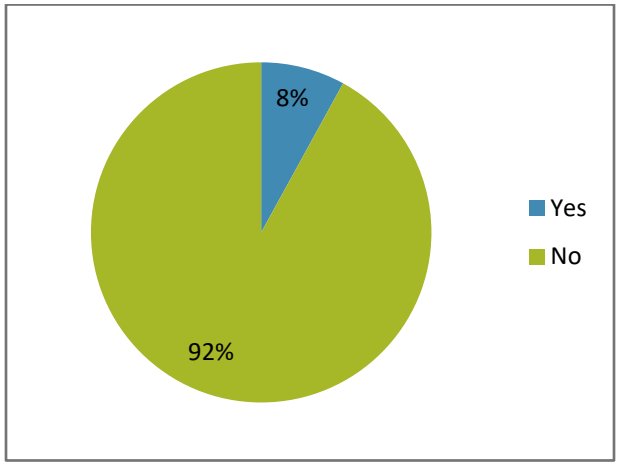


1 person was referred for crisis support. Throughout the 12 week support offered by the GBVNAS, individuals can require daily support whilst they try to understand and acknowledge their trauma. This requires a high level of support and often in the initial stages of care requires the supporting nurse to incorporate many aspects of the safety and stabilisation framework. Most of the individuals were referred onto to 3rd sector agencies for ongoing specialists support/counselling, and the GBVNAS were utilised as the conduit until long-term support became available which has been difficult during the pandemic.

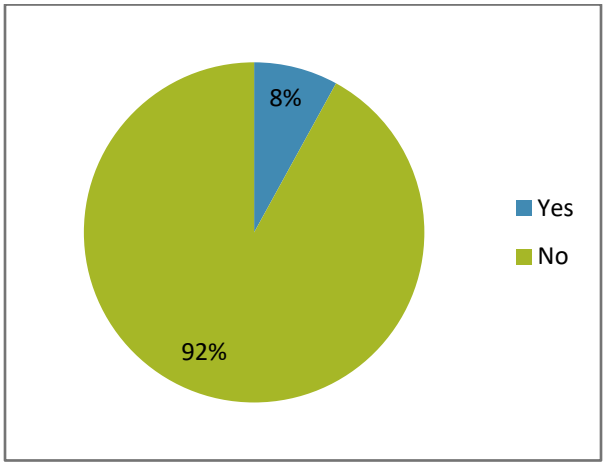
5.2 Proportion of people who, if required, received sexual health services for post exposure prophylaxis for Hepatitis B within 48 hours 4 People required PEP

5.3 Proportion of people who, if required, received sexual health services for post exposure prophylaxis for HIV within 72 hours

Indicator 5.2



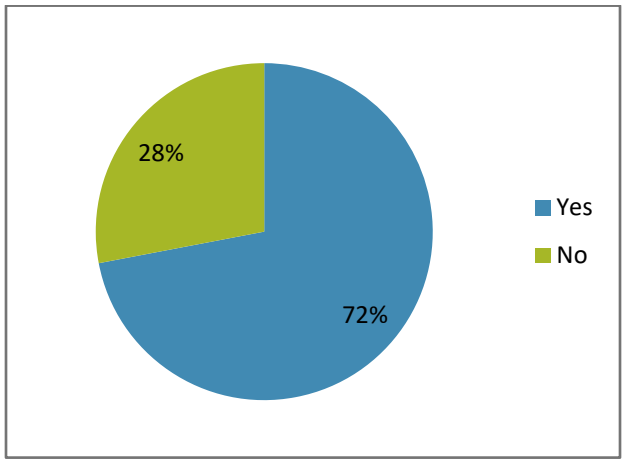
Indicator 5.3



All 4 individuals who attended the suite received post exposure prophylaxis (PEP) after appropriate assessment. This service has been integrated into the pathway, to help reduce further re traumatisation.

5.4a Proportion of people who, after 2 weeks, received STI screening and treatment

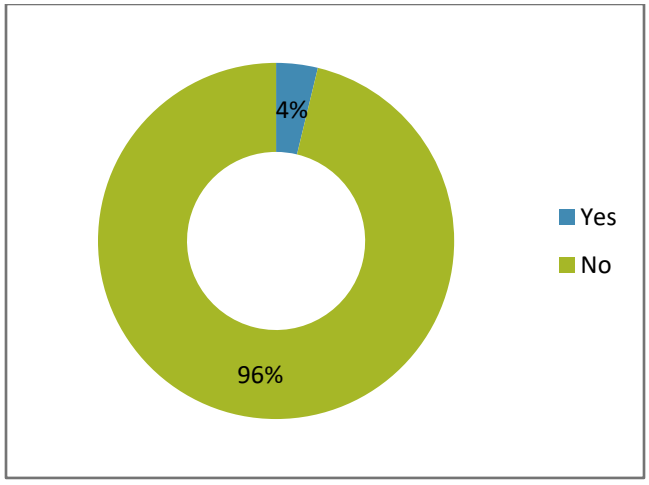
Indicator 5.4a



10 people used our service within 2 weeks and 5 people declined. Some patients will choose to receive STI screening and treatment in different board areas or anonymously therefore this is difficult data to capture accurately. The 5 patients who declined screening or treatment felt it was too traumatic to attend and disclose to the practitioner and have any tests taken so quickly after the assault then subsequently go on to have the required testing.

P6.1 Proportion of people who were referred to a Mental Health Service

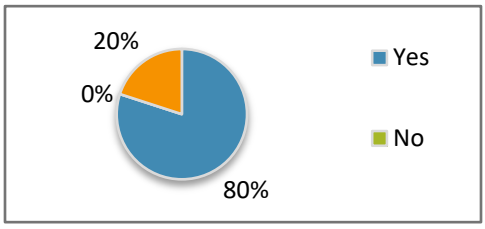
Indicator 6.1



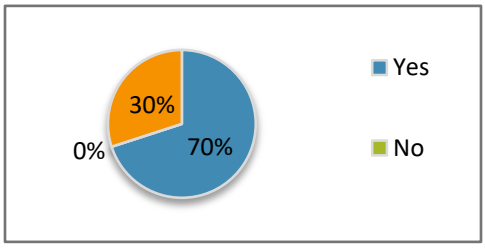
As part of our service development we have used patient feedback to drive service improvement, below is our feedback for 2019/2020.

The GBVNA Service value patient feedback and ensure this drives service delivery. Patient feedback is a qualitative measure and it often difficult to achieve accurate reflections given the level of trauma.

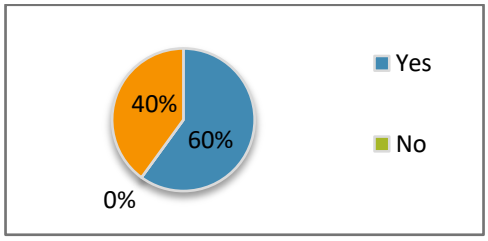
1. Were you informed of what would happen when you attended the hospital?



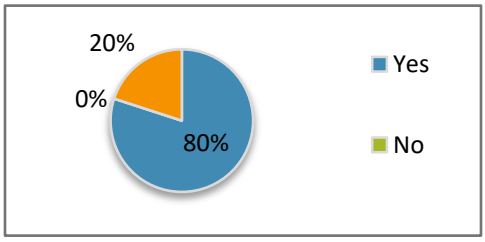
2. Did you feel the requirements for an examination was explained well to you?



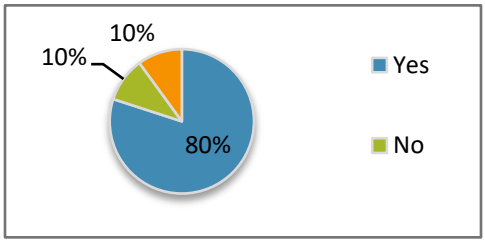
3. Was it better for you to have your examination within a hospital setting?



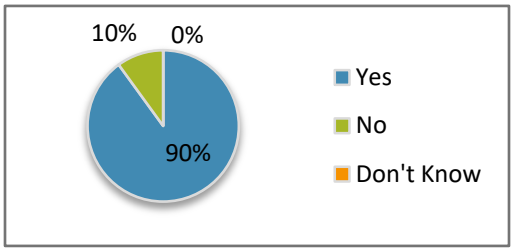
4. Did you feel that all your anxieties were listened to?



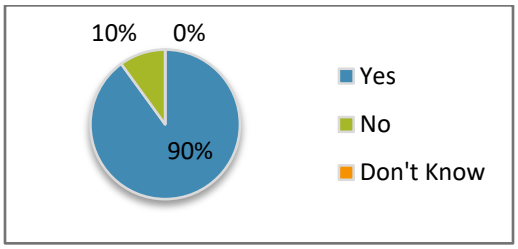
5. Were you offered Gender Based Violence Support at that time?



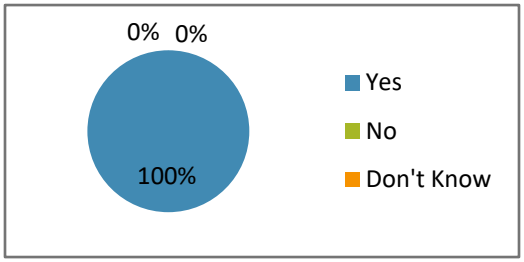
6. Were you contacted within 7 days of being at the suite



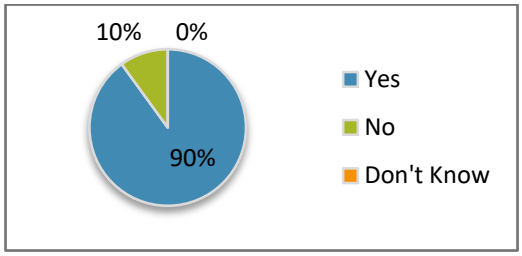
7. Did you accept support from GBV team?



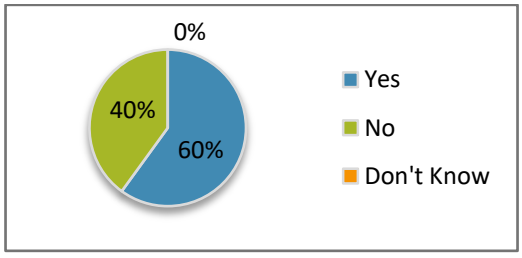
8. Did you find the support from the GBV team helpful?



9. Did you receive sexual health services as part of your care?



10. Were you referred to another agency for further support?



Feedback Questionnaire Comments

- **Nice room. I got biscuits and hot chocolate. I was so nervous and they helped me feel like I had done anything wrong.**
- **Do not know where I would be without their support. They helped me when I was really struggling and could not see how to get through this. They really listened when I was getting support.**
- **When it first happened, I spoke to my nurse a lot. Do not know what I would have done without her and it made me better just speaking to someone who really understood what it felt like to be me. Can't thank her enough**
- **Felt embarrassed and sick but the nurse helped me**
- **The nurse helped me to get my tablets sorted and helped me with my GP to understand what I was going through. She supported me until I went to FRASAC. She was so kind.**
- **The nurse informed me what to expect within sexual health and what I could expect during the tests that would be taken. She also helped me with the results. All tested and clear so I am feeling much better now**
- **She spoke to me like I had not made a mistake and this was not my fault.**
- **The GBVNAS nurse really helped me. I am now attending FRASAC and with all the help and support I am getting I finally feel like I am getting on with my life.**

A formal process is now in place to ensure we comply with the GDPR and Clinical Governance practices to obtain regular, anonymous patient feedback.

Where are the GBVNAS service now within the sexual assault support service?

At present the service are working with the CMO Taskforce around self-referral. The progress of this will be report in the 2020-2021 report.

5. Training

The Gender Based Violence Nurse Advisory Service are responsible for developing, co-ordinating and delivering a comprehensive programme of Gender Based Violence training for staff at all levels within NHS Fife and the Health and Social Care Partnership and to participate in the development and delivery of multi-agency training across Fife.

During 2019/2020, the Gender Based Violence Nurse Advisory Service provided several bespoke training sessions incorporating Gender Based Violence awareness and routine enquiry. The team have specifically promoted and encouraged the use of the DASH (The Domestic Abuse, Stalking and Honour Based Violence) Risk Identification, Assessment and Management Model amongst health professionals to enable appropriate referrals to MARAC. These sessions were facilitated Fife wide and targeted Health Visitors, Nurses, medical students and other NHS services including psychology and psychiatry. Training was also delivered to 12 out of 58 GP practices within Fife. *(See Figure 20.)*

The team also participated in 'Fresher's Week' with the wider sexual health team, attending colleges of further education, throughout Fife, raising awareness of gender based violence and signposting to supports available.

Figure 20. Training delivered by Gender Based Violence Nurse Advisory Service 2019/2020

Organisation	Training Delivered	Participants	Number Attended
NHS Fife	DASH Training (08/05/19)	North East Fife Health Visitors	4
NHS Fife	In Core training –Awareness of Gender Based Violence (Nov 19) Queen Margaret	NHS Bank Staff, new employees	25
NHS Fife	In Core training – Awareness of Gender Based Violence (Dec 19) Queen Margaret	NHS Bank Staff, new employees	30
NHS Fife	In Core training – Awareness of Gender Based Violence (Feb, 2020) Cameron Hospital	NHS Bank Staff, new employees	30
NHS Fife	In Core training – Awareness of Gender Based Violence (Feb, 2020) Queen Margaret Hospital	NHS Bank Staff, new employees	50
NHS Fife	Gender Based Violence Awareness and MARAC awareness (Feb, 2020)	Psychology and CPN's Lynebank Hospital	60
NHS Fife	Adult protection, protection for all. (Feb 2020)	Learning Disability and Psychiatry	50
NHS Fife	Presentation on sexual abuse victims and intimate examinations.	Carnegie Conference Centre (Feb 2020)	50
NHS Fife	Awareness of Gender Based Violence. February 2020	Community Midwives Victoria Hospital	20

6. Appendices

Appendix 1 Gender Based Violence Nurse Advisory Service (GBVNAS) Sexual Health Referral Pathway

Appendix 1.docx

Appendix 2 NHS Fife Process maps

Appendix 2.docx

Appendix 3 NHS SAST Team Process

Appendix 3.docx

Appendix 4 Safety and Stabilisation Assessment

Appendix 4.docx

Item 10.1

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Performance**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Discussion

This report relates to the:

- Annual Operational Plan (AOP), as impacted by the Joint Fife Mobilisation Plan (JFMP)

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report informs the Clinical Governance (CG) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of February 2021.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board. It is produced monthly and made available to Board Members via Admin Control.

The report is presented at the bi-monthly meetings of the Clinical Governance, Staff Governance and Finance, Performance & Resources Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

The May 2020 meeting of the SG Committee was cancelled due to the pandemic, but 'virtual' meetings have taken place bi-monthly since July 2020.

2.3 Assessment

The IPQR was changed for FY 2020/21, to include improvement actions which reflected the challenges imposed by the COVID-19 pandemic. These reflect the spirit of the JFMP, where possible.

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. The Scottish Government were provided with a plan which forecast recovery trajectories in the period up to the end of FY 2020/21, and progress against this (impacted by the second wave of the pandemic) is included in the IPQR at Annex 1. The projections take account of additional funding provided by the Scottish Government.

The Clinical Governance aspects of the report cover HSMR, Falls, Pressure Ulcers, Infection Control (SAB, ECB, C Diff, Caesarean Section SSI) and Complaints. A summary of the status of these is shown in the table below.

Performance is also reported for Adverse Events, SAB (Community), ECB (Community) and C Diff (Community), but these do not have targets. It is expected that a number of new measures/targets for Adverse Events will be introduced in the June IPQR, when the first FY 2021/22 performance data will be available.

Measure	Update	Local/National Target	Current Status
HSMR	Quarterly	1.00 (Scotland average)	Above Scottish average
Falls	Monthly	5.97 per 1,000 TOBD	Not achieving
Falls With Harm	Monthly	2.16 per 1,000 TOBD	Achieving
Pressure Ulcers	Monthly	0.42 per 1,000 TOBD	Not achieving
CS SSI [1]	Quarterly	2.5%	Achieving
SAB (HAI/HCAI)	Monthly	19.5 per 100,000 TOBD	Achieving
ECB (HAI/HCAI)	Monthly	36.6 per 100,000 TOBD	Achieving
C Diff (HAI/HCAI)	Monthly	6.7 per 100,000 TOBD	Achieving
Complaints (S1)	Monthly	80%	Achieving
Complaints (S2) [2]	Monthly	65%	Not achieving

[1] Formal data collection continues to be 'paused' (as per instruction from Scottish Government), but we are able to report on local data up to the end of December 2020

[2] Following discussion with the Nursing Director, we agreed to work towards achieving the 65% target by March 2021, from a starting point in July 2020 of around 30%; performance has been severely impacted in the final quarter of 2020 by the second wave of the pandemic, and a revised target for FY 2021/22 is to be agreed

2.3.1 Quality/ Patient Care

Refer to the Exec Summary for details on how the COVID-19 pandemic has affected service performance throughout NHS Fife.

2.3.2 Workforce

The report has been compiled by the Planning & Performance Team (PPT) with the support of Managers across the range of NHS Fife services.

2.3.3 Financial

Financial aspects are covered by the appropriate section of the IPQR.

2.3.4 Risk Assessment/Management

All current risks are related to the COVID-19 pandemic.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members are aware of the approach to the production of the IPQR since April 2020.

Standing Committees and Board Meetings were cancelled in May 2020, but restarted in July 2020, and the April IPQR will be available for discussion at the round of April/May meetings.

2.3.8 Route to the Meeting

The IPQR was drafted by the PPT, ratified by the Associate Director of Planning & Performance and reviewed by EDG members on 22 April. The report was authorised for release to Board Members and Standing Committees at EDG.

2.4 Recommendation

The CG Committee is requested to:

- **Discussion** – Examine and consider the NHS Fife performance, with particular reference to the CG measures identified in Section 2.3, above

3 List of appendices

None

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Fife Integrated Performance & Quality Report

Produced in April 2021

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).

A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

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

a. Clinical Governance

b. Finance, Performance & Resources
   - Operational Performance
   - Finance

c. Staff Governance

Section II provides further detail for indicators of continual focus or those that are currently underperforming. Each 'drill-down' contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions.

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 mainland NHS Boards.

Colour-coding is used in this table and also in the various drill-down charts and tables to illustrate performance relative to target and to other Mainland Health Boards.

In response to the COVID pandemic, a spreadsheet showing projected activity across critical services during the final 3 quarters of FY 2020/21 has been created and is being populated with actual figures as we go forward. In order to provide as up-to-date information as possible, some of the figures are initially provisional, and will be corrected if necessary the following month. The latest version of this is shown in Appendix 1.

Improvement Actions in the drill-downs carry a '20' or '21' prefix, to identify those continuing from 2019/20 and those identified as new for this FY. They are shaded in **BLUE** if they are assessed as being complete or no longer relevant.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 13 (45%) classified as **GREEN**, 3 (10%) **AMBER** and 13 (45%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits (mostly 5%) of standard/trajectory or considerably below standard/trajectory.

There was notable improvement in the following areas during the last reporting period:

- ECB infection rate – significant reduction in cases in February, and rate now better than the improvement trajectory (as is currently the case for C Diff and SAB)
- Complaints Stage 1 Closure Rate – monthly and rolling quarterly closure rates the highest since reporting started
- CAMHS and Psychological Therapies Waiting Times – number of clients starting treatment within 18 week of referral in both services at their highest levels for over 3 years

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). The current benchmarking status of the 29 indicators within this report has 7 (25%) within upper quartile, 14 (48%) in mid-range and 8 (27%) 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 2020/21	Reporting Period	Year Previous		Previous		Current			Reporting Period	Fife		Scotland
Clinical Governance	N/A	Major & Extreme Adverse Events	N/A	Month	Feb-20	22	Jan-21	29	Feb-21	20	↑	N/A			
	N/A	HSMR	N/A	Year Ending	Sep-19	1.04	Jun-20	1.00	Sep-20	1.01	↓	YE Sep-20	1.01	●	1.00
	N/A	Inpatient Falls	5.97	Month	Feb-20	7.37	Jan-21	8.80	Feb-21	9.59	↓	N/A			
	N/A	Inpatient Falls with Harm	2.16	Month	Feb-20	1.13	Jan-21	1.66	Feb-21	2.08	↓	N/A			
	N/A	Pressure Ulcers	0.42	Month	Feb-20	0.81	Jan-21	1.00	Feb-21	1.53	↓	N/A			
	N/A	Caesarean Section SSI	2.5%	Quarter Ending	Dec-19	2.3%	Sep-20	2.2%	Dec-20	2.4%	↓	QE Dec-19	2.3%	●	0.9%
	N/A	SAB - HAI/HCAI	19.5	Quarter Ending	Feb-20	11.9	Jan-21	21.7	Feb-21	19.4	↑	QE Dec-20	20.6	●	18.8
	N/A	SAB - Community	N/A	Quarter Ending	Feb-20	4.3	Jan-21	10.6	Feb-21	11.9	↓	QE Dec-20	12.8	●	9.6
	N/A	C Diff - HAI/HCAI	6.7	Quarter Ending	Feb-20	7.6	Jan-21	5.1	Feb-21	3.9	↑	QE Dec-20	7.7	●	16.1
	N/A	C Diff - Community	N/A	Quarter Ending	Feb-20	2.2	Jan-21	2.1	Feb-21	6.5	↓	QE Dec-20	2.1	●	4.3
	N/A	ECB - HAI/HCAI	36.6	Quarter Ending	Feb-20	44.5	Jan-21	51.0	Feb-21	33.6	↑	QE Dec-20	50.3	●	40.9
	N/A	ECB - Community	N/A	Quarter Ending	Feb-20	33.0	Jan-21	33.0	Feb-21	33.0	↓	QE Dec-20	27.0	●	37.9
	N/A	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Feb-20	75.6%	Jan-21	78.8%	Feb-21	88.2%	↑	2019/20	71.5%	●	79.9%
	N/A	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Feb-20	38.7%	Jan-21	31.3%	Feb-21	30.1%	↓	2019/20	35.7%	●	51.8%
Operational Performance	90%	IVF Treatment Waiting Times	90%	Month	Feb-20	100.0%	Jan-21	100.0%	Feb-21	100.0%	↔	N/A			
	95%	4-Hour Emergency Access	95%	Month	Feb-20	90.1%	Jan-21	90.1%	Feb-21	91.1%	↑	Feb-21	91.1%	●	86.2%
	100%	Patient TTG (Ongoing Waits)	N/A	Month	Feb-20	85.4%	Jan-21	57.4%	Feb-21	48.6%	↓	Dec-20	64.3%	●	37.0%
	95%	New Outpatients Waiting Times	N/A	Month	Feb-20	94.7%	Jan-21	51.2%	Feb-21	48.0%	↓	Dec-20	57.0%	●	47.8%
	100%	Diagnostics Waiting Times	N/A	Month	Feb-20	99.5%	Jan-21	89.2%	Feb-21	76.2%	↓	Dec-20	96.0%	●	55.9%
	95%	Cancer 31-Day DTT	N/A	Month	Feb-20	95.3%	Jan-21	97.9%	Feb-21	97.5%	↓	QE Dec-20	99.0%	●	98.6%
	95%	Cancer 62-Day RTT	N/A	Month	Feb-20	79.2%	Jan-21	82.4%	Feb-21	80.7%	↓	QE Dec-20	84.5%	●	86.2%
	90%	18 Weeks RTT	N/A	Month	Feb-20	80.1%	Jan-21	73.7%	Feb-21	73.6%	↓	QE Dec-20	67.6%	●	71.7%
	29%	Detect Cancer Early	29%	Year Ending	Jun-19	27.2%	Mar-20	24.6%	Jun-20	23.5%	↓	2018, 2019	26.1%	●	25.6%
	N/A	Freedom of Information Requests	85%	Quarter Ending	Feb-20	67.4%	Jan-21	87.5%	Feb-21	89.3%	↑	N/A			
	N/A	Delayed Discharge (% Bed Days Lost)	5%	Month	Feb-20	7.8%	Jan-21	4.9%	Feb-21	6.2%	↓	QE Sep-20	6.8%	●	5.1%
	N/A	Delayed Discharge (# Standard Delays)	N/A	Month	Feb-20	71	Jan-21	38	Feb-21	54	↓	Feb-21	14.46	●	12.03
	80%	Antenatal Access	80%	Month	Nov-19	87.5%	Oct-20	89.7%	Nov-20	88.4%	↓	FY 2019/20	89.0%	●	88.3%
	473	Smoking Cessation	473	YTD	Dec-19	87.9%	Nov-20	54.3%	Dec-20	50.6%	↓	FY 2019/20	92.8%	●	97.2%
	90%	CAMHS Waiting Times	N/A	Month	Feb-20	74.1%	Jan-21	83.0%	Feb-21	88.1%	↑	QE Dec-20	82.8%	●	73.1%
	90%	Psychological Therapies Waiting Times	N/A	Month	Feb-20	69.0%	Jan-21	77.1%	Feb-21	84.0%	↑	QE Dec-20	73.6%	●	80.0%
	80%	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Mar-19	60.2%	Dec-19	75.7%	Mar-20	79.2%	↑	FY 2019/20	79.2%	●	83.2%
	90%	Drugs & Alcohol Treatment Waiting Times	90%	Month	Nov-19	96.0%	Oct-20	90.9%	Nov-20	96.1%	↑	QE Dec-20	94.3%	●	95.7%
	N/A	Dementia Post-Diagnostic Support	N/A	Annual	2017/18	86.7%	2018/19	93.7%	2019/20	94.8%	↑	2018/19	93.7%	●	75.1%
	N/A	Dementia Referrals	N/A	Annual	2017/18	55.4%	2018/19	60.9%	2019/20	58.2%	↓	2018/19	60.9%	●	43.4%
Finance	N/A	Revenue Expenditure	£0	Month	Feb-20	N/A	Jan-21	-£3.987m	Feb-21	-£4.200m	↑	N/A			
	N/A	Capital Expenditure	£13.634m	Month	Feb-20	N/A	Jan-21	£6.832m	Feb-21	£8.551m	↑	N/A			
Staff Governance	4.00%	Sickness Absence	4.39%	Month	Feb-20	5.51%	Jan-21	5.04%	Feb-21	5.03%	↑	YE Mar-20	5.49%	●	5.31%

d. Assessment

Clinical Governance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
HSMR	1.00	N/A	N/A	YE Sep-20	1.01	YE Sep-20	
The HSMR for NHS Fife for the year ending September 2020 fell slightly in comparison to the year ending June 2020, and was marginally above the Scotland average. The drill-down narrative provides a detailed explanation of the measure and limitations associated with it.							
Inpatient Falls (with Harm) Reduce falls with harm by 20% by December 2020	2.16	Feb-21	2.16	Feb-21	2.08	N/A	N/A
There is a continued higher rate of falls with harm in in-patient settings than recorded at the same period last year. Activity described in the refreshed workplan includes the learning from care delivery during this time, with local review and improvement work underway. The impact of COVID on community inpatients wards led to a pause in improvement activity however this work has now re-started.							
Pressure Ulcers 50% reduction by December 2020	0.42	Never Met	0.42	Feb-21	1.53	N/A	N/A
ASD: Two clinical areas have been identified to participate in the next pressure ulcer improvement project. Project teams were given 4-6 weeks to carry out preparatory study before the project period began. Regular meetings are scheduled throughout the project. HSCP: The pressure ulcer rate in the community inpatient setting was 0.80 in February, significantly higher than in most previous months. However, there have been no grade 4 and only 4 grade 3 (4%) pressure ulcers reported in the last 12 months.							
Caesarean Section SSI We will reduce the % of post-operation surgical site infections to 2.5%	N/A	QE Dec-20	2.5%	QE Dec-20	2.4%	QE Dec-19	
Since the start of the Covid-19 pandemic, all mandatory SSI surveillance has remained paused. However, Maternity Services have continually monitored Caesarean Section SSI cases and where required (in the case of Deep or Organ Space) carried out SSI Clinical Reviews. This remains the case at the present time. Please note that the performance data provided is non-validated and does not follow the agreed NHS Fife Methodology. It is important to note that there has been no national comparison data published since Q4 2019.							
SAB (MRSA/MSSA) We will reduce the rate of SAB HAI/HCAI by 10% between March 2019 and March 2022	18.8	QE Feb-21	19.5	QE Feb-21	19.4	QE Dec-20	
Surveillance of SABs has continued throughout the COVID-10 pandemic. There were just two HCAI in February, and NHS Fife is achieving the trajectory for the 10% reduction target, to be met by March 2022. There has been one further ventilator associated pneumonia SAB in ICU in March, following two cases in January, but the incidence of these is expected to reduce as ICU COVID case incidence decreases.							
C Diff We will reduce the rate of C Diff HAI/HCAI by 10% between March 2019 and March 2022	6.5	QE Feb-21	6.7	QE Feb-21	3.9	QE Dec-20	
CDI surveillance has continued throughout the COVID-19 pandemic. NHS Fife remains below the national rate for HCAI and CAI CDIs, and also below the improvement trajectory for a 10% reduction by March 2022. Reducing the incidence of recurrence of infection continues to be addressed, to assist reducing the rates further.							
ECB We will reduce the rate of E. coli bacteraemia HAI/HCAI by 25% between March 2019 and March 2022	33.0	QE Feb-21	36.6	QE Feb-21	33.6	QE Dec-20	
ECB surveillance has continued throughout the pandemic. The target for NHS Fife is to achieve a 25% reduction of HCAI ECBs by March 2022 and we are currently below the trajectory line and in line to achieve this. Reducing CAUTI ECBs and UTIs is the focus for quality improvement, to achieve this target.							
Complaints - Stage 2 At least 75% of Stage 2 complaints are completed within 20 working days	N/A	Never Met	65%	QE Feb-21	30.1%	FY 2019/20	
There continues to be an ongoing challenge to investigate and respond to Stage 2 complaints within the national timescale. Complaint numbers continue to rise and there is a noted increase in the complexity of the complaints received. Although starting to reduce, PRD has responded to a high number of concerns and Stage 1 complaints relating to Covid vaccination appointments.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
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%	Sep-20	95%	Feb-21	91.1%	Feb-21	
Attendances remain below projected numbers, and there was a slightly improved performance in February, with a significant reduction in breaches for bed waits indicating a better overall hospital occupancy position.							
Patient TTG (Ongoing Waits) All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat	100%	Never Met	N/A	Feb-21	48.6%	Dec-20	
Waiting times performance recovery continued to slow in January and February as the Acute Hospital had to contend with the second wave of the COVID-19 pandemic and cancelled non-urgent elective surgery. At the end of February, the waiting list was 16% lower than at the end of February 2020 but 51% were waiting greater than 12 weeks for treatment compared to 15% in February 2020. Efforts are continuing to mitigate the situation, with particular attention focusing on urgent referrals whilst routine activity recommenced in March. A recovery plan has been developed and discussions are underway with Scottish Government to secure the additional resources required to deliver the plan.							
New Outpatients 95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment	95%	Mar-20	N/A	Feb-21	48.0%	Dec-20	
Waiting times performance recovery continued to slow in January and February as the Acute Hospital had to contend with the second wave of the COVID-19 pandemic which resulted in the suspension of routine activity. At the end of February, the waiting list was 42% higher than at the end of February 2020, with 52 % waiting more than 12 weeks compared to 5% waiting more than 12 weeks in February 2020. Efforts are continuing to mitigate the situation, with particular attention focusing on urgent referrals whilst routine activity recommenced in March. A recovery plan has been developed and discussions are underway with Scottish Government to secure the additional resources required to deliver the plan.							
Diagnostics 100% of patients to wait no longer than 6 weeks from referral to key diagnostic test (scope or image)	100%	Apr-16	N/A	Feb-21	76.2%	Dec-20	
Having recovered performance for diagnostics in Q3 of 2020/21 the onset of the second wave of the COVID-19 pandemic resulted in the suspension of routine activity during January and February and a resultant deterioration in performance, with 76% of patients waiting more than 6 weeks at month end. There were breaches both for Endoscopy and Imaging tests, however urgent (including urgent cancer) diagnostic tests were prioritised. It will be a major challenge to recover this performance in the new FY, with referrals anticipated to rise and activity continuing to be restricted due to the need for social distancing. With routine activity recommencing a recovery plan has been developed and discussions are underway with Scottish Government to secure the additional resources required to deliver the plan.							
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	N/A	Feb-21	80.7%	QE Dec-20	
February continued to see challenges in the 62 day performance. There were delays to breast surgery due to vacancy, but a locum is now in post. Routine staging and investigations contributed to the majority of breaches seen and the range of breaches were 4 to 55 days, with an average breach time of 17 days.							
FoI Requests At least 85% of Freedom of Information Requests are completed within 20 working days	N/A	QE Feb-21	85%	QE Feb-21	89.3%	N/A	N/A
NHS Fife has now completed 6 months under the new process for responding to requests for information, managed by specialist FOI staff. In that period, 287 requests have been closed. The rollout of newly drafted FOISA training for NHS and IJB personnel has started, in order to assist with the team interaction and engagement with FOI duties and obligations as well as solidifying sign-off arrangements for responses to requests. Planning for the delivery of a new Publication Scheme for NHS Fife is now underway.							
Delayed Discharge The % of Bed Days 'lost' due to Patients in Delay is to reduce	N/A	Jan-21	5%	Feb-21	6.2%	QE Sep-20	
The number of bed days lost due to patients in delay rose in February and is again above the target 5%. This is due to a combination of normal winter pressures (occupancy levels, ward closures due to significant covid outbreaks and care home closures across Fife), and the continued requirement to accommodate amber pathways to manage the pandemic.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
Smoking Cessation Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas	100%	YT May-19	100%	YT Dec-20	50.6%	FY 2019/20	●
Remote service provision is continuing, including established pathway to medications, and there has been a steady increase in number of clients self referring to the service (over 450 clients have contacted the service during the pandemic). From January, the specialist stop smoking midwife service staff have been deployed to clinics / long term absence, but the specialist service has agreed to provide support to pregnant mums until normal service can resume. The midwife service operates an opt-out service, requiring a call to every pregnant mum identified as a smoker following referral from midwife at booking. To date, over 60 mums have been referred, with a third of these keen to engage in a quit attempt.							
CAMHS Waiting Times 90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral	90%	Sep-16	N/A	Feb-21	88.1%	QE Dec-20	●
Fife CAMHS RTT has continued to increase towards the national standard of 90%, however this reflects the current need to focus the majority of the staffing resource on priority and urgent presentations at the expense of those who have waited the longest. Funding approval for additional staff has been provided by Fife HSCP. Once posts are recruited to, this will provide the capacity to achieve a more sustainable approach to reaching the RTT whilst at the same time permanently reducing the waiting list.							
Psychological Therapies 90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral	90%	Never Met	N/A	Feb-21	84.0%	QE Dec-20	●
February's improved RTT performance is influenced by expansion in capacity in cCBT services with low waiting times and also reduced activity due to staff AL. In addition, pressures in some areas to deal with urgent/priority referrals mean that relatively few longest waiting patients began treatment. The waiting list profile and demand–capacity gap in some service tiers remains of most relevance to the RTT trajectory.							

Finance, Performance & Resources Finance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
Revenue Expenditure Work within the revenue resource limits set by the SG Health & Social Care Directorates	Breakeven	N/A	Breakeven	Feb-21	-£ 4.200m	N/A	N/A
The position to month 11 is an underspend of £4.2m and the forecast underspend to the year end is £2.1m. The underspend position is driven largely by continued pausing of our elective activity in Q4 and a lower than planned level of critical care bed provision. Dialogue continues with Scottish Government colleagues to discuss the management of this residual forecast underspend. In our forecast we have assumed the creation of an IJB earmarked reserve for Health Delegated, comprising: core underspend (arising post the budget realignment process to Social Care highlighted last month); any qualifying Covid funding underspend; and qualifying late funding allocations.							
Capital Expenditure Work within the capital resource limits set by the SG Health & Social Care Directorates	£13.634m	N/A	£13.634m	Feb-21	£8.551m	N/A	N/A
The total Capital Resource Limit for 2020/21 is £13.634m including anticipated allocations for specific projects. The capital position for the 11 months to February records spend of £8.551m equivalent to 62.71% of the total allocation. The capital spend on the specific projects is on track to spend in full, notwithstanding the end loaded spend profile as in any financial year.							

Staff Governance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
Sickness Absence To achieve a sickness absence rate of 4% or less	4.00%	Never Met	4.39%	Feb-21	5.03%	YE Mar-20	●
Sickness absence levels continue to fluctuate, however, it is positive to note that the sickness absence rates have improved for the first eleven months of the year when compared with the same period of 2019/20, with a reduction of 0.51% in the year to date. The sickness absence rate has been above 5% for the months of November 2020 to February 2021, but this is in line with seasonal variations seen in previous years and the rate for this winter period is less than reported over the past 5 years.							

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources – Operational Performance

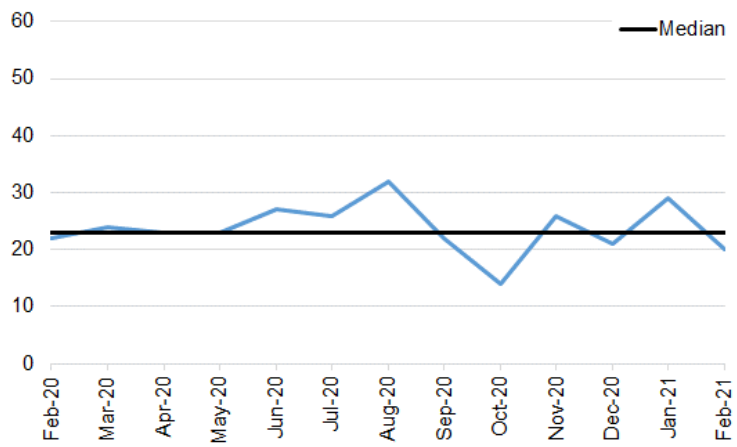
Finance, Performance & Resources – Finance

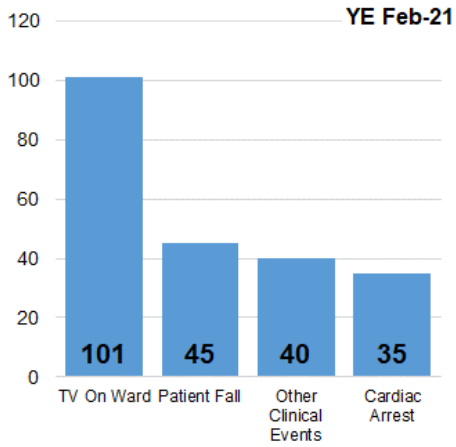
Staff Governance

Clinical Governance

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2019/20		2020/21										
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
ALL	NHS Fife	1308	1123	890	1066	1123	1329	1243	1285	1337	1301	1239	1280	1179
	Acute Services	634	472	371	475	463	561	506	604	555	637	597	567	509
	HSCP	624	627	486	558	627	730	695	639	748	634	616	692	643
	Corporate	50	24	33	33	33	38	42	42	34	30	26	21	27
CLINICAL	NHS Fife	924	800	608	726	740	909	837	921	899	948	919	896	815
	Acute Services	572	440	342	432	421	515	469	556	506	593	554	528	473
	HSCP	334	345	248	279	299	373	352	347	377	340	356	357	327
	Corporate	18	15	18	15	20	21	16	18	16	15	9	11	15

Commentary

There is nothing exceptional to report in the data.

Following a pause in local and significant adverse event review activity due to the pandemic, a recovery plan scheduling delayed reviews according to service and organisational priorities has been developed; this will be approved by the Medical Director and the Director of Nursing.

The NHS Fife Adverse Events/Duty of Candour Group which oversees the development and implementation of local adverse events management policy will consider a plan for review of the policy at its meeting later this month.

Clinical Governance

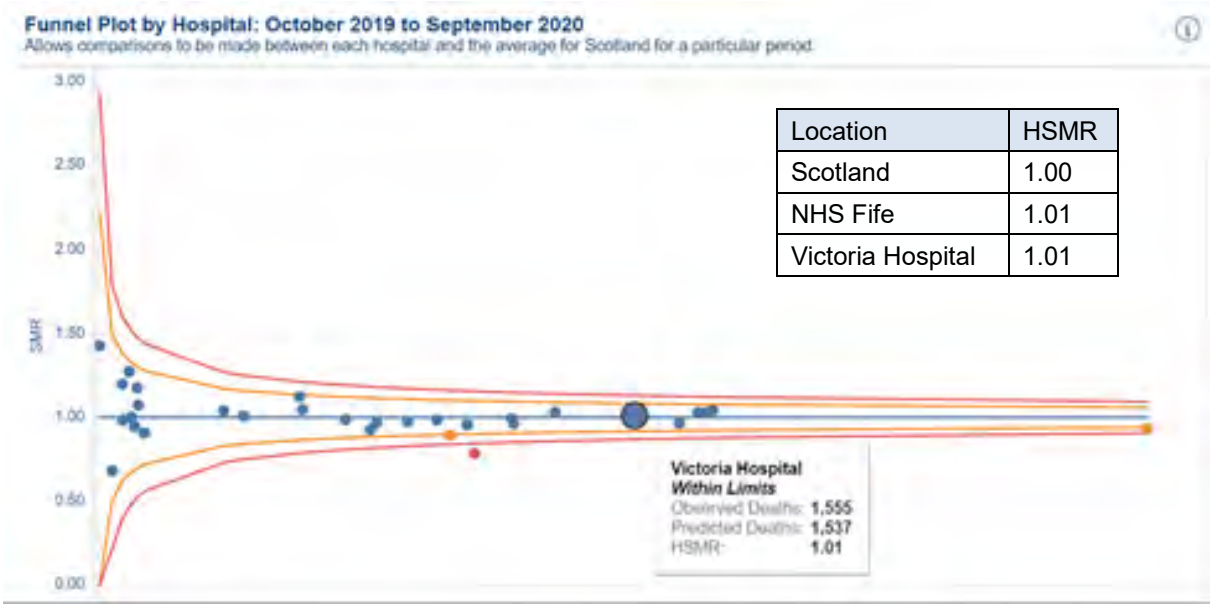
HSMR

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 deaths is more than predicted.

Reporting Period; October 2019 to September 2020[p]

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.

The rates for Scotland, NHS Fife (as a whole) and Victoria Hospital as an entity in itself, are shown in the table within the Funnel Plot.



Location	HSMR
Scotland	1.00
NHS Fife	1.01
Victoria Hospital	1.01

Commentary

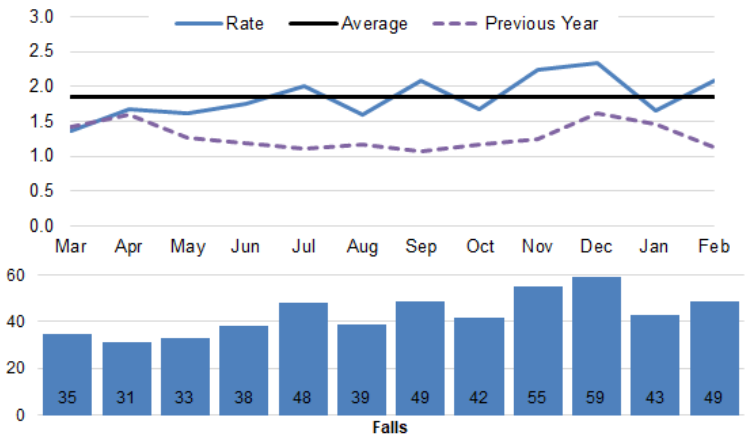
The annual HSMR for NHS Fife increased during the third quarter of 2020, with the difference between actual and predicted number of deaths producing a ratio just over 1. This should be seen as normal variation, but we will continue to monitor this closely.

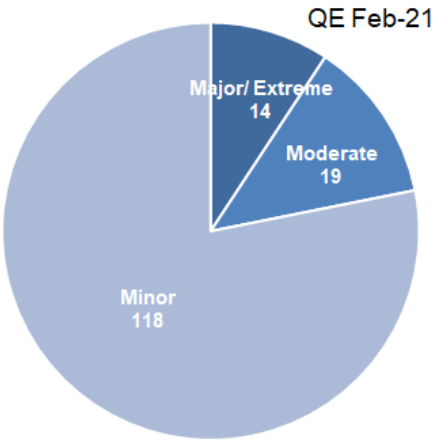
Clinical Governance

Inpatient Falls with Harm

Reduce Inpatient Falls With Harm rate per 1,000 Occupied Bed Days (OBD)
Improvement Target rate (by end December 2020) = ***2.16 per 1,000 OBD***

Local Performance





Service Performance

		2019/20	2020/21										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
With Harm	NHS Fife	1.37	1.67	1.62	1.75	2.01	1.60	2.08	1.68	2.24	2.35	1.66	2.08
	Acute Services	1.26	1.78	1.21	1.38	1.26	1.17	1.46	1.11	1.54	1.67	1.73	1.54
	HSCP	1.44	1.61	1.95	2.08	2.66	1.96	2.62	2.17	2.87	2.96	1.60	2.55

Key Challenges in 2020/21	As previously reported, the changes in service delivery, in clinical area function and staff deployment has been a significant challenge over this last year. This includes a change in numbers of patients in ward areas and the use of PPE and social distancing, all of which have had an impact on the way that staff deliver care. As services remobilise, continued review and a focus on local approaches aim to recover to a reducing trend in falls with harm.

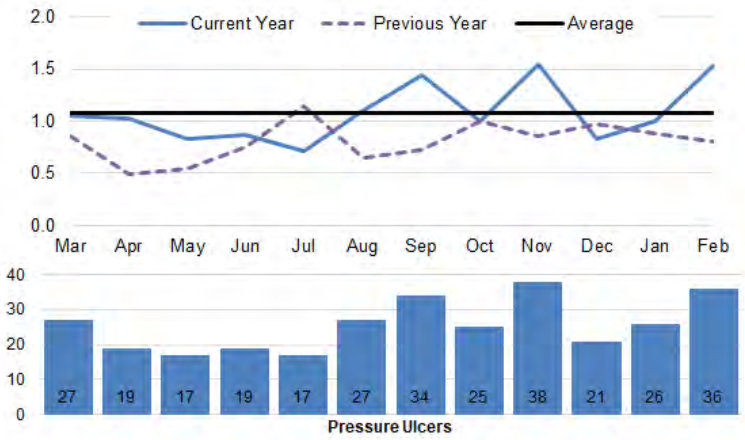
Improvement Actions	Update
20.3 Falls Audit *By Jul-21 (was Apr-21)*	Plans for this audit have been further delayed as a result of the ongoing situation. A number of areas are being prioritised and this will be programmed in over the coming months as more of a rolling audit. Local scrutiny will continue utilising the monthly performance report.
20.5 Improve effectiveness of Falls Champion Network *By Jul-21 (was Apr-21)*	This work has been significantly delayed and opportunities to refresh are being explored.Ongoing work to encourage attendance at the falls champion meetings, CNMs will now support. Further meetings still to be scheduled.
21.1 Refresh of Plans	The refreshed workplan has been agreed. This will remain a live document with flash reports at meetings to support update on progress. Action complete
21.2 Falls Reduction Initiative *By Jul-21*	A Falls Reduction Initiative has commenced in three Mental Health Inpatient wards with the aim of reducing all falls by 25% by July 2021
21.3 Integrated Improvement Collaborative *By Jun-21*	An Integrated Improvement Collaborative involving three community inpatient wards within the East was introduced last September, but was paused as a result of COVID. The work has re-commenced and is due to complete in May.

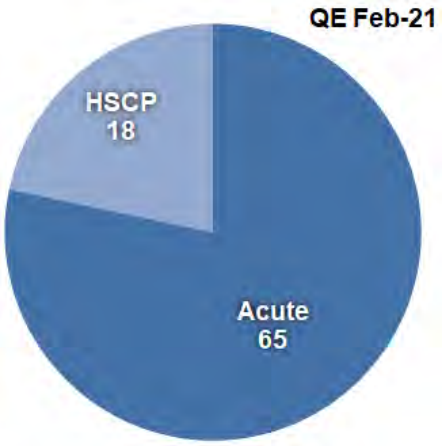
Clinical Governance

Pressure Ulcers

Achieve 50% reduction in pressure ulcers (grades 2 to 4) developed in a healthcare setting
Improvement Target rate (by end December 2020) = ***0.42 per 1,000 Occupied Bed Days***

Local Performance





Service Performance

		2019/20	2020/21										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grade 2 to 4	NHS Fife	1.06	1.02	0.83	0.88	0.71	1.11	1.44	1.00	1.55	0.83	1.00	1.53
	Acute Services	1.94	2.08	1.21	1.57	1.17	1.98	2.64	1.20	2.39	1.17	2.06	2.36
	HSCP	0.46	0.42	0.53	0.26	0.31	0.38	0.40	0.82	0.78	0.53	0.07	0.80

Key Challenges in 2020/21	Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

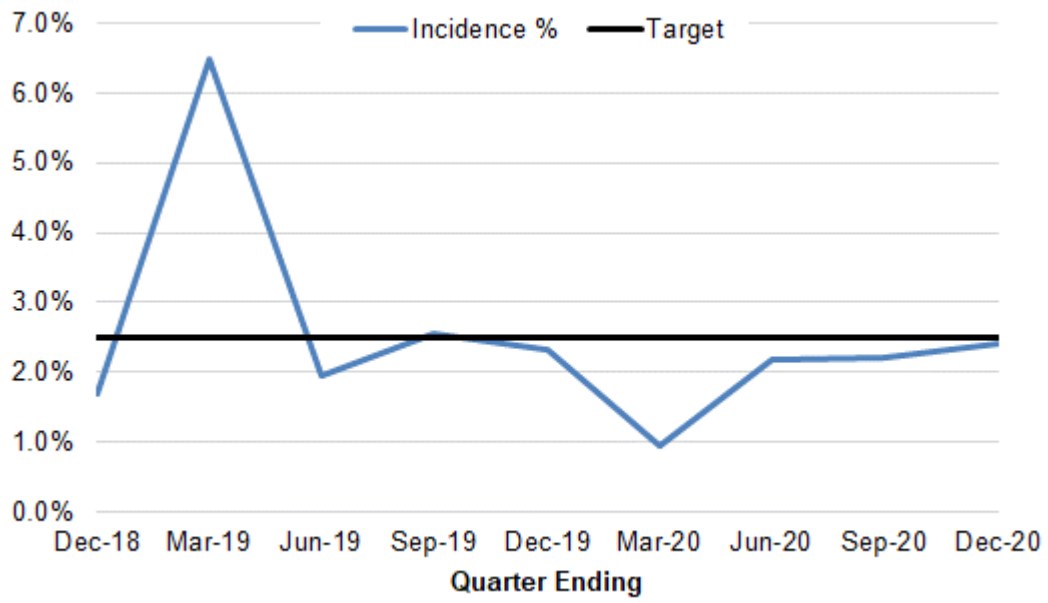
Improvement Actions	Update
20.4 Improve consistency of reporting	
20.5 Review TV Champion Network Effectiveness	
20.6 Reduce PU development (initially by redesign of Quality Improvement model)	
21.1 Improve reporting of PU	
21.2 Integrated Improvement Collaborative *By May-21 (was Feb-21)*	An integrated improvement collaborative started in September, with three wards in the East Division participating. The collaborative aims to enhance comfort rounding and person-centred approaches in reducing patient falls and pressure ulcers, whilst also increasing knowledge and confidence in applying improvement methodology to measure outcome. ASD continue to progress quality improvement with specific wards for improvement, supported by ongoing QI education.
21.3 Implementation of robust audit programme for audit of documentation *By Apr-21 (was Feb-21)*	A rolling programme of documentation audit has been developed. This will be carried out by the Senior Charges Nurses within each ward area, supported by the senior nursing team. This will also incorporate assessment documentation for the prevention and management of pressure ulcers. The rollout has begun across the HSCP and will be reviewed using PDSA quality improvement cycle.

Clinical Governance

Caesarean Section SSI

*To reduce C Section SSI incidence (per 100 procedures) for inpatients and post discharge surveillance to day 10 to **2.5%** by March 2021*

Local Performance



National Benchmarking

Quarter	2017/18				2018/19				2019/20		
Ending	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19
NHS Fife	3.0%	4.5%	4.0%	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%
Scotland	1.2%	1.3%	1.6%	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%

Key Challenges in 2020/21	NHS Fife SSI Caesarean Section incidence still remains higher than the Scottish incidence rate (no data for 2020 available at this stage)

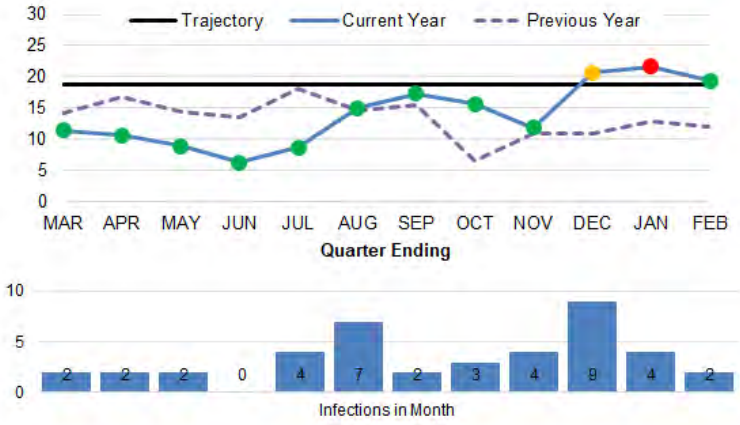
Improvement Actions	Update
20.1 Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	The SSI Implementation Group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there was a robust system in place for reviewing any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop. On resumption of the C-section SSI surveillance programme, we will continue to adopt the new methodology, which worked well previously in assessing SSI and type. Refresher training will be provided to staff to ensure awareness and understanding of the process. SSI incidence during 2020 has been calculated using unvalidated data, provided by Maternity Services, which does not follow the agreed methodology. The data has not been verified and there is no National comparison, so should be interpreted with caution. Action paused due to COVID-19
20.2 Support an Obesity Prevention and Management Strategy for pregnant women in Fife, which will support lifestyle interventions during pregnancy and beyond	

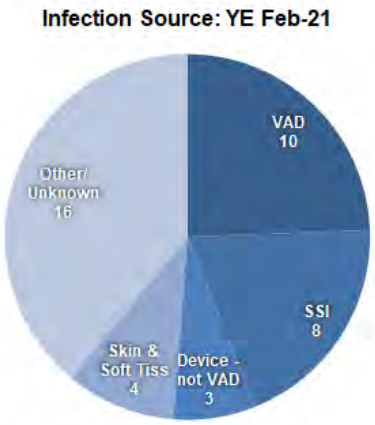
Clinical Governance

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2019/20				2020/21		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	13.7	15.5	10.9	12.5	6.3	18.7	20.6
Scotland	16.7	17.5	15.2	16.3	20.3	17.3	18.8

Key Challenges in 2020/21	Achieving a 10% reduction of healthcare-associated SAB by March 2022

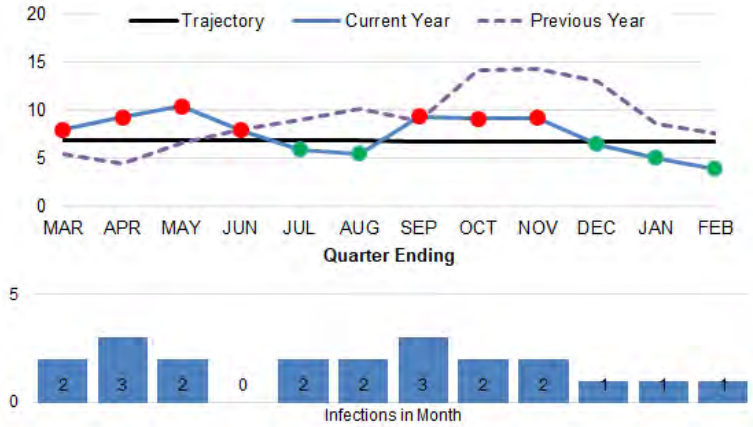
Improvement Actions	Update
20.1 Reduce the number of SAB in PWIDs *By Mar-22 (was Mar-21)*	There has been just 1 PWID to date in 2021 following only 5 in 2020, a marked improvement from 14 in 2019. Addiction services continue to be supported by the IPCT with the SAB improvement project, last meeting on 25th March. Significant reduction in 2020 has been deemed as multi-factorial. Nurse prescribing of antibiotics by ANPs to be planned for.
20.2 Ongoing surveillance of all VAD-related infections *By Mar-22 (was Mar-21)*	Monthly charts distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement as well as raising triggers and areas of concern. There was s single vascular access device SAB associated with the renal unit in January, following a cluster in August 2020.
20.3 Ongoing surveillance of all CAUTI *By Mar-22 (was Mar-21)*	Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions regarding catheter & urinary care. The group last met on 19th March. This QI group is contributed to by the ECB data.
20.4 Optimise comms with all clinical teams in ASD & the HSCP *By Mar-22 (was Mar-21)*	Monthly SAB reports distributed with Microbiology comments, to gain better understanding of disease process and those most at risk, is continuing. This allows local resources to be focused on high risk groups/areas and improve patient outcomes. The Ward Dashboard is continuously updated, for clinical staff to access and also to be displayed for public assurance.

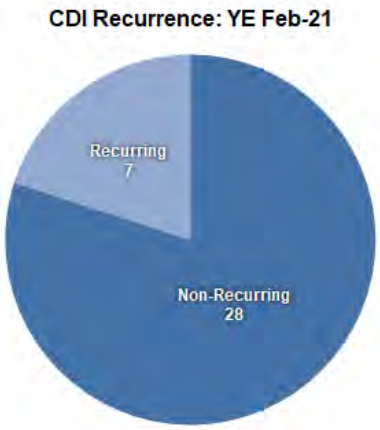
Clinical Governance

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2019/20				2020/21		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	8.0	8.9	13.1	8.0	7.9	9.3	7.7
Scotland	12.3	13.7	15.1	13.6	15.4	17.4	16.1

Key Challenges in 2020/21	Reducing healthcare-associated CDI (including recurrent CDI) to achieve the 10% reduction target by March 2022

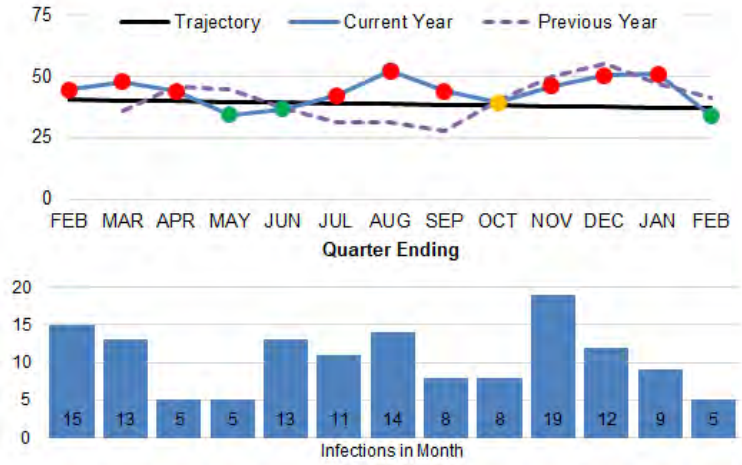
Improvement Actions	Update
20.1 Reducing recurrence of CDI *By Mar-22*	Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection. To reduce recurrence of CDI Infection, two treatments are utilized in Fife: 1) Fidaxomicin is used for patients at high risk of recurrent CDI 2) Bezlotoxumab is also used to prevent recurrence, whilst FMT (Faecal microbiota transplantation) is unavailable during the pandemic
20.2 Reduce overall prescribing of antibiotics *By Mar-22*	NHS Fife utilises National antimicrobial prescribing targets by NHS Fife microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage. Empirical antibiotic guidance has been circulated to all GP practices and the Microguide app has been revised.
20.3 Optimise communications with all clinical teams in ASD & the HSCP *By Mar-22*	Monthly CDI reports are distributed, to enable staff to gain a clearer understanding of the disease process, recurrences and rates. ICN ward visits reinforce SICPs and contact precautions, provide education to promote optimum CDI management and daily Medical management form completion. This has continued throughout the pandemic. The Ward Dashboard is continuously updated, for clinical staff to access CDI incidence by ward and is also to be displayed for public assurance.

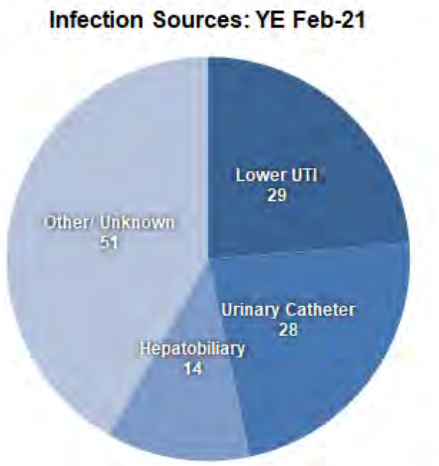
Clinical Governance

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2019/20				2020/21		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	42.1	31.0	60.0	47.9	36.4	45.3	50.3
Scotland	38.9	40.3	40.8	36.4	39.7	42.0	40.9

Key Challenges in 2020/21	Reducing CAUTI and UTI ECB in order to achieve overall 25% reduction in healthcare-associated ECB by March 2022

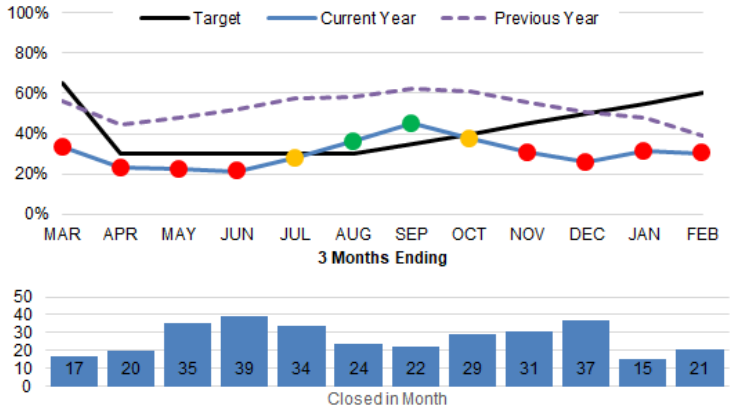
Improvement Actions	Update
20.1 Optimise communications with all clinical teams in ASD & the HSCP *By Mar-22*	Monthly reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB is investigated in detail to better understand how the infection might have occurred, and any issues are raised with appropriate clinical teams. All CAUTI ECBs associated with traumatic insertion, removal or self removal are submitted for DATIX. There has been a single trauma associated CAUTI to date in 2021 - learning from this will be fed back to the UCIG.
20.2 Formation of ECB Strategy Group	The key issues initially identified in this group have now been incorporated within the Urinary Catheter Improvement Group (UCIG) so this action is now complete
20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG) *By Mar-22*	The UCIG meeting last met in March to review the following topics: • A CAUTI QI programme which started at Cowdenbeath GP practice (currently paused) • E-documentation bundles for catheter insertion and maintenance • Continence services continue to support all care/nursing homes across Fife to promote catheter care and adequate hydration • Continence/hydration folders in use at all care and residential homes • Education 'Top Tips' videos and newsletters published on BLINK • Guidance on catheter maintenance solutions and Pathways for the management of difficult insertions have been completed

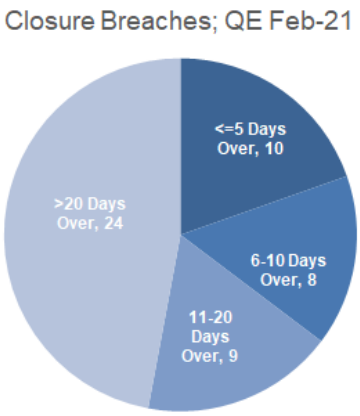
Clinical Governance

Complaints | Stage 2

At least 75% of Stage 2 complaints are completed within 20 working days
*Improvement Target for 2020/21 = **65%***

Local Performance





Local Performance by Directorate/Division

3-Month Ending	2019/20	2020/21									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	33.3%	22.9%	22.2%	21.3%	27.8%	36.1%	45.0%	37.3%	30.5%	25.8%	31.3%	30.1%
Ack <= 3 Days (Monthly)	94.1%	95.0%	97.1%	87.2%	97.1%	100.0%	95.5%	93.1%	100.0%	100.0%	100.0%	100.0%
ASD	56.2%	55.2%	54.3%	53.4%	54.6%	55.4%	56.0%	55.4%	54.2%	51.8%	50.7%	50.0%
HSCP	28.6%	28.4%	28.0%	26.8%	26.6%	28.0%	28.8%	27.8%	26.8%	25.4%	25.6%	26.1%

Key Challenges in 2020/21	Clearing the backlog of existing complaints Increase in complaints due to treatment delays (including diagnostics) General increase in complaints as we start to remobilise

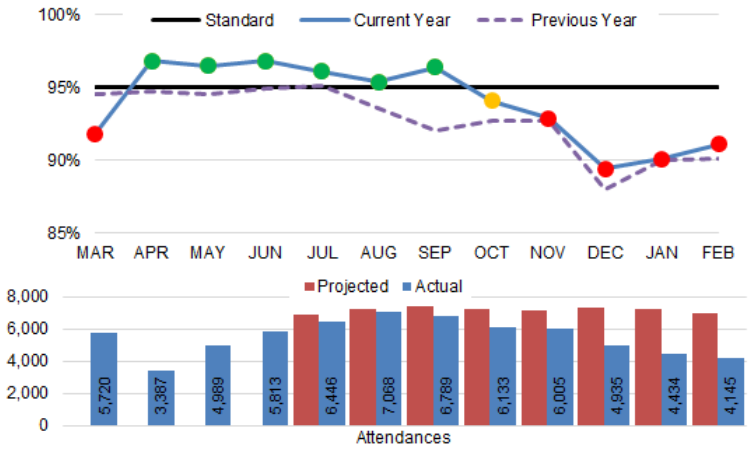
Improvement Actions	Update
20.1 Patient Relations Officers to undertake peer review	
20.2 Deliver education to service to improve quality of investigation statements	
20.3 Agree process for managing medical statements, and a consistent style for responses	
21.1 Agree process for managing complaint performance and quality of complaint responses *By Jun-21 (was Mar-21)*	The PRT has changed the way they work in order to adapt to the 'new normal'. This includes changing meetings, reports and forms, with an aim of improving and sustaining consistency and quality. Part of this has been achieved via the development of the Complaints section of the new NHS Fife website. PRT have been working with Mental Health and Learning Disabilities services in relation to Stage 2 complaint responses and a trial is in place where MH and LD draft their own complaint responses, with PRT reviewing for quality.
21.2 Deliver virtual training on complaints handling *By Sep-21 (was Mar-21)*	This action has been identified as a replacement for previous action 20.2, with the aim being to improve overall quality. While some training sessions have been delivered virtually, this is currently on hold due to the increase in the response to COVID-19.

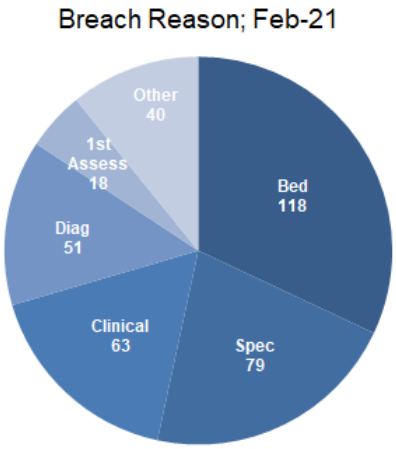
Finance, Performance & Resources – Operational Performance

4-Hour Emergency Access

At least 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident and Emergency treatment

Local Performance





National Benchmarking

Month	2019/20 MAR	2020/21 APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	91.8%	96.8%	96.5%	96.8%	96.1%	95.4%	96.4%	94.1%	92.9%	89.4%	90.1%	91.1%
Scotland	89.2%	94.9%	95.7%	95.6%	95.1%	92.9%	92.1%	89.6%	89.8%	86.4%	86.0%	86.2%

Key Challenges in 2020/21	Maintaining the reduction in numbers and the public using alternatives to emergency care Managing a department with red/green split during the return to normality, when injuries related to outdoor activity are likely to increase

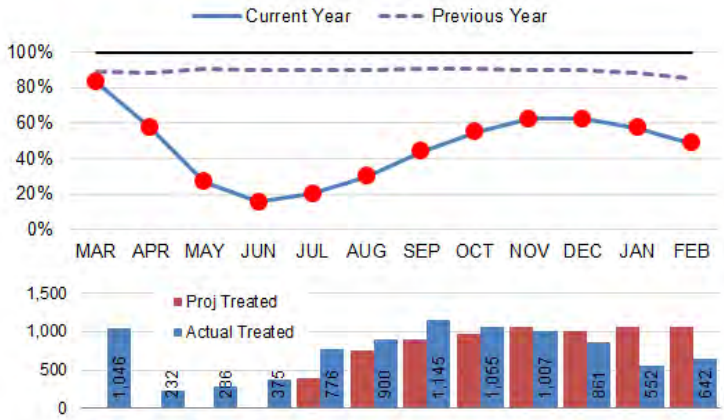
Improvement Actions	Update
20.1 Formation of PerformED group to analyse performance trends	
20.4 Development of services for ECAS	
20.5 Medical Assessment and AU1 Rapid Improvement Group	
21.1 Erroneous action, now removed, but the numbering has been retained for continuity	
21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub *By Mar-22*	ASD is supporting this initiative via the final triage of patients by consultants in Emergency Medicine and ongoing pathway planning. Adjustments to initial models are implemented where appropriate following review of data, to improve patient experience

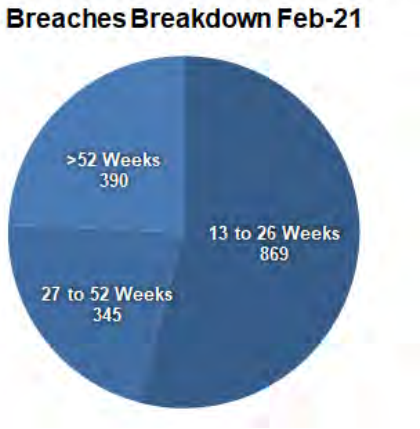
Finance, Performance & Resources – Operational Performance

Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

Local Performance





National Benchmarking

	2019/20	2020/21										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	83.1%	57.3%	26.8%	15.4%	20.2%	30.0%	44.1%	54.9%	62.3%	62.3%	57.4%	48.6%
Scotland	64.4%	46.6%	24.8%	17.3%	20.6%	24.9%	30.0%	34.2%	37.4%	37.0%		

Key Challenges in 2020/21	Recovery from COVID-19 Reduced theatre capacity due to increased infection control procedures and response to COVID-19

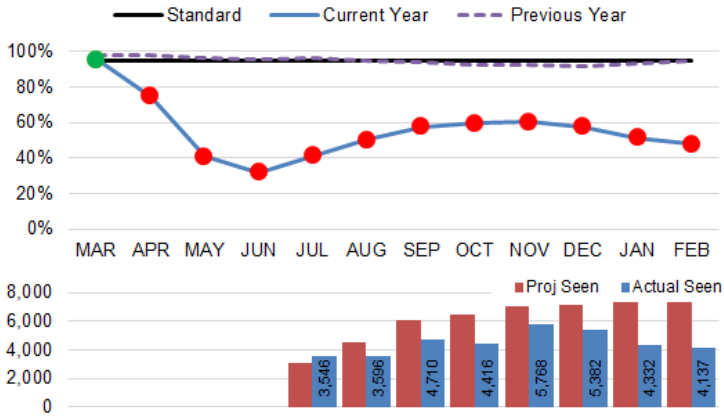
Improvement Actions	Update
20.2 Develop Clinical Space Redesign Improvement plan	
20.3 Theatre Action Group develop and deliver plan	
20.4 Review DCAQ and develop waiting times improvement plan for 20/21	
21.1 Develop and deliver transformation plan	This action is related to 20.2 and 20.3, above, but seeks to sustain delivery of improvements introduced during the pandemic Action complete for FY 2020/21, ongoing for FY 2021/22
21.2 Review DCAQ in relation to WT improvement plan	
21.3 Undertake waiting list validation against agreed criteria	

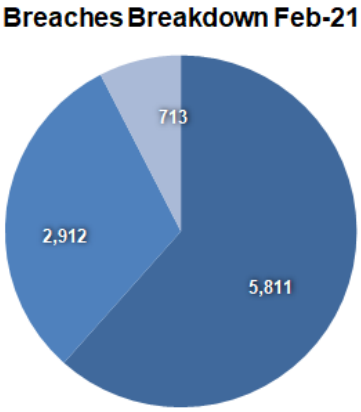
Finance, Performance & Resources – Operational Performance

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance





National Benchmarking

	2019/20	2020/21										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	95.2%	74.8%	40.9%	32.0%	41.1%	50.0%	57.4%	59.3%	60.3%	57.5%	51.2%	48.0%
Scotland	74.9%	57.8%	34.9%	28.5%			46.5%			47.8%		

Key Challenges in 2020/21	Recovery from COVID 19 Reduced clinic capacity due to physical distancing Difficulty in recruiting to specialist consultant posts

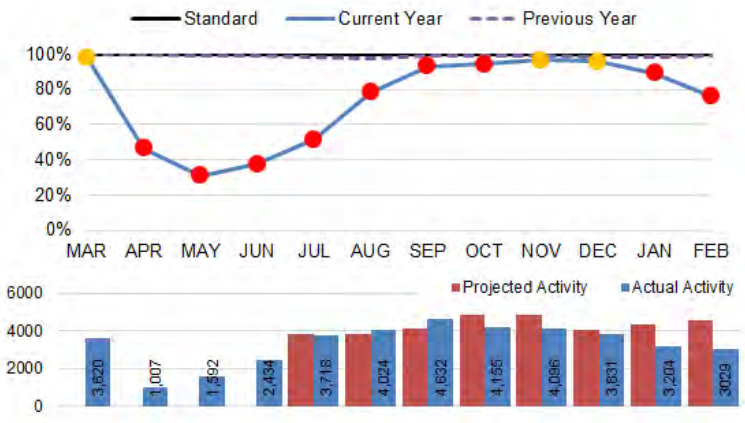
Improvement Actions	Update
20.1 Review DCAQ and secure activity to deliver funded activity in WT improvement plan	
20.2 Develop OP Transformation programme.	
20.3 Improve recruitment to vacant posts	Action complete for FY 2020/21, ongoing for FY 2021/22
21.1 Review DCAQ in relation to WT improvement plan	
21.2 Refresh OP Transformation programme actions	This action is related to 20.2, above, but seeks to sustain delivery of improvements introduced during the pandemic Action complete for FY 2020/21, ongoing for FY 2021/22
21.3 Develop clinic capacity modelling tool	
21.4 Validate new and review waiting list against agreed criteria	Action complete

Finance, Performance & Resources – Operational Performance

Diagnostics Waiting Times

No patient will wait more than 6 weeks to receive one of the 8 Key Diagnostics Tests appointment

Local Performance



National Benchmarking

	2019/20	2020/21									
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	97.8%	46.3%	31.1%	37.4%	51.4%	78.3%	93.1%	94.3%	96.5%	95.9%	89.2%	76.2%
Scotland	75.8%	28.4%	27.9%	35.4%	42.9%	49.3%	53.3%	52.3%	57.2%	55.9%		

Key Challenges in 2020/21	Recovery from COVID-19 Reduced capacity due to physical distancing and infection control procedures Difficulty in recruiting to consultant and specialist AHP/Nursing posts Endoscopy surveillance backlog

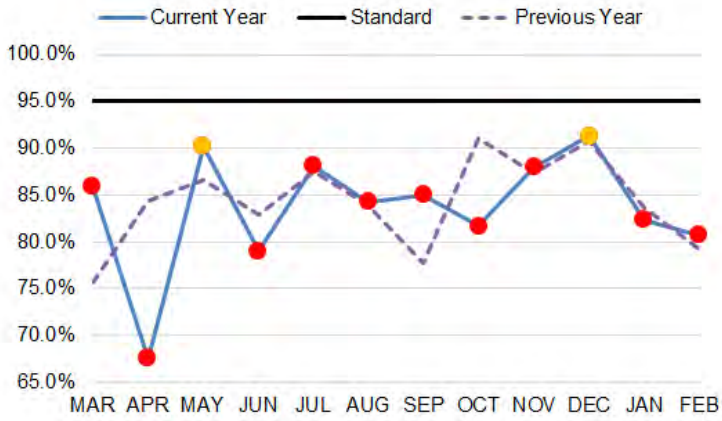
Improvement Actions	Update
21.1 Review DCAQ and develop remobilisation plans for Radiology and Endoscopy	
21.2 Undertake new and planned waiting list validation against agreed criteria	Action complete for FY 2020/21, ongoing for FY 2021/22
21.3 Improve recruitment to vacant posts	Action complete for FY 2020/21, ongoing for FY 2021/22

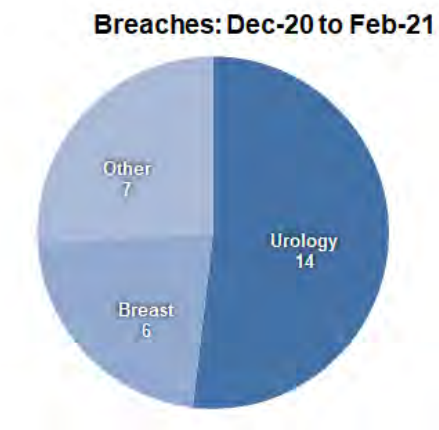
Finance, Performance & Resources – Operational Performance

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days

Local Performance





National Benchmarking

Month	2019/20	2020/21										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	85.9%	67.5%	90.2%	79.0%	88.2%	84.3%	85.0%	81.7%	88.0%	91.3%	82.4%	80.7%
Scotland	86.1%	82.6%	83.8%	84.3%	87.1%	86.6%	86.5%	84.9%	84.8%	85.3%	81.6%	81.9%

Key Challenges in 2020/21	Recovery from COVID-19, by assessing affected components of the cancer 'journey' and reviewing capacity against expected demand. Identification of key improvement areas in view of the pandemic response and as screening programmes restart

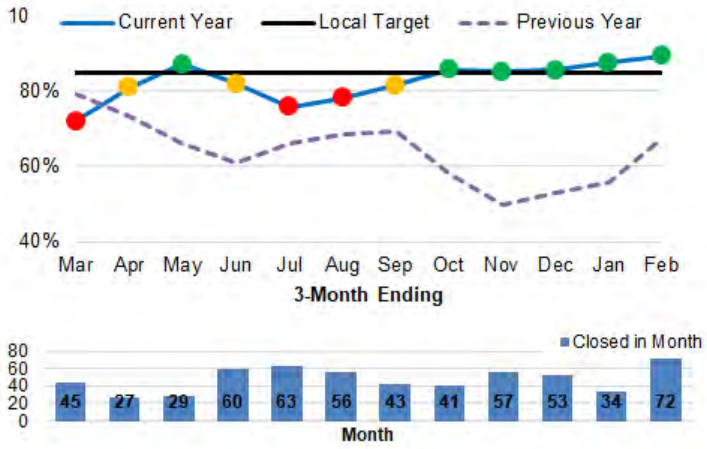
Improvement Actions	Update
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points *By Sep-21 (was Mar-21)*	This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team
20.4 Prostate Improvement Group to continue to review prostate pathway *By Sep-21 (was Mar-21)*	This is ongoing work related to Action 20.3, with the specific aim being to minimise waits post MDT. Funding from Scottish Government has been secured to clinically review MDT and outcomes – this work is ongoing.
21.1 Establishment of Cancer Structure to develop and deliver a Cancer Strategy	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan *By Sep-21 (was Mar-21)*	The National Cancer Recovery Plan has been published. A Strategic & Governance Cancer Group has been established with a Cancer Strategy Core Group to develop and take forward the NHS Fife Cancer Strategy.

Finance, Performance & Resources – Operational Performance

Freedom of Information Requests

In 2020/21, we will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance



Service Performance

Monthly	2019/20	2020/21										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Health Board	76.9%	100.0%	81.8%	72.7%	72.0%	93.6%	82.1%	96.8%	87.5%	93.5%	93.5%	91.0%
IJB	100.0%	100.0%	100.0%	60.0%	84.6%	66.7%	75.0%	50.0%	88.9%	14.3%	100.0%	100.0%

Key Challenges in 2020/21	Adequate resourcing to fully manage FOI Lack of FOI expertise and awareness within the organisation

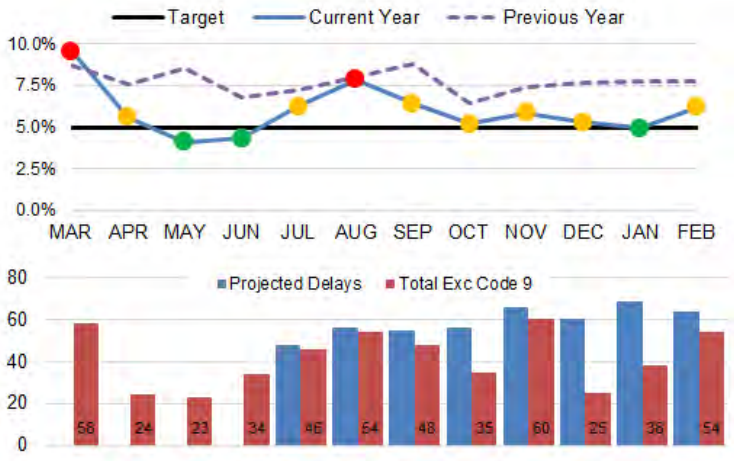
Improvement Actions	Update
20.5 Refresh process with H&SC partnership for requests received that relate to their services	
20.7 Formalise long-term resource requirements for FOI administration	
21.1 Organisation-wide Publication Scheme to be introduced *By Jul-21, Dec-21*	First draft Paper detailing the initial stages of the design of the new Publication Scheme to go to EDG in April / May. The Information Governance & Security Operational and Steering Groups will provide support for the planning and implementation of the Publication Scheme.
21.2 Improve communications relating to FOISA work *By Dec-21*	The first EDG Paper (1.0 - Process) passed through EDG in February. The Scottish Information Commissioner's Office has commended the work NHS Fife has undertaken so far to remedy the Board's previous low level of FOISA compliance. Increased and more detailed internal reporting is currently being considered.

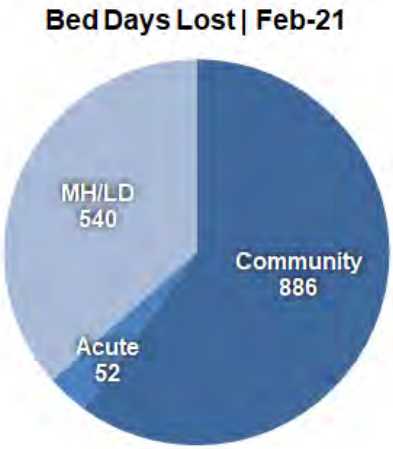
Finance, Performance & Resources – Operational Performance

Delayed Discharges (Bed Days Lost)

We will reduce the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

Local Performance





National Benchmarking

	Quarter Ending	2018/19			2019/20				2020/21	
		Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep
% Bed Days Lost	NHS Fife	4.5%	7.4%	8.9%	7.6%	8.0%	7.2%	8.3%	4.6%	6.8%
% Bed Days Lost	Scotland	6.9%	7.0%	6.5%	6.8%	7.2%	7.1%	7.3%	3.8%	5.1%

Key Challenges in 2020/21	Sustaining current performance as we return to 'normal' working Applying lessons learned during the pandemic, going forward

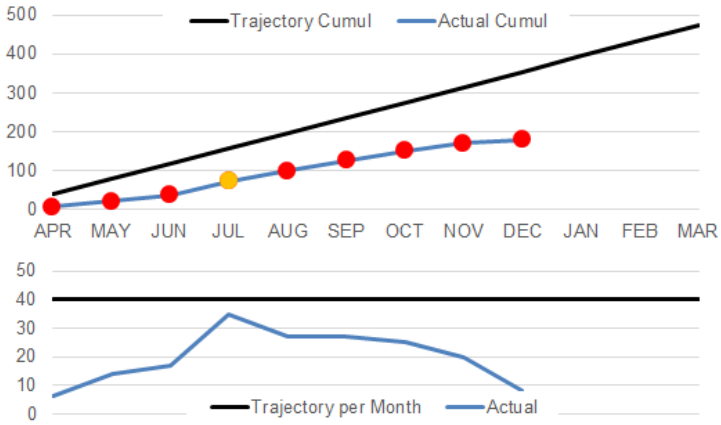
Improvement Actions	Update
20.1 Test a trusted assessors model for patients transferring to STAR/assessment beds	
20.3 Moving On Policy to be implemented	
20.4 Improve flow of comms between wards and Discharge HUB	
20.5 Increase capacity within care at home	
21.1 Progress HomeFirst model *By May-21 (was Mar-21)*	The working group continue to progress the actions to ensure 95% of all discharges occur safely and before 2 p.m. and to ensure assessments for LTC are not carried out within an Acute setting. The Oversight "Home First" group meeting will take place on the 16th April with H&SC, NHS Fife, Fife Council and Scottish Care to discuss and agree an action plan in line with local and national priorities.
21.2 Develop virtual community HUB across east hospitals to include Ninewells Hospital	Teams meetings with East Hospitals and Patient Flow Co-ordinators (including Ninewells) are in place Action complete

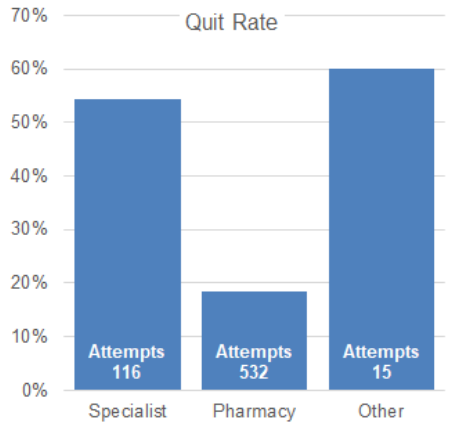
Finance, Performance & Resources – Operational Performance

Smoking Cessation

In 2020/21, we will deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance





National Benchmarking

		2020/21											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	6	14	17	35	27	27	25	20	8			
	Actual Cumul	6	20	37	72	99	126	151	171	179			
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	15.0%	25.3%	31.4%	45.6%	50.3%	53.4%	54.7%	54.3%	50.6%			
Scotland	Achieved												

Key Challenges in 2020/21	• Service Provision within GP practices, hospitals and community venues • Staffing levels due to redeployment and maternity leave • Unavailability of mobile unit (re-deployed during pandemic) • Building trust and confidence with client group • Inability to validate quits as part of an evidence based service • Limited interest from clients to engage with Near Me

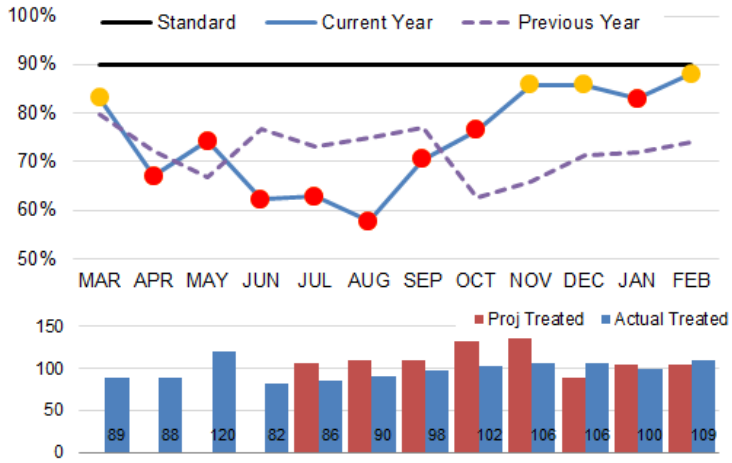
Improvement Actions	Update
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	Action paused due to COVID-19
20.3 'Better Beginnings' class for pregnant women	Action paused due to COVID-19
20.4 Enable staff access to medication whilst at work	Action paused due to COVID-19
21.1 Assess use of Near Me to train staff *By Jul-21 (was Mar-21)*	Near Me has been set up and clients are being offered this service, but there has been little uptake to date, possibly due to issues with IT availability and connectivity. Near Me used as part of new staff training.
21.2 Support Colorectal Urology Prehabillitation Test of Change Initiative *By Jul-21 (was Mar-21)*	Prehabilitation is a multimodal approach, which will minimise the risk of surgery being cancelled or SACT being delayed. It ensures patients are actively managed against the pathway, and is known to improve quality outcomes for patients. Patients identified as smokers and interested in quitting will have rapid access to support. New funding from April.

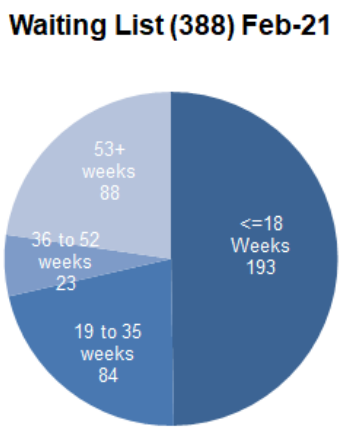
Finance, Performance & Resources – Operational Performance

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2019/20	2020/21										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	83.1%	67.0%	74.2%	62.2%	62.8%	57.8%	70.4%	76.5%	85.8%	85.8%	83.0%	88.1%
Scotland	64.3%	74.0%	58.2%	50.5%	57.9%	57.2%	65.9%	73.4%	72.9%	72.9%		

Key Challenges in 2020/21	Available resource to meet demand Impact of COVID-19 relaxation on referrals Change to appointment 'models' to reflect social distancing

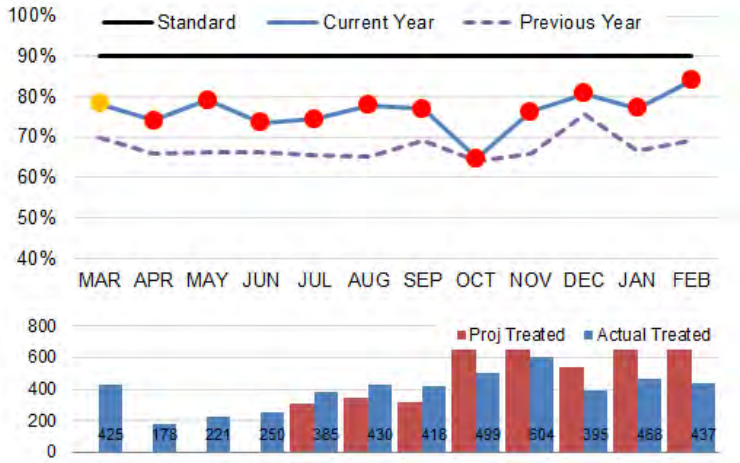
Improvement Actions	Update
20.1 Re-Introduction of PMHW First Contact Appointments System	
20.2 Waiting List Additional Staffing Resource	
20.3 Introduction of Team Leader Role	
21.1 Re-design of Group Therapy Programme *By Jul-21 (was Mar-21)*	Due to COVID-19 restrictions, group-based face to face therapy work is limited compared to pre-COVID practices. Alternative delivery models of group therapy have been designed with Decider Skills Training now being delivered by CAMHS Self Harm Service as a pilot in addition to Anxiety Management group and Mindfulness group trials. Successful delivery and assessment of impact will dictate wider roll-out across Fife CAMHS.
21.2 Use Centralised Allocation Process	
21.3 Build CAMHS Urgent Response Team *By Jul-21 (was Mar-21)*	The plan to develop a CAMHS URT was postponed due to the absence of key staff. The existing Self Harm Service has been maintained and supported to continue to deliver urgent assessments and interventions for children and young people who present with suicidal or self-harming behaviour, both through the urgent referral process and within acute hospital settings. Redesign of the service was reviewed again in March, however the ongoing COVID-19 position and the pending increase of the CAMHS staffing compliment has resulted in any change being postponed until normal service delivery is resumed and new staff are in post. Position will be reviewed again in July.

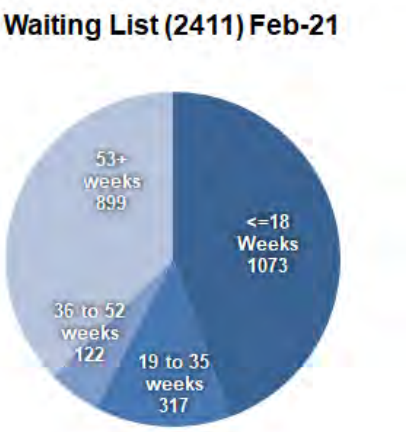
Finance, Performance & Resources – Operational Performance

Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment for Psychological Therapies

Local Performance





National Benchmarking

Month	2019/20	2020/21										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	78.4%	74.2%	79.2%	73.6%	74.5%	77.9%	77.0%	64.7%	76.3%	80.8%	77.1%	84.0%
Scotland	78.8%	74.0%	76.5%	72.7%	74.1%	75.2%	75.8%	79.4%	78.1%	83.2%		

Key Challenges in 2020/21	Predicted large increase in referrals post pandemic Identifying replacement for group therapies (no longer viable)

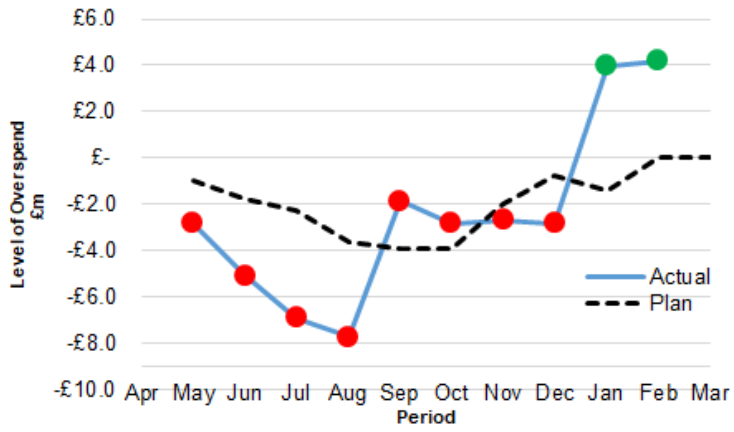
Improvement Actions	Update
20.2 Introduction of extended group programme in Primary Care	
20.3 Redesign of Day Hospital provision	
20.4 Implement triage nurse pilot programme in Primary Care	
20.5 Trial of new group-based PT options *By Sep-21(was Mar-21)*	Develop and pilot two new group programmes for people with complex needs who require highly specialist PT provision from Psychology service. We are awaiting results of Schema therapy group pilot. Development of Compassion Focused therapy group is ongoing, but there has been a delay in the start date for the pilot.
21.1 Introduction of additional on-line therapy options	
21.2 Development of alternative training and PT delivery methods	

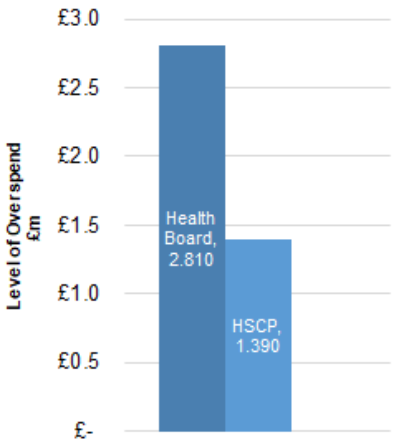
Finance, Performance & Resources – Finance

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 Analysis

Memorandum	Budget			Expenditure			Variance Split By			
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Core Unmet Savings £'000	Net Core Position £'000	Covid Unmet Savings £'000
Health Board	419,845	460,818	409,339	406,529	2,810	0.69%	3,005	-195	2,810	0
Integration Joint Board (Health)	359,601	405,351	367,194	365,804	1,390	0.38%	1,390	0	1,390	0
Risk Share	0	0	0	0	0	0.00%	0	0	0	0
Total	779,446	866,169	776,533	772,333	4,200	0.54%	4,395	-195	4,200	0

Key Challenges in 2020/21	Capturing full additional costs in respect of: Covid-19 mobilisation plans; the Covid-19 vaccination scheme; and the Community Testing Programme. Close monitoring of actual activity and spend will take place over the remaining weeks to ensure our operational activity and financial plans remain aligned. Balancing the overall NHS Fife position to a break even position given the number of variables in respect of core and Covid activity and the resulting financial impact.

Improvement Actions	Update
21.1 Local mobilisation plan *Ongoing throughout FY*	Partnering with the services to: • Identify additional spend relating to Covid-19 • Confirm final offsets against core positions • Understand and quantify the financial implications of remobilisation of core services across NHSF • Inform forecast outturn positions to the year end; in support of our statutory requirement to deliver a balanced RRL position. • Capture the overarching Board-wide workforce plan and additional costs of the immediate significant additional resource for: Test and Protect; Urgent Care redesign; extended flu immunisation; the Covid-19 vaccination programme; and the Community Testing Programme.
21.2 Savings	

Commentary
The position to month 11 is an underspend of £4.200m. This comprises a run rate underspend position of £4.395m; unmet core savings of £0.195m. All additional Covid-19 costs for April to February have been match funded from the SG Covid-19 funding allocations. **Whilst last month we reported a projected core underspend position of £4m; this forecast has now been updated, following a concerted effort to work towards a balanced break even**

position, to a projected underspend outturn of £2.1m.

The forecast position takes account of the non-recurring budget realignment process of £4.1m from Health delegated to Social Care. Whilst planning assumptions around the budget realignment process has removed any risk share cost (ie both partners would land a break even position); a core forecast underspend for both Health delegated, and Social Care is now projected following additional funding allocations. As such, the position reflects a year end transfer to an earmarked health delegated reserve which includes a level of core underspend; covid underspend; and late funding allocations; totalling c£11m. This funding will be carried forward by the Fife Council on behalf of the Integration Joint Board and will be clearly itemised and earmarked for specific purposes for 2021/22. Initial discussions with the IJB CFO indicate some of this funding may be earmarked towards Acute Set Aside budget pressures on a non-recurring basis.

NHS Fife and Fife Council continue to review the Integration Scheme and in particular the risk share agreement to inform arrangements moving forward.

In addition, the Health Board retained run rate position has improved reflecting further pausing of elective activity. The impact of lockdown and a further wave have had a significant impact on the forecast outturn; and we continue to work towards a balanced position taking into account funding and expected activity.

The forecast outturn to the year end is a projected underspend position of £2.1m which represents slippage in our elective programme; associated waiting times funding; and an element of surplus Covid funding and will be reported to Scottish Government in the monthly Financial Performance Return (FPR). The component parts which inform the forecast outturn are detailed in Table 5.

We continue to work towards a balanced position as we approach the financial year end.

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 The AOP process for the 2020/21 financial year was paused in the early part of the financial year as Boards and Scottish Government prepared to respond to the Covid-19 pandemic. A revised AOP financial plan was submitted in July which reflected both the mobilisation and the remobilisation plan high level impact on the financial position. Full Covid-19 funding has been received with the initial allocation made in the September allocation letter; and a final allocation recently received in the January allocation letter. A further Remobilisation Plan (RMP3) was submitted to Scottish Government at the end of February.

2. Financial Allocations

Revenue Resource Limit (RRL)

2.1 NHS Fife received confirmation of the January core revenue amount on 5 March. The updated core revenue resource limit (RRL) per the formal funding letter was confirmed at £839.648m. Anticipated allocations adjustments total £4.229m.

Non Core Revenue Resource Limit

2.2 In addition, NHS Fife 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 non-core RRL funding totals £22.292m.

Total RRL

2.3 The total current year budget at 28 February is therefore £866.169m as detailed in Appendix 1.

3. Summary Position

3.1 The revenue position for the 11 months to 28 February reflects an underspend of £4.200m.

3.2 Table 1 below provides a summary of the position across the constituent parts of the system for the year to date and includes both the core and savings positions. Unmet savings as a result of the impact of Covid have been funded and are reflected at a zero variance. An underspend of £2.810m is attributable to Health Board retained budgets; and an underspend of £1.390m is attributable to the health budgets delegated to the IJB. The in-year position reflects the non-recurring budget realignment process of £4.1m from Health Delegated to Social Care which was agreed, reported and reflected in January.

Table 1: Summary Financial Position for the period ended February 2021

Memorandum	Budget			Variance Split By			
	CY	Variance	Variance	Run Rate	Core Unmet Savings	Net Core Position	Covid Unmet Savings
	£'000	£'000	%	£'000	£'000	£'000	£'000
Health Board	460,818	2,810	0.69%	3,005	-195	2,810	0
Integration Joint Board (Health)	405,351	1,390	0.38%	1,390	0	1,390	0
Risk Share	0	0	0.00%	0	0	0	0
Total	**866,169**	**4,200**	**0.54%**	**4,395**	**-195**	4,200	**0**

				Variance Split By			
	CY	Variance	Variance	Run Rate	Core Unmet Savings	Net Core Position	Covid Unmet Savings
	£'000	£'000	%	£'000	£'000	£'000	£'000
Acute Services Division	228,148	-4,168	-1.99%	-4,118	-50	-4,168	0
IJB Non-Delegated	8,724	162	2.03%	162	0	162	0
Estates & Facilities	76,912	1,431	2.05%	1,407	24	1,431	0
Board Admin & Other Services	45,479	1,270	3.24%	1,439	-169	1,270	0
Non-Fife & Other Healthcare Providers	90,907	960	1.15%	960	0	960	0
Financial Flexibility & Allocations	17,159	3,102	100.00%	3,102	0	3,102	0
HB Offsets	0	0	0.00%	0	0	0	0
Health Board	**467,329**	**2,757**	**0.67%**	**2,952**	**-195**	**2,757**	**0**
Integration Joint Board - Core	450,215	1,229	0.30%	1,229	0	1,229	0
IJB Offsets	0	0		0	0	0	0
Integration Fund & Other Allocations	7,824	139	0.00%	139	0	139	0
Sub-total Integration Joint Board Core	**458,039**	**1,368**	**0.69%**	**1,368**	**0**	**1,368**	**0**
IJB Risk Share Arrangement	0	0		0	0	0	0
Total Integration Joint Board - Health	**458,039**	**1,368**	**0.69%**	**1,368**	**0**	**1,368**	**0**
Total Expenditure	**925,368**	**4,125**	**-0.43%**	**4,320**	**-195**	**4,125**	**0**
IJB - Health	-52,688	22	**-0.04%**	22	0	22	0
Health Board	-6,511	53	**-1.43%**	53	0	53	0
Miscellaneous Income	**-59,199**	**75**	**-0.14%**	**75**	**0**	**75**	**0**
Net Position Including Income	**866,169**	**4,200**	**0.54%**	**4,395**	**-195**	**4,200**	**0**

3.3 The position at month 11 is a core net underspend of £4.200m, following SG funding of unmet savings of £7.604m (£8.296m full year).

3.4 Funding allocations of £23.630m and £7.505m have been allocated to HB and HSCP respectively to match April to February Covid-19 costs incurred. Social Care funding of £19.966m has been passed to our Local Authority partners in-year. Further detail is provided in section 6 and later in Appendix 5.

4. Operational Financial Performance for the year

Acute Services

4.1 The Acute Services Division reports a **net overspend of £4.168m for the year to date**. This reflects an overspend in operational run rate performance of £4.118m, and overachieved savings of £0.050m per Table 2 below. The overall position is mainly driven by pay overspend in junior medical and dental staffing of £1.873m. Additional non pay cost pressures of £1.961m relate to medicines within Emergency Care. The balance is attributable to long standing over establishment of nursing posts within maternity. Various underspends across other areas of Acute arising from vacancies have helped to offset the level of overspend. The pausing of elective activity specifically in Q4 accounts for an underspend of £0.810m.

Funding of £7.7m has also been received for elective/planned care activity which we had already anticipated and reflected in our financial reporting to date. There is significant slippage in this activity (previously anticipating significant activity in quarter 4) and, in turn, the associated funding.

Table 2: Acute Division Financial Position for the period ended February 2021

Core Position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Core Unmet Savings £'000
Acute Services Division								
Planned Care & Surgery	70,779	74,442	67,777	66,676	1,101	**1.62%**	1,097	4
Emergency Care & Medicine	74,958	85,624	78,962	83,571	-4,609	**-5.84%**	-4,498	-111
Women, Children & Cinical Services	55,270	59,737	54,804	55,854	-1,050	**-1.92%**	-860	-190
Acute Nursing	858	695	622	542	80	**12.86%**	80	0
Other	1,683	1,815	1,460	1,150	310	**21.23%**	63	247
Total	**203,548**	**222,313**	**203,625**	**207,793**	**-4,168**	**-2.05%**	**-4,118**	**-50**

Estates & Facilities

4.2 The Estates and Facilities budgets report an **underspend of £1.431m** which is generally attributable to vacancies, energy, PPP and rates. These underspends are partly offset by an overspend in clinical waste costs

4.3 IJB Non-Delegated

The IJB Non-Delegated budget reports an **underspend of £0.162m.** Acute outpatients are reporting drug and medical supplies underspend in addition to underspend on NEF Clinics covered by NHS Tayside.

Corporate Services

4.4 Within the Board's corporate services there is **an underspend of £1.270m**. As previously reported, this position includes unfunded costs of £0.069m related to the significant flooding to the hospital and specific car parks in August. Further analysis of Corporate Directorates is detailed per Appendix 2.

Non Fife and Other Healthcare Providers

4.5 The budget for healthcare services provided out with NHS Fife is **underspent by £0.960m** per Appendix 3. Notwithstanding the in-year underspend, this area remains one of increasing challenge particularly given the relative higher costs of some other Boards, coupled with the unpredictability of activity levels and drug costs; and potential costs associated with patient treatment within the private sector.

Financial Plan Reserves & Allocations

4.6 As part of the financial planning process, expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year as part of the respective devolved budgets. A number of residual uplifts and cost pressure/developments and new in-year allocations are held in a central budget; with allocations released on a monthly basis. The **financial flexibility of £3.102m** released to the month 11 position is detailed in Appendix 4.

Integration Services

4.7 The health budgets delegated to the Integration Joint Board report an **underspend of £1.368m for the year to date** following the non-recurring budget realignment of health delegated underspend to Social Care. The underlying drivers for the run rate underspend include vacancies in sexual health and rheumatology, all AHP services, child health, community nursing, learning disabilities, psychology, community and general dental services across Fife Wide Division. Additional underspends are reflected in East Division following service redesign, and also against vacancies in community services, clinical governance, primary care support unit and administrative posts. The position has improved as a result of the current lockdown impacting on areas such as the childhood vaccination programme.

Income

4.8 A small over recovery in income of £0.075m 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 February 2021

Combined Position	Annual Budget	Budget	Actual	Net (Over)/Under
Pan-Fife Analysis	**£'000**	**£'000**	**£'000**	**£'000**
Pay	407,700	373,994	374,722	-728
GP Prescribing	70,708	64,899	65,730	-831
Drugs	33,294	30,926	31,566	-640
Other Non Pay	389,243	356,492	353,214	3,278
Efficiency Savings	-560	-195	0	-195
Commitments	24,983	3,241	0	3,241
Income	-59,199	-52,823	-52,898	75
Net overspend	**866,169**	**776,533**	**772,334**	**4,200**

Pay

5.2 The overall pay budget reflects an overspend of £0.728m. The majority of the overspend is within medical & dental staff with small offsetting underspends across other pay heads with the exception of nursing and midwifery & personal and social care. Within Acute there are a number of unfunded posts including Clinical Fellows within Emergency Care.

5.3 Against a total funded establishment of 8,044 wte across all staff groups, there was an average 8,164 wte core staff in post in February. The additional staff in post represent staff cohort groups organised nationally to help support the Covid-19 activity.

Drugs & Prescribing

5.4 Across the system there is a net overspend of £1.471m on medicines. The GP prescribing budget is overspent in-year by £0.831m with a forecast of breakeven. Significantly higher drug prices are being experienced, likely exacerbated by the impact of Covid on supply and demand, raw material availability, transportation, and production. Opportunity to realise planned saving schemes has not been possible as workforce is focused on Covid services and patient care. Implementation of Freestyle Libre (flash glucose monitoring system) continues to exceed original forecast and funding provided. The position to month 11 reflects £1.115m recharged to Covid costs, whilst local and national work continues to establish the true Covid-19 impact on prescribing. An update will be provided when more information becomes available.

Acute medicines have an overspend of £1.641m, with a forecast of £2.420m. The main overspend to date is in Neurology at £0.600m, where a high cost drug is being used by a small number of patients and is an ongoing cost pressure from prior years. However, in 20/21 Dermatology, GI, Neurology and Respiratory started to present increased costs due to the volume of patients being treated and new drugs that are being made available via homecare. The forecast assumes the overspending trajectory will continue, with an additional pressure of £0.6m for Haematology drugs which exceed the funding available from the new medicines reserve.

5.5 Other Non-Pay

Other non-pay budgets across NHS Fife are collectively underspent by £3.278m. This includes underspends across the system within sterile and diagnostics supplies, and travel and subsistence; and an updated position on the 2020/21 spend associated with the Royal Hospital for Sick Children which is significantly less than had been anticipated. As in every month, a detailed review of financial flexibility has been conducted.

6 Covid-19 Funding Allocation

6.1 We have received full Covid-19 funding with allocations made in 2 tranches (September and January). The funding allocations made across Scotland were informed on either actual costs or NRAC share; and reflected the return of offsetting cost reductions; and full funding of agreed unachieved efficiency savings. A summary of our Covid-19 funding is attached at Appendix 5.

6.2 A separate allocation of £1.5m relating to payments to primary care for additional costs in responding to the pandemic was received in the October allocation letter.

7 Financial Sustainability

7.1 The Financial Plan presented to Finance, Performance and Resources Committee in March highlighted the requirement for £20.015m cash efficiency savings to support financial balance in 2020/21. As part of the LMP, Boards were asked to provide an estimate of the impact of planned measures re Covid-19 on the delivery of planned Health Board savings. With our focus on responding to the Covid-19 pandemic, our planning assumptions reflected an anticipated achievable £11.7m of the target, with a resulting £8.3m underachievement of savings, which has now been fully funded by Scottish Government. Whilst good progress has been made to month 11, to support the delivery of the full £11m, c50% has been made on a recurring basis. The non-recurring 'tail' will form an opening pressure for next financial year and is as a consequence of our focus on the pandemic this year.

7.2 In addition to the £20.015m savings target, the IJB identified an additional savings target of £1.8m which was to be met from Health Delegated. This was linked to the budget realignment exercise described in 4.6 above; and has been funded through the wider LMP process.

7.3 Table 4 summaries the position for the 11 months to February 2021.

Table 4: Savings 20/21

Total Savings	Total Savings Target £'000	Forecast Achievement (Core) £'000	Funded unmet savings (Covid-19) £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Identified & Achieved to Feb £'000	Forecast / Unidentified to March £'000
Health Board	14,868	6,572	8,296	1,211	4,802	6,013	559
Integrated Joint Board	5,147	5,147	0	4,219	928	5,147	0
IJB additional savings	1,800	0	1,800	0	0	0	0
Total Savings	**21,815**	**11,719**	**10,096**	**5,430**	**5,730**	**11,160**	**559**

8 Forecast

8.1 Whilst last month we reported a projected core underspend position of £4m; this forecast has now been updated, following a concerted effort to work towards a balanced break even position, to a projected underspend outturn of £2.1m.

8.2 The forecast position takes account of the non-recurring budget realignment process of £4.1m from Health delegated to Social Care. Whilst planning assumptions around the budget realignment process has removed any risk share cost (ie both partners would land a break even position); a core forecast underspend for both Health delegated, and Social Care is now projected following additional funding allocations. As such, the position reflects a year end transfer to earmarked health delegated reserve which includes a level of core underspend; covid underspend; and late funding allocations; totalling c£11m. All funding will be carried forward by the Local Authority Partner on behalf of the Integration Joint Board and will be clearly itemised and earmarked for specific purposes for 21/22. Initial discussions with the IJB CFO indicate some of this funding may be earmarked towards Acute Set Aside budget pressures on a non-recurring basis.

8.3 NHS Fife and Fife Council continue to review the Integration Scheme and in particular the risk share agreement to inform arrangements moving forward.

8.4 In addition, the Health Board retained run rate position has improved reflecting further pausing of elective activity. The impact of lockdown and a further wave have had a significant impact on the forecast outturn; and we continue to work towards a balanced position taking into account funding and expected activity.

8.5 The forecast outturn to the year end is a projected underspend position of £2.1m which represents slippage in our elective programme; associated waiting times funding; and an element of surplus Covid funding and will be reported to Scottish Government in the monthly Financial Performance Return (FPR). The component parts which inform the forecast outturn are detailed in Table 5.

8.6 We continue to work towards a balanced position as we approach the financial year end.

Table 5 – Forecast Outturn Position

Forecast Outturn	Run Rate £'000	Offsets £'000	Savings £'000	Risk Share £'000	Total £'000
Acute Services Division	-5,875	3,743	-8,263	0	-10,395
IJB Non-Delegated	121	0	-33	0	88
Estates & Facilities	1,758	463	0	0	2,221
Board Admin & Other Services	1,082	51	0	0	1,133
Non-Fife & Other Healthcare Providers	845	0	0	0	845
Financial Flexibility	2,719	0	0	0	2,719
Miscellaneous Income	100	0	0	0	100
Savings funding			8,296		8,296
Health Board Retained Budgets	**750**	**4,257**	**0**	**0**	**5,007**
IJB Delegated Health Budgets	2,300	3,603	0	0	5,903
Budget realignment	-4,100				-4,100
Savings funding			1,800		1,800
Integration Fund & Other Allocations	0	0	0	0	0
Total IJB Delegated Health Budgets	**-1,800**	**3,603**	**1,800**	**0**	**3,603**
Covid	**1,354**				**1,354**
Offsets returned to SG	**0**	**-7,860**	**0**	**0**	**-7,860**
Total Forecast Outturn	**304**	**0**	**1,800**	**0**	**2,104**

9 Key Messages / Risks

9.1 The month 11 position reflects an underspend of £4.200m; which comprises a core underspend of £4.395m; and unmet core savings of £0.195m. All additional Covid-19 costs for the year to date have been match funded from the SG Covid-19 funding allocations.

9.2 The forecast outturn position to the year-end reflects a potential underspend of £2.1m which reflects the pausing of elective activity; the resulting impact on specific waiting times funding; and Covid funding allocations; and is net of an assumed transfer of Covid funding to our Local Authority Partner of £2.5m for Covid vaccination venue costs; and Community Testing Programme costs. There is a degree of risk to the forecast position, specifically relating to year end deliveries, which we are keeping under close review of the year end nears.

9.3 Notwithstanding, we continue to work towards our target balanced position and dialogue with Scottish Government is ongoing.

10 Recommendation

10.1 Members are invited to approach the Director of Finance for any points of clarity on the position reported and are asked to:

- **Note** the reported core underspend of £4.200m for the 11 months to February
- **Note** that funding allocations for Covid-19 reflected in the month 11 position match fund additional costs incurred across Health and Social Care
- **Note** the updated key assumptions which inform a potential forecast underspend position of £2.1m (related to elective activity and associated funding); and, in parallel, dialogue with Scottish Government colleagues is underway
- **Note** the plans to create an IJB Reserve for Health Delegated to cover ongoing Covid-19 costs into 2021/22.

Appendix 1: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
Apr-20	Initial Baseline Allocation	701,537			701,537	Includes 20-21 uplift
May-20	Confirmed Allocations	-1,307		3,413	2,106	
Jun-20	Confirmed Allocations			-534	-534	
Jul-21	Confirmed Allocations			5,614	5,614	
Aug-20	Confirmed Allocations		9,474	1,547	11,021	
Sep-20	Confirmed Allocations	-69	56,750	32,764	89,445	
Oct-20	Confirmed Allocations		2,528	3,668	6,196	
Nov-20	Confirmed Allocations			117	117	
Dec-20	Confirmed Allocations		2,187	4,932	7,119	
Jan-21	Confirmed Allocations		162	16,350	16,512	
Feb-21	Adult Flu Vaccine costs			271	271	Annual Allocation
	Insulin Pumps			309	309	National initiative
	Discovery 20-21		-36		-36	Annual Contribution
	Arcus Finance Business Partnering			-29	-29	Contribution for Finance Training
	Total Core RRL Allocations	**700,161**	**71,065**	**68,422**	**839,648**	
Anticipated	NDC Contribution		-781		-781	
Anticipated	Family Nurse Partnership		28		28	
Anticipated	Top Slice NSS		-16		-16	
Anticipated	Cancer Diagnostic Centre			-297	-297	
Anticipated	Capital to Revenue			-92	-92	
Anticipated	Covid Recognition Payment			4,357	4,357	
Anticipated	AFC pay award			1,030	1,030	
	Total Anticipated Core RRL Allocations	**0**	**-769**	**4,998**	**4,229**	
	IFRS			8,874	**8,874**	
	Donated Asset Depreciation			131	**131**	
	Impairment			500	**500**	
	Depreciation			12,959	**12,959**	
	AME Provisions			-172	**-172**	
	Total Non-Core RRL Allocations	**0**	**0**	**22,292**	**22,292**	
	Grand Total	**700,161**	**70,296**	**95,712**	**866,169**	

Appendix 2: Corporate Directories – Core Position

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Digital & Information	13,047	11,955	12,109	-153
Nhs Fife Chief Executive	216	198	237	-39
Nhs Fife Finance Director	6,498	5,921	5,339	581
Nhs Fife Medical Director	7,554	5,935	5,712	223
Nhs Fife Nurse Director	4,161	3,759	3,471	288
Legal Liabilities	-17,914	-18,297	-18,606	308
Early Retirements & Injury Benefits	814	746	698	48
Regional Funding	276	246	206	40
Depreciation	18,129	16,581	16,581	0
Nhs Fife Public Health	2,735	2,512	2,544	-32
Nhs Fife Workforce Directorate	3,228	2,954	2,879	74
Nhs Fife Major Incident - Flooding			69	-69
Total	**38,745**	**32,509**	**31,239**	**1,270**

Appendix 3: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	98	90	86	4
Borders	45	41	51	-10
Dumfries & Galloway	25	23	52	-29
Forth Valley	3,179	2,914	3,256	-342
Grampian	359	329	251	78
Greater Glasgow & Clyde	1,655	1,518	1,486	32
Highland	135	124	182	-58
Lanarkshire	114	105	226	-121
Lothian	31,518	28,892	26,976	1,916
Scottish Ambulance Service	101	93	94	-1
Tayside	41,030	37,609	37,421	188
	78,259	**71,738**	**70,081**	**1,657**
UNPACS				
Health Boards	10,627	9,741	10,419	-678
Private Sector	1,245	1,141	1,652	-511
	11,872	**10,882**	**12,071**	**-1,189**
OATS	711	652	162	490
Grants	65	65	63	2
Total	**90,907**	**83,337**	**82,377**	**960**

Appendix 4 - Financial Flexibility & Allocations

	CY Budget £'000	Flexibility Released to Feb-21 £'000
Financial Plan		
Drugs	197	0
CHAS	0	0
Unitary Charge	100	92
Junior Doctor Travel	20	14
Cost Pressures	616	561
Developments	3,249	1,839
Sub Total Financial Plan	**4,182**	**2,506**
Allocations		
Waiting List	2,020	0
AME: Impairment	640	0
AME: Provisions	-102	0
Neonatal Transport	6	2
Cancer Access	256	0
Endoscopy	85	0
ARISE	68	0
Covid 19	7,504	0
MPPP Respiratory Projects	29	0
Winter Funding	51	0
Capital to revenue	340	0
Baby Bliss	5	0
Best Start	32	0
MRI Van	39	0
Disestablished GPST	10	0
Carry Forward from 19/20	60	55
NSD Risk Share Return	539	539
R&D	4	
Reporting Radiographer Training	9	
Inequalities Fund	6	
Cancer Strategy	5	
Wellbeing Fund	32	
Insulin Pumps	309	
AFC pay award December to March	1,030	
Sub Total Allocations	**12,977**	**596**
Total	**17,159**	**3,102**

Appendix 5 – Covid-19 funding

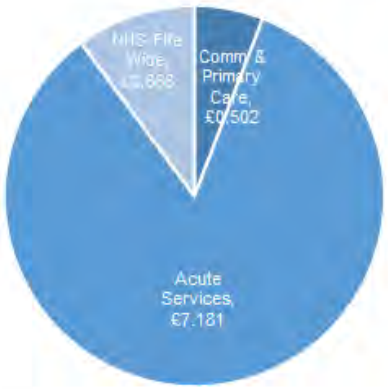
COVID funding	Health Board	Health delegated	Social Care delegated	Total	Capital	Primary Care Funding
	£000's	£000's	£000's	£000's	£000's	£000's
Allocation Q1 to Q4	22,540	6,546	4,458	33,544	999	1,325
Allocations received previously	1,296		9,779	11,075		
Funding Received Jan-21	10,765	-1,698	5,729	14,796		234
Total funding	**34,601**	**4,848**	**19,966**	**59,415**	**999**	**1,559**
Allocations made for Apr to Feb						
Planned Care & Surgery	1,878			1,878		
Emergency Care & Medicine	2,518			2,518		
Women, Children & Clinical Services	1,422			1,422		
Acute Nursing	17			17		
Estates & Facilities	1,690			1,690		
Board Admin & Other Services	5,774			5,774		
Income	682			682		
Test and Protect	1,353			1,353		
West Division		1,881		1,881		
Pharmacy Division		93		93		
Fife Wide Division		1,484		1,484		
East Division		945		945		
Primary Care		1,302		1,302		1,559
Social Care			19,966	19,966		
Unachieved savings	8,296	1,800		10,096		
Total allocations made to M11	**23,630**	**7,505**	**19,966**	**51,101**	**0**	**1,559**
Offsets returned to SG	-4,257	-3,603		-7,860		
Elective / Planned Care	7,724			7,724		
Capital					999	
Total	**27,097**	**3,902**	**19,966**	**50,965**	**999**	**1,559**
Balance In Reserves	**7,504**	**946**	**0**	**8,450**	**0**	**0**

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



Commentary

The total Capital Resource Limit for 2020/21 is £13.634m including anticipated allocations for specific projects. The capital position for the 11 months to February records spend of £8.551m equivalent to 62.71% of the total allocation. The capital spend on the specific projects is on track to spend in full, notwithstanding the end loaded spend profile as in any financial year.

Current Challenges	The medium-term programme of work required to address all aspects of backlog maintenance, statutory compliance, equipment replacement, and investment in technology considerably outstrips capital resource limit available. Careful assessments are made each financial year to allocate the resource limit to key areas of priority.

Improvement Actions	Update
21.1 Managing expenditure programme within resources available *By Mar-21*	Risk management approach adopted across all categories of spend

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 The capital plan for 2020/21 has been approved by the FP&R Committee and the NHS Fife Board. NHS Fife received a capital allocation of £7.394m in the August allocation letter, and allocations of: £0.999m for Covid equipment in the September allocation letter; £0.381m for Cancer Waiting Times equipment; £2.008m for radiology in the November allocation letter; and £0.400m for Hospital Eye Service in the December allocation letter. In the February allocation letter we received the following; £2.2m for the Elective Orthopaedic Centre; HEPMA £0.025m; Lochgelly Health Centre £0.025m; Kincardine Health Centre £0.025m; Additional £0.025m for Hospital Eye Service; and an allocation of £0.060m for radiology. We are still anticipating the capital to revenue transfer of £0.093m. The total capital plan is therefore £13.634m.

2. Capital Receipts

2.1 Work continues on asset sales with a disposal planned :

- Lynebank Hospital Land (Plot 1) (North) – Under offer – however the sale of this land will not complete in the current financial year.

Discussions with SGHSCD will be undertaken to highlight the potential risk of non delivery of the sale of land.

3. Expenditure To Date / Major Scheme Progress

3.1 The summary expenditure position across all projects is 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 £8.551m or 62.71% 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	£2.221m
Equipment	£3.892m
E-health	£0.664m
Elective Orthopaedic Centre	£1.346m

4. Capital Expenditure Outturn

4.1 As we near the end of quarter 4, it is 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 for any points of clarity on the position reported and are asked to:

note the capital expenditure position to 28 February 2021 of £8.551m and the forecast year end spend of the total capital resource allocation of £13.634m.

Appendix 1: Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2020/21 £'000
COMMUNITY & PRIMARY CARE			
Capital Minor Works	292	242	292
Statutory Compliance	203	149	203
Capital Equipment	99	62	99
Covid Community Equipment	26	26	26
Condemned Equipment	0	0	0
Lochgelly Health Centre	25	12	25
Kincardine Health Centre	25	12	25
Total Community & Primary Care	670	502	670
ACUTE SERVICES DIVISION			
Statutory Compliance	2,775	1,910	2,775
Capital Equipment	2,376	1,599	2,376
Covid Acute Equipment	973	753	973
Minor Works	205	121	205
Cancer Waiting Times Equipment	371	337	371
Hospital Eye Service	425	30	425
Radiology Funding	2,068	994	2,068
Condemned Equipment	91	91	91
Elective Orthopaedic Centre	2,200	1,346	2,200
Total Acute Services Division	11,483	7,181	11,483
NHS FIFE WIDE SCHEMES			
Equipment Balance	0	0	0
Information Technology	1,066	664	1,066
Minor Works	2	0	2
Statutory Compliance	12	0	12
Contingency	0	0	0
Asbestos Management	104	78	104
Fire Safety	85	83	85
Scheme Development	60	17	60
Vehicles	60	25	60
Capital In Year Contingency (EDG)	0	0	0
Total NHS Fife Wide Schemes	1,389	868	1,389
TOTAL CONFIRMED ALLOCATION FOR 2020/21	**13,541**	**8,551**	**13,541**
ANTICIPATED ALLOCATIONS 2020/21			
Capital to Revenue Transfer	93	0	93
Anticipated Allocation for 2020/21	**93**	**0**	**93**
Total Anticipated Allocation for 2020/21	**13,634**	**8,551**	**13,634**

Appendix 2: Capital Plan - Changes to Planned Expenditure

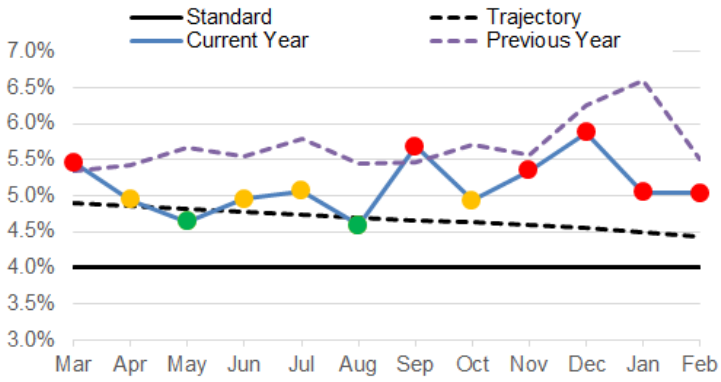
Capital Expenditure Proposals 2020/21 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to January £'000	February Adjustment £'000	Total February £'000
Community & Primary Care				
Capital Equipment	0	99	0	99
Condemned Equipment	0	0	0	0
Minor Capital	0	291	1	292
Covid Equipment	0	26	0	26
Statutory Compliance	0	153	50	203
Lochgelly Health Centre	0	0	25	25
Kincardine Health Centre	0	0	25	25
Total Community & Primary Care	**0**	**569**	**101**	**670**
Acute Services Division				
Capital Equipment	0	2,241	135	2,376
Condemned Equipment	0	91	0	91
Cancer Waiting Times Equipment	0	381	-10	371
Minor Capital	0	206	-1	205
Hospital Eye Service	0	400	25	425
Covid 19 Acute Equip	0	973	0	973
Radiology Funding	0	2,008	60	2,068
Statutory Compliance	0	2,842	-67	2,775
Elective Orthopaedic Centre	0	0	2,200	2,200
	0	**9,141**	**2,342**	**11,483**
Fife Wide				
Backlog Maintenance / Statutory Compliance	3,569	-3,559	2	12
Fife Wide Equipment	2,036	-1,925	-111	0
Information Technology	1,041	0	25	1,066
Minor Work	498	-497	1	2
Fife Wide Contingency Balance	100	-100	0	0
Condemned Equipment	90	-90	0	0
Scheme Development	60	0	0	60
Fife Wide Asbestos Management	0	104	0	104
Fife Wide Fire Safety	0	85	0	85
Fife Wide Vehicles	0	60	0	60
Capital In Year Contingency	0	0	0	0
Total Fife Wide	**7,394**	**-5,922**	**-83**	**1,389**
Total	**7,394**	**3,787**	**2,360**	**13,541**
ANTICIPATED ALLOCATIONS 2020/21				
Capital to Revenue Transfer	93	0	0	93
Anticipated Allocation for 2020/21	**93**	**0**	**0**	**93**
Total Planned Expenditure for 2020/21	**7,487**	**3,787**	**2,360**	**13,634**

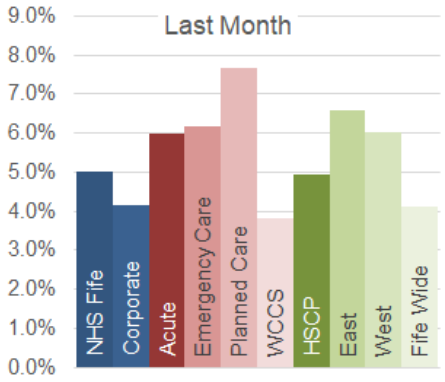
Staff Governance

Sickness Absence

To achieve a sickness absence rate of 4% or less
*Improvement Target for 2020/21 = **4.39%***

Local Performance (Source: Tableau, from December 2019)





National Benchmarking

Month	2019/20	2020/21										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	5.46%	4.95%	4.64%	4.96%	5.06%	4.58%	5.69%	4.93%	5.35%	5.87%	5.04%	5.03%
Scotland	5.20%	4.57%	4.54%	4.49%	4.57%	4.64%	4.96%	4.93%	4.96%	5.18%	4.82%	4.30%

Key Challenges in 2020/21	Recovery from COVID-19 and repurposing Promoting Attendance activities to support business as usual

Improvement Actions	Update
20.1 Targeted Managerial, HR, OH and Well@Work input to support management of sickness absence	
20.2 Early OH intervention for staff absent from work due to a Mental Health related reason	
21.1 Once for Scotland Promoting Attendance Policy	
21.2 Review the function of the Promoting Attendance Group	The review of the function of the NHS Fife Promoting Attendance Group and associated groups, to improve the governance arrangements of each group and how they interrelate, has commenced. The aim is to provide a Promoting Attendance framework with clear lines of reporting and escalation. Work on this has concluded for implementation from April 2021. Action complete
21.3 Restart Promoting Attendance Panels	

MARGO MCGURK
Director of Finance and Performance
20th April 2021

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

Appendix 1: NHS Fife Remobilisation Activity to end of Mar 2021

Higher than Projected | Lower than Projected

		Quarter End	Quarter End	Month End			Quarter End
		Sep-20	Dec-20	Jan-21	Feb-21	Mar-21	Mar-21
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,040	3,044	1,071	1,063	1,086	3,220
	Actual	2,590	2,930	556	644	1,049	2,249
	Variance	550	-114	-515	-419	-37	-971
OP Referrals Accepted (Definitions as per Waiting Times Datamart)	Projected	14,042	22,565	7,261	7,303	7,342	21,906
	Actual	15,774	17,683	4,854	5,258	7,570	17,682
	Variance	1,732	-4,882	-2,407	-2,045	228	-4,224
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	13,602	20,630	7,321	7,386	7,500	22,208
	Actual	11,852	15,566	4,332	4,137	5,719	14,188
	Variance	-1,750	-5,064	-2,989	-3,249	-1,781	-8,020
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,648	2,296	848	848	848	2,544
	Actual	1,110	1,258	410	360	545	1,315
	Variance	-538	-1,038	-438	-488	-303	-1,229
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,074	11,450	3,450	3,700	3,700	10,850
	Actual	11,264	10,835	2,797	2,671	4,010	9,478
	Variance	1,190	-615	-653	-1,029	310	-1,372
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	21,495	21,705	7,230	6,990	7,590	21,810
	Actual	20,303	17,073	4,403	4,145	5,557	14,105
	Variance	-1,192	-4,632	-2,827	-2,845	-2,033	-7,705
Number of A&E 4-Hour Breaches (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	775	1,000	390	325	270	985
	Actual	815	1,310	440	369	509	1,318
	Variance	40	310	50	44	239	333
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	9,225	10,100	3,450	3,220	3,300	9,970
	Actual	8,800	9,642	2,717	2,568	3,170	8,455
	Variance	-425	-458	-733	-652	-130	-1,515
Admissions via A&E (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	4,354	4,350	1,400	1,330	1,430	4,160
	Actual	4,467	4,227	1,329	1,232	1,559	4,120
	Variance	113	-123	-71	-98	129	-40
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,195	2,140	750	770	800	2,320
	Actual	2,097	2,481	742	776	1,058	2,576
	Variance	-98	341	-8	6	258	256
31 Day Cancer - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	309	309	103	103	103	309
	Actual	275	281	95	81		
	Variance	-34	-28	-8	-22		
CAMHS - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	325	356	104	105	86	295
	Actual	274	314	100	109		
	Variance	-51	-42	-4	4		
Psychological Therapies - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	970	1,956	724	745	516	1,985
	Actual	1,233	1,498	468	437		
	Variance	263	-458	-256	-308		

		Month End	Month End	Month End			Month End
		Sep-20	Dec-20	Jan-21	Feb-21	Mar-21	Mar-21
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	79	79	88	83	74	74
	Actual	75	51	65	91	98	98
	Variance	-4	-28	-23	8	24	24

[1] The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month

Item 10.2

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30th April 2021**
Title:	**Winter Performance Report 2020/21**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Discussion

This report relates to the:

- Winter Report 2020/21 – Complete winter data to 4 April 2021

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Fife Winter Report is to provide assurance that the Winter Plan is being delivered in accordance with the submission to Scottish Government in November 2020.

2.2 Background

The Winter Report is produced monthly and provides update on key performance metrics and actions agreed within the Winter Plan. Weekly meetings between Acute Services, H&SC and Planning commenced in November 2020 using the Winter Planning Weekly Scorecard to discuss agreed performance metrics and escalate issues when required.

The Winter Plan aims to:

- Describe the arrangements in place to cope with increased demand on services over the winter period and subsequent COVID-19 waves

- 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, and in accordance with national standards. (e.g. 4-hour emergency access target)
- Support a discharge model that has performance measures, a risk matrix and an escalation process
- Ensure staff and patients are well informed about arrangements for winter and COVID-19 through a robust communications plan
- Build on existing strong partnership working to deliver the plan that will be tested at times of real pressure

2.3 Assessment

A summary of performance of the following key winter metrics are as follows:

A&E

95% Standard has not been met since Week Ending 27th September. However, has been above the Scotland average since mid-December and has maintained above. Attendances have climbed on an upward trend since early February, continually through March and into April with pre-COVID levels of attendance becoming more frequent.

Covid-19

Since the start of the 2nd wave of Covid-19 our peak of weekly Covid-19 Bed days in Acute was 596 for both confirmed and suspected patients, with 564 of those being confirmed, this was reached week ending 17th January. During this same period our peak of weekly Covid-19 Bed days in community hospital was 404 for both confirmed and suspected patients, with 395 of those being confirmed, this was reached week ending 7th February.

Occupancy

VHK occupancy has reached above 90% for most of March, ending the month just below. This coincides with a rise in attendances during the same period. However, the Amber pathway has been under continual pressure winter, with stages during each month since December where this has breached 100%.

Occupancy within community hospitals has been consistently above 90% but closer to 95% all winter with 1 week in February and 2 during March where occupancy exceeded 100%. This may have been due to some wards having to close due to infection, but these have all re-opened now.

Delayed Discharges

The number of Delayed Discharges in VHK has been kept low below 25 bed days for the majority of winter with one exception week during February.

There has been an average of 300 bed days per week due to delayed discharges within community hospitals. Many of these delays are due to guardianship issues with the courts closed and have been out with our control.

Health & Social Care Placements

H&SCP achieved an average of over 100% of placements during this winter. With social care placements achieving an average of 94% overall, ICASS/H@H achieving and average of 95% overall, however have been held back slightly as the demand for ICASS was less than the target. All other placements achieved over 100%.

Most of the Winter Plan actions are complete or on track. The following actions are ongoing, with slippage, but due to be completed prior to next winter:

4.1.2 Implement Home First Model - more timely discharges & realistic home-based assessments
4.1.4 Restructure of medical assessment and admissions

A Winter Review Event was held on 12th April through MS Teams, with over 70 participants. The event included 2 group work sessions;

1. What worked well and not so well last winter
2. What key learning and actions could be taken forward for 2021/22

Table below summaries the responses.

What has worked well?	What has not worked as well?	Key Learning & Actions for 2021/22
Communication	SG Communication	Clearly identify and communicate trigger points
Collaboration	Recruitment, Retention and Workforce Planning 365	Flexible staff that can be moved across the organisation
IT Systems	Distinction between Summer and Winter, 365 planning and being proactive	365 Planning – plan demands for 12-month period
Flexibility	Transport	New Technology, digital development
The speed of Change	Remobilisation of some services, waiting times	Improve Contingency and Incident Planning

Feedback will be used to plan and implement next winter's plan at the Winter Planning Event in August although it has been agreed that planning for capacity and flow of the whole health and social care system will continue over the summer months.

A feedback questionnaire was distributed to all attendees after the event with a 45% return rate. Majority of attendees felt the event was worthwhile, with the right attendees and good group sizes for groupwork. The event was rated 4 out of 5 with all bar one attendee feeling able to contribute to the breakout discussions. There was positive feedback on the workshop being delivered over teams and the pre-allocation and size of the breakout groups which facilitated good discussion and debate. This will be a format that will be considered going forward for this type of event.

2.3.1 Quality/ Patient Care

The Winter Plan has been prepared prioritising patient care in the right place at the right time and by the right person.

2.3.2 Workforce

Workforce planning is key to Winter Planning

2.3.3 Financial

Financial planning is key to Winter Planning

2.3.4 Risk Assessment/Management

Options for Surge Capacity over winter have been risk assessed

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The Winter Report is produced by Planning and Performance Team, updates are provided for agreed actions in Winter Plan by relevant Services.

2.3.8 Route to the Meeting

Discussed at Silver and Bronze Winter Planning Groups

2.4 Recommendation

The Clinical Governance Committee is requested to:

- **Note** the contents of the Final Winter Report

3 List of appendices

- Winter Planning Monthly Report March 2021

Report Contact
Susan Fraser
Associate Director of Planning & Performance
Email Susan.Fraser3@nhs.scot

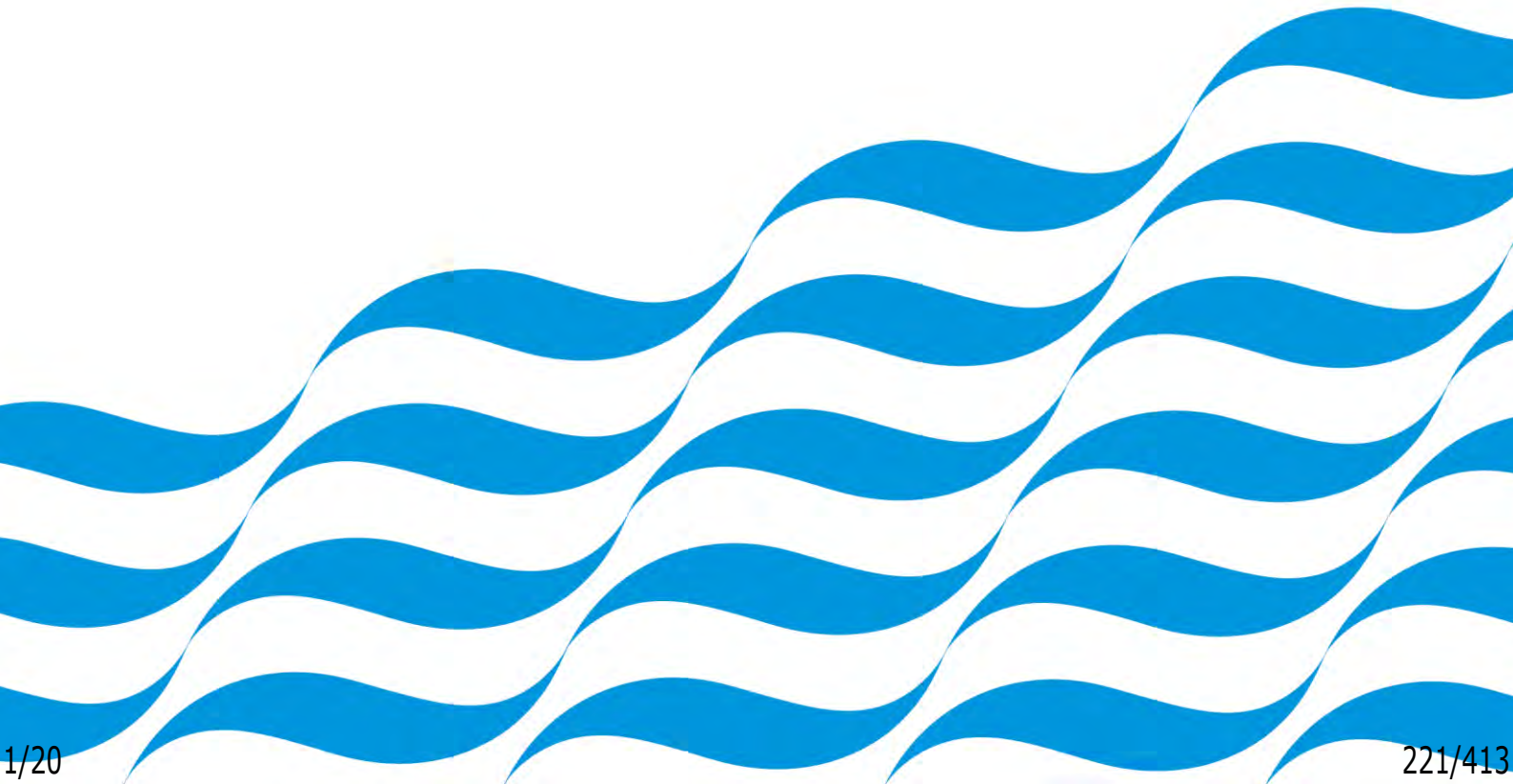
Fife Health & Social Care Partnership

NHS Fife

Winter Planning

Monthly Report

Week Ending 1st March to 4th April 2021



Contents

Introduction

The purpose of this report is to assure the Chief Executive and EDG that the Winter Plan is being delivered in accordance with the submission to Scottish Government and against agreed performance targets.

In 2020/21, the Winter Plan is closely aligned to the Remobilisation Plan and describes the actions that will be taken forward by NHS Fife and the Health and Social Care Partnership to optimise service resilience during the winter months and beyond in a COVID-19 sensitive environment. Executive leadership sits with the Director of Nursing and delivery lies with both the directors of Acute Services in NHS Fife and the Health and Social Care Partnership.

A Silver Command has been established for winter planning which meets weekly and agrees actions, supported by the Bronze Command for winter planning monitoring the dashboard weekly and escalating to Silver Command where appropriate. A monthly report is provided to the board for assurance. The weekly reporting will cease at the end of March with the monthly report going to the NHS Fife Board in May 2021. Weekly reporting has commenced in October 2020 as part of the Winter Plan 2020/21.

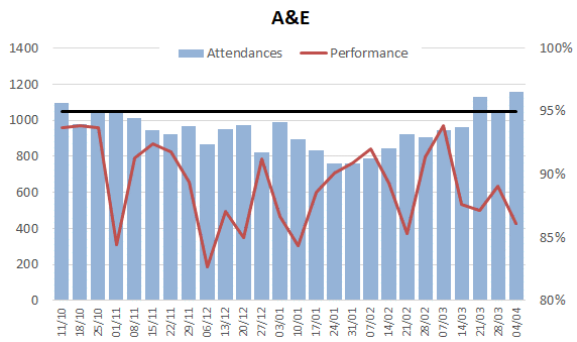
The Winter Planning Performance Review Summary will be considered by the Finance, Performance and Resources and Clinical Governance Committees.

Outlined below in Section C are the actions that were submitted to the Scottish Government at the end of October 2020 and current status of these actions.

Section A: Executive Summary

This is the final monthly report summarising performance against key indicators and actions for Winter 2020/21. The key points to note this month are as listed below.

A&E



Narrative

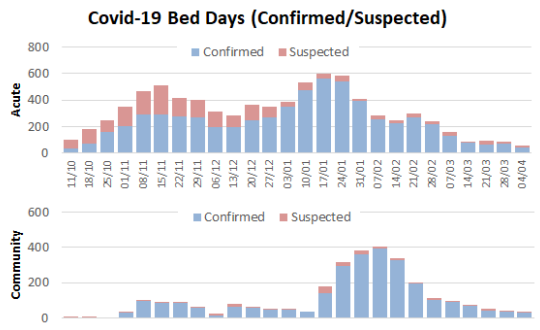
The 95% Standard has not been met since Week Ending 27th September. The board average has risen above the Scotland average since week ending 13th December and has maintained above.

Attendances have climbed through March, if this trend continues over 1200 per week, we will be back to pre-covid levels.

Commentary

A&E attendances have continued to increase through March, with pre-COVID levels of attendance becoming more frequent. This is presenting an increasing challenge and it is expected this trend will continue as COVID restrictions reduce. Bed waits accounted for 44% of all breaches in March as overall hospital capacity pressures continued to translate to further restriction at the front door.

Covid-19 Bed Days



Narrative

Since the start of the 2nd wave of Covid-19 our peak of weekly Covid-19 Bed days in Acute was 596 for both confirmed and suspected patients, with 564 of those being confirmed, this was reached week ending 17th January.

During this same period our peak of weekly Covid-19 Bed days in community hospital was 404 for both confirmed and suspected patients, with 395 of those being confirmed, this was reached week ending 7th February.

Commentary

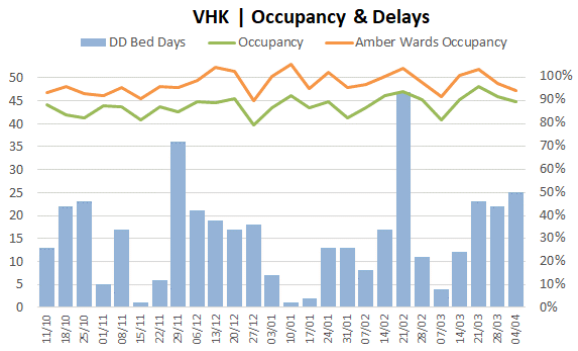
Acute

COVID bed days continued to decline for Acute with a noticeable reduction on the numbers of COVID patients on a daily basis. As well as the numbers of individual patients being lower, the average LoS of COVID patients also appears to have lowered.

HSCP

Covid-19 bed days increased within the community hospitals due to ward outbreaks in January and February. At the peak over 100 beds were closed. Additional testing prior to all patient transfers or admission have now been implemented to prevent further hospital acquired spread. Inpatient vaccination programmes commenced 15th February. There has been a steady decline since the last week in February and as at 20th April there are no active covid cases in any of the HSCP community hospital wards.

Acute Occupancy & Delays



Narrative

VHK occupancy has reached above 90% for most of March, ending the month just below. This coincides with a rise in attendances during the same period.

The Amber pathway has been under continual pressure reaching over 100% in the middle of the month. This has since come down just under 95%.

The number of Delayed Discharges in VHK during March is averaging out at 17, this has dropped since February where it was average at 21.

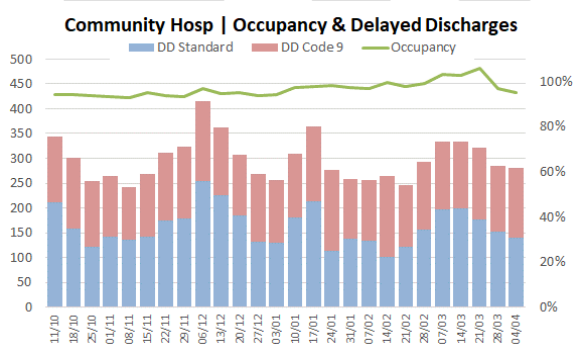
Commentary

From mid-March Acute has seen increasing admission pressures with weekly emergency adult admissions for March c.9% higher than that experienced Oct-Feb. This equates to roughly 2 x wards worth of additional emergency admissions on a weekly basis compared with the averages experienced through the rest of Winter. Emergency admissions continue to be on an upward trend through April, which gives significant pressure when trying to balance with the need to upscale elective activity.

To cope with this level of demand requires Acute to discharge and then re-admit into c.20% of its adult bed base on a daily basis.

Amber ward occupancy averaged 99% through March, with surge capacity maximised throughout, and often exceeded.

Community Occupancy & Delays



Narrative

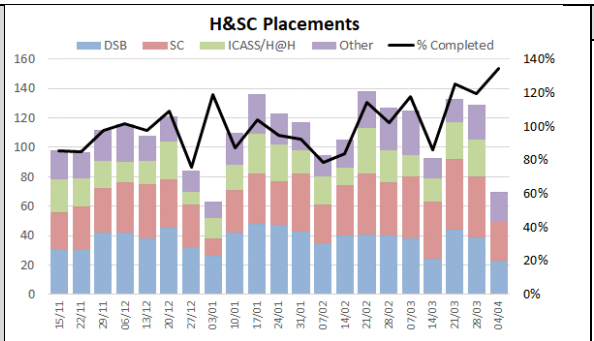
From the end of February into March occupancy within the community hospitals has been greatly under pressure above 90%. This has been brought back down by the end of March, however still 95%. This may have been due to some wards having to close due to infection, but these have all re-opened now.

There has been an average of 310 bed days lost per week in community hospitals due to delays in March. Many of these delays are due to guardianship issues with the courts closed and have been out with our control.

Commentary

Active management of all patients in delay continues with collaborative working across Acute and HSCP services. Covid outbreaks, the recent winter spell, significant care home closures and workforce pressures resulted in a reduced discharge profile over some weeks. The overall delay position shows an improved performance comparing with previous years - this is linked to a focus on HomeFirst, additional capacity within homecare & ICASS, and daily integrated capacity / flow huddles.

H&SCP Placements



Narrative

H&SCP achieved an average of 117% of placements during the 5-week period of March.

ICASS/H@H averaging out at 80% during this period however the demand has not been as high therefore the target could not be achieved.

Commentary

Proactive planning and daily communications across agencies and between HSC and acute has resulted in optimal performance.

ICASS/ H@H performance has been low because there were less referrals and very few waits throughout February and March.

Section B: Performance Summary to Week Ending 28th Feb 2021

Weekly Unscheduled Care Monitoring Report

Area	Indicator	Trend	08-Nov	15-Nov	22-Nov	29-Nov	06-Dec	13-Dec	20-Dec	27-Dec	03-Jan	10-Jan	17-Jan	24-Jan	31-Jan	07-Feb	14-Feb	21-Feb	28-Feb	07-Mar	14-Mar	21-Mar	28-Mar	04-Apr
Urgent Care	Contacts		1775	1810	1883	1743	1913	2209	2234	2262	2805	2481	2048	2019	1950	1921	1758	1883	1977	1958	1797	2058	1938	2802
	% ref to 2ndary Care		5.18%	4.36%	4.41%	6.20%	5.65%	3.80%	3.31%	4.64%	4.81%	4.19%	3.71%	3.62%	4.10%	3.80%	3.64%	4.46%	3.74%	4.03%	4.12%	5.05%	3.87%	6.17%
	Home Visits		133	144	151	137	129	170	145	194	234	184	134	129	110	113	123	124	120	119	112	107	97	158
	OoT Home Visits		26	13	21	27	21	41	39	43	25	45	16	14	10	9	20	9	18	15	26	12	10	27
	COVID Outcome		305	311	324	299	289	304	327	280	410	402	327	322	250	253	189	211	213	186	205	223	212	230
	RUC Outcome						227	435	435	360	409	434	377	365	383	372	398	373	410	412	358	446	428	488
Emergency Department	Attendances		1012	947	922	969	869	949	974	822	987	893	832	760	759	787	843	925	907	944	959	1130	1049	1160
	Performance		91.3%	92.4%	91.8%	89.4%	82.6%	87.0%	85.0%	91.2%	86.6%	84.3%	88.6%	90.1%	90.9%	92.0%	89.3%	85.3%	91.4%	93.9%	87.6%	87.2%	89.0%	86.1%
VHK	Admissions		669	668	669	697	637	685	649	563	629	638	597	603	595	632	568	727	594	658	725	742	694	756
	Emergency		590	588	589	620	559	606	589	520	604	594	543	563	547	582	532	694	549	583	661	669	633	679
	Discharges		645	636	676	650	627	648	659	539	591	603	582	574	582	587	561	672	663	625	631	721	647	719
Theatre Activity	Scheduled		297	247	241	237	258	223	269	112	76	134	121	100	154	131	152	153	200	187	244	233	204	191
	Cancelled		15	18	10	13	16	11	13	7	7	8	3	0	12	1	25	10	5	5	8	11	7	4
	Hospital Cancelled		1	0	1	1	1	1	0	0	3	0	0	0	1	1	0	0	0	0	0	1	1	0
VHK Bed Utilisation	Occupancy		87%	81%	87%	85%	89%	89%	90%	79%	86%	91%	86%	89%	82%	86%	91%	93%	90%	81%	90%	96%	91%	89%
	Amber Wards Occupancy		95.2%	90.2%	95.6%	95.1%	98.3%	103.7%	102.0%	89.3%	99.7%	105.0%	94.8%	101.7%	95.0%	96.6%	99.9%	103.2%	97.3%	91.3%	100.2%	102.9%	97.0%	93.9%
	COVID Bed Days		470	514	419	403	313	283	362	349	388	531	596	584	410	281	250	302	238	160	85	93	85	57
	DD Bed Days		17	1	6	36	21	19	17	18	7	1	2	13	13	8	17	47	11	4	12	23	22	25
HSC Placements	Target		117	115	114	115	114	111	111	111	53	126	131	130	127	121	125	121	124	106	108	106	108	52
	% Completed		102%	85%	85%	97%	102%	97%	109%	76%	119%	87%	104%	95%	92%	79%	84%	114%	102%	118%	86%	125%	119%	135%
	Completed		119	98	97	112	116	108	121	84	63	110	136	123	117	95	105	138	127	125	93	133	129	70
	DSB		40	31	31	42	42	38	45	32	26	42	48	47	43	35	40	41	40	38	24	44	39	23
	SC		28	25	29	30	34	37	33	29	12	29	34	30	39	26	34	41	36	42	39	48	41	26
	ICASS/H@H		27	22	19	19	14	16	26	9	14	17	27	25	16	19	12	31	22	15	16	25	25	0
	Other		24	20	18	21	26	17	17	14	11	22	27	21	19	15	19	25	29	30	14	16	24	21
Community Hospital	Admissions		46	38	38	47	48	45	46	33	32	43	35	40	35	31	41	63	47	47	27	50	45	44
	Discharges		37	44	46	41	38	52	46	37	30	26	42	46	36	24	43	46	43	40	30	63	47	46
	Occupancy		93%	95%	94%	93%	97%	95%	95%	94%	94%	98%	98%	98%	97%	97%	100%	98%	99%	103%	103%	106%	97%	95%
	COVID Bed Days		102	91	89	60	26	78	65	45	51	37	177	315	383	404	336	203	110	94	67	49	37	30
	DD Bed Days		242	269	312	324	414	362	307	269	256	310	365	276	258	257	264	245	293	333	333	321	285	281
	DD Standard		135	143	174	179	254	225	184	132	130	181	214	114	137	133	102	122	157	197	200	177	153	141
	DD Code 9		107	126	138	145	160	137	123	137	126	129	151	162	121	124	162	123	136	136	133	144	132	140

Section C: Winter Plan Monitoring of Actions

Key:	Blue	Complete
	Green	On Track as expected
	Amber	Work ongoing, but slippage (with no concerns about impact on Winter Planning)
	Red	Work ongoing, but concerns about impact on Winter Planning

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.1.1	Scheduling of Unscheduled Care – creation of an integrated flow and navigation centre to triage, assess and manage unscheduled care	Nov-20	DOA DOHSC		DCOO GM EC	DGM West				Integrated flow and navigation hub soft launched on 1st December. Continuous monitoring of impact and pathway effectiveness underway, but there are significant medical staffing demands associated with the model.	Flow and navigation is now fully implemented in Fife. All calls from 111 are being directed to the hub. At present there is a test of change to consider whether all 4-hour ED pathway presentations should directly be managed within ED. This is due to be evaluated by the end of April. Fife is committed to working system wide to ensure that the right model for Fife is realised and will ensure that people are seen timely by the right person in the right place. Data is demonstrating the number of scheduled attendances at ED is increasing steadily and redirections to MIU's are also increasing. This is in line with the aim of scheduling unscheduled care.
4.1.2	Implement Home First Model - more timely discharges & realistic home-based assessments	Sept-21	DOHSC			DGM West				Short like working group established and critical appraisal be undertaken to look at pinch points in the system to inform a home first model by winter 2021. Delayed due to having to utilise all discharge options to cope with demand and enhance flow as a result of covid. Timescale changed to June 2021 and then further changed to September 2021	Home first strategy group reinstated. Home to assess model being worked through.
4.1.3	Scale up direct entry to STAR units from community MDT's	Nov-20	DOHSC			DGM West				Link social workers from STAR support locality MDT's. Early discussions ongoing regards the pathway.	Access to STAR from community settings now being progressed due to the success of the model.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.1.4	Restructure of medical assessment and admissions	Apr-21	DOA		GM EC					The COVID 19 red pathway for admission will limit any changes that can be made to patient pathway and flow in the short term. Completion date changed to April 2021	covid red pathway remains in place within Acute Division from admission to discharge to ensure safe patient care and optimise flow.
4.1.5	Process re the use of Near Me for Unscheduled Care	May-21	DOA		DCOO					Use of digital technologies, including Near Me, in place for virtual assessment	Under Redesign of Urgent Care (RUC) virtual appointments, including using Near Me, are a vital component of the revised pathway. Initial triage is through NHS 24, before appropriate referral to ED virtual assessment.
4.1.6	Right Care – Right Place campaign to increase awareness of alternatives to the Emergency Department for minor, non-urgent illnesses and injuries and encourage local people to make use of local services	Mar-21	DON	Comms						Soft launched locally 1 December using national campaign assets. NHS Fife website updated, main banner promotion and regular social media posts. Media release and interview with Medical Director for local radio, prior to Christmas. Main national campaign will commence in January 2021 Staff Link Hub to support UC redesign created and working on the creation of a Ref Help section by end of December. Continues until 31 March 2021 in line with SG guidance and national public communications campaigns	The impact of the national campaign has been minimal, this was due in part to the soft launch of the initiative and the communications channels chosen to promote this service change to the general public. The benefit of the soft launch did help to refine campaign messages and ensured that the new service locally and at NHS24 was not overwhelmed with calls over Christmas & New Year and Easter. The SG are now looking to extend the Right Care, Right Place campaign to national TV, Radio and Billboard advertising and are in discussion with CEO around the timing of the next phase of this campaign. NHS Fife will continue to use the national campaign assets and personalise them for our local need, we will also continue to adhere to the national campaign scheduling and channels to ensure that we compliment and not confuse national and local messaging with the general public.
4.1.7	Ensure national winter campaigns, key messages and services (including NHS 24 and NHS Inform) are promoted effectively across Fife and supported by relevant local information and advice	Mar-21	DON	Comms						Show you care prepare national campaign started on 4 December and NHS Fife communications supporting national messages and campaign, winter section updated on website and local comms via Social media, Staff Link and local media. Continues until 31 March 2021 in line with SG guidance and national public communications campaigns	NHS Fife adopted national campaign material and assets to remote winter preparedness via our own local and established communications channel. I think the refreshed campaign was well received and captured the mood of the nation on the back of the clap for carers weekly event. However, this will undoubtably mean that the national campaign messages and proposition will need to be re-worked for this coming winter and nationally they may take the decision to revisit the popular

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
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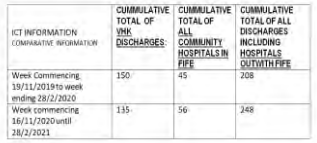
											"Mr Owl" animation. NHS24 who run the campaign will be sharing the campaign evaluation with NHS Strategic Comms leads in late April.
4.1.8	New model of care for Respiratory Pathway	Nov-20	DOA DOHSC		GM EC	DGM West				A new nurse led advice line for respiratory patients that screens all referrals on the same day (GP and high health gains). This prevents deterioration and unnecessary admission. New pathway directly into hospital at home for direct step up. Another pathway has been developed for palliative care patients.	Nurse advice line in situ. This advice line is open to both patients, their carers and professionals. This has proved beneficial to both. Patients can be visited or advised to prevent admission or crisis and professionals can discuss patients and likewise prevent admission and improve patient and professional support. There has also been communications set up with Ninewells colleagues to allow a referral pathway from our Tayside colleagues ensuring that all respiratory patients in Fife have an equitable service. There are potential improvements to be made from developing a communication between AU1 and the community respiratory team and widening awareness in GP Practices. The recent data suggests that telephone calls to this advice line are on average 150 calls per week. The Hospital @ Home pathway is currently under review and on track given the current staffing situation. Plan to have this completed and implemented by the end of April 2021. Pathway for palliative care patients is in use and extremely beneficial. Patients have been able to be cared for at home who otherwise would have been admitted. This joint working approach has been to both the benefit of patients, carers and the health care professionals involved. Improvements to this would benefit from capturing the data and embedding this in everyday practice. Plan to develop questionnaire to capture patient experiences.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.1.9	Ensure adequate Community Hospital capacity is available supported by community hospital and intermediate care redesign	Oct-20	DOHSC			DGM West				community hospital capacity monitored daily. Surge areas have been identified and utilised as per winter plan.	Community Hospitals continue to be monitored daily. Winter plan will cease on 31st March.
4.1.10	Review capacity planning ICASS, Homecare and Social Care resources throughout winter including 7-day access to H@H	Oct-20	DOHSC			DGM West				Capacity reviewed daily and additional recruitment underway to increase further ICAS & H@H capacity to support increased in demand.	ICT have taken a number of Discharges from 16th November 2020 until 28th February 2021. Total Discharges 248 of which 135 were for VHK and facilitated 56 discharges from within Community Hospitals in Fife.  ICT INFORMATION COMPARATIVE INFORMATION / CUMMULATIVE TOTAL OF VHK DISCHARGES: / CUMMULATIVE TOTAL OF ALL COMMUNITY HOSPITALS IN FIFE / CUMMULATIVE TOTAL OF ALL DISCHARGES INCLUDING HOSPITALS OUTWITH FIFE Week Commencing 19/11/2019to week ending 28/2/2020: 150 / 45 / 208 Week commencing 16/11/2020until 28/2/2021: 135 / 56 / 248 Hospital at Home - Total for Fife - 23rd November 2020 to 28th February 2021 GP Admissions total of 265 104 Step-downs accepted totalling 369.
4.1.11	Focus on prevention of admission with further developments into High Health Gain, locality huddles to look at alternatives to GP admissions	Oct-20	DOHSC			DGM West				Eight locality huddles in operation. Prevention of admission continues at 35% and data indicates a net reduction in admissions for VHK. Data to be interrogated further. Frailty model embedded and frailty practitioner now in post.	8 locality MDTs are established within the respective localities. Direct referrals from GP's demonstrating integration of health & social care working. Improved outcomes for patients/clients. Increased referrals to Complex Care team for frailty 69%. Increased capacity due to Frailty Practitioner in post. Division of Complex Care team to allow focus on Frailty. Long Term funding has been secured. (Frailty) Seeking patients views and measuring HHG intervention (Frailty). Advice line numbers averaging 92.6 per week (Frailty)
4.1.12	Continue to Test change to reconfigure STAR bed pathway	Nov-20	DOHSC			DGM West				Stroke pathway has been developed. Small TOC completed.	Prior to Covid the STAR bed was being used successfully by Letham Ward at Cameron Hospital for patients who needed further therapist input

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
										Scaled up.	prior to discharge home. Since Covid began the bed has not been in use.
4.1.13	Weekly senior winter monitoring meeting to review winter planning metrics and take corrective action	Oct-20	DOA DOHSC	AD P&P	DCOO GMs	DGM West				Daily senior meeting in place to review daily metrics and corrective action taken in real time.	Useful information which allows for planning and action in real time.
4.2.1	Implementation of a sustainable 7-day OT and PT service for acute being progressed through the Integrated Capacity and Flow Group- invest to save to support effective patient flow and address de-conditioning.	Dec-20	DOA		GM WCCS		1.6 Band 6 PT 1.0 Band 5 OT 1.8 Band 4 HCSW 1 Band 4 HCSW	£72.5k		1.0 Band 5 PT and 0.5 OT in place to support Monday - Saturday Service. Sunday currently staffed by volunteers. No plans for further recruitment this winter but early planning for winter 2021/22	Positive impact on patient flow but reliant on staff good will. A stable, sustainable and fully resourced service will need to be in place for winter 21/22
4.2.2	Paediatric nurse staff levels currently being reviewed. The increased activity associated with winter combined with the requirement for managing Covid-19 pathways will require additional staff to ensure safe staffing levels	Oct-20	DOA		GM WCCS		13.3 band 5 3 band 3			Funding for 8WTE agreed. 8 additional staff to be recruited. Remainder to be subject of a business case in Q3 if still required	Additional staff not yet in place but recruitment is progressing. Staff good will has ensured patient safety
4.2.3	Implement flexible staffing models to utilise resources accordingly – managed by tactical workforce group, chaired by Associate Director of Nursing	Nov-20	DON		DCOO	DGM West				The workforce hub has been re-instated the partnership	The HSCP Workforce Mobilisation Hub (WMH) was re-established in October 2020. A Care Home Hub was established alongside the WMH and a Head of Nursing post was appointed to in December, to provide clinical leadership and management to both of these Hubs and to ensure safe staffing across the HSCP and Care Homes within Fife. The WMH collates and coordinate staffing information from across all Community Health Services and the Care Homes to ensure services have sufficient workforce and to provide assurance to the board Nurse Director, all areas are able to deliver safe, effective and patient centred care in line with the organisational priorities.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
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4.2.4	Ensure NHS Fife staff are kept informed about preparations for winter including arrangements for staff flu vaccinations, local service arrangements and advice for patients	Nov-20	DON	Comms						Flu section on NHS Fife website and Staff Link Hub, lead from the Front Staff Flu Vaccination Campaign instigated. Winter hub live on NHS Fife website Regular updates on Staff Link and weekly CE update throughout December, January and February	Good staff engagement and interaction with flu vaccination on website, staff link and regular CE weekly updates. The lead from the front campaign proposition had a good response from staff and allowed them to take ownership of the campaign. The dedicated Web page received over 11,000 visits from go live on 1st October to date.
4.2.5	Occupational Health medical and nursing support was increased temporarily to support the pandemic efforts, funding has been secured to recruit to these posts on a substantive basis	Nov-20	DOW	Workforce						Complete	While Recruitment has been completed, new staff will not take up post until later this year, it is anticipated that the additional resources will support ongoing COVID-19 activity and help to sustain OH services for the future and in anticipation of long term support requirements for staff.
4.2.6	Staff health and wellbeing signposting resources were provided from April 2020 and an expanded Staff Listening Service, (accessible to Health, H&SC Partnership, and care home staff), available from April 2020 to 31 March 2021	Nov-20	DOW / DON	Workforce/ Nursing						Expanded listening service in place until 31/03/2021.	The Department of Spiritual Care has provided essential support to staff throughout COVID-19. Over the past 12 months, the Department have supported over 3,000 contacts with health and social care staff. The intention of the Listening Service is to provide an easily accessible and confidential space for staff to talk about their experiences in a safe way and has provided 237 1:1 session's. The current staff support provision has been met from current staffing levels – however as wider services a remobilised, the Department will not have capacity to meet current levels of service from current resources.
4.2.7	Mental Health Occupational Health nursing input in place for staff support from August 2020	Aug-20	DOW	Workforce						Completed	This post is now funded on a substantive basis, with initial feedback being that the additional MH OH support for staff has been well received. Outcomes are being monitored and feedback provided via OH Head of Service at regular intervals. Any impact on MH related reasons for absence will also be checked.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.2.8	Agree Flow & Navigation Care workforce levels and secure staffing as early as possible. All rotas in place to ensure public can access OOH across the winter period	Oct-20	DOHSC			DGM West				Recruitment commenced for key posts. Contingency plans in place. Hub has been sufficiently staffed since go live date. Weekly recording commenced. Key posts all recruited to or in the process of being recruited to.	Current interim model is staffed applying MDT approach within hub including A&C staff, nursing and paramedics with medical and nursing staff available virtually within ED/MIU aspect of flow. Modelling work still being progressed and tested.
4.2.9	Create and enact a workforce plan to staff surge capacity taking into account Fife Council Christmas shut down	Oct-20	DOHSC		DCOO GMs	DGM West				Workforce hub reinstated which will be open over Christmas and new year. Social work staff involvement. Senior rota in place to cover out of hours.	Flow over Christmas and new year was optimal.
4.3.1	Whole System Pathway Modelling – development & implementation of capacity tool	Nov-20	DOA		GM EC	DGM West				Capacity tool complete. Daily meetings to proactively determine red flags and take corrective actions to maximise flow.	Daily meetings well established with proactive planning in place.
4.3.2	Daily Dynamic discharge and EDD to be embedded in all wards	Nov-20	DOA		GM EC	DGM West				EDD embedded.	Work ongoing around EDD's to ensure they reflect patient discharge planning and wards are keeping them up to date using real time data
4.3.3	Plan for Surge Capacity (including Community Hospitals, Care Home, Home care ICASS & H@H)	Oct-20	DOA DOHSC		DCOO	DGM West	See App2	Acute HSC		Surge plan complete across Acute and HSCP. Command structures in place for escalation. Daily surge meetings to assess capacity utilising real time intelligence.	Surge beds used as per escalation plan throughout winter.
4.4.1	Implementation of rapid diagnostic outpatient appointments for inpatients to ensure that no inpatient discharges are delayed whilst waiting on diagnostics	Oct-20	DOA		GM WCCS					Complete in Radiology	Positive impact on patient flow but has been under-utilised. This will be improved for winter 21/22
4.4.2	OPAT expansion to release bed capacity	Oct-20	DOA		GM EC					Unit working at full capacity for the staffing model and successfully delivering on bed day savings.	OPAT continues to evolve. SLWG set up to make further improvements and connect with community teams to deliver further on in patient bed days.
4.4.3	Configure SSSU as amber Unit to support peaks in Orthopaedic Trauma demand	Sep-20	DOA		GM PC					SSSU open Mon-Fri to Support Trauma/Emergency Surgery	SSSU remains open. This has a huge benefit as it not only allows us to accommodate the elective program but also allows ward 52 to maintain a Green/Amber split as we need to maintain a high number of amber beds and ward 52 staff have the skill mix to look after complex surgical patients.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
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4.4.4	In line with SG guidance, configure green elective areas and pathways within DIU, Ward 52 and Day Unit (within QMH) to maintain elective activity over winter	Sep-20	DOA		GM PC					Ward 52 now includes 4 SHDU beds	Green SHDU beds have moved back into critical care and are no longer located within ward 52. This is de-escalation as planned as there are currently no positive covid patients within critical care now.
4.4.5	Set-up weekly theatre meetings to review theatres lists 3 weeks in advance, including full review of patients waiting by clinical priority to determine list allocation to be escalated to Clinical Prioritisation Group	Sep-20	DOA		GM PC					Weekly meetings take place every Monday chaired by the PCD Clinical Directors	The weekly clinical prioritisation meetings continue and are allowing us to ensure that patients with the highest level of urgency are prioritised through the elective program. Hope this helps
4.5.1	Corporate Business Continuity Plan has been reviewed by the NHS Fife Resilience Forum	Aug-20	DPH	Business Continuity						The Plan was submitted and accepted by the NHS Fife Resilience Forum and EDG	Plan in place
4.5.2	Corporate Business Continuity Policy has been reviewed by the NHS Fife Resilience Forum	Aug-20	DPH	Business Continuity						The Plan was submitted and accepted by the NHS Fife Resilience Forum and EDG	Plan in place
4.5.3	Business Continuity templates to be updated, re-issued to all departments and returned	Oct-20	DPH	Business Continuity	DCOO	DGM West				All business continuity plans updated using new template across all of the HSCP and Acute Services Division.	winter and business continuity ensured that every service was safe to start over winter months.
4.5.4	Ensure severe weather communications plan is in place and provided to NHS Fife Resilience Forum and EDG	Oct-20	DON	Comms						Adverse weather communications plan reviewed and shared with LRP and Fife Council Comms	Well received by all parties, clear actions and opportunities for continued collaboration across all parties to ensure timely and consistent weather updates, advice and if appropriate actions to be taken.
4.5.5	Local Resilience Partnership to hold a workshop to look at how Fife would manage events/incidents over winter including Covid-19, season flu, winter weather and EU-exit	Nov-20	DPH	Public Health						First workshop held on the 18th November further workshop being planned Complete	Workshop took place and provided other Fife Agencies with an insight into issues and problems other agencies were likely to experience

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.6.1	Point of Care Testing (POCT) in A&E and Admissions Unit	Dec-20	DOA		DCOO			Funded separately		POCT commenced mid-December 2020 - successfully implemented and monitored by Laboratory managers	POCT for COVID-19 is now embedded Business as Usual (BAU) for all red admissions to ED/AU1 and all Amber GP referrals (both medical and surgical) into AU2. This has significantly reduced any IPCT disturbance from incorrectly placed patients by identifying any asymptomatic COVID +ve patients much earlier and allowing for early intervention from front door teams. It has also ensured known COVID status for the majority of patients prior to movement to downstream wards within Acute.
4.6.2	Define and agree paediatric COVID pathways to stratify patient flow based on clinical urgency and IPC measures	Dec-20	DOA		GM WCCS					Complete	Positive impact on patient flow. Clear escalation plans have enabled good decision-making.
4.6.3	Package of education/training to support best practice in IPC in NHS Fife acute & community settings	Oct-20		IPCT						Complete	Due to COVID-19 restrictions on unnecessary travel and with best practice to consider new ways of working and technologies such as virtual meetings to ensure a COVID-19 safe working environment. The IPCT have been promoting a blended learning approach for winter preparedness education and training. IPCNs have collaborated on several new training presentations on topics relevant to staff that are normally covered in education sessions, including outbreaks and terminal cleans. The presentations have been recorded with a voice over, available on Blink and can be accessed by all NHS Fife staff IPCT have also advertised training sessions that have been hosted via Microsoft Teams and open to all staff across NHS Fife to access. These sessions have been advertised weekly via Staff 'Blink' app and have links for each session allowing staff a choice of dates and times to book. These

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					sessions include a presentation delivered by an IPCN, who is available for questions and answers session following the presentation providing the attendees the opportunity to clarify any points raised or ask about best practice in their area of practice. From October to date, there have been 27 sessions held with a further 3 planned. The IPCT continue to offer telephone support and ward based support, including real time feedback to HCWs in their clinical environment promoting best practice and improving patient, staff and visitor safety. Bespoke training available on request and facilitated in line with COVID secure guidance. The IPCT have also promoted the national training resources as per NHS Education for Scotland (NES) and Health protection Scotland (HPS) such as guidance posters, training videos and presentations as well as eLearning via TURAS Learn. With this blended learning approach to winter preparedness training and education the IPCT aimed to provide a variety of different learning formats for all NHS Fife staff to support best practice.
4.7.1	Deliver the staff vaccination programme to health and frontline social care staff (NHS, Fife HSCP, independent and third sector) through peer vaccinator programme, occupational health clinics, care-home based and pharmacy delivery in order to achieve 60% national target and	Dec-20	DOHSC			DGM West				Flu staff vaccination programme complete. Target achieved.	There many valuable learnings from the planning and execution of the 2020/21 flu vaccination programme, which were documented into actions. The lessons learned and actions were used for the COVID Vaccination Programme and will be carried forward for future flu programmes.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
	65% local target for uptake										
4.7.2	Implement actions required for staff and community seasonal flu vaccination delivery under the Joint Fife HSCP & NHS Fife Flu Silver Group	Dec-20	DOHSC			DGM West				As above	As above
4.7.3	Ensure data collection methods enable weekly monitoring of flu vaccination uptake	Oct-20	DOHSC			DGM West				Monitoring and uptake rates collected.	We learned that data collection methods were not real-time, manual and time consuming. The outcome of which has been a real-time Vaccination Management Tool offering real-time monitoring or progress and uptake along with vaccination recording for the patient record.
4.7.4	Raise awareness of the flu campaign and encourage health and care staff and key workers in the public sector to take up the offer of a free flu vaccination and lead by example	Feb-21	DOHSC	Comms						Lead from the Front Staff Campaign and assets shared with HSCP and Fife Council campaign to end mid-December in line with roll-out of C19 vaccine	See 4.2.4 outcome
4.8.1	Produce plan for possible second Covid-19 wave in Acute and H&SC	Oct-20	DOA DOHSC		DCOO	DGM West				Escalation plan produced across Acute and HSCP Acute Second wave plan is completed, Critical care escalation commenced. Acute Second wave plan is completed, Critical care escalation commenced.	No outcome
4.8.2	Refer to Business Continuity plans in event of resurgence in Covid-19 cases	Oct-20	DOA DOHSC		DCOO	DGM West				Business continuity plans and impact analysis in place for all HSCP services and Acute Services	No outcome
4.8.3	Engage in regular review of care homes in collaboration with the HSCP	Oct-20	DPH	Public Health						Care Home Oversight Group established that meets regularly Complete	The Care Home Oversight Group meeting regularly identified potential issues early and helped enhance the relationship with the Care Homes and their staff and improved our

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
											understanding of the issues Care Homes were having day to day
4.8.4	Support weekly asymptomatic staff Covid-19 testing in care homes	Oct-20	DPH	Public Health						Complete	Positive impact in establishing a relationship with Care Home staff
4.8.5	Support symptomatic residents Covid-19 testing in care homes, and flu testing where there is a suspected outbreak	Oct-20	DPH	Public Health						Complete	Positive impact in establishing a relationship with Care Home staff
4.8.6	Carry out resident Covid-19 surveillance testing on a care homes in Fife	Oct-20	DPH	Public Health						Complete	Positive impact in establishing a relationship with Care Home staff
4.8.7	Increase capacity and skills with Health Protection Team for outbreak management for care homes in Fife	Nov-20	DPH	Public Health				Funded Separately		Complete	Additional staff in place and the capacity and skills of the Health Protection Team enhanced in dealing with outbreaks in Care Homes
4.8.8	Increase and sustain capacity to undertake all contact tracing requirements for Fife residents as part of the National Contact Tracing Test and Protect Programme.	Nov-20	DPH	Public Health						Complete	Additional staff recruited and still ongoing allowing the Test and Protect Programme to be fully implemented and it is still working very successfully
4.8.9	Maintain surge capacity to manage abrupt changes in incidence of Fife Covid-19 positive cases throughout the winter months	Oct-20	DPH	Public Health						Complete	Surge Capacity successfully maintained with additional staffing and amazing input by all of the Public Health Dept
4.8.10	Develop action plans for outbreak prevention and management of high-vulnerability settings and events. The aim of identifying these settings is to minimise the outbreak risks.	Feb-21	DPH	Public Health						On Track as expected, but to enable better identification of areas in which the virus is suspected to be high a number of asymptomatic community testing stations are being set up in a number of areas in Fife so to better identify these sites to try and minimise the number of outbreaks in the community. The first of these	Community Testing Sites (both symptomatic and asymptomatic) are up and running with action plans in place to minimise the outbreak risks in these settings

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
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										sites is expected to start operating wc 01/02/21 with a soft launch. Completion date changed to February 2021	
4.8.11	Promote local and national messages associated with COVID-19 and Test and Protect	Mar-21	DPH	Comms						a range of local campaigns have been activated via LRP Public Comms Group , these are also in line with National Campaign material and messages and have included a range of strands and themes identified by PH or community feedback, such as Car Sharing , 2 meters is, when to get tested, Self-Isolating and support. Will be ongoing throughout 2021 in line with SG guidance and national public communications campaigns	On-going work at national and local level to respond to the changes in response to the global pandemic beyond the specific winter messages and challenges.
4.8.12	Review of outbreak management guidance in line with latest national guidance	Oct-20	DON	IPCT						Complete	Health Protection Scotland (HPS) confirmed for winter illnesses such as Norovirus and influenza there was no change in guidance for winter 2020/21 from previous guidance, thus NHS Fife outbreak guidance for these conditions and outbreaks remains extant. For COVID-19, guidance has evolved and developed through the pandemic and on growing evidence base. NHS Fife IPCT follow the mandated NIPCM chapter 3 – Healthcare Infection Incidents, Outbreaks and data Exceedance. To support the early recognition of potential infection incidents and to guide the incident management process within healthcare settings. An early and effective response to an actual or potential healthcare incident, outbreak or data exceedance has been crucial to reduce the risk of onward transmission.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress	Outcome
				Corp	Acute	H&SC					
4.8.13	Local delivery framework for COVID-19 immunisation to be developed and implemented using outputs of national work	Apr-21	DOP	Pharmacy		DGM West				1)>32k people vaccinated as at 1 February. Care home staff and residents first doses complete. HSC staff first doses close to completion. Over 80s first doses should be complete by 4th Feb. 2) 13 Community clinics opening between 1st and 8th February with goal of vaccination cohorts 4, 5 and 6 by mid-March. Recruitment is ongoing 3) Plan for vaccination of eligible long stay in patients begins w/c 1st February. Housebound population also being vaccinated from this date 4) NHS Fife has engaged with national scheduling approach	The COVID vaccination programme in Fife continues to be successfully delivered. The Board has met Scottish Government direction and targets and continues to develop the workforce and structures towards a sustainable and substantive model. Ultimately the programme has been successful in vaccinating the population and driving down COVID infections. A full lessons learned review will be undertaken in due course
4.8.14	PMO to be established for COVID-19 immunisation programme and required workforce to be recruited for the next 12 months which encompasses the different delivery models required at each stage of the plan	Apr-21	DOP	Pharmacy		DGM West				PMO is established. Supporting governance in place and agreed 1) Risk register in place and monitoring ongoing. Currently 38 recorded risks - the profile is these is reducing in severity as delivery commences 2) EQIA has been approved and published 3) Command structure, including Silver command, 3x bronze commands and PMO shown to be effective 4) Close working relationships in place with comms and patient relations teams. Weekly comms bulletins are circulated to all staff Date revised to April 2021	The PMO has supported the governance of the programme and will continue to provide this function for the immediate future, while engaging with relevant areas of the organisation to operationalise ongoing requirements. Key governance items, including EQIA, risk management and reporting have been successfully delivered ensuring the Board meets its obligations A full lessons learned review will be undertaken in due course

Final Report for ICC on 14th April 2021
(Validated Data up to 28th February 2021)

Section 1– Board Wide Issues
Key Healthcare Associated Infection Headlines up to 02 December 2020

1. Achievements:

The IPCT are happy to be welcoming 3 new trainee IPCNs who joined the team in February 2021.

NHS Fife IPCT are supporting a research project "The experience of isolation for infection control in hospital: a qualitative exploration of the patient and family perspective." The aim of this study is to explore, to understand the patients' experiences and their close family members' perceptions of being cared for in isolation for IPC when infected or colonised by antimicrobial resistant organisms i.e. when contact precautions are in place. NHS Fife is 1 of 4 Scottish Boards participating in this research.

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

Annual rates ending Dec 2020 showed a **DECREASE** from Dec 2019.
NHS Fife is on track to achieve the 10% reduction in Healthcare associated SAB by 2021/22 (using 2018/19 as the base year).
During 2020, there were no MRSA bacteraemias. This is the first year on record for NHS Fife.

There has now been a marked reduction in PWID SABs in 2020 and Fife is now **BELOW** the national rate for PWID SABs:

***Clostridioides difficile* Infection (CDI)**

For Q3 2020, Fife was **BELOW** the Scottish Rate for **HCAI & CAI** CDIs.
There was **REDUCTION** in the number of CDI cases in 2020, compared with 2019.

1.1 Challenges:

4th of November 2020
The ICM escalated to the HAI Executive that there is currently a substantial increase in workload and demand on the IPCT due to the COVID-19 pandemic response. The IPCT (draft) Business continuity plans are required to be introduced to prioritise the COVID-19 response as an interim measure. Additional resources are required to support the care home sector.

Workforce continues to be challenging, with 2 IPCNs have now left our service to follow different career pathways. The IPCT have also been unsuccessful in recruiting to the substantive post of Lead IPCN in 2020 and most recently in 2021. As a result the IPCT workforce has been added to the risk register.

However there is a recruitment drive to full fill current vacancies and to recruit to new posts created to support care homes currently in progress.

SABs

- Vascular access devices (VAD) remain the greatest challenge for Hospital acquired SABs, ongoing improvement works.

ECBs

- Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the 2 areas to address to reduce the ECB rate.

CDI

- Whilst Fife's CDI rates are well below the national rates, the HCAI incidence must still reduce further to meet the HCAI reduction target.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

- National surveillance programme for SSI 2020 has been paused due to the COVID-19 pandemic.

COVID-19 pandemic

As the prevalence of COVID-19 reduces across Scotland in 2021, the IPCT shall support the safe remobilization of services.

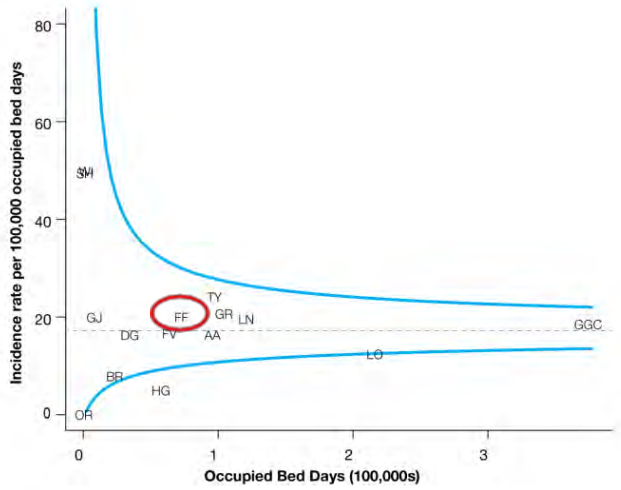
- The IPCT shall undertake patient contact tracing in the hospital environment for patients and support Occupational Health where necessary with HCWs
- The IPCT shall support clinical teams with outbreak management in NHS Fife, Problem Assessment Groups (PAGs) and Incident Management Teams (IMTs) meeting to be held for NHS Fife outbreaks and reported to Health Protection Scotland accordingly, requesting support as required.
- Providing a programme of education and training
- Supporting the vaccination programme- Bronze logistics group
- Membership of the following local NHS Fife groups: HCT, STAC, LRP and Remobilisation
- NHS Fife IPCT representatives at the weekly national meeting with HPS/ARHAI Scotland

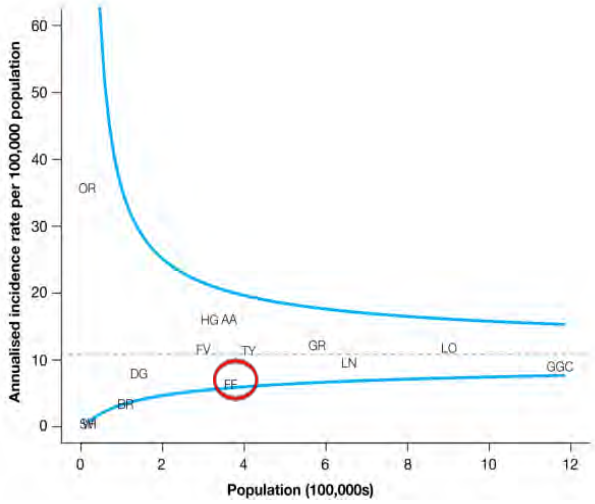
2. ***Staphylococcus aureus*** **incorporating MRSA/CPE screening compliance**

2.1 Trends – Quarterly

***Staphylococcus aureus* Bacteraemias (SABs)**				
Local Data: Q4 Oct-Dec 2020 (Q4 2020 HPS National comparison awaited)				
In Q4 2020 NHS Fife had:	27 SABs	16 HCAI/HAI 11 CAI	This is UP from	20 Cases in Q3 2020

Q3 2020 (July-Sept) - HPS Validated data with commentary			
Healthcare associated SABs		Community associated SABs infection	
HCAI SAB rate: **20.0**	**Per 100,000 bed days**	CAI SABs rate: **6.4**	Per 100,000 Pop
No of HCAI SABs: 15		No of CAI SABs: 6	
This is **ABOVE** National rate of 17.3		This is **BELOW** National rate of 10.8	





For HCAI & CAI SABs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline)		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2022**
SAB by rate 100,000 Total bed days	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**
Current 12 Monthly HCAI SAB rates for Year ending Sept 2020 (HPS)		
SAB by rate 100,000 Total bed days	**12.6** per 100,000 TBDs	
SAB by Number of HCAI cases	**40**	

Local Device related SAB surveillance

- There were 2 SABs in ICU in January 2021, both of which were ventilator (for Covid management) associated pneumonia, ongoing surveillance
- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- Unfortunately, the Renal Unit had a dialysis line related SAB in January 2021. The IPCT will continue to support the renal staff around VAD care and provide ongoing surveillance.

As of **16/03/2021** the number of days since the last confirmed SAB is as follows:	
CVC SABs	371 Days
PWID (IVDU)	21 Days
Renal Services Dialysis Line SABs	50 Days

Acute services PVC (Peripheral venous cannula) SABs	202 Days

Please see other SAB graphs & report attachments within 4.1b of Agenda

2.2 Current SAB Initiatives

Fife-wide Collaborative Improvement Initiatives: NHS Fife will continue to:

- Collect and analyse SAB data on a monthly basis to understand the magnitude of the risks to patients in Fife.
- Provide timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs where possible.
- Examine the impact of interventions targeted at reducing SABs.
- Use results locally for prioritising resources.
- Use data to inform clinical practice improvements thereby improving the quality of patient care.
- Liaise with Drug addiction services re PWID (IVDU) SABs. Last meeting 25/3/21 – Discussed significant reduction in SABs numbers during 2020. The consensus was that it was multifactorial; 2020 saw a 40% drop in attendees through Addictions, there was a 200% increase in foil smoking and a significant increase in hand gel and soap being given out.

2.3 National MRSA & CPE screening programme

MRSA

An uptake of 90% with application of the MRSA Clinical Risk Assessment (CRA) screening is necessary in order to ensure that the national policy for MRSA screening is effective

NHS Fife achieved **95%** compliance with the **MRSA** CRA in Q1 (Jan-Mar) 2021

This was **DOWN** on Q4 2020 (98%) & **ABOVE** the compliance target of 90%.

This National Scottish average for Q1 2021 is still to be published.

MRSA Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	Q1 2019 Jan-Mar	Q2 2019 Apr- June	Q3 2019 Jul-Sept	Q4 2019 Oct-Dec	Q1 2020 Jan-Mar	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar
Fife	88%	93%	93%	93%	83%	98%	88%	98%	95%
Scotland	83%	89%	88%	88%	87%	84%	86%	82%	n/k

CPE (Carbapenemase Producing Enterobacteriaceae)

From April 2018, CRA has also included screening for CPE.

NHS Fife achieved **88%** compliance with the **CPE** CRA for Q1 2021 (Jan-Mar)

This is **DOWN** from 98% in Q4 2020

The National Scottish average for Q1 2021 is still to be published.

Quarter	Q1 2019 Jan-Mar	Q2 2019 Apr- June	Q3 2019 Jul-Sept	Q4 2019 Oct-Dec	Q1 2020 Jan-Mar	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar
Fife	73%	75%	83%	80%*	93%	95%	85%	98%	88%
Scotland	81%	86%	86%	85%	85%	80%	85%	79%	n/k

CPE CRA screening KPI compliance Summary- Commenced from April 2018

MDRO CRA Patientrack Update

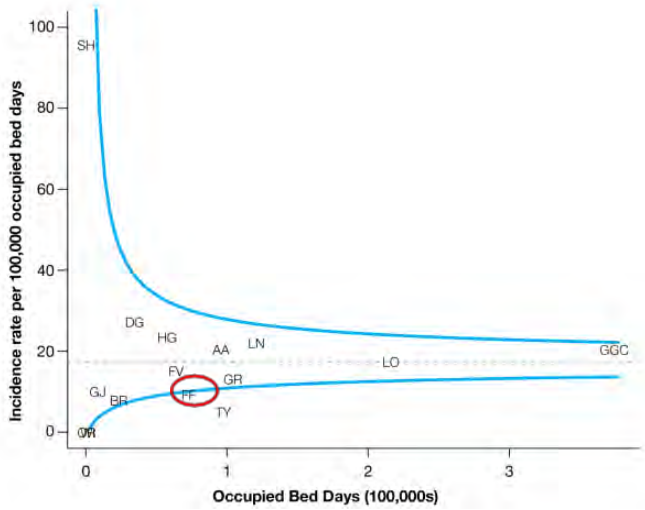
- Patientrack have now added the CPE and MRSA assessments onto a test environments.
- Ongoing quality assurance will continue in 2021 before being rolled out to wards

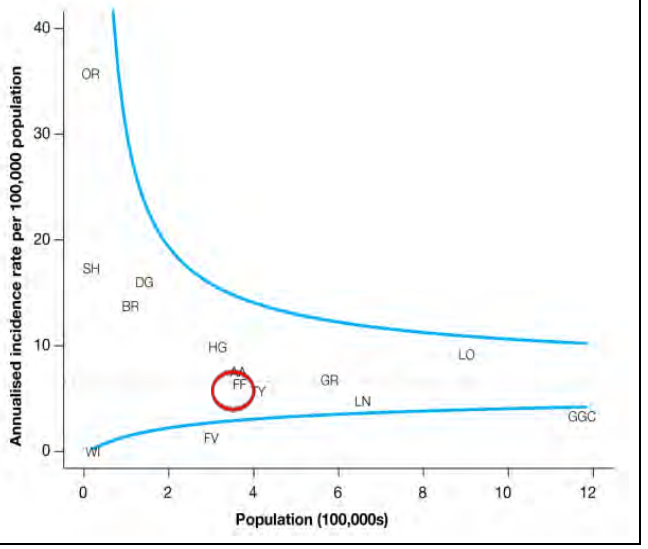
- *3* *Clostridioides difficile* Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dec 2020 (Q4 2020 HPS National comparison awaited)				
In Q4 2020 NHS Fife had:	7 CDIs	5 HCAI/HAI/Unknown 2 CAI	This was **DOWN** from	13 Cases in Q3 2020

Q3 2020 (July-Sept)			
With HPS Quarterly epidemiological data Commentary *Please note for HPS reporting- the CDI denominator may vary from locally reported denominators. This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards.			
NHS Fife is well **WITHIN** the 95% confidence interval when compared to NHS Scotland Q3 2020			
Healthcare associated CDIs		Community associated CDIs infection	
HCAI CDI rate: **9.3**	**Per 100,000 bed days**	CAI CDIs rate: **6.4**	Per 100,000 Pop
No of HCAI CDIs: 7		No of CAI CDIs: 6	
This is **BELOW** National rate of 17.4		This is **BELOW** National rate of 6.6	





New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline)		
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2022**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**
Current 12 Monthly HCAI CDI rates for Year ending September 2020 (HPS)		
CDI by rate 100,000 Total bed days	**9.8** per 100,000 TBDs	
CDI by Number of HCAI cases	**31**	

3.2 Current CDI initiatives

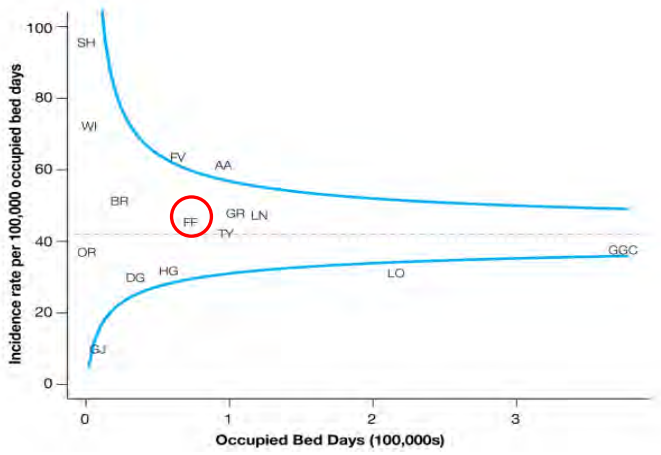
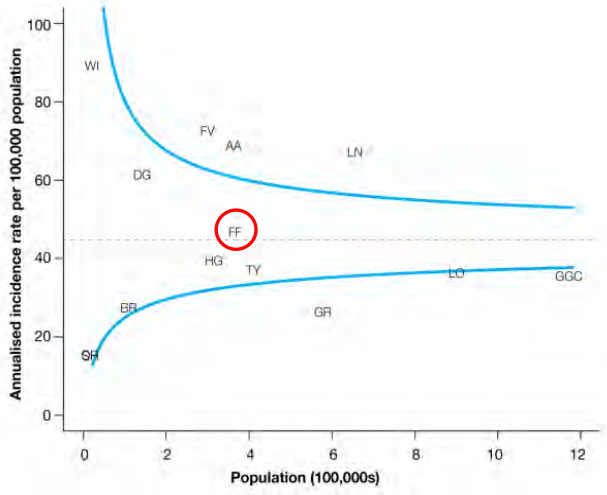
Follow up of all hospital and community cases continues to establish risk factors for CDI

- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- In 2021 innovative work will be focused on our patients with recurrent CDI.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Bezlotoxumab for recurrent CDI currently used in Fife.

4.0 *Escherichia coli* Bacteraemias (ECB)

4.1 Trends:

***Escherichia coli* Bacteraemias (ECB)**				
Local Data: Q4 Oct-Dec 2020 (Q4 2020 HPS National comparison awaited)				
In Q4 2020 NHS Fife had:	63 ECBs	40 HAI/HCAIs 23 CAIs	This is **DOWN** from	69 Cases in Q3 2020
Q4 2020 There were 8 Urinary catheter associated ECBs. (3 x HAI & 5 x HCAI) The 3 hospital CAUTIs are at VHK 22, Glenrothes 1 & Balcurvie wards There have been **NO** CAUTIs associated with trauma in Q4 2020.				

Q3 2020 (July-September)			
HPS Validated data ECBs with HPS commentary *Please note for HPS reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **45.3**	**Per 100,000 bed days**	CAI ECBs rate: **46.9**	Per 100,000 Pop
No of HCAI ECBs: 34		No of CAI ECBs: 44	
This is **ABOVE** National rate of 42.0		This is **ABOVE** National rate of 44.7	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

1) 25% reduction ECBs - 2021/2022		
New standards for reducing all Healthcare Associated ECB by 25% by 2021/22 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2022**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending September 2020 (HPS)		
ECB by rate 100,000 Total bed days	**48.5** per 100,000 TBDs	
ECB by Number of HCAI cases	**154**	

2) 50% Reduction ECBs - 2023/2024		
New standards for reducing all Healthcare Associated ECB by 50% by 2023/2024 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 50% reduction target by 2023/4**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**22.0** 100,000 TBDs
ECB by Number of HCAI cases	**160**	**80**

2020-2017 NHS Fife's Urinary catheter Associated ECBs –
HPS data Q2 data still awaited

Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2020 Q4		***30%**	
2020 Q3	14.6%	**33 %**	* Locally calculated data- TBC by HPS when Q4 data published on Discovery
2020 Q2	22.4 %	**25.5 %**	
2020 Q1	16.7 %	**35.7 %**	
2019 TOTAL	16.1 %	**24.5 %**	
2018 TOTAL	14.5 %	**24.2 %**	
2017 -TOTAL	11.8 %	**10.4 %**	
Data from NSS Discovery ARHAI Indicators			

Healthcare Associated Infections (HCAI)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HCAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2020 Q4		***16.7%**	
2020 Q3	25.9%	**36.4 %**	* Locally calculated data- TBC by HPS when Q3 data published on Discovery
2020 Q2	17.5 %	**13.3 %**	
2020 Q1	24.1 %	**17.9 %**	
2019 TOTAL	22.8 %	**28.0 %**	
2018 TOTAL	22.1%	**36.6 %**	
2017 TOTAL	18.3 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current ECB Initiatives

Urinary catheter Group work following raised ECB CAUTI incidence

The IPC Surveillance team continue to liaise with the Urinary Catheter Improvement Group.
This group aims to minimize urinary catheters to prevent catheter associated healthcare infections & trauma associated with UC insertion/maintenance/ removal & self-removal & to establish Catheter Improvement work in Fife.
The Infection control surveillance team continue to work with the Urinary Catheter Improvement group meeting- last held on **26th of March 2021.**

Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.

Monthly ECB reports & graphs are distributed within HSCP & Acute services

Up to 26.01.2020: There have been **THREE** trauma associated CAUTIs in 2020 & none in 2021

Catheter insertion/Maintenance bundles now inserted in MORSE for District nurse documentation

Patientrack CAUTI bundles still to be implemented for Acute services/HSCP but in progress with eHealth. There is no fixed timescale but it is hoped this will be installed in 2020.

Pathway for management of difficult catheter insertions & associated problems- included in training pack & to go on BLINK
Team Lead- Continence Advisory Service:
-have developed a Continence Link Folder for Nursing and Residential Care Homes.
-Every patient in residential/care home should now have a catheter passport if catheter in situ.
-Continence link folders include information on Continence assessment, sheaths, Catheters, resources for Bristol stool chart, Hydration/Healthy bladder, incontinence care.
-All residential homes have been contacted & supported to ensure the packs have been incorporated into care.
-3rd 'Tip top' video has been published on 'catheter choice'

Cowdenbeath practice: CAUTI Quality improvement program commenced Augt 2020- currently on hold due to pandemic response.

4 Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non-compliance.
- The hand hygiene compliance for the last 12 months NHS Fife can be found in Section 11.
- Reporting of Hand Hygiene performance is based on local data submitted by each ward.
- A minimum of 20 observations are required to be audited per month per ward.
- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP can be viewed on 'Ward Dashboard'

5.1 Trends

- NHS Fife overall results remain consistently ABOVE 98%
- This is ABOVE the Overall target set of 95%

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for 3rd Quarter (Oct-Dec 2020) was **95.8%**
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the *National Monitoring Framework* for *NHS Scotland National Cleaning Services Specification*. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

Domestic Location	Q3 Oct-Dec 20	Q2 Jul - Sep 20
Fife	95.8 ↑	95.4
Scotland	95.7	95.6

- The National Cleaning Services Specification – quarterly compliance report result for Q3 (Oct-Dec) 2020 shows NHS Fife achieving **GREEN** status.
  -There are currently no figures available for Q4 Jan-Mar 2021

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 20	Q2 Jul - Sep 20
Fife	↑96.0	95.0
Scotland	96.8	96.6

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct-Dec) 2020 shows NHS Fife achieving **GREEN** status.
  -There are currently no figures available for Q4 Jan-Mar 2021

6.2 Current Initiatives

- Areas with results below 90% for all Hospital & Healthcare facilities have been identified to relevant managers for action.

7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place. Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any) & how many days the closure lasted. A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda. All ward/ bay closures due to Norovirus & Influenza are reported to HPS weekly plus all closures due to an Acute Respiratory Illness (ARI). All Influenza patients admitted to ICU are also notifiable to HPS

January - February 2021

Norovirus

There has been NO new ward closures due to a Norovirus outbreak since last ICC report

Seasonal Influenza

There has been NO new closures due to confirmed Influenza since the last reporting period.

Norovirus in Scotland up to the end of week 14 of 2021 (week ending 04 April 2021) is 13.

- In comparison, to the end of week 14 in 2020 PHS received 189 laboratory reports of norovirus.
- The five-year average for the same time period between years 2015 and 2019 was 482.

Weekly national seasonal respiratory report- week 12 (week ending 31/03/2021), provisional data showed:

- The rate of influenza-like illness (ILI) was at Baseline activity level (0.4 per 100,000).
- The incidence rate of influenza was at Baseline activity level (0.0 per 100,000 population).
- There were no influenza cases detected this week. This may be related to current restrictions and an increased uptake of flu vaccine; however, data are provisional and may be subject to change.
- The proportion of NHS24 calls for respiratory symptoms remained at Baseline activity level.
- Non-flu respiratory pathogens were within expected activity levels.

- Influenza vaccine uptake up to end of week 7 in Scotland in most eligible cohorts is higher than in previous seasons, although the data are not directly comparable.

7.2 COVID-19 pandemic

NHS Fife is currently managing the pandemic COVID-19 across all of its services.
Please note COVID-19 cases are being reported on the Scottish Government website.

COVID-19 incidents/clusters/outbreaks Jan – Feb 2021
Please note HPS/ARHAI Scotland no longer request the reporting of single cases of COVID-19 out with the RED pathway

Hospital and Ward	Patient cases	Staff cases	Date of first reporting to ARHAI	Date incident closed with ARHAI Scotland
Victoria Hospital - V41	21	14	05/01/2021	23/02/2021
Victoria Hospital - V54	2	0	07/01/2021	07/01/2021
Victoria Hospital - AU2	2	0	07/01/2021	25/01/2021
Victoria Hospital - V44	4	2	07/01/2021	19/01/2021
Queen Margaret Hospital - Ward 7	4	0	13/01/2021	05/02/2021
Glenrothes Hospital - Ward 3	14	4	13/01/2021	23/02/2021
Victoria Hospital - AU1-Amber	2	0	13/01/2021	28/01/2021
Glenrothes Hospital - Ward 2	14	2	14/01/2021	23/02/2021
Cameron Hospital - Letham Ward	15	8	14/01/2021	01/03/2021
Adamson Hospital - Tarvit	15	6	14/01/2021	23/02/2021
Cameron Hospital - Balcurvie ward	14	6	18/01/2021	23/02/2021
Cameron Hospital - Sir George Sharp Unit (SGSU)	4	1	01/02/2021	23/02/2021
Victoria Hospital - V6	8	4	12/02/2021	26/02/2021
Victoria Hospital - V23	3	0	16/02/2021	26/02/2021
Glenrothes Hospital - Ward 1 Bay 6	3	0	19/02/2021	01/03/2021

8) Surgical Site Infection Surveillance Programme

A letter on 25 March 2020 from the Chief Nursing Officer revised HAI surveillance requirements with temporary changes to routine surveillance:

- All mandatory and voluntary Surgical Site Infection (SSI) surveillance should be paused until further notice

8 a) Caesarean section SSI
All Caesarean Section surveillance has been postponed due to the COVID19 pandemic until further notice

8 b) Hip Arthroplasty SSI
All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 c) Hemi arthroplasty SSI
All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 d) Knees SSI
All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 e) Large Bowel SSI
All large bowel surveillance has been postponed due to the COVID19 pandemic until further notice

9. Hospital Inspection Team

No further inspections for NHS Fife since last report

10. Assessment

- **CDIs**: Low levels of *Clostridioides difficile* continues although healthcare associated (HAI/HCAI/Unknown) infections need to be reduced to achieve target.
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs.
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce Peripheral Vascular Catheter infections and Dialysis line infections have been effective but remains a challenge & local surveillance continues.
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement group
- Addressing Lower UTI related ECBs
- **SSIs surveillance** currently suspended during COVID pandemic for:
- C-sections,
- Large bowel surgery
- Orthopaedic procedure surgeries
  -Total hip replacements, Knee replacements & Repair fractured neck of femurs
  -Local data collection will resume for quality assurance from October 2020
  - Feedback forums to clinical teams for all SSIs is firmly established to address SSI challenges where they occur.

11. Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are categorized as:
Healthcare Associated (HCAI & HAI) or **Community** Onset (Community or Not known).
Please see HPS definition of Healthcare Associated & Community infections in 'References & Links'

The 2019 Scottish Government's new standards aim to reduce the Healthcare Associated Infections.

The information provided is local data, and may differ from the national surveillance reports carried out by Health Protection Scotland. This is due to some Fife residents who are treated at other health boards being allocated back to Fife's data. However, these reports aim to provide more detailed and up to date local information on HAI activities than is possible to provide through the national statistics.

Hand hygiene and cleaning compliances are shown by Total Fife, VHK & QMH.

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NHS Fife TOTAL

Monthly HAI Case Numbers (SAB, C Diff & ECB)

	NHS Fife								
	SAB			C Diff			ECB		
Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI / UnKnown	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Jan-19	4	3	7	5	0	5	6	11	17
Feb-19	6	4	10	0	1	1	12	4	16
Mar-19	3	4	7	3	2	5	18	9	27
Apr-19	6	5	11	1	1	2	16	11	27
May-19	4	1	5	2	1	3	11	13	24
Jun-19	2	2	4	3	1	4	10	6	16
Jul-19	10	5	15	2	2	4	10	12	22
Aug-19	1	2	3	3	0	3	11	11	22
Sep-19	3	4	7	3	1	4	7	4	11
Oct-19	2	2	4	7	0	7	22	13	35
Nov-19	6	2	8	3	2	5	21	6	27
Dec-19	3	2	5	3	1	4	11	8	19
Jan-20	4	1	5	3	0	3	14	10	24
Feb-20	4	1	5	2	1	3	15	7	22
Mar-20	2	4	6	2	0	2	13	9	22
Apr-20	2	7	9	3	0	3	5	8	13
May-20	2	4	6	2	0	2	5	12	17
Jun-20	0	2	2	0	1	1	13	12	25
Jul-20	4	2	6	2	4	6	11	11	22
Aug-20	7	2	9	2	1	3	14	14	28
Sep-20	2	3	5	3	1	4	8	11	19
Oct-20	3	5	8	2	1	3	6	7	15
Nov-20	4	4	8	2	0	2	19	9	28
Dec-20	9	2	11	1	1	2	12	7	19
Jan-21	4	4	8	1	1	2	9	13	22
Feb-21	2	5	7	2	3	5	3	9	12

Hand Hygiene Monitoring Compliance (%) TOTAL FIFE												
	Mar-20	Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct - 20	Nov 20	Dec 20	Jan 21	Feb 21
Overall	99	100	100	99	99	99	98	99	99	98	N/K	N/K
AHP	100	100	100	100	100	99	99	98	99	98	N/K	N/K
Medical	99	100	99	99	99	99	99	99	99	97	N/K	N/K
Nurse	99	100	100	100	99	99	99	100	100	100	N/K	N/K
Other	97	100	99	100	97	96	96	99	100	95	N/K	N/K

Please note: there is no hand hygiene information since December 2020, available on `Ward Dashboard`.

	Cleaning Compliance (%) TOTAL FIFE											
	Mar-20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21
Overall	95.7	*	*	95.3	95.2	95.1	95.6	95.8	95.7	96.0	95.8	95.9

	Estates Monitoring Compliance (%) TOTAL FIFE											
	Mar-20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb -21
Overall	95.8	*	*	96.7	94.1	94.5	95.8	96.0	95.7	96.2	95.7	96.3

* Suspended all monitoring activity for April for Domestic Services & Estates Department on the Facilities Monitoring Tool (FMT). Therefore, there will be no monthly figures to report for April and May 2020.

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Victoria Hospital

	VHK					
	SAB >48hrs admx		CDI >48hrs admx		ECB >48hrs admx	
Month	HAI & HCAI	Community / Not Known	HAI/ HCAI / UnKnown	Community	HAI & HCAI	Community / Not Known
Jan-19	4	n/a	1	n/a	2	n/a
Feb-19	6	n/a	0	n/a	3	n/a
Mar-19	3	n/a	1	n/a	2	n/a
Apr-19	2	n/a	0	n/a	5	n/a
May-19	2	n/a	0	n/a	3	n/a
Jun-19	0	n/a	1	n/a	2	n/a
Jul-19	3	n/a	2	n/a	2	n/a
Aug-19	1	n/a	0	n/a	2	n/a
Sep-19	1	n/a	0	n/a	2	n/a
Oct-19	0	n/a	2	n/a	6	n/a
Nov-19	2	n/a	1	n/a	5	n/a
Dec-19	1	n/a	2	n/a	4	n/a
Jan-20	2	n/a	0	n/a	1	n/a
Feb-20	3	n/a	1	n/a	3	n/a
Mar-20	2	n/a	1	n/a	3	n/a
Apr-20	1	n/a	1	n/a	2	n/a
May-20	1	n/a	1	n/a	0	n/a
Jun-20	0	n/a	0	n/a	5	n/a
Jul-20	4	n/a	0	n/a	2	n/a
Aug-20	6	n/a	1	n/a	9	n/a
Sep-20	2	n/a	2	n/a	1	n/a
Oct-20	1	n/a	0	n/a	2	n/a
Nov-20	3	n/a	2	n/a	1	n/a
Dec-20	5	n/a	1	n/a	2	n/a
Jan-21	3	n/a	1	n/a	6	n/a
Feb-21	1	n/a	1	n/a	2	n/a

		Cleaning Compliance (%) Victoria Hospital										
	Mar-20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct -20	Nov 20	Dec 20	Jan-21	Feb-21
Overall	95.4	*	*	*	96.9	94.6	95.6	95.1	95.4	95.8	95.8	95.9

		Estates Monitoring Compliance (%) Victoria Hospital										
	Mar-20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct -20	Nov 20	Dec 20	Jan-21	Feb-21
Overall	95.9	*	*	*	97.5	94.2	95.6	95.8	96	96.4	95.2	96.9

* We have suspended all monitoring activity for April for Domestic Services & Estates Department on the Facilities Monitoring Tool (FMT). Therefore, there will be no monthly figures to report for April to June 2020.

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Queen Margaret's Hospital

	QMH					
	SAB >48hrs		CDI >48hrs admx		ECB >48hrs admx	
Month	HAI & HCAI	Community /	HAI /HCAI /	Community	HAI & HCAI	Community /
Jan-19	0	n/a	0	n/a	0	n/a
Feb-19	0	n/a	0	n/a	0	n/a
Mar-19	0	n/a	0	n/a	1	n/a
Apr-19	0	n/a	0	n/a	0	n/a
May-19	0	n/a	0	n/a	0	n/a
Jun-19	0	n/a	1	n/a	0	n/a
Jul-19	0	n/a	0	n/a	0	n/a
Aug-19	0	n/a	2	n/a	1	n/a
Sep-19	0	n/a	0	n/a	0	n/a
Oct-19	0	n/a	1	n/a	0	n/a
Nov-19	0	n/a	1	n/a	0	n/a
Dec-19	0	n/a	0	n/a	0	n/a
Jan-20	0	n/a	1	n/a	2	n/a
Feb-20	0	n/a	0	n/a	0	n/a
Mar-20	0	n/a	0	n/a	3	n/a
Apr-20	1	n/a	0	n/a	1	n/a
May-20	0	n/a	0	n/a	4	n/a
Jun-20	0	n/a	0	n/a	1	n/a
Jul-20	0	n/a	0	n/a	0	n/a
Aug-20	1	n/a	0	n/a	0	n/a
Sep-20	0	n/a	0	n/a	0	n/a
Oct-20	1	n/a	0	n/a	0	n/a
Nov-20	0	n/a	0	n/a	1	n/a
Dec-20	0	n/a	0	n/a	1	n/a
Jan-21	0	n/a	0	n/a	2	n/a
Feb-21	0	n/a	0	n/a	1	n/a

	Cleaning Compliance (%) Queen Margaret's hospital											
	Mar-20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21
Overall	97.0	*	*	95.9	95.8	96.1	96.3	96.9	96.2	96.9	96.1	96.5

	Estates Monitoring Compliance (%)Queen Margaret's hospital											
	Mar -20	Apr-20	May-20	June-20	July-20	Aug-20	Sept-20	Oct - 20	Nov 20	Dec 20	Jan - 21	Feb - 21
Overall	95.5	*	*	95.3	94.2	95.7	96.3	96.9	96.1	97.1	96.2	95.6

* We have suspended all monitoring activity for April for Domestic Services & Estates Department on the Facilities Monitoring Tool (FMT). Therefore, there will be no monthly figures to report for April - May 2020.

Community Hospitals

	COMMUNITY HOSPITALS					
	SAB >48hrs admx		CDI >48hrs admx		ECB >48hrs admx	
Month	HAI & HCAI	Community /	HAI /HCAI /	Community	HAI & HCAI	Community /
Jan-19	0	n/a	1	n/a	0	n/a
Feb-19	0	n/a	0	n/a	1	n/a
Mar-19	0	n/a	1	n/a	0	n/a
Apr-19	0	n/a	0	n/a	1	n/a
May-19	0	n/a	2	n/a	2	n/a
Jun-19	0	n/a	0	n/a	1	n/a
Jul-19	0	n/a	0	n/a	0	n/a
Aug-19	0	n/a	1	n/a	0	n/a
Sep-19	0	n/a	0	n/a	0	n/a
Oct-19	0	n/a	0	n/a	1	n/a
Nov-19	0	n/a	0	n/a	2	n/a
Dec-19	1	n/a	1	n/a	0	n/a
Jan-20	0	n/a	0	n/a	1	n/a
Feb-20	0	n/a	0	n/a	0	n/a
Mar-20	0	n/a	0	n/a	0	n/a
Apr-20	0	n/a	0	n/a	0	n/a
May-20	0	n/a	0	n/a	0	n/a
Jun-20	0	n/a	0	n/a	2	n/a
Jul-20	0	n/a	1	n/a	0	n/a
Aug-20	0	n/a	0	n/a	0	n/a
Sep-20	0	n/a	1	n/a	0	n/a
Oct-20	0	n/a	0	n/a	0	n/a
Nov-20	0	n/a	0	n/a	2	n/a
Dec-20	0	n/a	0	n/a	1	n/a
Jan-21	0	n/a	0	n/a	0	n/a
Feb-21	0	n/a	0	n/a	0	n/a

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Outs of Hospital Infections

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HAI & HCAI	Community /	HCAI / UnKno	Community	HAI & HCAI	Community /
Jan-19	0	3	3	0	4	11
Feb-19	0	4	0	1	8	4
Mar-19	0	4	1	2	15	9
Apr-19	4	5	1	1	10	11
May-19	2	1	0	1	6	13
Jun-19	2	2	1	1	7	6
Jul-19	7	5	0	2	8	12
Aug-19	0	2	0	0	8	11
Sep-19	2	4	3	1	5	4
Oct-19	2	2	4	0	15	13
Nov-19	4	2	1	2	14	6
Dec-19	1	2	0	1	7	8
Jan-20	2	1	2	0	10	10
Feb-20	1	1	1	1	12	7
Mar-20	0	4	1	0	7	9
Apr-20	0	7	2	0	2	8
May-20	1	4	1	0	1	12
Jun-20	0	2	0	1	5	12
Jul-20	0	2	1	4	9	11
Aug-20	0	2	1	1	5	14
Sep-20	0	3	0	1	7	11
Oct-20	1	5	2	1	6	7
Nov-20	1	4	0	0	15	9
Dec-20	4	2	0	1	8	8
Jan-21	1	4	0	1	1	13
Feb-21	1	5	1	3		9
Mar-21						

References & Links

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website:

Clostridioides difficile: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/

Staphylococcus aureus : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/

For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets

There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website:

http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Understanding the Report Cards – Hand Hygiene Compliance
Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used.

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – *'Out of Hospital Infections'*
Clostridium difficile infections and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.

For HPS categories for Healthcare Associated Infections:
https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/

Categories of Healthcare & community Infections

		Quarterly Epidemiology Commentary category	
		Healthcare associated infection case	Community associated infection case
CDI[1] Enhanced ECB[2] Enhanced SAB[3] surveillance category	Hospital acquired infection (HAI)	X	
	Healthcare associated infection (HCAI)	X	
	Community infection (CA)		X
	ECB/SAB not known		X
	CDI unknown	X[1]	

HPS **ECB** & **SAB** definitions for Hospital Acquired, Healthcare Associated, Community or Not known

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission
OR
-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained
OR
-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.
OR
-Resides in a Nursing home, long term facility or residential home
OR
-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.
OR
-Underwent venepuncture in the 30 days before +ve BC
OR
-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC

of the criteria for the healthcare associated blood stream infections **Not known**: -Only to be used if the ECB is not a HAI and unable to determine if community or HCAI	OR -Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion OR -Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

HPS **CDI** Definition for Hospital Acquired, Healthcare Associated, Unknown or Community onset

HPS Linkage Origin Definitions

CDI Origin	Origin sub category : definitions
Healthcare	**HAI :** Specimen taken after more than 2 days in hospital (day three or later following admission on day one)
	HCAI : Specimen taken within 2 or less days in hospital and a discharge from hospital 4 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital within 4 weeks of the specimen date **Unknown** : Specimen taken 2 or less days in hospital and a previous discharge from hospital 4-12 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital in 4-12 weeks prior to the specimen date
Community	**CAI :** Specimen taken 2 or less days in hospital and no hospital discharges in the 12 weeks prior to specimen date; or not in hospital when specimen taken and no hospital discharges in the 12 weeks prior to specimen date.

CDI Surveillance Protocol link: https://www.hps.scot.nhs.uk/web-resources-container/protocol-for-the-scottish-surveillance-programme-for-clostridium-difficile-infection-user-manual/

Item 10.4

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**HIS Inspection Glenrothes Hospital**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Lynn Barker, Associate Director of Nursing**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Awareness

This report relates to a:

- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is presented to the Clinical Governance Committee for awareness and noting. It provides an update on the HIS Inspection, which took place at Glenrothes Hospital in July 2020.

2.2 Background

In March 2020, inspections of NHS hospitals and services in Scotland were paused, as a result of the COVID-19 pandemic.

In July 2020, hospital inspections were reinstated with a combined focus on both safety and cleanliness and care of older people in hospital. Inspection activity focused on community hospitals, in the first instance.

On 7th and 8th July 2020, Health Improvement Scotland (HIS) carried out an unannounced inspection at Wards 1 and 2 of Glenrothes Hospital. This was the first inspection in Scotland by HIS following the outbreak of COVID 19. This inspection focussed on the impact of COVID-19 and the care older people receive whilst in hospital.

Ward 1 is a 17 bedded GP managed ward and Ward 2 is a 17 bedded MOE consultant led ward serving Glenrothes and the surrounding communities.

2.3 Assessment

This inspection resulted in four areas of good practice and five requirements.

The areas of good practice included good standard of hospital cleanliness and excellent infection control support.

The five requirements were as follows:

- 4 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic
- 1 requirement relates to the condition of patient equipment.

A robust Improvement Action Plan was implemented which outlined the prioritisation of actions aligned with each of the five requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing.

The teams have completed the actions identified in the Improvement Action Plan with support from Lead Nurse, Head of Nursing and Hospital Service Manager.

2.3.1 Quality / Patient Care

HIS inspections help to ensure that healthcare services are meeting the required standards of care, that good practice is identified and areas for improvement are addressed.

2.3.2 Workforce

Inspections provide an opportunity for the workforce to review workforce and workload planning; to ensure that standards of care and good practice are identified. Going forward, HIS will include review of safe staffing legislation implementation in inspections.

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

The Action Plan developed following the inspection addresses issues identified in documentation, to improve assessment of risk in patient care.

2.3.5 Equality and Diversity, including health inequalities

n/a

2.3.6 Other impact

Potential reputational risk following inspection

2.3.7 Communication, involvement, engagement and consultation

Inspection report and action plan shared and discussed with staff

2.3.8 Route to the Meeting

Infection Control Committee

2.4 Recommendation

- **Awareness:** note the contents of the paper.

3 Appendix

Action plan

Report Contact
Lynn Barker, Associate Director of Nursing
lynn.barker@nhs.scot

Healthcare Improvement Scotland | Inspections and reviews To drive improvement

Healthcare Improvement Scotland | Inspections and reviews To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland: unannounced hospital inspection

Glenrothes Hospital, NHS Fife

7–9 July 2020

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: _____

Date: _____

NHS board Chief Executive

Signature: _____

Full Name: _____

Date: _____

1. NHS Fife must ensure that all older people who are admitted to hospital are accurately assessed in line with the national standards. This includes nutritional screening and assessment including oral health assessment. There must be evidence of reassessment where required. (See page 13). This is to comply with Food, Fluid and Nutritional Care Standards (2014) criteria 2.1, 2.2, 2.3 & 2.4.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1	Every patient should receive a robust full review and assessment on admission to the ward to ensure that the care and treatment plan describes care provided. All staff to ensure they complete every section of the patient care record on admission to the ward. SCN/CNs will complete quality assurance checks of the patient documentation to ensure robust assessments are in place on admission to the ward; this will include a review of all admission documentation within 24 hours of admission to the ward.	31/08/2020	**Senior Charge Nurses (SCNs) Glenrothes Hospital**	An admission prompt was introduced to support staff to ensure robust assessment of patients on admission. A rolling programme of monthly audit of nursing care documentation commenced in August 2020 across Fife HSCP wards. The audit tool applied is currently being tested and aligned to an inter rater reliability tool to support a consistent approach. Actions and issues will be escalated to the Head of Nursing via the Lead Nurses and fed back to the appropriate SCNs and CNs.	15/07/2020 and ongoing
2	Senior Nursing Leadership Team requires assurance that the standard of documentation is safe, effective and person centred. To maintain sustained improvement the Lead Nurse will conduct random weekly audits of patient documentation and feed back to SCN's in real time.	31/08/2020	**Lead Nurse**	A rolling programme of monthly audit of nursing care documentation commenced In August 2020 The Lead Nurse for Glenrothes Hospital has reviewed notes for new admissions to wards at	31/08/2020 & every month thereafter

				Glenrothes Hospital using the new tool on a weekly basis. A selection of nursing notes audited, identified that all had all been fully reviewed upon transfer from acute. The quality of person centred care planning across all wards is improving supported by guidance from the Documentation Information Folders that have been revisited.	13/07/2020
Ref:	**Action Planned**	**Timescale to meet action**	**Responsibility for taking action**	**Progress**	**Date Completed**

3	All staff to receive enhanced training on how to access the Patientrack IT system and extract required information to assess plan and implement appropriate care and treatment effectively. SCN/CNs to ensure staff have access to appropriate systems to extract appropriate information to complete care and treatment plan effectively. All staff to ensure MUST is re-assessed and completed on admission as per NHS Fife Wide Policy for the Provision of Food, Fluid and Nutritional Care in hospitals.	31/08/2020	**Lead Nurse, SCNs / CNs**	PatientTrak training took place on 24/07/2020 across all wards. Early indications are that MUST and Nutrition Profile completion figures within reports have improved as more staff trained and competent in use. Further training organised for deeper understanding of frailty assessment on PatientTrak. Training in September 2020. Senior Nursing Team has also received PatientTrak training. SCN's have confirmed that all staff have appropriate access to required IT systems. PatientTrak audit data for community hospitals is now available for both weekly and monthly datasets. Compliance audits undertaken by the Lead Nurse have shown increased compliance in completion of the MUST assessment.	24/07/2020 Completed 30/09/2020 22&24/07/2020 07/10/2020
Ref:	**Action Planned**	**Timescale to meet action**	**Responsibility for taking action**	**Progress**	**Date Completed**

4	All HSCP inpatient wards require to meet the agreed standard in relation to patient care documentation. ADoN to commission an external audit and review of all community hospital inpatient wards.	30/09/2020	**Associate Director of Nursing (ADoN)**	Between July 2020 and August 2020 the ADoN commissioned an external review of nursing documentation across FHSCP An audit was undertaken between July and August 2020. Issues identified from the audit have informed testing of new audit documentation for nursing documentation. The ADoN facilitated feedback sessions with a presentation on 11/11/2020 to all areas.	31/08/2020
5	The patient care and treatment record is fit for purpose. Senior Leadership Team to request a progress report on documentation review. Future work on this will be fed back to all staff across HSCP and ASD.	31/10/2020	**Senior Nurse Leadership Team**	Progress with regards to the care and treatment documentation will be reported to the ADoN via the NHS Fife Record Keeping Group. The NHS Fife Record Keeping Group was due to meet on 3rd September 2020 however due to COVID work commitments and restrictions this has not yet taken place.	03/09/2020

2. NHS Fife must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient's condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions (see page13). This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing &

Midwifery Council, 2015); Care of Older People in Hospital Standards (2015) criteria 1.1, 1.4 and 11.2a; and Food, Fluid and Nutritional Care Standards (2014) criterion 2.9a.

6	Every patient's care and treatment plan is safe, effective and person centred and accurately describes the care that is delivered to the patient on a daily basis. All inpatient care and treatment plans should be developed in partnership with patients, family and carers Exemplar Admission Documentation and Care Plans to be completed and shared with the teams. Local ward based education in care planning to take place with Lead Nurse. Wider work on person centred care planning to take place with Lead Nurse and Head of Nursing.	30/09/2020	**Lead Nurse /Head of Nursing (HoN)**	Local education sessions have taken place to support staff and ensure that they fully understand the patient focus required. There is documented evidence that care plans are being developed with patients. Following the external audit, a number of good examples of care planning were identified – these have been shared with teams, supported by the Head of Nursing ,and have been used as working examples of how to undertake good care planning. Ward 1, Glenrothes have highlighted specific areas on the nursing admission documentation as a prompt to ensure staff completed this information. In addition, the HoN and Lead Nurse are exploring other tools to inform a local approach to person centred care planning eg., recently published guidance from the Mental Health Welfare Commission –	31/08/2020 31/08/2020 15/07/2020

				guidance on care planning. These will be discussed at the NHS Fife Record Keeping Group.	
7	The Falls Intervention Plan is completed in line with NMC standards for record keeping. All staff will complete the Falls Intervention Plan on admission and at regular intervals thereafter. All staff will review the Falls Intervention Plan as an integral part of a post fall review. SCNs/CNs Will conduct quality checks of falls intervention plan as integral part of post falls review process. Falls Process Measures to be fully completed and deficits addressed.	31/08/2020	**SCNs Glenrothes Hospital**	SCN leading on ensuring compliance with NMS standards for record keeping. All patients transferred to the ward will have a new falls intervention plan completed. Compliance with this will be undertaken as a test of change. Quality checks regarding completion of the Falls Intervention Plans will be undertaken via the documentation audit on a weekly basis. Quality check – high risk patients will have their falls intervention plan checked on a monthly basis as part of the wider documentation audit. Quality checks also undertaken as part of the regular communication at Safety briefs, ward meetings and via weekly documentation audits.	31/08/2020

3 NHS Fife must ensure that where wound assessment charts are in place, for those patients with a known pressure ulcer or break in skin integrity, they are fully and accurately completed (see page 13). This is to comply with Standards for Prevention and Management of Pressure Ulcers (2016) Standard 6.1

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
8	The Pressure Ulcer Assessment (PURA) is completed in line with Standards for Prevention and Management of Pressure Ulcers (2016). This will be monitored by the SCN on a weekly basis. Individualised care / intervention plan aligned to risk are in place and are reviewed regularly in line with risk assessment. Commission and engagement with HSCP Tissue Viability Service to deliver education sessions and carry out randomised audits. Tissue Viability Process Measures to be fully completed, outcome shared with staff and deficits addressed. Lead Nurse will discuss data with SCN during 121 s.	31/08/2020	**SCNs Glenrothes Hospital**	Initiated – commenced in practice. At a recent TV Steering Group (19.11.20) the recently published revised standards (Oct 2020) were discussed. The current self-assessment framework will be refreshed and aligned to the new standards. Progress against each of the standards will be reported via the steering group. The next meeting of the group is planned for January/February 2021. Ward 2, Glenrothes Hospitals will commence reporting against compliance of the skin bundles, auditing 5 patients per week. This data will compliment the wards' quality board data.	31/08/2020

				The Tissue Viability Nursing Services has undertaken training sessions and audits on wards 1 (on 30/09/2020) and 2 (on 18/11/2020) at Glenrothes Hospital. TVN service has also completed Wound care plan audits, giving direct feedback to SCN's. Report to be sent to Lead Nurse/HoN	30/09/2020 18/11/2020 30/09/2020 18/11/2020

4 NHS Fife must ensure that, where required, oral care is given and documented appropriately (see page 13). This is to comply with Best Practice Statement for Working with Dependent Older People to Achieve Good Oral Health (May 2005) Section 3.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed

9	All patients will have an oral assessment and referral to appropriate service as required. All interventions in relation to oral health will be accurately documented in the patients' records. The Lead Nurse will liaise with oral health / dental team to introduce documentation that enables a thorough and accurate initial assessment and ongoing record of oral care and health.	30/09/2020	**Lead Nurse / HoN**	The compliance of good oral hygiene assessment and ongoing referral will be captured within the rolling programme of documentation audit. Any areas of non compliance will be escalated via the documentation audit assurance process. The Lead Nurse has liaised with the oral hygiene team in relation to a new oral hygiene assessment tool. The tool will be submitted to the NHS Fife Record Keeping group for approval prior to implementation.	Evaluation date (14th September 2020) 15/07/2020 15/07/2020

5 NHS Fife must ensure that the condition of all patient equipment allows it to be effectively decontaminated (see page 15). This is to comply with Healthcare Associated Infection (HAI) standards (2015) Criteria 8.1

10	There is a review of the system to which near patient equipment and furniture is inspected and reviewed, and a system of timeous replacement is in place. Up to date training available for MICAD system on request for all staff.	30/09/2020	**Lead Nurse / Service Manager**	Working collaboration with the Infection Control and Prevention Team and Estates Manager to ensure the near patient equipment and furniture is compliant with HAI standards.	Evaluation date (14th September 2020)

				Following the inspection, the facilities officer and hospital services manager undertook an inspection walkaround to review the patency of all near patient equipment and furniture. Subsequently a log of equipment and furniture which requires replacement/repaired was developed. A rolling programme of replacement/repair has been established, which will ensure a bay per ward per month will be updated. To date the following has been auctioned: • 8 bed side lockers has been purchased and delivered • 8 over bed table have been purchased and delivered • 14 high back patient chairs have been re-varnished • 9 dining room chairs have been re-varnished Equipment audits will continue via the safe and clean Audit. Since the inspection the escalation process for the safe and clean audit has been	29/11/2020 29/11/2020 29/11/2020

				strengthened to escalate any issues identified. This importance of the escalation process has been reinforced at the daily huddles which will be the ongoing forum to raise operational issues or concerns on a daily basis.	15/07/2020

Overarching actions undertaken in response to the unannounced inspection visit to Glenrothes Hospital 7th – 9th July 2020.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
11	ALL SCN/CNs across the HSCP to receive feedback following the HIS inspection to ensure wider awareness of the issues raised and to facilitate implementation of all relevant actions outlined in the action plan. Feedback at ADoN SCN Meeting. Share learn summary with all SCN/CNs across the HSCP.	30/09/2020	**ADoN**	Feedback provided to SCNs/CN's on the Learn summary to be shared following publication of report. Glenrothes SCNs were provided with immediate feedback given on 15th July 2020 ADoN provided feedback and actions with Senior Nursing Team via Teams meeting on the 25/07/2020 Feedback and discussion sessions took place on the	20/07/2020 15/07/2020 25/07/2020

				29/07/2020 and 06/08/2020 with all the SCN/CNs within the Partnership. Further feedback session and presentation given by the ADoN on the 11/11/2020 of the finding s of external audit.	29/07/2020 06/08/2020 11/11/2020

Item 10.5

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**HIS Inspection Adamson Hospital**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Lynn Barker, Associate Director of Nursing**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Awareness

This report relates to a:

- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is presented to the Clinical Governance Committee for awareness and noting. It provides an update on the HIS Inspection, which took place at Adamson Hospital, Cupar, in October 2020.

2.2 Background

In March 2020, inspections of NHS hospitals and services in Scotland were paused, as a result of the COVID-19 pandemic.

In July 2020, hospital inspections were reinstated with a combined focus on both safety and cleanliness and care of older people in hospital. Inspection activity focused on community hospitals, in the first instance.

On 28th October 2020, Health Improvement Scotland (HIS) carried out an unannounced inspection at Tarvit ward, Adamson Hospital. This inspection focussed on the impact of COVID-19 and the care older people receive whilst in hospital.

Tarvit Ward is a 23 bedded community hospital ward serving Cupar and surrounding areas. The ward is a mixture of 19 GP managed beds and 4 palliative care beds.

2.3 Assessment

This inspection resulted in three areas of good practice and eight requirements.

The areas of good practice included good standard of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention.

The eight requirements were as follows:

- 6 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic
- 2 requirements in relation to infection control practices supporting a safe environment for both people experiencing care and staff

A robust Improvement Action Plan was implemented which outlined the prioritisation of actions aligned with each of the eight requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing.

The teams are working towards achievement of the Improvement Action Plan, which is almost complete. This has been with support from Lead Nurse, Head of Nursing and Hospital Services Manager: there has been extensive support and work with the team to address the recommendations.

2.3.1 Quality / Patient Care

HIS inspections help to ensure that healthcare services are meeting the required standards of care, that good practice is identified and areas for improvement are addressed.

2.3.2 Workforce

Inspections provide an opportunity for the workforce to review workforce and workload planning; to ensure that standards of care and good practice are identified. Going forward, HIS will include review of safe staffing legislation implementation in inspections.

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

The Action Plan developed following the inspection addresses issues identified in documentation, to improve assessment of risk in patient care.

2.3.5 Equality and Diversity, including health inequalities

n/a

2.3.6 Other impact

Potential reputational risk following inspection

2.3.7 Communication, involvement, engagement and consultation

Inspection report and action plan shared and discussed with staff

2.3.8 Route to the Meeting

Infection Control Committee

2.4 Recommendation

- **Awareness:** note the contents of the paper.

3 Appendix

Action plan

Report Contact
Lynn Barker, Associate Director of Nursing
lynn.barker@nhs.scot

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland: unannounced hospital inspection

Adamson Hospital, NHS Fife

Tuesday 27 and Wednesday 28 October 2020

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature:
Full Name:
Date:

NHS board Chief Executive

Signature
Full Name:
Date:

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

1. NHS Fife must ensure that all older people who are admitted to hospital are accurately assessed in line with the national standards. This includes nutritional assessment including screening for the risk of malnutrition. Staff should have access to suitable weighing scales in order to accurately monitor patient weights and carry out nutritional screening. There must be evidence of reassessment, where required (see page 13).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.2. ring the COVID-19 pandemic.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1.1 1.2	Every patient should receive a robust full review and assessment on admission to the ward to ensure that the care and treatment plan describes care provided along with regular reassessments which align to person centred care plan management plans – how can we be assured this is happening (see comments) All staff to ensure they complete every section of the patient care record on admission to the ward. This will be monitored by SCN/CNs who will complete quality assurance checks of the patient documentation to ensure robust assessments are in place on admission to the ward; this will include a review of all admission documentation within 24 hours of admission to the ward.	31/12/20	SCN , Lead Nurse, CSM	A two-tier rolling audit programme is being trialed across the HSCP wards - 5 audits will be undertaken by SCNs/ CNs on a monthly basis and 5 audits will be undertaken by the Lead Nurses/CSM on a monthly basis. Support & education will be provided to the teams as required and issues escalated accordingly. Audit compliance will be shared with the clinical teams to share learning and monitored to provide assurance to Senior Leadership. Documentation Assurance.docx Admission Flowchart.docx	15/3/2021

				Admission stickers have been introduced to review quality of assessments and documentation within 24 hours of transfer/admission to the ward. SCN on ward meeting with every member of staff to ensure understanding and compliance Admission Sticker.docx admission checklist audit.docx	01/03/21
1.3	Weighing scales ordered.	31.12.20		Weighing scales arrived on the Ward in December 2020. Fews and MUST.docx	31.12.20

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

2 NHS Fife must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient's condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions (see page 13).
This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, 2015); Care of Older People in Hospital Standards (2015) criteria 1.1, 1.4, and 11.2a; and Food, Fluid and Nutritional Care Standards (2014) Criterion 2.9a.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
2.1	Senior Nursing Leadership Team requires assurance that the standard of documentation is safe, effective and person centred. To maintain sustained improvement the Lead Nurse will conduct random monthly audits of 5 sets of notes and feed back to SCN's in real time.	01/03/2021	SCN and Lead Nurse	NHS Fife wide documentation review SLWG set up to address transfer documentation and patient centred care planning. Local review by SCN and Lead nurse of 5 sets of notes on monthly. This review supplements the formal monthly review	01/03/2021

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

3 NHS Fife must ensure a consistent approach to mealtimes is implemented in all wards and that staff co-ordinate the meals appropriately. All non-essential staff activity (clinical and non-clinical) is stopped during patient mealtimes and the principles of Making Meals Matter are implemented. An adequate number of staff are available at mealtimes to support patients (see page 13).
This is to comply with the Food, Fluid and Nutritional Care Standards (2014), criteria 4.1a and 4.7

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
3.1 3.2	All SCNs will ensure that "Making Meals Matter" is implemented in all areas: Members of the MDT advised that this will be strictly adhered to unless the patients' condition contradicts this.	Immediate	SCNs	Safety huddles in place. Mealtime "pause" commenced at 11.45am, patients are prepared for the mealtime and also a mealtime coordinator has been introduced on ward to ensure patients are prepared properly and the pause happens. Meal Coordinator Role.docx	10/03/2021

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

4 NHS Fife must ensure that when fluid balance charts and food record charts are commenced for patients who require them, they are accurately completed, and appropriate action taken in relation to intake or output as required. This includes the recording of nutritional supplements (see page 13).
This is to comply with the Food, Fluid and Nutritional Care Standards (2014), Criterion 4.1(g)

Ref:	Action Planned	Timescal eto meet action	Responsibility fortaking action	Progress	Date Complete d
4.1	All staff will fully complete Fluid Balance Charts andFood Intake Charts and take appropriate actions. The ward aims to improve completion and accuracy of Food intake Charts with the use of red mats. Red mats are used to identify patients who require closer monitoring of dietary intake and food record charting.	31/12/20	SCN	Fluid balance audit commenced on the 08032021 - being undertaken daily with up to 5 fluid balance charts being audited Discussed at all safety huddles and as part of the handover. Education relating to nutritional and fluid care management was undertaken in November 2020. Further education and training is being arranged in relation to completion of fluid balance charts – these will be validated daily by the nurse in charge. An audit tool has been introduced to measure quality and compliance of information.	11/03/2021
4.2	A ward based process will be developed to provide assurance on the accuracy of completion of fluid balance charts	30/11/20	SCN		30/11/2020

				Staff will also be reminded during handovers and safety huddles on the importance of accurate fluid management. The SCN will ensure that this is discussed individually with every Registered Nurse at their dedicated 1:1. The Fluid Management Specialist Nurse is a member of the improvement collaborative team.  Fluid audit tool.docx  RECORD OF CONVERSATION FOR	

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

5 NHS Fife must ensure that the SSKIN bundles are consistently and accurately completed to ensure that the frequency of repositioning is indicated and the results of skin inspection are documented (see page 13).
This is to comply with Prevention and Management of Pressure Ulcers (2020) standard 6.1

Ref:	Action Planned	Timescale to meet action	Responsibility fortaking action	Progress	Date Completed
5.1	All staff will fully complete SKINN Bundles consistently, accurately and take appropriate actions. Compliance will be monitored within the remit of the audit programme.	31/12/20	SCN, LN	PURA & SSKIN Compliance Data Tarv Individual 1:1 discussions have taken place. Work taking place as part of the improvement collaborative has evidenced improvement.	11/03/2021
5.2	The ward is part of an Integrated Improvement Collaborative focusing on a number of areas forimprovement.	30/04/2021	SCN/LN	Tarvit ward is participating in an improvement collaborative which includes focus on reducing hospital acquired pressure ulcers. The ward completes weekly process measures data (5 patients per week). Overall compliance has been good and weekly	

				data is monitored and discussed during the improvement collaborative. The overall process measures data (overall) demonstrates how the ward has responded to issues (see annotated compliance chart). TV Agenda (240221).docx Outcome data demonstrated that between Jul-20 and Nov-20 the ward had no hospital acquired pressure ulcers.	

People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

6. NHS Fife must ensure that all documentation including wound charts are signed, dated and timed (see page 13).
This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015); and Generic Medical Record Keeping Guidelines (2009).

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
6.1	Wound management chart should be fully completed and signed and dated. All staff have been reminded of the importance of documentation completion. Evidence of improvement will be provided via informal and formal documentation audit.	31/01/ 2021	SCN, LN, CSM	Education sessions have taken place with Tissue Viability Nurses. Ongoing rolling programme of education led by Tissue Viability Nurses and SCN currently being organised with dates being planned over the remainder of the year.	31/01/2021

Infection control practices support a safe environment for both people experiencing care and staff.

7 NHS Fife must ensure that all staff perform hand hygiene at appropriate opportunities, as per the World Health Organisation's Five Moments for Hand Hygiene guidelines (see page 16).
This is to comply with Healthcare Associated Infection (HAI) standards (2015) Criteria 6.1.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
7.1	All staff must ensure hand hygiene is completed appropriately in relation to Infection Control Standards Feedback given to staff on the day of the inspection. Hand hygiene weekly audits will continue	31/12/20	SCN	Audited for the past two weeks and has shown compliance. Will be monitored at the weekly quality meetings moving forward. Is included in the quarterly quality assurance reports which are shared with the ADoN and HoNs. Quality Assurance Report up to 31st Dec	11/03/2021

7.2	QI boards are being implemented across the HSCP wards Data will be displayed and provide a forum for team discussions.			Quality Boards – training is being provided to identified staff, this will enable capability and capacity to extract data for display.	11/03/2021

Infection control practices support a safe environment for both people experiencing care and staff.

8 NHS Fife must ensure that the condition of all patient equipment allows it to be effectively decontaminated (see page 16). This is to comply with Healthcare Associated Infection (HAI) standards (2015) Criteria 8.1.

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
8.1	There is a review of the system to which "near patient" equipment and furniture is inspected and reviewed, and a system of timeous replacement is in place.	31/12/20	SCN, LN, CSM	Equipment monitoring recorded on safe and clean audit and there is a rolling programme to replace equipment with facilities. Chairs affected have been replaced Up to date training available for MICAD system onrequest for all staff.	December 2020 December 2020

INFORMATION GOVERNANCE & SECURITY STEERING GROUP

Terms of Reference

1. PURPOSE

1.1 Information Governance & Security (IG&S) refers to the structures, policies and practice in place to ensure the confidentiality, availability and integrity of the information processed by or on behalf of NHS Fife, including patient records and all corporate records which are pertinent to regulations, and to enable the ethical and safe use of them for the benefit of individual patients and the public good.

1.2 Information Assurance refers to the practice of assuring information and managing risks related to the use, processing, storage, and transmission of information or data and the systems and processes used for those purposes.

1.3 It is the key purpose of the IG&S Group to act as a Steering Group providing, whole system leadership, oversight and assurance to the organisation and will ensure that all IG&S risks have effective and appropriate mitigations. Accountable to the Clinical Governance Committee but also provide assurance reporting to relevant governance committees as appropriate. The governance relationships are illustrated in Appendix 1. Digital & Information Governance.

2. COMPOSITION

2.1 The membership of the IG&S Group will be:

- Chair – Senior Information Risk Owner (SIRO), Director of Finance
- Vice Chair - Caldicott Guardian, Medical Director
- Associate Medical Director
- Director of Nursing
- General Practitioner
- Director of Public Health or Deputy
- Director of Workforce or Deputy
- Director of Acute Services or Deputy
- Director of H&SCP or Deputy
- Director of Pharmacy or Deputy
- Associate Director of Planning
- Associate Director – Digital & Information
- Associate Director of Research & Development
- Staff side representation - member from APF

If members are unable to attend, a deputy at an appropriate level of seniority must attend in their place

In regular attendance:-

- The NHS Fife Data Protection Officer- as required by the General Data Protection Regulation and Chair of the IG&S Operational Group
- Head of Communications
- Head of Patient Relations
- Head of Digital Operations
- Head of Corporate Governance

The Group may invite others to routinely attend the meeting. However only appointed members are entitled to attend Group meetings and it is for those members to determine whether others should attend for a particular meeting or specific agenda item.

3. MEETINGS

3.1 The Group shall meet as necessary to fulfil its remit but not less than four times a year.

3.2 Meetings of the Group will be quorate when at least six Members are present, one of whom must be, SIRO (Senior Information Risk Owner), Associate Director – Digital & Information or Medical Director.

3.3 The agenda and supporting papers will be sent out at least five clear days before the meeting. Members are required to review the papers in advance and raise any concerns or comments at the meeting, in support of this verbal updates will be by exception.

3.4 In the event of a planned meeting not being quorate, the recommendations of those who attended will be circulated within 7 days of the meeting for agreement by the majority of the group members.

4. REMIT

4.1 To draw up and agree, before the start of each financial year, an Annual Work Plan which schedules the Group's activities to ensure they cover its assurance needs in the forthcoming year and to monitor this throughout the year.

4.2 To seek assurances regarding compliance with legislative requirements (including subject access request timescales) with the Access to Health Records Act 1990, Data Protection Act (2018), General Data Protection Regulation (GDPR). GDPR sets out seven Principles, Lawfulness, fairness and transparency, Purpose limitation, Data minimisation, Accuracy, Storage limitation, Accountability and Integrity and confidentiality (security)

4.3 To seek assurance that General Data Protection Regulation assurance documentation is available as per requirement to demonstrate organisation GDPR compliance to the regulator.

4.4 To seek assurances regarding compliance with legislative requirements (including freedom of information request timescales) with the Freedom of Information (Scotland) Act 2011.

4.5 To seek assurances regarding compliance with legislative requirements with the Public Records (Scotland) Act 2011.

4.6 To seek assurances regarding compliance with legislative requirements within the NHS Scotland Information Security Policy Framework 2018. This single 2018 framework integrates the controls of ISO27001:2013, alongside the legal compliance requirements of NIS:2018 and security aspects of GDPR:2018 thereby obviating the need for health boards to reference to all three standards. Although not a legal requirement, the 2018 ISPF controls additionally address the features of the Public Sector Action Plan (PSAP) and Cyber Essentials (CE) to which health boards need to comply with independent assurance verification of the CE critical controls.

4.7 To seek assurances regarding Information Governance and Information Security Policies and Procedures and whether these have been reviewed and updated within their scheduled review timescales.

4.8 To seek assurance that the Board is complying with all NHS Scotland strategies, policies, and codes of practice relating to IG&S.

4.9 To seek assurances regarding the management and mitigation of information governance and security risks and that management have an adequate improvement plan in place to mitigate any high risks in a timely manner

4.10 Monitor reports relating to information security and adverse event logs, and seek assurance that management are taking appropriate action.

4.11 Direct the IG&S Operational Group workplan and act as an escalation body for the IG&S Operational Group for issues, providing decision support when required.

5. AUTHORITY & REPORTING

5.1 For Governance purposes the Information Governance & Security Steering Group reports to the Clinical Governance Committee.

5.2 The Group is authorised by the Chief Executive to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

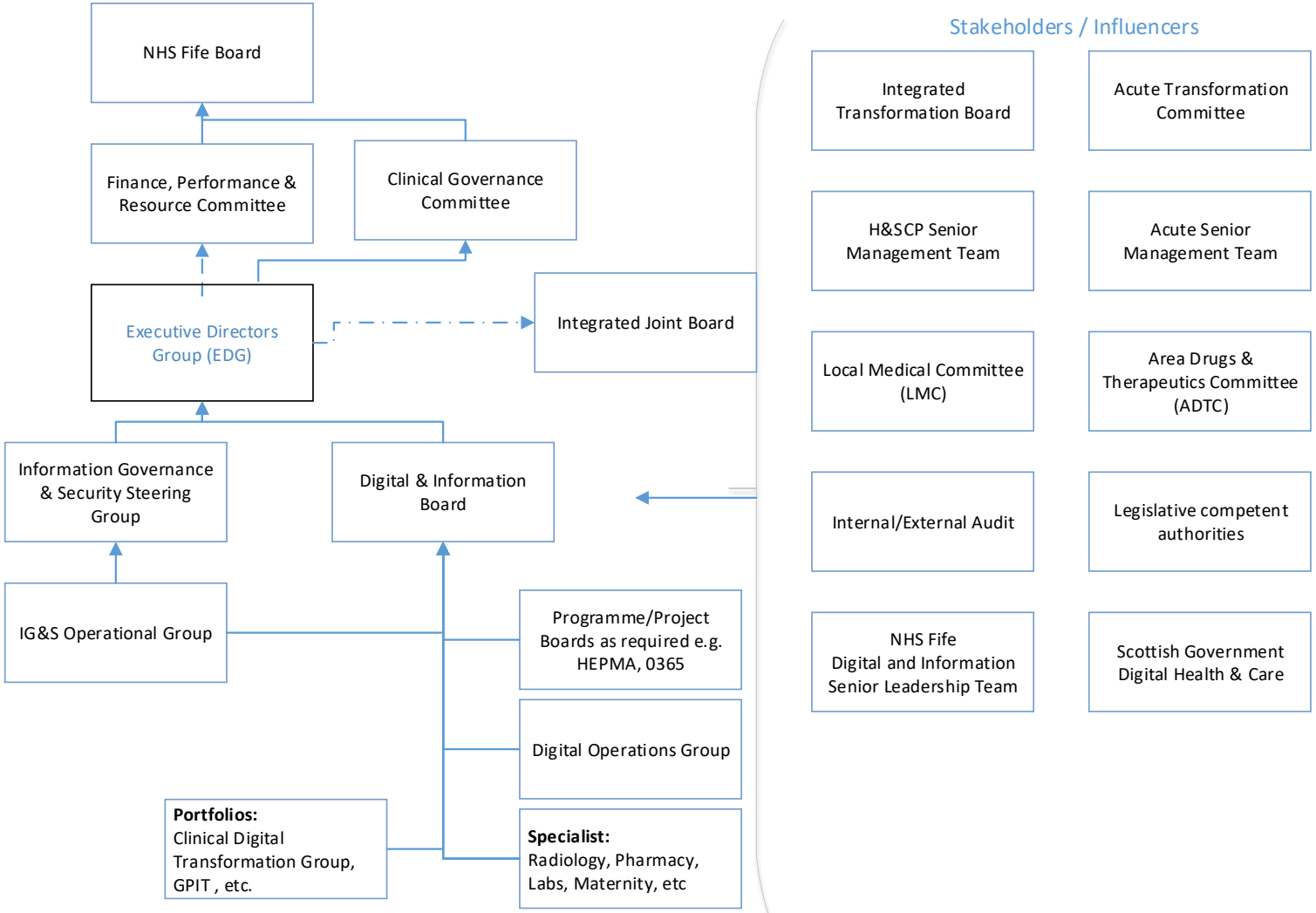
5.3 In order to fulfil its remit, the Information Governance & Security Steering Group may obtain whatever professional advice it requires and requires Directors or other managers of the Board to attend meetings.

5.4 The Group will provide an annual assurance statement to the Board, via the Clinical Governance Committee, confirming that the group has discharged its remit and thereby achieved and maintained the Best Value standards, relevant to the Group's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements" – *"There is a robust information governance framework in place that ensures proper recording and transparency of all the organisation's activities and supports appropriate exploitation of the value of the organisation's information."* This assurance allows the Chief Executive to provide an overview in the Board's Annual Governance Statement regarding any significant lapses in information security.

5.5 The group shall prepare an annual report (for the year ending 31 March) to inform the assurance Statement to be agreed at its first meeting after 31 March which should be no later than 30 April.

5.6 Minutes of the Group are also presented to the Fife H&SCP Clinical and Care Governance Committee and Audit & Risk Committee by the SIRO who provides a report, on an exception basis, on any particular issues which the SIRO wishes to draw to the Board's attention.

Appendix 1: Digital & Information Governance



NHS FIFE
CLINICAL GOVERNANCE COMMITTEE

DATE OF MEETING:	22 April 2021
TITLE OF REPORT:	Medical Education
EXECUTIVE LEAD:	Dr Chris McKenna
REPORTING OFFICER:	Professor Morwenna Wood

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

SBAR REPORT

Situation

The General Medical Council have developed "Promoting excellence: standards for medical education and training" which became effective on 1 January 2016. NHS Fife is assessed as a Local Education Provider by these standards for medical students and doctors in training on placement.

Requirement 2.2 states:

Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.

Background

The universities of Edinburgh, Dundee, St Andrews and Aberdeen every year place medical students with NHS Fife in order for them to gain experience and receive teaching in a clinical setting. The number of students on placement throughout the year will be approximately 450 from Edinburgh, 200 from Dundee, 180 from St Andrews, 92 from the Scottish Graduate Entry Medical programme (ScotGEM) and 25 from Aberdeen.

The Medical ACT Allocation for 2019/20 to NHS Fife was £3,031,778 for taking medical students on placement the previous year. There has been an additional £1,640,000 added to fund ScotGEM years 1-3 in Fife. ScotGEM is a partnership venture with the universities of St Andrews, Dundee and Highland & Islands and the Health Boards of Dumfries & Galloway, Highland, Tayside and Fife. Year 1 began in August 2018 and has been taught in primary care by Generalist Clinical Mentors (GCM). NHS Fife currently have 9 year 1 GCMs, 4 year 2 GCMs, 2 year 3 GCMs, a Fife Regional GCM and a Lead GCM. The teaching the students receive is modelled on case based learning within a host GP practice. Year 3 began in August 2020 which saw the introduction of Longitudinal Integrated Clerkship (LIC) where the students spend a year in the same GP practice following a variety of patient's through their primary and secondary care journey. The planning for year 4 remains a work in progress and the students will join the final year cohort of medical students from the University of Dundee.

NHS Fife has approximately 220 Deanery approved doctor-in-training posts that are part of regional and national training programmes: 69 Foundation Doctors, 31 Core Trainees, 46 General Practice Trainees and 74 further trainees in a range of specialties.

Assessment

NHS Education Scotland (NES) coordinate the undergraduate survey and this year it reported an exceptionally high number of green flags, confirming that the quality of undergraduate education carried out in NHS Fife is excellent – see RAG Report attached in Appendix 1. The numbers are lower than last year due to all students being withdrawn from placement in March 2020 due to the COVID19 pandemic. The only red flag received can be explained due to that particular specialty being between Local Module Leads for a short while. The positive feedback received from all universities is due to the dedication, enthusiasm and commitment that the NHS Fife Local Module Leads have towards undergraduate medical education. This can be seen as the new academic year began in August 2020 and the way the Local Module Leads have adapted to ensure that education can still go ahead for medical students.

The GMC coordinate the postgraduate survey and the results are available online to the public. This year's results, again, show a mixture of positive and negative feedback across the specialties. The Director of Medical Education will coordinate with the relevant clinical leads in order to develop a response to the data and develop improvement plans to address any issues. Positive feedback will be celebrated and good practice can be shared. Scottish Trainee Survey data can be found in appendix 2.

NHS Fife still offers excellent postgraduate training thanks to the efforts of all of our educators, and with continuing support the less than perfect areas can be brought up to the same standard as those receiving the excellent feedback.

Recommendation

NHS Fife should continue to support medical education and the trainers that deliver it.

Management and clinical colleagues need to work together to gain better postgraduate feedback as some things are beyond either parties individual control.

Time for training should be recognised in job plans; efforts are being made to ensure that all educators have sufficient time in their job plans, although initial results are very positive this work is still in progress.

Perhaps there needs to be greater awareness in NHS Fife that trainees are here to be trained and not simply to deliver service. Departments must be able to support the training requirements of the individual trainee doctors.

Objectives: (must be completed)	
Healthcare Standard(s):	General Medical Council: Promoting excellence: standards for medical education and training.
HB Strategic Objectives:	To improve the training experience of doctors in NHS Fife.

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

Impact: (must be completed)	
Financial / Value For Money	No requirement for spend. Participation in undergraduate medical education attracts funding from NHS Education Scotland and generates income for the Board. NES provides the basic salary for all trainees, with the board only expected to pay their out of hours work.
Risk / Legal:	NES quality assure education and training in our Board and the DME report is an essential part of the Quality Assurance Framework. GMC survey is freely available to the public online and poor survey results risks reputational damage. Trainee doctors may be removed from NHS Fife leaving departments unable to provide service, leading to departmental closures.
Quality / Patient Care:	It is critical to patient care that sufficient doctors are trained in Scotland.
Workforce:	The delivery of medical education by clinicians is in addition to their direct clinical care activities. Having realistic time in job plans is essential. A reduction in the trainee cohort would lead to devastating consequences for many departments.
Equality:	Access to medical education is subject to robust equality and diversity protocols, including an initiative to widen access to medical school places from low income families.

Appendix 1 – 2019/2020 Undergraduate Teaching Report

2019/20 Detailed Undergraduate Teaching Report: NHS Fife

School	Site	Specialty	Year	Number of respondents
St Andrews	Cameron Hospital	Rehabilitation Medicine	3	23 (50)
St Andrews	Queen Margaret Hospital	Psychiatry	3	4 (8)
St Andrews	Stratheden Hospital	Old Age Psychiatry	3	7 (14)
Dundee	Stratheden Hospital	Psychiatry	4	3 (9)
St Andrews	Stratheden Hospital	Psychiatry	3	7 (14)
Edinburgh	Victoria Hospital	Anaesthesia	6	10 (16)
Dundee	Victoria Hospital	Anaesthetics	5	2 (4)
St Andrews	Victoria Hospital	ANP GI/Cardiology	3	20 (63)
St Andrews	Victoria Hospital	Cardiology	3	4 (8)
Dundee	Victoria Hospital	Child Health	4	14 (19)
Edinburgh	Victoria Hospital	Child Life and Health	5	6 (10)
St Andrews	Victoria Hospital	Clinical Reasoning	3	54 (113)
Edinburgh	Victoria Hospital	Critical Care	6	11 (18)
St Andrews	Victoria Hospital	Dermatology	3	7 (16)
St Andrews	Victoria Hospital	Emergency Medicine	3	54 (116)
St Andrews	Victoria Hospital	Endocrinology	3	1 (7)
St Andrews	Victoria Hospital	ENT	3	9 (15)
St Andrews	Victoria Hospital	Every Person Every Time	3	26 (46)
Dundee	Victoria Hospital	Foundation Medicine	5	1 (6)
St Andrews	Victoria Hospital	Gastrointestinal	3	20 (38)
Dundee	Victoria Hospital	General Medicine	4	14 (18)
Dundee	Victoria Hospital	General Surgery	4	4 (5)
Edinburgh	Victoria Hospital	General Surgery	6	12 (35)
St Andrews	Victoria Hospital	Haematology	3	10 (17)
Dundee	Victoria Hospital	Intensive Care Medicine	5	2 (3)
St Andrews	Victoria Hospital	Inter Professional Care	3	41 (94)
St Andrews	Victoria Hospital	Loss	3	51 (95)
Edinburgh	Victoria Hospital	Medicine	6	15 (47)
St Andrews	Victoria Hospital	Medicine of the Elderly	3	19 (37)
Edinburgh	Victoria Hospital	Medicine of the Elderly	6	8 (29)
St Andrews	Victoria Hospital	Neurology	3	9 (16)
Dundee	Victoria Hospital	Obstetrics & Gynaecology	4	10 (16)
Dundee	Victoria Hospital	Obstetrics & Gynaecology	5	2 (6)
Edinburgh	Victoria Hospital	Obstetrics and Gynaecology	5	4 (9)
St Andrews	Victoria Hospital	Orthopaedics	3	57 (116)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.5
- Score more than or equal
- No results available

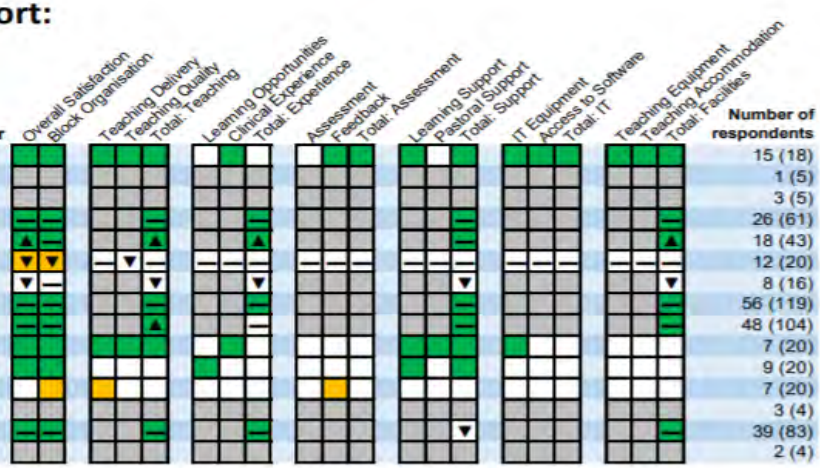
Notes

This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown regardless of the number of responses available. Figures in brackets are the potential number of respondents. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Trend data: indicates an improvement in the flag from the previous year, a deterioration and no change. **No Trend data for Glasgow Medical School is shown because the 2019/20 RAG outcomes are not comparable to previous years. The data from the 2019/2020 academic year is incomplete due to teaching being curtailed because of lockdown restrictions for the COVID-19 pandemic.**

NHS Fife

NHS Education for Scotland

2019/20 Detailed Undergraduate Teaching Report: NHS Fife



School	Site	Specialty	Year	Number of respondents
Edinburgh	Victoria Hospital	Orthopaedics / Principles of Surgery	4	15 (18)
St Andrews	Victoria Hospital	Paediatric Physiotherapy	3	1 (5)
Dundee	Victoria Hospital	Paediatrics	5	3 (5)
St Andrews	Victoria Hospital	Palliative Care	3	26 (61)
St Andrews	Victoria Hospital	Peri-operative Care	3	18 (43)
Edinburgh	Victoria Hospital	Renal	5	12 (20)
St Andrews	Victoria Hospital	Renal Medicine	3	8 (16)
St Andrews	Victoria Hospital	Reproductive Health	3	56 (119)
St Andrews	Victoria Hospital	Surgery	3	48 (104)
Dundee	Victoria Hospital	Surgery Specialties - Ophthalmology	4	7 (20)
Dundee	Victoria Hospital	Surgery Specialties - Otolaryngology	4	9 (20)
Dundee	Victoria Hospital	Surgery Specialties - Urology	4	7 (20)
St Andrews	Victoria Hospital	Urology	3	3 (4)
St Andrews	Victoria Hospital	When Organs Fail	3	39 (83)
Edinburgh	Whytemans Brae Hospital	Psychiatry	5	2 (4)

Appendix 2 – STS Data 2020 NHS Fife

STS Data for departments not on Triage/High Performers lists

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Lynebank Hospital	Child & Adolescent Psychiatry	ST								1
Lynebank Hospital	Child & Adolescent Psychiatry	ST								1 (aggregated)
Lynebank Hospital	Child & Adolescent Psychiatry	All posts								1
Lynebank Hospital	Child & Adolescent Psychiatry	All posts								1 (aggregated)
Lynebank Hospital	Psychiatry of Learning Disability	Core								1
Lynebank Hospital	Psychiatry of Learning Disability	Core	W —	W —	W —	W —	W —	W —	W —	5 (aggregated)
Lynebank Hospital	Psychiatry of Learning Disability	ST								1
Lynebank Hospital	Psychiatry of Learning Disability	ST								4 (aggregated)
Lynebank Hospital	Psychiatry of Learning Disability	All posts								2
Lynebank Hospital	Psychiatry of Learning Disability	All posts	W —	W —	W —	W —	W —	W —	W —	11 (aggregated)
NHS Fife	Public health medicine	ST								2
NHS Fife	Public health medicine	ST								4 (aggregated)
NHS Fife	Public health medicine	All posts								2
NHS Fife	Public health medicine	All posts								4 (aggregated)
Queen Margaret Hospital	Community Health	ST								1
Queen Margaret Hospital	Community Health	ST								1 (aggregated)
Queen Margaret Hospital	Community Health	All posts								1
Queen Margaret Hospital	Community Health	All posts								1 (aggregated)
Queen Margaret Hospital	Dermatology	ST								1
Queen Margaret Hospital	Dermatology	ST								1 (aggregated)
Queen Margaret Hospital	Dermatology	All posts								1
Queen Margaret Hospital	Dermatology	All posts	G	W		W	W	W	W	5 (aggregated)

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Queen Margaret Hospital	General Psychiatry	Foundation								2
Queen Margaret Hospital	General Psychiatry	Foundation	W —	W —	R —	W —	W —	W —	W —	9 (aggregated)
Queen Margaret Hospital	General Psychiatry	GPST								1
Queen Margaret Hospital	General Psychiatry	GPST	W —	W —	W —	W —	W —	W —	W —	5 (aggregated)
Queen Margaret Hospital	General Psychiatry	Core								1
Queen Margaret Hospital	General Psychiatry	Core								4 (aggregated)
Queen Margaret Hospital	General Psychiatry	ST								1
Queen Margaret Hospital	General Psychiatry	ST								3 (aggregated)
Queen Margaret Hospital	General Psychiatry	All posts	W —	W ▲	W —	W —	W ▲	W —	W —	5
Queen Margaret Hospital	Geriatric Medicine	Foundation								1
Queen Margaret Hospital	Geriatric Medicine	Foundation								1 (aggregated)
Queen Margaret Hospital	Geriatric Medicine	All posts								1
Queen Margaret Hospital	Geriatric Medicine	All posts	G —	W —	W —	W —	W —	W —	W —	11 (aggregated)
Queen Margaret Hospital	Old Age Psychiatry	Foundation								1
Queen Margaret Hospital	Old Age Psychiatry	Foundation	W	W	W	W	W	W	W	5 (aggregated)
Queen Margaret Hospital	Old Age Psychiatry	GPST								1
Queen Margaret Hospital	Old Age Psychiatry	GPST								2 (aggregated)
Queen Margaret Hospital	Old Age Psychiatry	Core								1
Queen Margaret Hospital	Old Age Psychiatry	Core								3 (aggregated)
Queen Margaret Hospital	Old Age Psychiatry	All posts								3
Queen Margaret Hospital	Old Age Psychiatry	All posts	W —	W —	P —	W —	W —	W —	W —	10 (aggregated)
Queen Margaret Hospital	Ophthalmology	GPST								1
Queen Margaret Hospital	Ophthalmology	GPST								3 (aggregated)
Queen Margaret Hospital	Ophthalmology	ST								3
Queen Margaret Hospital	Ophthalmology	ST	W —	W —	W —	W —	W —	L —	W —	17 (aggregated)
Queen Margaret Hospital	Ophthalmology	All posts								4

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Queen Margaret Hospital	Ophthalmology	All posts	G	G	W	G	G	G	A	20 (aggregated)
Queen Margaret Hospital	Rehabilitation Medicine	GPST								2
Queen Margaret Hospital	Rehabilitation Medicine	GPST								4 (aggregated)
Queen Margaret Hospital	Rehabilitation Medicine	All posts								2
Queen Margaret Hospital	Rehabilitation Medicine	All posts								4 (aggregated)
Queen Margaret Hospital	Trauma and Orthopaedics	ST								1
Queen Margaret Hospital	Trauma and Orthopaedics	ST								4 (aggregated)
Queen Margaret Hospital	Trauma and Orthopaedics	All posts								1
Queen Margaret Hospital	Trauma and Orthopaedics	All posts								4 (aggregated)
Queen Margaret Hospital	Urology	ST								2
Queen Margaret Hospital	Urology	ST								2 (aggregated)
Queen Margaret Hospital	Urology	All posts								2
Queen Margaret Hospital	Urology	All posts								2 (aggregated)
Stratheden Hospital	Child & Adolescent Psychiatry	Core								1
Stratheden Hospital	Child & Adolescent Psychiatry	Core								4 (aggregated)
Stratheden Hospital	Child & Adolescent Psychiatry	All posts								1
Stratheden Hospital	Child & Adolescent Psychiatry	All posts	W	W	W	W	W	W	W	6 (aggregated)
Stratheden Hospital	General Psychiatry	Foundation								3
Stratheden Hospital	General Psychiatry	Foundation	W	W	P	W	W	W	W	9 (aggregated)
Stratheden Hospital	General Psychiatry	ST								1
Stratheden Hospital	General Psychiatry	ST								1 (aggregated)
Stratheden Hospital	General Psychiatry	All posts								4
Stratheden Hospital	General Psychiatry	All posts	W	R	R	R	W	W	W	20 (aggregated)
Stratheden Hospital	Old Age Psychiatry	Foundation								1
Stratheden Hospital	Old Age Psychiatry	Foundation								4 (aggregated)
Stratheden Hospital	Old Age Psychiatry	All posts								1

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Stratheden Hospital	Old Age Psychiatry	All posts	W —	R —	W —		W —	W —	W —	6 (aggregated)
Victoria Hospital	Anaesthetics	Foundation								4
Victoria Hospital	Anaesthetics	Foundation	W —	W —	W —	W —	W —	W —	W —	14 (aggregated)
Victoria Hospital	Anaesthetics	Core	W —	W —	W —	W —	W —	W —	W —	6
Victoria Hospital	Anaesthetics	ST	W —	W ▲	W ▲	W —	W —	W —	W —	5
Victoria Hospital	Anaesthetics	All posts	W —	L ▲	W ▲	W —	W —	W —	W —	15
Victoria Hospital	Cardiology	Core								1
Victoria Hospital	Cardiology	Core	G	W		W	W	W	W	5 (aggregated)
Victoria Hospital	Cardiology	ST								1
Victoria Hospital	Cardiology	ST								2 (aggregated)
Victoria Hospital	Cardiology	All posts								2
Victoria Hospital	Cardiology	All posts	G —	W —	W —	W —	W —	W —	W —	8 (aggregated)
Victoria Hospital	Endocrinology & Diabetes	Core								2
Victoria Hospital	Endocrinology & Diabetes	Core	W —	W —	R —	W —	W —	L —	W —	8 (aggregated)
Victoria Hospital	Endocrinology & Diabetes	ST								1
Victoria Hospital	Endocrinology & Diabetes	ST								1 (aggregated)
Victoria Hospital	Endocrinology & Diabetes	All posts								3
Victoria Hospital	Endocrinology & Diabetes	All posts	W —	W —	R —	W —	W —	L —	W —	9 (aggregated)
Victoria Hospital	General Internal Medicine	Foundation	W ▼	W —	R ▲	W —	W ▲	W ▼	W ▲	40
Victoria Hospital	General Internal Medicine	GPST								2
Victoria Hospital	General Internal Medicine	GPST								4 (aggregated)
Victoria Hospital	General Internal Medicine	Core	P ▼	W —	R ▼	R ▼	W —	P ▼	P —	7
Victoria Hospital	General Internal Medicine	ST	L ▲	W —	R —	W —	W —	W —	W —	6
Victoria Hospital	General Internal Medicine	All posts	W ▼	W —	R —	P ▼	W ▲	W ▼	R —	55
Victoria Hospital	General Psychiatry	GPST								1
Victoria Hospital	General Psychiatry	GPST								4 (aggregated)

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Victoria Hospital	General Psychiatry	All posts								1
Victoria Hospital	General Psychiatry	All posts								4 (aggregated)
Victoria Hospital	Geriatric Medicine	Foundation	W ▼	W —			W —	W —	W —	5
Victoria Hospital	Geriatric Medicine	GPST								4
Victoria Hospital	Geriatric Medicine	GPST	G —	P —	P —	W —	P —	W —	R —	31 (aggregated)
Victoria Hospital	Geriatric Medicine	Core								3
Victoria Hospital	Geriatric Medicine	Core	G —	W —	P —	W —	W —	L —	W —	13 (aggregated)
Victoria Hospital	Geriatric Medicine	ST								1
Victoria Hospital	Geriatric Medicine	ST								4 (aggregated)
Victoria Hospital	Geriatric Medicine	All posts	W —	W —	W —	W —	W —	W —	W —	13
Victoria Hospital	Haematology	ST								1
Victoria Hospital	Haematology	ST	W —	W —	W —	W —	W —	W —	W —	5 (aggregated)
Victoria Hospital	Haematology	All posts								1
Victoria Hospital	Haematology	All posts	L —	W —	W —	W —	W —	W —	W —	5 (aggregated)
Victoria Hospital	Histopathology	ST								2
Victoria Hospital	Histopathology	ST								4 (aggregated)
Victoria Hospital	Histopathology	All posts								2
Victoria Hospital	Histopathology	All posts								4 (aggregated)
Victoria Hospital	Intensive Care Medicine	Foundation								2
Victoria Hospital	Intensive Care Medicine	Foundation	G —	L —	W	W —	W —	W —	W —	5 (aggregated)
Victoria Hospital	Intensive Care Medicine	ST								3
Victoria Hospital	Intensive Care Medicine	ST	W —	W —	L ▲	W —	G —	L —	W —	17 (aggregated)
Victoria Hospital	Intensive Care Medicine	All posts	G ▲	G ▲	W —	W —	G —	W —	W —	5
Victoria Hospital	Neonatal Medicine	ST								2
Victoria Hospital	Neonatal Medicine	ST								2 (aggregated)
Victoria Hospital	Neonatal Medicine	All posts								2

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Victoria Hospital	Neonatal Medicine	All posts								2 (aggregated)
Victoria Hospital	Otolaryngology	ST								2
Victoria Hospital	Otolaryngology	ST								3 (aggregated)
Victoria Hospital	Otolaryngology	All posts								2
Victoria Hospital	Otolaryngology	All posts	W —	W —	W —	W —	W —	W —	W —	15 (aggregated)
Victoria Hospital	Paediatrics	Foundation								3
Victoria Hospital	Paediatrics	Foundation	G —	W —	W —	W —	W —	W —	W —	15 (aggregated)
Victoria Hospital	Paediatrics	GPST								4
Victoria Hospital	Paediatrics	GPST	W —	P —	W —	R —	W —	W —	W —	30 (aggregated)
Victoria Hospital	Paediatrics	ST	W —	W —	W ▲	W —	W —	W —	W —	9
Victoria Hospital	Paediatrics	All posts	W —	W —	W ▲	W ▲	W —	W —	W —	16
Victoria Hospital	Palliative Medicine	GPST								1
Victoria Hospital	Palliative Medicine	GPST								4 (aggregated)
Victoria Hospital	Palliative Medicine	ST								1
Victoria Hospital	Palliative Medicine	ST								2 (aggregated)
Victoria Hospital	Palliative Medicine	All posts								2
Victoria Hospital	Palliative Medicine	All posts	G —	W —	W —	L —	W —	L —	G —	6 (aggregated)
Victoria Hospital	Renal Medicine	Core								2
Victoria Hospital	Renal Medicine	Core	W —	W —	W —	W —	W —	W —	W —	8 (aggregated)
Victoria Hospital	Renal Medicine	ST								1
Victoria Hospital	Renal Medicine	ST								2 (aggregated)
Victoria Hospital	Renal Medicine	All posts								3
Victoria Hospital	Renal Medicine	All posts	W —	W —	W —	W —	W —	W —	W —	10 (aggregated)
Victoria Hospital	Respiratory Medicine	Foundation								1
Victoria Hospital	Respiratory Medicine	Foundation								2 (aggregated)
Victoria Hospital	Respiratory Medicine	Core								3

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Victoria Hospital	Respiratory Medicine	Core	W	W	W	W	W	W	W	7 (aggregated)
Victoria Hospital	Respiratory Medicine	All posts								4
Victoria Hospital	Respiratory Medicine	All posts	W —	W —	R —	W —	W —	W —	W —	10 (aggregated)
Victoria Hospital	Trauma and Orthopaedics	ST	W —	W —	W —	W —	W —	W —	W —	7
Victoria Hospital	Trauma and Orthopaedics	All posts	L —	L —	W —	W —	G —	W —	L —	7
Victoria Hospital	Urology	Foundation								1
Victoria Hospital	Urology	Foundation								1 (aggregated)
Victoria Hospital	Urology	ST								1
Victoria Hospital	Urology	ST								2 (aggregated)
Victoria Hospital	Urology	All posts								2
Victoria Hospital	Urology	All posts								3 (aggregated)
Whytemans Brae Hospital	General Psychiatry	Foundation								1
Whytemans Brae Hospital	General Psychiatry	Foundation								1 (aggregated)
Whytemans Brae Hospital	General Psychiatry	Core								1
Whytemans Brae Hospital	General Psychiatry	Core								3 (aggregated)
Whytemans Brae Hospital	General Psychiatry	All posts								2
Whytemans Brae Hospital	General Psychiatry	All posts	W —	W —	R —	W —	W —	W —	W —	11 (aggregated)
Whytemans Brae Hospital	Geriatric Medicine	Foundation								1
Whytemans Brae Hospital	Geriatric Medicine	Foundation								1 (aggregated)
Whytemans Brae Hospital	Geriatric Medicine	All posts								1
Whytemans Brae Hospital	Geriatric Medicine	All posts								1 (aggregated)
Whytemans Brae Hospital	Old Age Psychiatry	ST								2
Whytemans Brae Hospital	Old Age Psychiatry	ST								3 (aggregated)
Whytemans Brae Hospital	Old Age Psychiatry	All posts								2
Whytemans Brae Hospital	Old Age Psychiatry	All posts								3 (aggregated)

Item 14.2

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**30 April 2021**
Title:	**NMAHP Professional Assurance Framework Survey November 2020**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Janette Owens, Director of Nursing**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Awareness

This report relates to a:

- Government policy / directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is presented to the Clinical Governance Committee for awareness and noting.

Accountability for the quality of nursing, midwifery and AHP care is devolved to the Board Director of Nursing to ensure there is clarity of professional responsibility and robust accountability structures for professional nurses, midwives and AHPs.

A Professional Assurance Framework (PAF) was developed in 2018, which sets out how the Director of Nursing provides assurance to NHS Fife Board on the quality and professionalism of nursing, midwifery and AHP care. The framework provides evidence that structures and processes are in place to provide the right level of scrutiny and assurance across all nursing, midwifery and AHP services.

2.2 Background

The Framework applies to all nurse, midwife and allied health professional registrants, irrespective of their grade or seniority. It is closely aligned with the statutory regulatory frameworks and professional guidance that underpin nursing, midwifery and allied health professional practice. Crucially, it enables nurses, midwives and AHPs to carry out their clinical responsibilities confident in their knowledge of accountability both for their actions and those actions which they have delegated to others.

2.3 Assessment

The PAF can be used in the following ways:

- Confirm there is a system of assurance in place for which the Chief Executive is ultimately accountable
- Review and strengthen what is already in place in relation to nursing, midwifery and allied health professional roles and practice, leadership, governance and reporting arrangements and highlight where improvements are required
- Clarify what is expected of nurses, midwives and AHP professional leaders and operational managers
- Provide guidance on what should be in place in organisational structures
- Reinforce the importance of professional conduct and competence during appraisal, personal development and review processes
- Assist managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required.

The PAF itself is under review by the Associate Director of Nursing (Corporate) and the Associate Director of AHPs to ensure that all references, changing models, are current.

An electronic survey, supported by NHS Fife Communications Team, was carried out between August and October 2020. Senior NMAHPs were asked to complete the survey on behalf of their teams, with a 77% response rate.

The survey (Appendix 1) was undertaken across the Nursing, Midwifery and AHP professions to ascertain any gaps, challenges and identify areas of good practice.

The survey was based on the **4 Primary Drivers** contained within the PAF and indicators were identified to assess services' compliance.

PRIMARY DRIVER NO 1:
'Practitioners are equipped, supervised and supported according to regulatory requirements'

The indicators within this driver were, in the main, 'always' or 'frequently' completed. Specific attention will be focussed, going forward, on:

- ensuring that a senior NMAHP is involved in performance appraisal
- monitoring inter-agency and cross professional formal education and development

PRIMARY DRIVER NO 2:
'Dispersed professional leadership focuses on outcomes and promotes a culture of parity and respect'

The indicators within this driver were, in the main, 'always' or 'frequently' completed. Specific attention will be focussed, going forward, on:

- ensuring that a senior nurse/midwife / AHP agrees staffing levels with operational managers informed by the Health and Care (Staffing) (Scotland) Act

PRIMARY DRIVER NO 3:
'There is clear accountability for standards and professionalism at each level to the NHS Fife Board and Scottish Government'

The indicators within this driver were, in the main, 'always' or 'frequently' completed. Specific attention will be focussed, going forward, on:

- ensuring measures are in place to demonstrate / improve professional, person-centred behaviours

PRIMARY DRIVER NO 4:
'NHS Fife Board has a clear understanding about the quality of the nursing, midwifery and AHP services'

The indicators within this driver were, in the main, 'always' or 'frequently' or 'sometimes' completed. Specific attention will be focussed, going forward, on:

- ensuring that a quality report is made to the NHS Fife Board via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports and demonstrates evidence of the learning and continuous improvement

2.3.1 Quality / Patient Care

The Framework applies to all nurse, midwife and allied health professional registrants. It enables nurses, midwives and AHPs to carry out their clinical responsibilities confident in their knowledge of accountability, supporting excellence in person-centred care.

2.3.2 Workforce

The Framework encompasses Health and Care (Staffing) (Scotland) Act, leadership development, performance appraisal and delegation of duties.

2.3.3 Financial

Robust management of workforce planning and review will support financial governance

2.3.4 Risk Assessment/Management

The Framework confirms that there is a system of assurance in place.

2.3.5 Equality and Diversity, including health inequalities

The Framework ensures that processes are in place to provide assurance across all services, promoting equality and diversity agenda.

2.3.6 Other impact

The Framework assists managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required, to ensure that the people of Fife can expect the highest standard of person-centred care

2.3.7 Communication, involvement, engagement and consultation

The Survey was completed by senior NMAHPs across NHS Fife and Fife Health and Social Care Partnership. It is being shared with the respondents to discuss with their teams.

2.3.8 Route to the Meeting

- Associate Director of NMAHPs meeting

2.4 Recommendation

- **Awareness:** note the contents of the paper.

Report Contact
Janette Owens, Director of Nursing
janette.owens@nhs.scot

APPENDIX 1

NHS Fife

NURSING, MIDWIFERY ALLIED HEALTH PROFESSIONS

PROFESSIONAL ASSURANCE FRAMEWORK
STOCKTAKE SURVEY NOVEMBER 2020

NMAHP Professional Assurance Framework (PAF) Stock-take Survey

	answered	55
	skipped	0

PRIMARY DRIVER 1

Q1.1 Each registered practitioner meets professional regulatory (NMC/HCPC) requirements

		Response Percent	Response Total
1	Always	94.44%	51
2	Frequently	5.56%	3
3	Sometimes	0.00%	0
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Comments: (13)

1	24/07/2020 15:38 PM ID: 145588781	SOP in place to support
2	30/07/2020 16:27 PM ID: 145865838	Any one found to have lapsed would be acted upon in line with NHS policy
3	31/07/2020 12:17 PM ID: 145895102	All registered staff are members of HCPC.
4	04/08/2020 12:07 PM ID: 146040593	system in place to check registrations
5	10/08/2020 11:49 AM ID: 146304618	Rare occasion of failing to do so is managed according to Board HR policy.
6	18/08/2020 16:26 PM ID: 146697700	HCPC register checked annually annual TURAS regular supervision induction for new staff
7	25/08/2020 17:03 PM ID: 147073989	All registered podiatrists are bound by HCPC regulations.
8	31/08/2020 15:34 PM ID: 147339456	Regular at least monthly 1:1's as well as seeing each other at appropriate opportunities
9	01/09/2020 06:14 AM ID: 147355408	Robust system in place, SOP and monthly checks
10	01/09/2020 14:27 PM ID: 147378165	pre employment check Each OT head of service maintains records and has access to HCPC live system. Registration cycle is 2 yearly and occurs as a whole profession
11	17/09/2020 13:53 PM ID: 145686664	Staff are reminded to familiarise themselves regularly with HCPC requirements.

Q1.1 Each registered practitioner meets professional regulatory (NMC/HCPC) requirements

			Response Percent	Response Total
12	17/09/2020 16:55 PM ID: 148410959	Small team and checked regularly at 1:1s etc		
13	18/09/2020 13:59 PM ID: 148454257	All Dietitians must be registered by HCPC to work in the NHS		

Q1.2 Practitioners work to NMC Code / HCPC Standards of conduct, performance and ethics

		Response Percent	Response Total
1	Always	88.89%	48
2	Frequently	11.11%	6
3	Sometimes	0.00%	0
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Comments: (14)

1	24/07/2020 15:38 PM ID: 145588781	continually reviewing and updating SOP's and procedures to support practice
2	29/07/2020 14:17 PM ID: 145799176	however individuals do at times do practice out with
3	30/07/2020 16:27 PM ID: 145865838	Anyone who didn't would be dealt with appropriately in line with NHS policies
4	31/07/2020 12:17 PM ID: 145895102	All members of staff are reminded to familiarise themselves with HCPC Standards and a number of staff attended the PAF event held in October 2019. They were charged with disseminating information across their team. Any issues are dealt with promptly.
5	04/08/2020 12:07 PM ID: 146040593	A few individuals do not and have been addressed through conduct/performance processes.
6	10/08/2020 11:49 AM ID: 146304618	Any deviance to working to the NMC code is managed according to policy
7	18/08/2020 16:26 PM ID: 146697700	regular audit of standards TURAS appraisal clinical & professional supervision annual notes audit
8	25/08/2020 17:03 PM ID: 147073989	The governance of all registered podiatrists lies within the service.
9	31/08/2020 18:12 PM ID: 147345255	currently no staff under investigation/ capability
10	01/09/2020 06:14 AM ID: 147355408	Standards of the code are conduct are actively promoted t all times. Any registrant not adhering to the code would be managed under the conduct policy.
11	01/09/2020 14:27 PM ID: 147378165	Performance monitored continually through structured supervision system and TURAS appraisal
12	17/09/2020 13:53 PM ID: 145686664	This is the expectation and where they don't, this is dealt with appropriately.
13	17/09/2020 16:55 PM ID: 148410959	Againb small team so easy to monitor
14	27/09/2020 13:36 PM ID: 148960719	any practitioner found not to be working to NMC Code will be subject to investigation through relevant HR polices

Q1.3 An up-to-date record is held of each practitioner's registration details

		Response Percent	Response Total
1	Always	100.00%	54
2	Frequently	0.00%	0
3	Sometimes	0.00%	0
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Q1.3 An up-to-date record is held of each practitioner's registration details

		Response Percent	Response Total
Comments: (16)			
1	24/07/2020 15:38 PM ID: 145588781	central database for ICASS	
2	28/07/2020 21:47 PM ID: 145767043	Spreadsheet available and checked	
3	29/07/2020 14:17 PM ID: 145799176	we have a SOP to ensure and assure	
4	30/07/2020 16:27 PM ID: 145865838	Yes there is a system in place where the registration is checked at the end of every month. In addition an email is forwarded to the staff member a month in advance advising them their renewal is due however it is the sole responsibility of the staff member to ensure it does not lapse	
5	31/07/2020 12:17 PM ID: 145895102	Held and monitored as part of our governance activity.	
6	04/08/2020 12:07 PM ID: 146040593	SOP with system in place to check registrations monthly.	
7	10/08/2020 11:49 AM ID: 146304618	There is an up to date SOP guiding how this information is held and how it is reviewed and updated.	
8	18/08/2020 13:51 PM ID: 146688717	Annual online check	
9	18/08/2020 16:26 PM ID: 146697700	annual HCPC registration check recorded for all staff	
10	25/08/2020 17:03 PM ID: 147073989	Details are easily sourced on the HCPC site and details are also held electronically in the department's shared drive.	
11	31/08/2020 15:34 PM ID: 147339456	Yes updated monthly	
12	01/09/2020 06:14 AM ID: 147355408	SOP and monthly checks completed by SCN/Team leads, checked by Lead Nurse and sent to HoN. Each Team Leader/SCN holds a record at ward/service level.	
13	01/09/2020 09:19 AM ID: 147359523	within Directorate office	
14	01/09/2020 14:27 PM ID: 147378165	Available live through HCPC website & registration cycle is 2 yearly and occurs as a whole profession. (31st October)	
15	17/09/2020 13:53 PM ID: 145686664	Required for governance of the service.	
16	27/09/2020 13:36 PM ID: 148960719	Checked monthly by the Directorate office .	

Q1.4 Professional values and attitudes are explicitly assessed as part of the interview process (values based interviews)

		Response Percent	Response Total
1	Always	74.07%	40
2	Frequently	20.37%	11
3	Sometimes	5.56%	3
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Comments: (14)			
1	28/07/2020 21:47 PM ID: 145767043	Value based interviews have been routine practice for three years	
2	29/07/2020 14:17 PM ID: 145799176	at all times we strive to proceed with VB interviews	
3	31/07/2020 12:17 PM ID: 145895102	We changed to values based interviews in summer 2019 and have updated our person specifications to include this.	
4	04/08/2020 12:07 PM ID: 146040593	Values integral to job descriptions and assessed at interview.	
5	10/08/2020 11:49 AM ID: 146304618	This is a core part of the interview and application process.	
6	18/08/2020 16:26 PM ID: 146697700	Professional values and attitudes are part of every interview (interview questions available) but not specifically using the value based interview model value based interviewing is included as part of NHS Fife recruitment training	
7	25/08/2020 17:03 PM ID: 147073989	All interviews are conducted in a values based format.	
8	31/08/2020 15:34 PM ID: 147339456	Assessed through questioning and good conversations that take place during interview process	

Q1.4 Professional values and attitudes are explicitly assessed as part of the interview process (values based interviews)

			Response Percent	Response Total
9	01/09/2020 06:14 AM ID: 147355408	Historically this was not the case, but more recently and in the last few years all interviews have been values based.		
10	01/09/2020 09:19 AM ID: 147359523	"values based" approach to interviews not universally used but professional values are explored		
11	01/09/2020 14:27 PM ID: 147378165	Interviews follow organisational standards. person specifications make clear reference to values and attitudes.		
12	17/09/2020 13:53 PM ID: 145686664	We have moved to values based interviews over the past year.		
13	17/09/2020 16:55 PM ID: 148410959	Yes and as part of routine 1:1 and appraisal processes		
14	18/09/2020 13:59 PM ID: 148454257	This depends on the grade of post and work area required. Situational clinical area questions are usually part of the questions asked		

Q1.5 A senior nurse /midwife/AHP is involved in the recruitment of all nurses, midwives or AHPs

		Response Percent	Response Total
1	Always	85.19%	46
2	Frequently	14.81%	8
3	Sometimes	0.00%	0
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Comments: (11)

1	28/07/2020 21:47 PM ID: 145767043	All interviews involve a line manager and a senior podiatrist
2	29/07/2020 14:17 PM ID: 145799176	this is not 100% and some times managers go ahead without a senior nurse
3	30/07/2020 16:27 PM ID: 145865838	At least one member of staff is at a higher grade than the vacancy being recruited too
4	31/07/2020 12:17 PM ID: 145895102	All interviews are held with senior AHPs however the recruitment sign off process does not have a senior AHP oversight and decisions are being made by senior managers. Increasing questions regarding service redesign and necessity of posts.
5	10/08/2020 11:49 AM ID: 146304618	this is the case to the best of my knowledge.
6	18/08/2020 16:26 PM ID: 146697700	Appropriate grade of senior depending on grade of post being recruited to frequent use of other relevant professions
7	19/08/2020 18:18 PM ID: 146802940	Recruitment panel for interviews to appoint Acute TVN team overseen by Band 7 TVN with input from HON
8	25/08/2020 17:03 PM ID: 147073989	The professional head of service or service manager always leads the recruitment process through to appointment.
9	01/09/2020 14:27 PM ID: 147378165	CPD and recruitment materials demonstrate profession specific involvement of Occupational Therapists in recruitment of OT's. Until re-establishment of Professional Lead post in Feb 2020 there was potential for senior OT posts to be recruited too in the absence of a OT of appropriate seniority
10	18/09/2020 13:59 PM ID: 148454257	This depends on the grade of staff being interviewed for and the availability of Dietitians available for the interview. The appointing officer is always grades higher than the post
11	27/09/2020 13:36 PM ID: 148960719	seniority of the nurse will depend on the band being interviewed for

Q1.6 Each practitioner holds their own training record and understands their responsibility along with their manager for meeting mandatory training requirements

		Response Percent	Response Total
1	Always	75.93%	41
2	Frequently	18.52%	10
3	Sometimes	5.56%	3
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	54
		skipped	1

Comments: (13)

Q1.6 Each practitioner holds their own training record and understands their responsibility along with their manager for meeting mandatory training requirements

			Response Percent	Response Total
1	28/07/2020 21:47 PM ID: 145767043	This is the expectation but the department also keeps an up to date record of all mandatory training which is reviewed and updated regularly		
2	29/07/2020 14:17 PM ID: 145799176	I would not suggest that all registrants do hold their own training records - not until revalidation so some panic to collate information.		
3	30/07/2020 16:27 PM ID: 145865838	There is a spreadsheet. I encourage all TL to check this monthly and highlight to relevant staff monthly any gaps in training		
4	31/07/2020 12:17 PM ID: 145895102	It is increasingly difficult for clinical staff to manage the volume of mandatory training requirements balanced with clinical availability.		
5	04/08/2020 12:07 PM ID: 146040593	Meeting training requirements can be challenging however staff/managers aware of their responsibilities.		
6	10/08/2020 11:49 AM ID: 146304618	There are locally based training records held. I could not confirm that each individual practitioner holds this personally.		
7	18/08/2020 16:26 PM ID: 146697700	TURAS completed annually record of mandatory training updated on a monthly basis by all staff		
8	25/08/2020 17:03 PM ID: 147073989	Each staff member has an appraisal using TURAS and a designated appraiser.		
9	01/09/2020 06:14 AM ID: 147355408	This is encouraged, staff are given certificates and also encouraged to log all training for NMC purposes as well as on Turas. I am not aware if all staff are fully compliant, keeping their own records as this is their responsibility.		
10	01/09/2020 14:27 PM ID: 147378165	held by individuals and reviewed as part of TURAS appraisal		
11	17/09/2020 13:50 PM ID: 145588443	This is audited per team monthly		
12	17/09/2020 13:53 PM ID: 145686664	Mandatory training remains difficult to balance with clinical time. There are increasing requirements for mandatory training, and typically any new training eg ASP, trauma informed etc, all become mandatory to ensure all staff have a basic understanding. Whilst this is understandable, it also has a negative impact on clinical time and is often what staff complain about in supervision.		
13	21/09/2020 11:39 AM ID: 148559038	Each practitioner will have there PDP on TURAS, and mandatory training will be reflected within this.		

Q1.7 Performance appraisal is undertaken by operational line managers. A senior NMAHP must be involved in the appraisal meeting if the line manager is not employed as a Registered NMAHP.

			Response Percent	Response Total
1	Always		61.11%	33
2	Frequently		14.81%	8
3	Sometimes		16.67%	9
4	Occasionally		1.85%	1
5	Never		5.56%	3
			answered	54
			skipped	1

Comments: (17)

1	24/07/2020 18:17 PM ID: 145600417	Previously some of the senior midwives/nurses were performance reviewed by mangers who were not registrants, this has now been rectified
2	27/07/2020 08:48 AM ID: 145662663	My eKSF and TURAS has always been completed a Service Manager and not a Senior Nurse. My 3 yearly revalidation however is completed by the Head of Nursing.
3	28/07/2020 21:47 PM ID: 145767043	This is not undertaken as yet as until lately there were only two managers for over 70 staff which made this impossible. We have now recruited one further manager but this is still a challenge. Managers are aware of good and poor performance and reacts approproately
4	29/07/2020 14:17 PM ID: 145799176	performance appraisal is strong advocated however timescales do slip for completion, and again a senior nurse is not always involved if the manager is employed as a clinical service manager and has an NMC registration they still go ahead with out a senior nurse
5	31/07/2020 12:17 PM ID: 145895102	Responsibility for performance appraisal is disseminated to senior AHPs throughout the service with oversight by the operational line managers. Operational line managers carry out performance appraisal for the senior AHPs.
6	04/08/2020 12:07 PM ID: 146040593	Most staff are line managed by nurses but some gaps at senior level.
7	10/08/2020 11:49 AM ID: 146304618	In my experience of my last appraisal this was carried out by my line manager who is not a nurse. I am unsure if there was nursing involvement in the discussion.
8	12/08/2020 10:02 AM ID: 146407857	Appraisals/PDP's are not expected as part of the Nurse Bank nationally however I do offer this.
9	18/08/2020 16:26 PM ID: 146697700	Band 8A has performance appraisal with professional lead rather than service line manager Where line manager is of a different profession, professional supervisor provides comments
10	25/08/2020 17:03 PM ID: 147073989	All staff are line managed within their profession. Appraisal is undertaken by senior colleagues but not operational line managers as there is a lack of capacity for this.
11	01/09/2020 06:14 AM ID: 147355408	I complete Turas and performance appraisals in my area of responsibility and also the SCN/Team leads in my areas however I have not always received a performance appraisal and I know of many others also who have not.
12	01/09/2020 09:19 AM	cascade approach used within bigger teams - Band 7 completes appraisal for Band 6s, Band 6s then complete for Band 5/4/3/2s

Q1.7 Performance appraisal is undertaken by operational line managers. A senior NMAHP must be involved in the appraisal meeting if the line manager is not employed as a Registered NMAHP.

			Response Percent	Response Total
	ID: 147359523			
13	01/09/2020 14:27 PM ID: 147378165	Absence of Senior OT input into Head OT appraisals. OT management dispersed across a range of operational mangers		
14	17/09/2020 13:51 PM ID: 145590069	Line management structure too flat with only 2 line managers and over 70 staff so this was not practical. Restructuring of management system in progress		
15	17/09/2020 13:53 PM ID: 145686664	Performance appraisals are distributed within the service. Senior clinicians are appraised by the operational managers. The senior clinicians then appraise other members of staff. All appraisers are senior NMAHPs.		
16	17/09/2020 16:55 PM ID: 148410959	I support managers in most relevant appraisals		
17	18/09/2020 13:59 PM ID: 148454257	The clinical leads supervise this process for their teams. The department does not have any managers, all Dietitians have a clinical work load.		

Q1.8 Practitioners have access to a professional supervisor (mandatory in professionally isolated multi-agency settings)

			Response Percent	Response Total
1	Always		68.52%	37
2	Frequently		12.96%	7
3	Sometimes		12.96%	7
4	Occasionally		5.56%	3
5	Never		0.00%	0
			answered	54
			skipped	1

Comments: (12)

1	28/07/2020 21:47 PM ID: 145767043	Pre covid this had just been implemented but has now been put on hold as service structure does not support it meantime. . Previously there was peer support and this has been superceded by team meetings where clinical leads support staff. Individual support is available to all.
2	31/07/2020 12:17 PM ID: 145895102	Supervision has been embedded in our practice for over 20 years.
3	04/08/2020 12:07 PM ID: 146040593	All staff have access to supervision. Uptake is variable.
4	18/08/2020 16:26 PM ID: 146697700	This has changed 2019/2020 to ensure all physiotherapy staff whose line manager is not a physiotherapist have a professional supervisor
5	25/08/2020 17:03 PM ID: 147073989	All staff have access to senior or lead podiatry colleagues.
6	31/08/2020 15:37 PM ID: 147339931	Still in the process of developing supervision in Radiology , with support from PEL. We are the pilot site for Scotland for supervision withinh the radiographer AHP group
7	01/09/2020 06:14 AM ID: 147355408	All staff are encouraged to engage in supervision, again not mandatory so uptake is sometimes poor. There is a lack of available professional supervisors due to the lack of supervision training.
8	01/09/2020 09:19 AM ID: 147359523	Not universally available but professional supervision is available in relation to child protection via Child protection Nurse Advisers team
9	01/09/2020 13:09 PM ID: 147377095	Unsure what questions means.
10	01/09/2020 14:27 PM ID: 147378165	Well established and structured supervision system with previous professional body compliance. Supervision group oversees supervision training, resource updates and compliance with guidance.
11	17/09/2020 13:53 PM ID: 145686664	Supervision has been embedded within the service for over 20 years.
12	20/09/2020 21:36 PM ID: 148538622	All new team members are assigned a named mentor

Q1.9 Inter-agency / cross-professional formal education and development is monitored through governance arrangements

			Response Percent	Response Total
1	Always		46.30%	25
2	Frequently		37.04%	20
3	Sometimes		12.96%	7
4	Occasionally		3.70%	2
5	Never		0.00%	0
			answered	54
			skipped	1

Comments: (6)

Q1.9 Inter-agency / cross-professional formal education and development is monitored through governance arrangements

			Response Percent	Response Total
1	28/07/2020 21:47 PM ID: 145767043	This is dependent in the training organiser.		
2	04/08/2020 12:07 PM ID: 146040593	variety of cross professional education but not clear that it is monitored in any formal way?		
3	18/08/2020 16:26 PM ID: 146697700	formal links with HEIs PEF NES		
4	25/08/2020 17:03 PM ID: 147073989	Cross professional formal education is not common but is monitored within the organisation where appropriate.		
5	01/09/2020 09:19 AM ID: 147359523	Inter-agency education in relation to child protection practice		
6	18/09/2020 13:59 PM ID: 148454257	Most education is provided out of Fife due to the size of the department and the numbers in Scotland. Training in specialised areas is usually national		

Q1.10 Implementation of NES and NMC quality standards (e.g. QSPP and Standards for Learning and Assessment in Practice)

		Response Percent	Response Total
1	Always	64.81%	35
2	Frequently	25.93%	14
3	Sometimes	5.56%	3
4	Occasionally	0.00%	0
5	Never	3.70%	2
		answered	54
		skipped	1

Comments: (9)

1	24/07/2020 15:38 PM ID: 145588781	students limited recently for AHP staff groups due to staffing levels and covid 19
2	28/07/2020 21:47 PM ID: 145767043	Not sure what this means but the departmetn adheres to NES quality standards for practice placement
3	31/07/2020 12:17 PM ID: 145895102	Links with university and PELs.
4	04/08/2020 12:07 PM ID: 146040593	implemented and reviewed,
5	18/08/2020 16:26 PM ID: 146697700	Clear distribution lines throughout organisation for reporting
6	25/08/2020 17:03 PM ID: 147073989	NES quality standards are implemented to support learning as appropriate.
7	01/09/2020 14:27 PM ID: 147378165	AHP PEF input
8	17/09/2020 16:55 PM ID: 148410959	I see an active lead on this but on occasion some work is needed but this is rare
9	18/09/2020 13:59 PM ID: 148454257	HCPC provide the generic and specific AHP standards

PRIMARY DRIVER 2

Q2.1 Senior practitioners have access to leadership development

		Response Percent	Response Total
1	Always	47.06%	24
2	Frequently	37.25%	19
3	Sometimes	15.69%	8
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	51
		skipped	4

Comments: (15)

1	24/07/2020 15:38 PM ID: 145588781	information shared via email and discussions at 1:1 meetings

Q2.1 Senior practitioners have access to leadership development

			Response Percent	Response Total
2	28/07/2020 21:47 PM ID: 145767043	Although available as part of NHS Fife leadership programme not all staff take the opportunity. Places however are limited on this and other leadership development courses due to demand and/or cost. Due to COVID the service has moved to a locality model with a lead podiatrist in each. These staff are currently supported to succeed in this role		
3	29/07/2020 14:17 PM ID: 145799176	this is a key aspect of any nursing role and is strongly supported in the HSCP		
4	30/07/2020 16:27 PM ID: 145865838	There are frequent opportunities through out the year		
5	31/07/2020 12:17 PM ID: 145895102	All senior AHPs have access to leadership development as part of their appraisal plan. We use a range of formal and informal methods to support staff.		
6	04/08/2020 12:07 PM ID: 146040593	A variety of leadership development opportunities for staff. Uptake is variable.		
7	10/08/2020 11:49 AM ID: 146304618	I have always had access to leadership development and have been actively encouraged to take part. I encourage all staff to do the same.		
8	12/08/2020 10:02 AM ID: 146407857	If bank staff request this it may be supported however this is challenging on a bank only contract		
9	18/08/2020 16:26 PM ID: 146697700	internal and external training opportunities always available and supported peer mentorship		
10	25/08/2020 17:03 PM ID: 147073989	Many senior practitioners have accessed leadership develop opportunities.		
11	31/08/2020 15:34 PM ID: 147339456	There may be a bit of a wait to access training but it is encouraged.		
12	01/09/2020 06:14 AM ID: 147355408	Training and courses available mainly on line.		
13	01/09/2020 14:27 PM ID: 147378165	Number of staff have participated in multi professional training. Leadership development opportunities across health and social care is part of OT managers agenda		
14	18/09/2020 06:55 AM ID: 148426912	Difficult at the moment due to the current situation, but I understand online resources are being developed.		
15	27/09/2020 13:36 PM ID: 148960719	leadership development is limited and places on courses is competitive.		

Q2.2 Protocols are in place to support and advise practitioners on delegation of clinical and non-clinical activities within the NHS and in multi-agency settings

		Response Percent	Response Total
1	Always	66.67%	34
2	Frequently	19.61%	10
3	Sometimes	9.80%	5
4	Occasionally	1.96%	1
5	Never	1.96%	1
		answered	51
		skipped	4

Comments: (8)

1	28/07/2020 21:47 PM ID: 145767043	This was always the case until this month as we updated all our protocols. There is a need to update HCSW duties in line with new ways of working post covid
2	31/07/2020 12:17 PM ID: 145895102	As part of individual staff appraisal plans and with reference to the 4 pillars of practice plans are agreed for clinical and non-clinical activities. We are actively considering introducing work plans. All staff attend a staff induction and have to revise this on a 3 yearly basis. This is also raised as part of their local induction and mentoring plan.
3	12/08/2020 10:02 AM ID: 146407857	Support sought from PPD
4	25/08/2020 17:03 PM ID: 147073989	There is a clear understanding of delegation and support from lead podiatrists to ensure safe practice.
5	01/09/2020 06:14 AM ID: 147355408	There are various groups looking at the policies/protocols to streamline these and ensure fit for purpose and regular review.
6	01/09/2020 14:27 PM ID: 147378165	RCOT Code of ethics guides delegation. RCOT briefing; 2020 - Delegation
7	17/09/2020 13:51 PM ID: 145590069	Not sure what is meant by this question
8	18/09/2020 13:59 PM ID: 148454257	Work is allocated by the clinical leads taking account of each team members experience and development needs

Q2.3 A senior nurse/midwife agrees staffing levels with operational managers informed by Safe Staffing Legislation (Common Staffing Method).A senior AHP agrees staffing levels with operational managers.

		Response Percent	Response Total
1	Always	58.82%	30
2	Frequently	21.57%	11
3	Sometimes	11.76%	6
4	Occasionally	1.96%	1
5	Never	5.88%	3
		answered	51
		skipped	4

Comments: (18)

1	24/07/2020 18:17 PM ID: 145600417	There are often challenges to staffing requests from senior management team
2	28/07/2020 21:47 PM ID: 145767043	Line managers are involved in staffing negotiations with their line manager but that does not always lead to agreed staffing levels. Current AHP management structure which is reliant on temporary contracts is not ideal and not what services would wish
3	29/07/2020 14:17 PM ID: 145799176	there are regular examples of senior managers adjusting staffing levels with our Senior Nursing oversight. the senior nurses always lead on the WFP annual programme however out with that there are instances of it not being the case
4	30/07/2020 16:27 PM ID: 145865838	Wokrforce tools is undertaken twice yearly to aid this
5	31/07/2020 12:17 PM ID: 145895102	There is no safe staffing tool - waiting for guidance on AHP safe staffing levels. Managers have attended an awareness raising session in readiness for the legislation being enacted. Will implement safe staffing once guidance is agreed. Senior managers make final decisions on recruitment approval. We are unsure if Associate Director of AHPs has oversight but no discussion has taken place at service level.
6	04/08/2020 12:07 PM ID: 146040593	Managers need reminding at times where redesign processes are happening.
7	12/08/2020 10:02 AM ID: 146407857	This takes place at staffing huddles within directorates
8	18/08/2020 16:26 PM ID: 146697700	.
9	19/08/2020 18:18 PM ID: 146802940	As TV Team is not managed by an operational team the process described above would differ slightly as there is no operational manager. However staffing levels will continue to be monitored by TV Lead Nurse and HON and Common Staffing Method applied where required. Advise would be sought from Nurse for Workforce it there was a change to the service affecting staffing levels.
10	25/08/2020 17:03 PM ID: 147073989	All staff are involved in planning service resource to meet the needs of the population. A planning and assurance group has been set up for this purpose.
11	31/08/2020 15:34 PM ID: 147339456	Currently under review, SCN involvement
12	31/08/2020 18:12 PM ID: 147345255	community nursing has identified a deficit in staffing levels and awaiting response from executive level from 2018 workforce tool. Continuously discussed and risk on register. No 22.5% back fill in service either.
13	01/09/2020 06:14 AM ID: 147355408	Levels are agreed in line with clinical demand, this is not in line with the current establishments, work force planning and safe staffing legislation.
14	01/09/2020 09:19 AM ID: 147359523	work is ongoing in relation to exploring nursing establishment with senior directorate management
15	01/09/2020 14:27 PM ID: 147378165	Absence of formal tools that meet needs of the profession across a variety of settings. Some tools currently being tested and evaluated.
16	17/09/2020 13:51 PM ID: 145590069	Not sure if this is done on a formal basis
17	17/09/2020 16:55 PM ID: 148410959	Clear process in division albeit sometimes has to be refreshed with folks
18	18/09/2020 13:59 PM ID: 148454257	This does not happen. There are many areas where Dietetic staffing is limited or not in place Not the model of delivery of service

Q2.4 An explicit decision-making process underpins which professional is most appropriate to provide specific aspects of care based on assessed need and person-centred outcomes.

		Response Percent	Response Total
1	Always	58.82%	30
2	Frequently	27.45%	14
3	Sometimes	9.80%	5
4	Occasionally	1.96%	1
5	Never	1.96%	1
		answered	51
		skipped	4

Comments: (13)

1	24/07/2020 15:38 PM ID: 145588781	all staff trained in Personal outcomes approach and majority of trained staff attended good conversations training including nursing. further work required in H@H
2	28/07/2020 21:47 PM ID: 145767043	Since COVID and the establishment of locality teams this had become possible. If staff return to single chair working where one practitioner is responsible for a geographic area this becomes more of a challenge and relies on staff to know when to escalate to a more senior staff member.
3	31/07/2020 12:17 PM	Care aims decision making and person centred outcomes is embedded in our practice. Staff always endeavour to support those most proximal to

Q2.4 An explicit decision-making process underpins which professional is most appropriate to provide specific aspects of care based on assessed need and person-centred outcomes.

			Response Percent	Response Total
	ID: 145895102	the patient without becoming proximal themselves.		
4	04/08/2020 12:07 PM ID: 146040593	Clinical teams assess patient need and allocate care accordingly.		
5	10/08/2020 11:49 AM ID: 146304618	This process does take place but I cannot be sure that the decision making process is always explicit.		
6	18/08/2020 16:26 PM ID: 146697700	multidisciplinary assessment/ goal setting / formal & informal team communication - all recorded in multidisciplinary patient records		
7	25/08/2020 17:03 PM ID: 147073989	Care aims methodology is embedded in the service to support clinical decision making and self management.		
8	31/08/2020 15:34 PM ID: 147339456	MDT involvemt is key to decision making		
9	31/08/2020 18:12 PM ID: 147345255	referral pathways in use		
10	01/09/2020 06:14 AM ID: 147355408	Individual care plans and person centred care. Evidence of assessment to where decisions have been reached.		
11	01/09/2020 14:27 PM ID: 147378165	Job descriptions inform appropriateness of staff for some aspects of clinical and care delivery. systems in place to ensure that the needs are correctly understood and best identifies personal outcomes and those who require to be involved.most appropriate person.		
12	18/09/2020 13:59 PM ID: 148454257	Desirable not in place.		
13	20/09/2020 21:36 PM ID: 148538622	N/A		

Q2. 5 An independent and objective senior nurse /midwife / AHP sits on disciplinary panels where professional conduct / competence / capability is an issue

			Response Percent	Response Total
1	Always		78.43%	40
2	Frequently		13.73%	7
3	Sometimes		3.92%	2
4	Occasionally		0.00%	0
5	Never		3.92%	2
			answered	51
			skipped	4

Comments: (9)

1	24/07/2020 15:38 PM ID: 145588781	not been required
2	28/07/2020 21:47 PM ID: 145767043	I am confident this would be the case
3	30/07/2020 16:27 PM ID: 145865838	As the lead nurse my role would be to investigate and present at a panel providing I was independent and objective of the issue
4	18/08/2020 16:26 PM ID: 146697700	.
5	19/08/2020 18:18 PM ID: 146802940	TV service have not had experience of this but HON aware of the process.
6	25/08/2020 17:03 PM ID: 147073989	This is required infrequently.
7	31/08/2020 18:12 PM ID: 147345255	I have not had once since starting post
8	01/09/2020 14:27 PM ID: 147378165	Professional Lead Role
9	20/09/2020 21:36 PM ID: 148538622	A disciplinary panel has not been held, however an independent and objective senior nurse would sit on the panel

Q2. 6 A system is in place to enable all staff to raise a concern if they are asked to undertake a task for which they do not feel competent?

			Response Percent	Response Total
1	Always		90.20%	46
2	Frequently		5.88%	3
3	Sometimes		3.92%	2
4	Occasionally		0.00%	0

Q2. 6 A system is in place to enable all staff to raise a concern if they are asked to undertake a task for which they do not feel competent?

		Response Percent	Response Total
5	Never	0.00%	0
		answered	51
		skipped	4

Comments: (9)

1	24/07/2020 15:38 PM ID: 145588781	supervision structure and escalation process in place
2	28/07/2020 21:47 PM ID: 145767043	Staff have been made aware that if there are such concerns they raise it with locality leads and if not satisfied to contact line manager
3	30/07/2020 16:27 PM ID: 145865838	Staff know to always practice within their scope
4	31/07/2020 12:17 PM ID: 145895102	Supervision is embedded; staff can speak to their team lead or operational manager or their staff-side rep.
5	18/08/2020 16:26 PM ID: 146697700	regular clinical & professional supervision clear line management structure to raise concerns
6	25/08/2020 17:03 PM ID: 147073989	Staff are encouraged to raise concerns through their line manager, H&S rep or TU rep.
7	01/09/2020 06:14 AM ID: 147355408	Escalation process in place, staff aware
8	01/09/2020 14:27 PM ID: 147378165	Staff have access to line mangers and supervision. RCOT guidance on Scope of Practice. Cross profession support
9	17/09/2020 13:51 PM ID: 145590069	Speak to clinical lead who may escalate to line manager

PRIMARY DRIVER 3:

Q3.1 There is a formal system for involving the senior nurse / midwife / AHP in professional issues involving nurses and midwives and AHPs e.g. HR issues, the workforce and clinical governance implications of service design/redesign

		Response Percent	Response Total
1	Always	70.00%	35
2	Frequently	20.00%	10
3	Sometimes	4.00%	2
4	Occasionally	6.00%	3
5	Never	0.00%	0
		answered	50
		skipped	5

Comments: (8)

1	28/07/2020 21:47 PM ID: 145767043	The service has had a planning and assurancegroup in place for a couple of years to discuss such issues
2	29/07/2020 14:17 PM ID: 145799176	this is always the aspiration for this to happen however in practice clinical service managers with a NMC registration occasionally do this without a senior nurse
3	31/07/2020 12:17 PM ID: 145895102	As the lines of assurance and management sit within different divisions of the partnership, there is complexity in the overall governance. We are aware of the organisational change policy that is in place when considering service redesign and work closely with HR.
4	04/08/2020 12:07 PM ID: 146040593	Involved in all service redesign projects to date.
5	25/08/2020 17:03 PM ID: 147073989	Processes are in place to involve AHP managers in decisions that affect their professions.
6	01/09/2020 06:14 AM ID: 147355408	Now working with NHSSotland HR policies. HR sometimes unavailable for assistance at meetings but able to give advice to managers.
7	01/09/2020 14:27 PM ID: 147378165	Supervision structure includes all head OT's and forms part of regular discussion. Access to Associate Director of AHP's
8	18/09/2020 13:59 PM ID: 148454257	Desirable but does not always happen. Smaller professions are often missed out

Q3.2 The senior nurse/midwife/AHP reviews workforce data with operational managers e.g. actual against proposed skill mix, vacancies, absence rates

		Response Percent	Response Total
1	Always	72.00%	36
2	Frequently	16.00%	8

Q3.2 The senior nurse/midwife/AHP reviews workforce data with operational managers e.g. actual against proposed skill mix, vacancies, absence rates

		Response Percent	Response Total
3	Sometimes	4.00%	2
4	Occasionally	2.00%	1
5	Never	6.00%	3
		answered	50
		skipped	5

Comments: (11)

1	31/07/2020 12:17 PM ID: 145895102	Head of Service works with operational managers to monitor and review workforce data. Associate Director of AHPs has high level knowledge of service but is not involved in the detail. This is complicated by the organisational structure.
2	04/08/2020 12:07 PM ID: 146040593	regular discussions 1:1s with Lead Nurses and Senior Managers.
3	18/08/2020 16:26 PM ID: 146697700	monthly management team meetings discussion and approval of each vacancy annual report with evaluation and recommendations
4	19/08/2020 18:18 PM ID: 146802940	N/A for TV Team
5	25/08/2020 17:03 PM ID: 147073989	This is undertaken regularly as operational managers are also professional leads.
6	31/08/2020 18:12 PM ID: 147345255	Part of monthly 1:1
7	01/09/2020 06:14 AM ID: 147355408	Reviewed monthly at meetings with Lead Nurse. Lead Nurse provided figures and addresses any vacancies with senior managers.
8	01/09/2020 14:27 PM ID: 147378165	Reviewed with each vacancy. evidence of regular discussions with operational leads and OT managers
9	17/09/2020 16:55 PM ID: 148410959	sometimes they have to be reminded but decisons do not progress without this
10	18/09/2020 13:59 PM ID: 148454257	This does not happen. Spread sheet is completed each year.
11	20/09/2020 21:36 PM ID: 148538622	Workforce planning is discussed

Q3.3 A measure is used to demonstrate / improve professional, person-centred behaviours

		Response Percent	Response Total
1	Always	36.00%	18
2	Frequently	30.00%	15
3	Sometimes	20.00%	10
4	Occasionally	10.00%	5
5	Never	4.00%	2
		answered	50
		skipped	5

Comments: (12)

1	24/07/2020 18:17 PM ID: 145600417	Via action plan completion
2	28/07/2020 21:47 PM ID: 145767043	This is undertaken only as part of patient care review
3	29/07/2020 14:17 PM ID: 145799176	not that I am aware of
4	31/07/2020 12:17 PM ID: 145895102	All staff members carry out a yearly appraisal and measure themselves against the national KSF profiles in discussion with their appraiser. Supervision discussions are a quality measure.
5	04/08/2020 12:07 PM ID: 146040593	A variety of measures utilised but could be more consistent.
6	10/08/2020 11:49 AM ID: 146304618	I am not sure if my understanding of this question is correct. I would read it as improvement action planning.
7	18/08/2020 16:26 PM ID: 146697700	CARE measure patient questionnaires
8	25/08/2020 17:03 PM ID: 147073989	Reviews of compliments, queries and complaints support service improvement.
9	31/08/2020 18:12 PM ID: 147345255	i dont understand this question
10	01/09/2020 06:14 AM ID: 147355408	Role modelling, NMC code adhered to. Unsure of a measure?

Q3.3 A measure is used to demonstrate / improve professional, person-centred behaviours

			Response Percent	Response Total
11	01/09/2020 14:27 PM ID: 147378165	No formal tools consistently deployed across the profession for the purpose of measurement, but these behaviours will be monitored, reviewed and discussed at informal and formal supervision and reviews.		
12	18/09/2020 13:59 PM ID: 148454257	Only if required		

Q3.4 Summaries of learning and improvement from quality measures (such as quality indicators, complaints and critical incident investigations) are used for organisational learning and are embedded within governance structures?

		Response Percent	Response Total
1	Always	64.00%	32
2	Frequently	28.00%	14
3	Sometimes	6.00%	3
4	Occasionally	2.00%	1
5	Never	0.00%	0
		answered	50
		skipped	5

Comments: (12)

1	28/07/2020 21:47 PM ID: 145767043	This I snot undertaken on a formal basis apart from during the service annual review process
2	29/07/2020 14:17 PM ID: 145799176	this is reflected in our quality report and is on agendas in our senior nursing meetings
3	30/07/2020 16:27 PM ID: 145865838	Any learning is shared Fife wide
4	31/07/2020 12:17 PM ID: 145895102	As part of governance systems, we submit and are measured on our service assurance report on a yearly basis; this includes feedback on safety improvements eg 7 minute briefings; complaints and compliments; quality indicators etc.
5	04/08/2020 12:07 PM ID: 146040593	Regular review of incident and performance data and processes to review and share learning in place.
6	10/08/2020 11:49 AM ID: 146304618	I think the use of these summaries could be improved upon.
7	18/08/2020 16:26 PM ID: 146697700	annual strategic plan with quality indicators reviewed, including Datix reports etc
8	25/08/2020 17:03 PM ID: 147073989	All complaints are investigated and shared with staff members. Critical incidents are investigated through Datix and local review.
9	31/08/2020 18:12 PM ID: 147345255	When started post these were no being used but are now integral, and expected to be fed back to teams at monthly meetings.
10	01/09/2020 06:14 AM ID: 147355408	Clinical care governance meetings held quarterly, new group set up to look at the learning from SAER/LAER and how this is disseminated.
11	01/09/2020 14:27 PM ID: 147378165	These tend to be shared throughout operational channels which makes it difficult professionally top ensure cross speciality learning for the profession. Most services embedded within their Clinical governance structures.
12	17/09/2020 16:55 PM ID: 148410959	Standing agenda item on govenrance structured meetings

Q3.5 A recognised and well-publicised escalation process is in place to ensure nurses / midwives /AHPs are able to bring concerns to the attention of senior managers and that they receive feedback

		Response Percent	Response Total
1	Always	64.00%	32
2	Frequently	26.00%	13
3	Sometimes	10.00%	5
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	50
		skipped	5

Comments: (7)

1	29/07/2020 14:17 PM ID: 145799176	I think nurses know when and how to escalate but I think what they escalate can sometimes be unclear
2	31/07/2020 12:17 PM ID: 145895102	We have a Datix system for reporting incidents, complaints and concerns. There is a whistleblowing policy which all staff should be aware of.
3	18/08/2020 16:26 PM ID: 146697700	Line management communication day-to-day + regular supervision + Datix reporting & feedback

Q3.5 A recognised and well-publicised escalation process is in place to ensure nurses / midwives /AHPs are able to bring concerns to the attention of senior managers and that they receive feedback

		Response Percent	Response Total
4	25/08/2020 17:03 PM ID: 147073989	Staff are represented by chosen colleagues on the planning and assurance group. iMatter is valuable in supporting concerns to be highlighted.	
5	01/09/2020 06:14 AM ID: 147355408	Staff are aware of escalation process although this would not be well publicised.	
6	01/09/2020 09:19 AM ID: 147359523	not necessarily "well publicised" but staff are aware	
7	01/09/2020 14:27 PM ID: 147378165	Supervision and TURAS systems support this, Staff aware of processes for raising employee concerns.	

Q3.6 PIN Guidelines and Policies underpin practice?

		Response Percent	Response Total
1	Always	76.00%	38
2	Frequently	24.00%	12
3	Sometimes	0.00%	0
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	50
		skipped	5

Comments: (2)

1	18/08/2020 16:26 PM ID: 146697700	All NHS Ffie policies & procedures available, referred to & implemented
2	25/08/2020 17:03 PM ID: 147073989	All practice is underpinned by national, professional and local policy.

PRIMARY DRIVER 4

Q4.1 There is a formal system for reporting to the Board Director of Nursing on quality and safety issues involving nurses, midwives and AHPs?

		Response Percent	Response Total
1	Always	75.51%	37
2	Frequently	22.45%	11
3	Sometimes	2.04%	1
4	Occasionally	0.00%	0
5	Never	0.00%	0
		answered	49
		skipped	6

Comments: (7)

1	24/07/2020 15:38 PM ID: 145588781	not had to use
2	28/07/2020 21:47 PM ID: 145767043	I really needed to be able to answer unknown. What I can say is that if we need to report to the DoN then we have to go through the AHP associate director who then would then escalate
3	31/07/2020 12:17 PM ID: 145895102	Whilst there is a clear professional assurance line we have found the system for raising concerns and receiving feedback is difficult due to the complexity of the PAF/line management structures.
4	25/08/2020 17:03 PM ID: 147073989	A formal system is in place that is clearly documented.
5	31/08/2020 18:12 PM ID: 147345255	this is escalated through the Heads of Nursing
6	01/09/2020 06:14 AM ID: 147355408	infrequent 1-1's with HoN but know when to escalate and how to escalate, can contact them if required. HoN would escalate to the Board Director of Nursing.
7	01/09/2020 14:27 PM ID: 147378165	DATIX system well established

Q4.2 A quality report is made to the NHS Fife Board via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports and demonstrates evidence of the learning and continuous improvement arising from these?

		Response Percent	Response Total

Q4.2 A quality report is made to the NHS Fife Board via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports and demonstrates evidence of the learning and continuous improvement arising from these?

		Response Percent	Response Total
1	Always	67.35%	33
2	Frequently	16.33%	8
3	Sometimes	10.20%	5
4	Occasionally	4.08%	2
5	Never	2.04%	1
		answered	49
		skipped	6

Comments: (10)

1	24/07/2020 15:38 PM ID: 145588781	do not input to this
2	24/07/2020 18:17 PM ID: 145600417	Unit reports have been introduced as essential to the areas since 2017
3	28/07/2020 21:47 PM ID: 145767043	Again this is a unsure response but what is always done is an annual review of service as part of the partnership governance process. The descriptor above seems more technical
4	31/07/2020 12:17 PM ID: 145895102	Service annual assurance report is provided to the clinical and care governance committee. All staff are involved in the annual iMatter process with data being fed back to the Board. Report on performance indicators to FWD on a quarterly basis, information collated for annual report.
5	04/08/2020 12:07 PM ID: 146040593	regular reports provided.
6	19/08/2020 18:18 PM ID: 146802940	TV Steering Group
7	20/08/2020 13:34 PM ID: 146847831	No formal AHP workload tool like nursing at present, but similar completed through Health and Social Care Governance Review process.
8	25/08/2020 17:03 PM ID: 147073989	Service reports are provided and the service is scrutinised through the governance committee channels.
9	01/09/2020 06:14 AM ID: 147355408	Annual report produced, not widely available and shared.
10	01/09/2020 09:19 AM ID: 147359523	not known

Q4.3 There is a reporting and escalation mechanism in place for professional assurance to the CNO acting on behalf of the named government minister?

		Response Percent	Response Total
1	Always	71.43%	35
2	Frequently	20.41%	10
3	Sometimes	6.12%	3
4	Occasionally	0.00%	0
5	Never	2.04%	1
		answered	49
		skipped	6

Comments: (4)

1	24/07/2020 15:38 PM ID: 145588781	I am sure there is but I am not familiar with it
2	28/07/2020 21:47 PM ID: 145767043	Again I would prefer to answer unknow to this one but it is not an option
3	31/07/2020 12:17 PM ID: 145895102	Via associate director and director of NMAHP in Fife.
4	25/08/2020 17:03 PM ID: 147073989	Professional assurance is reported to the Director of Nursing.

Item 15.1

NHS Fife

Meeting:	**ASD Clinical Governance Committee**
Meeting date:	**17th March 2021**
Title:	**ASD CGC Minutes 17/3/21**
Responsible Executive:	**Dr R Cargill/Mrs L Campbell**
Report Author:	**RC/LC**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging issue (COVID 19 mobilisation)

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

- Safe

2 Report summary

2.1 Situation

Meeting scheduled for 20th January 2021 was cancelled.
ASD CGC meeting of 17th March 2021 minutes attached for info.

2.2 Background

Whilst meetings of the committee were suspended during 2020 & early 2021, significant ongoing clinical governance activity was maintained and can be used to provide assurance to the board that monitoring of quality and safety within the division has been maintained.

2.3 Assessment

See attached minutes for March 2021.

2.4 Recommendation

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

2 List of appendices

The following appendices are included with this report:

ASD CGC minutes 170321

Report Contact

Dr R Cargill
Associate Medical Director

Lynn Campbell
Associate Director of Nursing

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 17TH MARCH 2021 AT 2.00PM VIA MS TEAMS

Present	Designation
Dr Rob Cargill	Associate Medical Director – ASD (CHAIR)
Mrs Lynn Campbell	Associate Director of Nursing - ASD
Dr Annette Alfonzo	Clinical Director – Emergency Care Directorate (from end Item 6.4)
Dr Sally McCormack	Clinical Director – Emergency Care Directorate
Mrs Norma Beveridge	Head of Nursing – Emergency Care Directorate
Ms Arlene Saunderson	Head of Nursing – Planned Care Directorate
Ms Aileen Lawrie	Associate Director of Midwifery
Ms Marie Paterson	Head of Nursing - ASD
Mrs Donna Galloway	General Manager, Women, Children & Clinical Services Directorate
Mrs Jane Anderson	Radiology Clinical Services Manager
Mrs Miriam Watts	General Manager, Emergency Care Directorate
Dr John Morrice	Associate Medical Director – Women & Children

Apologies	Designation
Mr Ben Hannan	Chief Pharmacist - ASD
Mr Satheesh Yalamarthi	Clinical Director – Planned Care Directorate
Dr Tahir Mahmood	Clinical Director – Clinical Services Directorate
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator

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)
Mrs Pauline Hope	Clinical Nurse Manager – Planned Care Directorate (Guest)
Dr Gavin Simpson	Consultant in Intensive Care Medicine
Mr Alan Timmins	Pharmacist (rep Mr B Hannan)

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.

Dr Cargill informed those attending that the Echo Pen was being used to record the meeting for assistance with production of the minutes.

3 Unconfirmed Minute of ASDCGC Meeting held on 11th November 2020

Dr Cargill referred to the minutes and asked for any anomalies. Ms Paterson advised that she was present at the meeting but was not listed in the attendees. Miss Godsell to amend. The minutes were approved as an accurate record. **LG**

4 Matters Arising

4.1 Action List

Action 311 – T&O Donation - Dr Cargill advised that due to COVID and also changes within the Executive Team and the Non Executive Directors that there is still no nominated Chairperson for the Tissue & Organ Donation Committee. Action remains open.

Action 315 – Everlight Report – Dr Cargill advised that Mrs Anderson has prepared a report for the Committee and it will be submitted to the May meeting. Regard as complete.

Action 318 – The LATE Audit – Dr Cargill advised that the Vascular Access Strategy Group which he chaired was now closed and now there is a Vascular Access Reference Group which Miss Saunderson and colleagues continue to work with and as required they are calling on medical and other representation depending on the issue eg: clinical, service or access issue. Support from others (Radiologists, Anaesthetists etc) has been useful and is working well. Regard as complete.

Action 319 – EIDO Consent Forms – No representation from Ortho or Planned Care to update on the issue. c/f to May 2021. **LG**

Action 323 – Peri- Arrest Audit – Item will be covered on the agenda. Regard as complete.

Actions 324 – WCCS – Presentation – Ms Lawrie said she did not think there was any real need to re-submit or escalate anything from this presentation. Regard as complete.

Action 325 – WCCS – Paediatrics – The action was around audits which had titles but no content. Ms Lawrie said this was an error in the embedding of the document but moving forward the system of reporting has been changed. It was agreed not to re-submit the audit information. Regard as complete.

Action 326 – WCCS Radiology – Mrs Campbell said this related to queries with the criteria in the Everlight report – what were the markers/framework in Radiology? Dr Cargill suggested that we consider the Everlight report at the next meeting and if this question remains relevant then it can be raised again. Regard as complete.

Action 327 – ECD Directorate Report – Pressure Damage – This will be covered within the Directorate report. Regard as complete.

Action 328 – ECD – Portacath Paper– Dr Cargill said this was a new procedure and the action was to ensure that a follow up safety audit was included on the workplan. ECD confirmed it had been included. Regard as complete.

Action 329 – PCD LEARN Summaries – Review of drugs being stored in the CD cupboard. Miss Saunderson said that this practice has continued and this particular drug is stored in the CD cupboard and entered in the book, same as other drugs. Mr Hannan has made a suggestion to move back to standard practice so a conversation will take place around this. Regard as complete.

Action 330 – Cancer Waiting Times - Dr Cargill said this related CWT and the continued exclusion of Endometrial Cancer from reporting and same level of scrutiny. Dr Cargill said this would likely require some specialty input from the

Gynaecology team and whether they want to progress this. Dr Morrice was unaware but agreed to look into this. **JM**

5 Hospital/Board or Population Level Reports

Scheduled Governance Items :

- **Integrated Performance & Quality Report**

Dr Cargill referred to the IPQR report and said this was included for information/discussion by exception. Dr Cargill added that for the purpose of the Committee we tend to concentrate on the first two sections – Quality and Performance. Dr Cargill asked for any issues? Mrs Campbell highlighted the rise in harms and complaints and said that this will likely be picked up in the Directorate reports but these are broadly reflective of the data this quarter.

The report was noted.

- **Mortality Report**

Dr Cargill highlighted that one of the documents pertaining to the Public Health intelligence for mortality was missing and would be circulated in retrospect. **LG**

Dr Cargill noted that early in the pandemic we saw a significant increase in hospital mortality rates and were able to attribute that to the drop in hospital occupancy with the same number of deaths.

Additional acute hospital deaths in the December 2020 / January 2021 wave of the pandemic reflect;

- A significant increase (an excess of 90 deaths) in mortality from COVID 19
- an increase in cancer deaths compared with previous years which may reflect pandemic effects on non-COVID illness. Patients may have been presenting late.
- a significant shift in place of death to acute hospital care which may reflect limited community infrastructure for end of life care during the pandemic.

Dr Cargill advised this was an interesting analysis and provides a coherent explanation. Dr Cargill asked that due to it's importance that this remain open for discussion/comments at the next meeting once the report has been circulated. **LG**

- **Detect Cancer Early 2018 – 2019**

Dr Cargill highlighted that the Detect Cancer Early reports related to information from 2018 - 2019, when the DCE programme commenced.

In 2018 and 2019 there were 25,412 patients diagnosed with breast, colorectal or lung cancer.
• For people with breast, colorectal or lung cancer, one in four (25.6%) were diagnosed at the earliest stage (stage 1). This is a relative increase of 9.8% from the baseline which falls below the Local Delivery Plan standard of a 25% increase.
• People living in the most deprived areas are less likely to be diagnosed at an earliest stage (23.8%) than those from least deprived areas (28.9%).
The proportion of patients diagnosed with stage 1 breast cancer increased from baseline (38.7%) to year 4 (41.2%) but have seen small decreases each year since

to year 8 (39.6%).
• The percentage of patients diagnosed at stage 1 for colorectal cancer has decreased over the time period. The percentages fell gradually from the baseline (17.8%) to 15.1% in year 5 but climbed back up to 17.2% in year 8.
• Lung cancer has seen an increase over the time period in patients diagnosed at stage 1, a 43.3% relative increase from baseline (13.2%) to year 8 (18.8%).

Dr Cargill asked Mrs Galloway if she had anything to highlight about these reports. Mrs Galloway said that this is now part of the revamped Cancer Strategy and is not aware that the bids have progressed. Dr Cargill said he thought this was a benchmarking exercise across Scotland but note the report for information.

- **Deteriorating Patient Group:**
- **Cardiac Arrest/Peri-Arrest Reports**

Dr Cargill thanked Dr Simpson for attending the Committee.

Dr Cargill advised that Dr Simpson had agreed to continue leadership of the Deteriorating Patient Group which covers a number of important workstreams.

Dr Simpson updated the Committee of activity from the past 12 months and to provide re-assurance that NHS Fife are continuing the good work around the Deteriorating Patient.

Dr Simpson spoke to the Committee and the following points were noted:

- Cardiac Arrest and Peri Arrest audits is one of the outcome markers for Deteriorating patients.
- There is a national drive that SPSP requires all hospitals in Scotland to have a Deteriorating Patient programme, and there are a number of guidelines and a structure from 2016 which is currently being updated nationally to what the directives should be and how deteriorating patients should be managed in hospitals. Dr Simpson said that NHS Fife adhere to most of those directives and Fife is performing well in comparison to some hospital sites.
- 5 years ago Fife had a poor cardiac arrest rate and this was an indication of Fife not having a comprehensive plan for managing deteriorating patients, hence a Short Life Working Group (SLWG) was set up and created a programme called Know the Score which confirmed future actions for Fife. This was very successful and it had 5 domains within Know the Score that were felt to be the important ones and this remit has been retained throughout.
- Cardiac Arrest rates have dropped to around a fifth of what they were 5 years ago. The overall incidence of adult in-hospital cardiac arrest attended by the hospital-based resuscitation team is 0.74 per 1000 hospital admissions.
- Cardiac arrests numbers spiked in December. It is not unusual to see a national increase in incidence in the winter months, however, the cardiac arrest SBAR review group will examine these specific cases to determine cause.
- Survival to hospital discharge is 28% (7 out of 25 events). For comparison, UK survival rates for in hospital cardiac arrest is 23.5% (National Cardiac Arrest Audit (NCAA) 2018 -2019).
- NHS Fife were previously part of the NCAA which NHS Fife had to pay for but

a decision was taken this year to leave and the reports are now produced every quarter by the Clinical Governance team.

- There have been 37 Cardiac Arrests over the last year (Apr – Apr) which is a big decrease.
- There is an Emergency Bleep Meeting (EBM) Process which has been running for circa 5 years and this analyses all the cardiac arrests. This process has still been running throughout COVID albeit not as comprehensively as normal.
- The Peri-Arrest audit shows that there has been around 200 additional 2222 calls across Fife – half of these were bona fida cardiac arrest calls and the other half were calls which were necessary as well.
- Dr Simpson advised that the Deteriorating Patient Group is currently being resurrected. The SLWG was started to develop the programme and once this was fulfilled the group was retired but it was agreed that this needs to resume. An initial meeting was held and the Terms of Reference (ToR) have been drafted and is almost ready to share. The ToR will define what the new group's remit and key objectives will be within the framework of NHS Fife and this will be aligned with the SPSP work as it produces it's new guidelines for 2021. Some of the specifics that will require close monitoring by the group are DNACPR and Hospital Anticipatory Care Plan (HACP) use, response to deterioration/SSR sticker but the complete uptake on that has not been very good but this is something that we aim to focus on and improve.
- The EBM and analysis of cardiac arrests is well established. Dr Simpson highlighted the process for reviewing cardiac arrests and advised that there have not been any EBM's for the last 6 – 12 months as the SAER's were paused during COVID and we need to discuss how we can safely restart these cluster reviews with a format that is efficient and works well as there are a number outstanding awaiting review.
- Early Warning Scores (EWS) – Fife is still using the Fife EWS which has hard alerting and runs in conjunction with the Patientrak system. Fife made the safe decision to remain in FEWS but will further review and potentially change to NEWS2 at some point this year. Dr Simpson said this move would be a big project and a group would require to be formed to look at this specific changeover.
- Dr Simpson said all in all Fife is doing well and will carry on with the improvements over the next 12 months.

Mrs Campbell asked about the lines of governance and the appropriate Committee for the Terms of Reference to sit, whether it was the Resuscitation Committee of this Committee? Dr Cargill responded that this Committee is hosting the governance arrangements on behalf of NHS Fife so that would need to be clear in the Terms of Reference. Dr Simpson said that he would ensure this was included.

Dr Morrice said that he appreciated the input into Paediatrics and asked if this is Fife wide is this relevant to children too? Dr Simpson said that the principles of triaging patients are broadly the same but the Early Warning Scores may differ. Dr Simpson added that Paediatrics and Obstetrics would have the opportunity to feed in their information and processes and these would be amalgamated into the guidance. The original SLWG was Acute Adult but if we are going to be comprehensive for Fife this should Include Acute Adult and Paediatrics but are hoping to get representation on the group form all specialities.

Dr Cargill thanked Dr Simpson for his attendance and update.

- **CPR SBAR & EBM Outcomes**

This item was covered under Deteriorating Patient Group.

- **Fluid reporting – For Noting**

Dr Cargill referred to the fluid reports submitted by D McDougall who unfortunately, could not attend the meeting . The programme is now a national programme and our compliance with this is excellent and the results from that are encouraging.

Ms Saunderson commented that the report made interesting reading and said that although she was aware the Learnpro modules were available for fluid management for registered nurses and healthcare support workers it may be helpful to re-emphasise this. Ms Saunderson added that the modules are not Mandatory but are helpful tools. Ms Sanderson noted that there was a lot of work ongoing and highlighted that the paper submitted by Ms Ridley was undated so would feed that back as uncertain when this was written.

Dr Cargill advised that there had been a request from this group to himself and Dr McKenna about making the Fluid Management module training on Leanrpro mandatory, the request was declined. Dr Cargill said there is a balance between mandatory training being what NHS Fife has a responsibility for as employers and important training which is about clinical education and clinical expertise and it was felt that Fluid training fell into the clinical education category. Dr Cargill added that it was important that staff were up to date in their clinical practice and tools like this are essential to aid learning. Dr Cargill said that it was not appropriate or enforceable to make this training mandatory, Mrs Campbell agreed and said the issue is raising awareness of the modules and targeting the areas that would potentially benefit from it. Ms Saunderson disagreed and said from a surgical nurse point of view it should be mandatory. Dr Cargill said it may be important for practice but not clinical essential/mandatory and would encourage Ms Saunderson to think about it from those aspects and Mrs Campbell suggested SCN's locally may define what the ward team should undertake.

The report was noted.

- **OPAH Action Plans**

There were no OPAH action plans for submission.

6 Emergency Care Directorate

6.1 Directorate Governance – Specialty National Reports

- **SICSAG – Fife perspective**

Mrs Beveridge advised that the full report was included for members but the team have prepared a summary which is quite interesting.
The following points were noted:

- NHS Fife has cared for 56 COVID-19 positive patients since September

2020, this cohort of patients have been reviewed and data collated to give our organisation a local perspective when reviewing Scotland wide data.

- Incidence of patients being intubated and ventilated in ICU:
  Scotland 36% - Fife 75%

  Incidence of Non Invasive Ventilation (NIV):
  Scotland 54% - Fife 16%
  Mrs Beveridge said that this figure may be reflective of using Ward 51 and the ward 51 activity won't be included in this report as the information was extracted from the Ward Watch system.

  During Wave 1 of COVID19, we reported a significantly higher use of Renal Replacement Therapy (RRT) but this time it has been much less. This could be attributed to the type of patient group. Scotland 50% - Fife 71%

  Mrs Beveridge noted that the average length of stay was slightly longer in Fife than in other areas:
  Patients staying over 3 weeks - Scotland 1 in 4, Fife 1 in 5
  Patients staying over 4 weeks - Scotland 1 in 6, Fife 1 in 8

  In Fife 61% of the patients were male.
  19 patients died in this cohort of patients in Fife (crude unit mortality of 34%).
  In Scotland the 30 day crude mortality (after discharge form ICU) was 36%.

Mrs Beveridge said that a Deep Dive is planned for the service. Dr Cargill asked which issues/concerns would be covered by the Deep Dive. Mrs Beveridge said there weren't really particular concerns to note, it would be the ICU group as a whole especially around the Renal Replacement Therapy.

Dr Cargill thanked Mrs Beveridge for the update.

- **Lung Cancer Summary 2018 - Scotland**

Dr McCormack spoke to the Lung Cancer Summary and advised that Fife had done extremely well and noted that Fife had 100% accuracy in the random 24 sets of notes assessed for the Quality Performance Indicators. Dr McCormack complimented the Respiratory team for their work on this. There were no actions to take forward from the summary.

The overall accuracy of recording of the sampled Lung Cancer QPI dataset was 97.3% at Scotland level which exceeds the PHS recommended minimum standard of 90%.

The accuracy of recording of individual data items within the Lung Cancer QPI sample ranged from 92.2% to 99.7% across all NHS Boards.

One of the 13 data items assessed were recorded with 100% accuracy.

The report was noted.

6.2 Directorate Level Outcomes Data:

- **Clinical Audit**

- **Penicillin Allergy De-labelling Business Case**

Dr Alfonzo spoke to the Penicillin Allergy business case. Dr Alfonzo said that at the time of submission the Scottish Antimicrobial Prescribing Group were still doing a pilot study, which has now been completed and the protocol finalised so the ask now is to implement an approved protocol to initiate Penicillin De-labelling within NHS Fife.

Dr Alfonzo advised that the protocol provides a patient information sheet, the exclusion criteria and a letter to the patient and their GP about the outcome of the trial so there is established documentation to support Penicillin de-labelling and an established protocol in place. Dr Alfonzo said that the reason for doing this was that over the national incidences that about 10% of patients who are documented in having an Penicillin allergy, only 5% have a true allergy and the study revealed that 17% of people in NHS Fife had an allergy, and by treating people with alternative drugs NHS Fife are potentially doing themselves a dis-service by giving patients less effective treatment, prolonging their hospital stay and having a higher re-admission rate. Dr Alfonzo added that the team within the OPAT service would like to support this and would assist with all the implementation, the patient findings, the drug therapy and the observation period, at least initially to ensure this is working smoothly. It was noted that there are patient safety considerations to be taken into account but throughout the study there has been no reports of anaphylaxis. Dr Alfonzo asked Mr Timmins if he had any comments to make. Mr Timmins had nothing specific to add other than it is a big problem patients being inadvertently administered Penicillin when they are documented as being Penicillin allergic so to be clearer about allergy status would be a benefit all round.

Dr Cargill asked Dr Alfonzo if this was a formal clinical trial reporting to the Scottish Antimicrobial Prescribing Group (SAPG) or are we implementing a protocol and this is a local test of clinical safety? Dr Alfonzo said that things have progressed since this paper was submitted and this has now been trialled in five Scottish Health Boards and the outcome has already been established, therefore no trial is needed now, just implementation.

Dr Cargill asked for clarity around the reporting arrangements. Dr Alfonzo said as this is still new there is a reporting mechanism across all Health Boards capturing their experience and that the risk is, there is very clear exclusion criteria and did not forsee any issues with it. Mr Timmins added that the SAPG like to collect data to feed back on the success rate rather than any formal trial. Dr McCormack noted that the protocol states there needs to be a Senior Clinician available in case of any marked reaction so clear guidelines and a timeline would be required before delegating this to ward staff to carry out. Dr Cargill said that may be contingent on demonstrating the safety of the local approach and that is the ask of this Committee today. Dr Alfonzo to investigate regarding a local reporting plan to this Committee prior to the Committee agreeing to implementation of this. **AA**

The clinical proposal was noted meantime.

- **ECD Projects registers March to December 2020**

Dr McCormack referred to the list of ECD projects registered for Clinical Effectiveness. The project register shows many overdue reports, this has been looked at and it was felt appropriate to put new dates for the work which was put on hold during the pandemic specifically those in the Emergency Department. One project on Gentamicin prescribing had had it's report done but not been submitted previously but the report concluded that regular audits should be done with each intake of junior doctors. Dr McCormack said some of the findings within the audit were not significant in terms of statistics but they could be going forward. Dr McCormack said that there was a noticed improvement on the appropriate duration of prescribing of gentamicin and also initial gentamicin levels being measured.

D Cargill asked if these are the audits registered and reported on the Clinical Effectiveness register? Dr McCormack confirmed this was one of them. Dr Cargill said that there are a lot of audit programmes going on that are not on the register or being reported and trying to get a single source of the audit programmes across the Directorate. Dr McCormack said that they have validated everything that is on the register and have managed to source a few more but due to a lack of SPA time we haven't increased the number of audits and this is something that needs to be progressed. Dr McCormack pointed out that there were a few errors in the report and the RAD unit was not completed in April 2020 as this is due to begin in April 2021.

The project audit was noted.

6.3 Specialty/departmental audit & assurance data (incl guidance)

- **Clinical Quality Indicators**
- **Lung Cancer Report/Action Plan – Fife**

This item was covered under 6.1.

- **Melanoma Report/Action Plan – 2019/2020**

Dr McCormack spoke to the Melanoma report from 2019/2020. It was noted that Fife has achieved a high level of case ascertainment and was commended on the Pathology department managing to achieve 100% in terms of the QPIs associated with Pathology.

- There were 58 (71 in 2019/20) patients diagnosed with Malignant Melanoma. There were a total of 324 cases across the SCAN region.
- NHS Fife met 6 of the 14 QPIs (including sub QPI) for Melanoma. QPI 3 and QPI 6 were narrowly missed, achieving 93.1%.
- Case ascertainment for NHS Fife is 83%. Allowance should be made when reviewing results where numbers are small and variation may be due to chance.
- There were no other actions for Fife except to ensure we are always updating when the surgeons are removing Melanomas – this is normally an annual action.

The report was noted.

- **Missing Patients Q3**

Mrs Beveridge spoke to the Missing Patients report for Quarter 3 which is produced by Ian Bease. NHS Fife audits are looking at the acute data and acknowledge that this is an artificially low reporting quarter in comparison with the same period in the previous year (143 missing patients reported to Police Scotland against 261 in 2020), a reduction of 45%.

The report notes that Acute services at VHK reported 53 patients missing during the reporting period, in comparison to 101 last year, a reduction of 48%. The most notable levels of recorded incidents continue to be within the Emergency Department and the newly introduced Ward 6. During the most recent quarter, Emergency Department reported 13 of the 18 cases reported to Police Scotland, the equivalent of 72% of all VHK missing patient reports. No corresponding DATIX entries were created for those missing patient reports. The remaining 5 incidents within Victoria Hospital relate to Patients either self discharging and absenting themselves to source drugs or alcohol and 3 corresponding DATIX entries were correctly created in this respect. This indicates only 17% of Patients reported to Police Scotland are recorded on DATIX. Mrs Beveridge said there was some work ongoing with the ED and Ian Bease regarding categorising the severity of the risks correctly. Mrs Campbell noted the low figures and previous concerns around our use of the risk assessment process and the significance risks for vulnerable patients, moving forward as activity increases within the hospital we need to try and make that improvement with our use of the process as it could easily become a serious issue.

Ms Paterson asked if numbers were artificially low because people were not reporting incidents. Mrs Beveridge said it was likely to be because there are less patients in the hospital due to COVID.

- **Violence & Aggression**

Mrs Beveridge advised that specifically for the Acute services there were 43 incidents at the Victoria Hospital, a 15% reduction from the previous quarter and a sustained reduction this time which is good news. The Emergency Department is where most of the reported incidents happen although we are encouraging people to report incidents but Mrs Beveridge was unsure if it is artificially low or we may be getting better at reporting incidents and in terms of the support we have now going into these wards, we have Health & Safety and Violence & Aggression training led by Stuart Armstrong which is an genuine improvement. Ms Saunderson asked if the low numbers was attributed to less patient traffic through Accident & Emergency? Mrs Beveridge said that will also be a contributing factor but reiterated that there was a lot of good work going on. Ms Saunderson it reinforces what the staff have to put up with in Accident & Emergency.

The report was noted.

6.4 Departmental Reports

Mrs Dodds presented the departmental report and the following points were noted.

Incidents
There were 556 incidents reported between 1/1/21 and 28/2/21, this showed a reduction for both months. The incidents were broken down into severity and the top 5 sub-categories remain the same. Patient Information was showing an increase and this is due to incorrect MCCD (death certificate completion), although

this has improved slightly for January & February and less Datix have been completed. It was noted that the junior doctors were receiving more support with this which may attribute to the reduction.

Major & Extreme Incidents
There were 23 major reported incidents. The main themes were:

- 9 of these relate to cardiac arrests which will go through the Emergency Bleep Group review.
- 6 related to Pressure Ulcers
- 1 patient absconded from ED and was later found dead
- 1 issue regarding MCCD completion which will proceed to an LAER and is now subject to a formal complaint.

SAER's & LAER's
There are 20 LAER's ongoing – 11 of these are outstanding.
There are 20 SAER's ongoing – 5 of these are awaiting a re-scheduled meeting date due to the process being put on hold due to COVID19. Mrs Dodds said the Directorate do have a high number at present and are finding it challenging in finding the right people to take on the lead position whilst managing their clinical workload. Mrs Dodds added that they had a good meting with Lynn Campbell and Dr Cargill recently regarding Directorate complaints and incidents and will progress the outcomes from the meeting.

There are also some Tissue Viability actions outstanding due to training being delayed as staff are finding it difficult to find the time to complete this training on Learnpro.

Patient Falls
There have been 165 patient falls reported. There were 3 major harm, 2 moderate harm and 16 minor harm. Wards 53, 41 & 42 have seen an increase in falls and this there is evidence of multiple falls of the same patient where the patient has a cognitive decline despite having a supervision procedures in place. Mrs Dodds said that she had carries out an audit regarding falls and there are areas of improvement to pick up but there was also a lot of good practice going on too.

Tissue Viability
There have been 37 Tissue Viability incidents of pressure damage reported which are hospital acquired and numbers remain high in ITU. There are 6 incidents graded as major harm and education is available for staff.

Medication Incidents
The two main themes are consistently administration and prescribing.

SABs
There has been 1 CVC SAB recorded during this period (Renal).

Complaints
Complaints are concerning at the moment and work continues in drafting responses in a timely fashion. The main themes are delay in treatment, disagreement with clinical management plan/treatment, communication and attitude and behaviours – in particular associated with COVID. Concerns have been raised with regards to the front door and staff members not social distancing. There is also a reported increase in requesting urgent reviews from patients who are unhappy waiting for outpatient appointments.

Directorate Risk Register
The risk register is up to date and managed robustly.

RAD Unit
The RAD Unit is nearing completion with construction work due to be finalised on 31st March 2021 and this will provide huge improvement for Medicine of the elderly patients. Mrs Dodds added that funding has also been received for Ward 32 for their Bus Stop Café and de-escalation rooms which will provide better amenities for the patients.

Mrs Campbell said more of an observation, but something for us all to consider as we strengthen the safer staffing legislation, we do recognise that staffing has an impact on some of these things but we don't necessarily report staffing issues on Datix but we need to be better at doing this as it would support assessment and reporting. Mrs Campbell added that a focus on harms for the whole division will be required as we move forward this year.

Ms Saunderson commented that the ECD specialty summary on page 7 was very informative and well presented. Mrs Beveridge thanked Ms Saunderson for the compliment.

Dr Morrice asked if there was any further information regarding the complaints about the front door? Mrs Dodds said the main theme is the attitudes and behaviours of how people are being allowed into the hospital, they do not fell that we are complying with COVID guidelines and complaints being received about the security officers too. Dr Morrice said that this affects all Directorates apart from Paediatrics, who have a separate front door and commented that they hadn't had any complaints about their front door and asked if these were valid complaints and if so, what was being done about this? Mrs Dodds said that she thought the public were frustrated, they have time on their hands and it tends to comes on the background of something having gone wrong on the ward with the patient and they have been quite angry and what is being visualised at the front door is not correct to the complainants, some of he comments are that we are being forced to lockdown and NHS staff are not complying so it has been escalated to others. Dr Morrice said that also lack of visiting will add to the public discontent. Dr Cargill said that the ED gets a disproportionate amount of these with the number of attendances too.

Dr Cargill thanked Mrs Dodds for the Directorate report.

Dr McCormack commented regarding the speciality summary and said one thing of concern to note was general concerns across the whole Directorate for outpatient waits due to COVID. The main concern to highlight was the Diabetic service as there has been a number of new Type 1 diabetics presenting and there has also been 2 deaths. Dr McCormack added that they have liaised with Communications and there has been some information regarding patient education has been sent out and the Diabetic team are also going to prepare some information to Primary Care and to work with the MCN to try and improve this.

- **SAER Learn Summaries (included within Departmental Report)**

This item was included within the Directorate report.

6.5 New Interventional Procedures

- **Botox Migraine**

Dr McCormack spoke to the Interventional Procedure and advised that Fife would like to introduce this and is already an outlier for not having this service. Patients would be appropriately selected by Neurology for Botulinum toxin type-A (BTX-A) injection for treating chronic migraine (CM) covering distinct injection points in the head and neck regions, provided with the relevant information sheet and will have gone through the required treatment before getting to the Botox stage. A Specialist Nurse has been trained to deliver this service and would be supported by the Neurologist, specifically Dr Saturno.

Dr McCormack added the Service will be subject to an annual safety audit – data concerning adverse events/side effects will be collected from patients by the Specialist Nurse at each appointment.

Outcome measures: the response to treatment will be assessed by a headache diary pre and post intervention. The patient will start the diary 2-3 months before first treatment. After two courses (8 months after first treatment), the data collected will determine whether patients are responders, and hence eligible to continue to receive treatment.

In addition, patients' functional improvement will be assessed at 0, 4, and 8 months by the Headache Impact Test questionnaire (HIT-6). This is included in the diary provided to patients at the time of referral for Botox treatment.

Non-responders Botox will be stopped after 2 courses if the following criteria are met:

- the person is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles)
- the headache has changed from chronic to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months

In patients with a good response treatment will be stopped after 2 years, this treatment is in line with other Health Boards.

Mrs Campbell said that she was unsure how many companies produce the required Botox and noted some of the training seems to have been sponsored by one company and wanted to be clear that everything is above board regarding conflicts of interest etc. Dr McCormack said there are some generic Botoxes but Botox as a trade name, only some are licensed for certain procedures. Mr Timmins said that was correct and only one of the brands was licensed for this procedure and confirmed all background checks have been completed. Mrs Campbell appreciated the assurance.

Dr Cargill asked about the feedback to this Committee and said that it should include number of starts, number of stops, compliance for start/stop criteria and any outstanding safety issues and said probably minimum 1 year given the low volume. Dr McCormack said it was likely to be 18 months to produce any worthwhile data. Dr Cargill asked that it be included on the Directorate workplan. Dr Cargill said that he was content to sign this procedure off. **ECD**

6.6 SPSO Recommendations

There were no SPSO recommendations to report.

7 Planned Care Directorate

7.1 Directorate Governance – Specialty National Reports

7.2 Directorate Level outcomes data:

- **Clinical Audit**
- **PCD Projects**

Ms Saunderson referred to the register of projects and advised that a number of them have been registered but the vast majority of them have not been completed. There are 18 overdue and 3 due for completion this year with only 1 having been completed in the last 6 months. Ms Saunderson said she thought the Directorate team need to go through these projects and get an update of timescales and ensure all the necessary people are included as at least one project is missing from the register. Dr Cargill said that would be helpful as we need an accurate picture of the priorities, what is completed and awaiting report, what has not been undertaken etc. Ms Saunderson to follow up. **AS**

7.3 Specialty/departmental audit, assurance data (incl guidance)

- **Clinical Quality Indicators**
- **ENT Clinical Governance Meeting**

There were no issues highlighted. Report noted.

- **General Surgery Datix Group Meeting**

There were no issues highlighted. Report noted.

- **Ophthalmology CG Meeting**

There were no issues highlighted. Report noted.

Ms Saunderson said there was nothing exceptional to highlight from the ENT/General Surgery or Ophthalmology meetings. Ms Saunderson added that it demonstrates that Clinical Governance is on the various agendas for the specialities, but commented that at the same time did not want to overload the agenda with these items. Ms Saunderson said she needed to pick up with the Directorate about the best way to highlight this type of activity, there is good work going on and want to present that back to the Committee.

Mrs Campbell said she quite liked the way the information is laid out but how do we extract anything of note. Ms Saunderson asked Dr Cargill for his thoughts on this? Dr Cargill said that he did not feel strongly and suggested that either on a rolling programme each specialty has an opportunity to showcase their governance and put that in an annualised workplan or an exception report can come to the Committee if issues arise. Business as usual reports will simply be noted by the Committee. Dr Cargill said it was up to the Directorate but as long there is a

coverage of the governance. Ms Saunderson said she was reassured with that.

Mrs Beveridge said that the ECD Directorate have had the same debate about presenting information so business as usual for reporting in and highlighting anything by exception.

7.4 Directorate Report

Incidents
There were 263 incidents reported from 1/1/21 to 28/2/21. 5 were reported as major and 1 reported as extreme.

SAER & LAER Investigations
All current SAERs (6) are being progressed, four of which are currently overdue.
There is an ongoing LAER investigation remaining from 2019. The report has been returned to the Lead Reviewer for final review. The Directorate have one LAER which is now overdue. All remaining LAERs (7) are within the investigation period and continue to be progressed.

It was noted that the Directorate has a number of outstanding actions arising from SAER and LAER investigations. Work remains ingoing in order to finalise these actions.

Patient Falls
During the reporting period, there were 56 Falls reported which represented a 3% increase.

Medication Incidents
There were 27 medication related incidents. These were noted as:
81% - No Harm outcome
11% - Minor Harm outcome
7% - Moderate Harm outcome

Tissue Viability
During January and February 2021, there were 15 Tissue Viability related incidents reported as developing on ward or caseload. These were all graded as moderate harm. Focussed work has commenced to review pressure care area in Wards 44 and 54.

Risk Register
The Risk register is reviewed at regular intervals ensuring all risks are managed and updated accordingly.

SABs
There were no hospital acquired SABs or device related SABs within this reporting period for PCD.

Complaints
The Directorate closed 9 Stage 1 complaints and 8 Stage 2 complaints.
The number of complaints fully upheld was 3, partially upheld was 1 and not upheld was 4. There are a number of outstanding complaints awaiting conclusion.

SPSO
There were no SPSO outcomes during this period.

Legal Claims
There has been one legal claim received for Clinical Negligence in Orthopaedic Trauma.

Patient Experience
Feedback of patient experience continues to be received.

Fife Elective Orthopaedic Centre (FEOC)
The ground preparation work commenced for the FEOC on 1st March 2021 and due to be completed in September 2022. This building should accommodate planned Orthopaedic activity for the next 20 years. The FEOC is being developed alongside the National Treatment Centre Programme.

- **SAER Learn Summaries**

Ms Saunderson referred to the LEARN Summaries and highlighted some points from them:

- An SAER was commissioned for a patient who had to have two knee operations in close proximity and then developed skin necrosis 3 weeks later which eventually resulted in amputation.
- One incident in Theatre – 3 patients who were undergoing spinal anaesthetics for Caeserean sections and the patients were give 1mg of morphine instead of 0.1mg. The wrong morphine was selected from the Controlled Drugs cupboard and neither the nurse nor the Anaesthetist picked this up. The patients recovered and there were no side effects.

Mrs Campbell commented on the Incident themes mentioned in the Directorate report on page 5 and asked what the "other Clinical Events" related to as there were 49 incidents categorised under this. Mrs Campbell wondered if there was a "theme" as that is a significant number. Ms Saunderson agreed to look in this. **AS**

Dr Cargill asked if there was anything else that could have been done in relation to availability or storage of restriction of morphine strengths that could have made it easier for our staff to make the right choice? Ms Saunderson said that they had implemented a dedicated coloured plastic box in each of the CD cupboards for dedicated storage for the preservative free morphine as this type would only be used when doing spinals however staff would also carry out all the normal checking standards as per SSUMP. This adverse event has been widely shared with the teams who are aware of why this strength is now placed in this box within the CD cupboard.

Mr Timmins said it was quite a nasty incident and it comes back to human error, there were 3 people reading the label and they all got it wrong, they understood why they were doing this but did not carry out the check. Mr Timmins queried whether it should be a single person check then that person is aware the responsibility lies with them. Dr Cargill said that often when we identify an issue we identify human error which is the most difficult to control, where as process error might be a solution for example: keep the blue box in one theatre rather than each theatre having access to this type of morphine. Dr Cargill asked if there was something that the organisation could do to assist with making the right choice?

Mrs Campbell said it was an interesting question that has been considered I other cases but we do need to think about an effective way to do this. Mr Timmins said

that single person administration topic was discussed at the Safer Use of Medicines group just before the second wave of COVID so it will likely come to Marie Paterson to progress with further discussions. Mr Timmins added that with controlled drugs it remains that we need 2 people for the witnessing but there are things we could do to change the checking process. Dr Cargill said that this should be regarded as work in progress.

PCD/ Pharmacy

7.5 New Interventional Procedures

- **Rezum Procedure**
  Dr Cargill explained this is a minimally invasive Prostate surgery which the Urologists have now implemented. This procedure did have the usual business and governance requisites in place and a report will be expected back at the Committee in due course.

- **Cytosponge**
  Dr Cargill said this is a minimally invasive test that replaces Upper GI Endoscopy screening for Barratt's Oesophagus and detects pre-malignant changes using a sponge rather than direct visualisation. There was a desire to get this in place when the Endoscopy screening was suspended to allow screening to continue. This is part of a national programme but will receive a report on the local experience and safety of Cytosponge in due course.

- **Colon Capsule Procedure**
  Ms Saunderson said this procedure is an alternative to Colonoscopy in medium risk patients and is a pill camera for diagnostics examinations of the colon. The patient takes bowel preparation to clean the colon and this is done in an outpatient setting. Ms Saunderson understands that if this is given the sanction to proceed then the company comes in and administer this – they anticipate they will do 150 patients per year, although there are issues in relation to the prescribing which have not yet been concluded. Mr Timmins elaborated on the prescribing issue and advised that the drugs are supplied by Ninewells and there are questions about electronic transmissions of prescriptions – this has gone to Central Legal Office for clarification.

  Dr Cargill said that despite the procedure already being agreed, there are still unresolved issues about prescribing and reporting. Mrs Campbell asked about any risks with this procedure as this is not stated on the form. Dr Cargill said that implementation is not a service imperative and the issues raised need clarified before approval. Ms Saunderson to take forward with the Directorate. This item to be carried forward to the next meeting.

  AS LG

- **Surgical Care Practitioner**
  Ms Saunderson said this procedure was submitted to the last Clinical Governance Committee and although in principle there was general agreement about the procedure Dr Cargill had requested clarity around the audit processes. Ms Saunderson said that additional information has been included on the documentation regarding a respective yearly report being carried out by the Nurse Practitioner.

  Dr Cargill asked members if, considering the additional information provided, if they were content to approve the extended role for the Surgical Care

Practitioner? Mr Timmins was unclear if the individual was a registered Prescriber of the drugs to be administered? Ms Saunderson advised that she is a Non Medical Prescriber. Dr Cargill confirmed the approval of the procedure.

7.6 SPSO Recommendations

There was no SPSO activity.

8 Women, Children & Clinical Services Directorate

8.1 Speciality National Reports

- **Peri-Natal Mental Health**

Ms Lawrie said that the Peri-Natal Mental Health was for information. Ms Lawrie added that NHS Fife were successful in securing funding for Mental Health pathways. The SBAR provides the background information and how the services are progressing.

The report was noted.

- **MBRRACE 2018**

Ms Lawrie said these are annual reports for retrospective data.

Ms Lawrie said MBRRACE 2020 is reporting on births from 2018 and data is presented as crude and stabilised rates which is more indicative. The crude mortality rate is the number of deaths divided by the number of total births (or live births in the case of neonatal mortality) for 2018 and provides a snapshot of the mortality in an organisation for that time period. The stabilised rate allows for the effects of chance variation due to small numbers. There are also adjusted to account for key factors which are known to increase the risk of peri-natal mortality.

The extended peri-natal rate and stillbirth rate was 5% above the national average but still within an Amber RAG status. The neonatal deaths were 5% below the national average and again within an Amber RAG status.

Ms Lawrie said that the recommendations from MBRRACE were to:

- Review the data that was entered locally about your Health Board to ensure it is accurate
- Review exiting records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care implemented.

The Committee is asked to note that:

- All stillbirths and neonatal deaths were reviewed by a multidisciplinary team.
- There is an improvement in the RAG status.
- Known reasons for the poor RAG status include:
  High proportions of population based risk factors eg: BMI, smoking and deprivation.

Ms Lawrie said that the numbers have decreased since so NHS Fife have not kept at that high rate nationally. McQic are taking some work forward in relation to this.

The update was noted.

-

- **National Neonatal Audit Project (report on 2020)**

Ms Lawrie spoke to the NNAP report which was reporting on data from 2019 and the data suggests that Fife is performing well in most of the indicator areas. The performance areas that we need to review and action are:

- temperatures/obs in neonates on admission to neonate unit.

It was noted that there is a peri-natal hypothermia bundle and some multi-disciplinary work is going on with changes being made to how neonates are being dealt with in Theatre and also clinical follow up at 2 years of age but as a Multi-Disciplinary group Ms Lawrie assured the Committee that actions are being taken.

Mrs Campbell was unclear about reporting and asked about double inputting with electronic systems and if this was happening with Badgernet and other systems? Ms Lawrie said that the department uses Maternal Badger which is the full Electronic Patient Record (EPR) and Baby Badger which is not the full EPR . Ms Lawrie said that she should get funding to adapt this to achieve the full EPR and noted that it is not double entry but it is some electronic data and some written data.

Dr Cargill asked what the solution to the 2 year follow up issue? Ms Lawrie said there was development of the high risk baby clinic for all infants born under 30 weeks and standardised assessment by trained assessors and the use of a specific follow up tool and Ms Lawrie was hopeful of an increase in the Neonatology team. Dr Morrice confirmed that he hoped that the Directorate had managed to recruit 2 more Consultants today who will contribute to the follow up of high risk neonates and this will link in with the Community Child Health Service as there is an interface between Neonates and Community for babies who are graduates from the Neonatal Unit and there is some good news there for the Neuro-Disability service which all links in.

The update was noted.

8.2 Directorate Level Outcomes Data

- **Clinical Audit**

- **WCCS Presentation**

Dr Cargill advised this was carried forward from the last meeting but was unable to open the presentation. Dr Cargill asked if this was new data being presented? Mrs Galloway said the information was not current and thought that only Dr Mahmood had access to the original presentation. Mrs Galloway asked if there was a requirement to refresh the data and submit to a future meeting? Dr Cargill said that if there is a prospectus audit programme for the Directorate then that will suffice as it will be covered at a future date.

Mrs Galloway also said that the Directorate report is not as good as it should be and this is partly attributed to the Clinical Governance Lead retiring and the Clinical Governance structures within the Directorate not being wholly in place. Mrs Galloway was confident that future reports will be better.

8.3 Directorate Reports

- **Women & Children**

The report included the specialty reports which were covered under 8.1 .

The Directorate have 6 ongoing SAER's, 2 completed and 2 awaiting the final report. It was noted that there are also 3 current risks on the risk register.

- **Radiology Report/s**

Mrs Anderson spoke to the Radiology report and wanted to highlight 3 key points all relating to the referral processes and information sharing.

Mrs Anderson said the first point related to Ionising Radiation Medical Exposure Regulations (IR(ME)R) level 1 procedures within NHS Fife, there is a responsibility on referrers to speak with patients who are known to be pregnant and have a discussion with them regarding risks to themselves and to the unborn foetus before they are referred to Radiology. In addition, it is important that this information is shared with Radiology that this conversation has taken place although this presents a challenge as there is no field in Trak for that information to be recorded so currently referrers are being asked to make a note in the comments field where the clinical information is inserted. Mrs Anderson said that this change was accepted by Dr McKenna at the IR(ME)R Board in September but this has not been shared with referrers as yet as the January meeting of the Committee was cancelled. Mrs Anderson added that the department do have a good information sheet for referrers which is easy to follow but Mrs Anderson said she was seeking support in sharing this information so that referrers and non-medical referrers are aware of their responsibility.

Dr Cargill asked for clarity of this was women who might be or who are known to be pregnant? Mrs Anderson said known to be pregnant, the other responsibility lies with the IR(ME)R operators in Radiology so they would cover that aspect. Mrs Anderson added that these are sometimes emergency cases so she is looking for a channel out to the GPs and clinical teams.

Dr Cargill asked members for their thoughts on how we support the messaging and the Radiology team across the clinicians who will be requesting Ionising Radiation procedures in pregnant women? Dr Cargill said that this would require to be discussed between clinical teams and requesting teams about how this will work as it is quite a big change in practice. Mrs Beveridge suggested disseminating the information via the normal routes from Clinical Leads to the various groups. Mrs Beveridge also said that she would discuss offline with Mrs Anderson regarding the AHP group. **RC** **NB/JA**

Mrs Anderson said the second point was the Radiology Significant Findings Alert which has been in place for a while and Radiology sent an email alert when there is an unexpected significant finding. These alerts are sent to generic email inboxes which have been identified by clinical teams. Mrs Anderson said that lately the Radiology admin staff are having to double check if the emails have been acted upon as there is no acknowledgment being returned, which is a simple task to do. Mrs Anderson said this is causing issues for the Radiology team, if the team check Trak and it is apparent that the patient does not have a follow up appointment then a Datix is raised. Mrs Anderson advised that they have done some work with the

Planned care Directorate to raise awareness around this. Mrs Anderson asked members for support or likewise to advise if there was any challenges with the method?

Dr Alfonzo said that now that this is in place, is our duty to respond to the alerts and will remind Consultants to acknowledge the alert. Dr Alfonzo agreed to send a reminder to medical colleagues in the Directorate. Mrs Beveridge commented that we desperately wanted this alert in place and it was an action from a number of SAERs and LAERs. Mrs Beveridge said she was happy to participate in any discussions. **AA** **NB/JA**

Mrs Campbell said she has certainly seen a number of SAERs where something has been missed and it may be helpful to get a sense of the numbers and to keep an eye on this issue as the impact is significant. Mrs Campbell added that it may be helpful to report back to this Committee and hear how we are improving. **JA**

Dr McCormack wondered if there was a pathway that we needed to create in order for clinicians to act on the email alerts instead of reading and not actioning immediately.

Mrs Galloway questioned whether this fed into the larger issue around results reconciliation for Laboratories and Radiology which was supposed to be a major Clinical Governance advantage but was stopped at the go live stage because it was too big a piece of work and was never picked up, this has been asked for several times but it does not appear on any workplans anywhere. Mrs Galloway said there may be more influence if a request came from this Committee. Dr Cargill responded and said that a recommendation for results reconciliation for all diagnostics likely needs to be taken to the Clinal Governance Oversight Group to determine if this will be one of our Board priorities going forward, if so how do we construct that?

Dr Cargill said there may be further work to do with who is receiving the email alerts as there will be some thoughts around if a clinician receipts the alert they will be responsible for the follow through of activity. Dr Alfonzo suggested that a team approach to the alerts may be better than an individual approach.

Dr Cargill asked Mrs Anderson what was the best approach in progressing this issue? Mrs Anderson said to improve communication would help. Dr Cargill agreed to work in conjunction with Radiology on this issue. **RC**

Mrs Anderson raised the final issue of EGFR, examinations which require patient to have contrast eg. CT, MRI – Radiology requires an EGFR value for a patient and in Trak there is a way that clinicians can bypass this and by doing this it is causing frustrations within the vetting team and subsequently delays to patient management. Mrs Anderson asked that this information be shared to improve the service. Dr Cargill advised that he had asked Dr Jamieson to contact the Clinical Directors and Dr Morrice to have a discussion about the best way of doing this and need to find the correct balance to take that forward.

Dr Cargill thanked Mrs Anderson for highlighting the issues within the department.

- **Laboratory Report**

Mrs Galloway presented the information for Laboratories.

Mrs Galloway advised that it has been a challenging year for the Laboratories as well. It was noted that :

- There have been no extreme or major adverse events reported in the last 6 months.
- Laboratories are very audit heavy because of the accreditation.
- Wrong Blood and Tube and Patient ID represent around 50% of the incidents. Incidents continue to be Datixed.
- Dr Roy in ED has shown some good leadership around these incidents and the ED's incidents have reduced as a result.
- Non-Conformances and errors – there is a very robust quality management system (QMS) in place and we are accredited to ISO 15189.
- Microbiology was selected as an example of how many audits are carried out on an annual basis and from the audits how many non-conformances are picked up. Some of the non-conformances are relatively easy to correct and others may take longer as issue is not closed off until the root cause is found.
- The number of audits has been reduced across all disciplines in the last year. Recurringly, the root causes are communication and human error.
- A number of non-conformances reported against equipment – the molecular analysers – plans are in place to refresh and replace them.
- In regard to external audit and benchmarking reports, we tend to perform well across all disciplines, for benchmarking we remain the cheapest and most effective service in Pathology considering the challenges the service has endured particularly with staffing levels. Mrs Galloway said that we invite Boards to come and participate in cross board auditing which is quite valuable.
- Laboratories will be aiming to achieve Point of Care accreditation ISO 22870 so work is beginning around that.

Dr Cargill thanked Mrs Galloway for keeping abreast of all the audits and accreditations.

Mrs Campbell asked that the Incidents improvement information within ED be shared at the next Committee meeting as it would be useful to know the detail to open a discussion. Mrs Galloway said that she would refresh the audit and bring back to the Committee. **DG**

- **SAER Learn Summaries**

There were no SAER summaries submitted.

8.4 Specialty/departmental audit, assurance data and clinical guidance

- **Maternity Unit Self Assessment Study**

Ms Lawrie advised this was for the Committee's information and is part of research that will be linked to an accreditation for the Midwifery Led Unit (MLU). Fife is the only unit in Scotland to work to the accreditation and are working alongside units from various European countries. Ms Lawrie said that we have been informed that we are nationally one of the top 10 functioning midwifery units. Fife will receive a Beacon award for that. Dr Cargill congratulated the team on the award.

- **SBAR Community Paediatrics**

Dr Morrice spoke to the Committee about Community Paediatrics and advised that the service has been historically run by Associate Specialists and a number of these individuals have retired over the last 4/5 years leaving the service with significant gaps to fill. There has been significant service re-design with ADHD specialist nurses and ADHD pharmacy, we have been looking at various kinds of ways to mitigate the risks. Dr Morrice said that there was some good news in that we have managed to recruit a new experienced Community Paediatrician who commences in post next week and the prospect of another couple of trainees coming off programme who are committed geographically to Fife.

Dr Morrice highlighted the SBAR and said that this was included to raise awareness of the difficulties the service faces and these are on the risk register. Dr Morrice said one if the issues is the staffing of the ADHD service and where this sits as in other Boards this would fit under the umbrella of CAHMS, although there is resistance from CAHMS to absorb this significant workload.

The update was noted and there were no significant actions for the Committee.

8.5 New Interventional Procedures

There were no new Interventional procedures for the Directorate.

8.6 SPSO recommendations

There were no SPSO recommendations.

9 Divisional Risk Register – Active Risks

Dr Cargill advised there were no overdue risks but there were a few due for review this week so asked the relevant risk owners to update these timeously. Dr Cargill added that if the risks were not clinical, service or business then to please consider if these were in the correct place.

10 Attendance Matrix

The attendance matrix is for Corporate governance of the Committee. The matrix was noted.

11 Terms of Reference for ASD CGC

Dr Cargill said that the Terms of Reference required to be reviewed and asked members to check if the membership and remit of the Committee was current and feedback as soon as possible. The Terms of Reference would then be subject to approval from NHS Fife Clinical Governance Committee. **ALL**

12 Items for information only:

12.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

12.2 SIGN Guidance

The SIGN guidance is an indication of what reports are expected to be published. The guidance was noted.

12.3 ASD CGC Workplan/s 2020-2021 & 2021- 2022

The workplan provides information on the regular reporting cycle. The workplans were noted.

12.4 Infection Control Committee Minutes of 3rd February 2021

Not submitted – carry forward to May 2021. **LG**

12.5 HAIRT Report
The HAIRT report was noted.

12.6 NHS Fife CP&PAG Minute of 22nd February 2021

Not submitted – carry forward to May 2021. **LG**

12.7 Resuscitation Committee Minutes of 13th January 2021

The Resuscitation Committee minutes were noted.

12.8 Hospital Transfusion Committee Minutes of 11th December 2020

No further meetings have taken place since February 2020.

12.9 Patientrak Meeting

No further meetings have taken place.

12.10 Divisional Report – COVID 19 Incidents

Dr Cargill and Mrs Campbell have been providing monthly feedback regarding COVID incidents. The report is attached for information.

13 AOCB

Mrs Beveridge complimented Dr Cargill and said that this had been a good meeting.

Mrs Galloway asked about future submissions and when papers would be required. Dr Cargill advised that the cut off date was 10 business days prior to the meeting date.

14 Date of Next Meeting/s:

Wednesday 12th May 2021 at 2.00pm via MS Teams

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 12.30PM ON WEDNESDAY 3 FEBRUARY 2021 VIA MICROSOFT TEAMS

Present: Dr Chris McKenna (Chair)
Dr Annette Alfonzo
Dr Marie Boilson
Ms Claire Fernie
Mr Scott Garden
Dr Iain Gourley
Dr David Griffith
Ms Louise Noble (representing Lynn Barker)
Mr Euan Reid
Ms Rose Robertson

In attendance: Mrs Sandra MacDonald (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were noted for Ms Lynn Barker, Ms Karen Baxter, Dr Rob Cargill, Ms Claire Dobson, Mr Ben Hannan, Dr Helen Hellewell, Dr John Kennedy, Dr Tahir Mahmood.

2 MINUTES OF PREVIOUS MEETING ON 2 DECEMBER 2020

The minutes of the meeting held on 2 December 2020 were confirmed as a true record.

3 SUMMARY OF ACTION POINTS FROM DECEMBER 2020 MEETING

The summary of action points was reviewed and updated.

IT Repository for Clinical Guidance Documents
It was noted that the Senior Project Manager who had originally been tasked with progressing the implementation plan is leaving NHS Fife. Another Project Manager has been identified to take this forward and a timescale is being agreed. Mr Garden to update the ADTC in due course. Dr Griffith highlighted his experience with Microguide and offered to contribute to the process if necessary. **SG**

Lithium SBAR
Dr Boilson advised that proposals to bring lithium monitoring into mental health monitoring services were discussed and agreed at LMC. Euan Reid to link with David Binyon, Lead Pharmacist for Mental Health, to bring a summary update to the next ADTC meeting. Action to be closed thereafter. **ER**

DOACs and Prescribing in Renal Impairment
Mr Garden provided an update on discussions with Dr Glyn McCrickard. A

follow-up meeting is scheduled for the end of February and wider issues in renal impairment will be discussed. Mr Garden to feed back at the next ADTC meeting in April. **SG**

Steroid Emergency Card
Mr Reid advised that the ADTC-Collaborative are setting up a short-life working group to look at a once for Scotland approach. Update to be brought back as an agenda item in due course. **Action closed.**

National Immunoglobulin Request Form
Mr Reid provided an update in relation to the work ongoing within Pharmacy to review procedures and liaise with specialist teams regarding patient reviews. To be removed from the action list and added to the Agenda for the ADTC meeting in June. **Action closed.**

National PACS2 Review Panel Membership
There was consensus that NHS Fife should consider National PACS2 Review Panel membership in the future but due to capacity issues it would be difficult to contribute at present. Mr Garden to discuss with Laura McIver, HIS Chief Pharmacist. **SG**

Annual Declarations of Interests
S MacDonald to issue a reminder to ADTC members who have not yet returned their annual declarations of interest. **SM**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 Fife Formulary Committee

Mr Reid introduced the update report from the Formulary Committee meeting on 20 January and highlighted key points.

A Formulary submission for silver nitrate which had been deferred pending discussions with other specialties was approved for restricted use by the colorectal team only for removal of over-granulating tissue and cauterisation around the stoma site. A Formulary submission for budesonide 1mg orodispersible tablets (Jorveza®) for eosinophilic oesophagitis was approved subject to MSDTC approving the protocol and a submission for carfilzomib in combination with lenalidomide and dexamethasone (Kyprolis®) for treatment of adult patients with multiple myeloma who have received only one prior therapy was approved subject to Clinical Director approval. Updated Formulary Chapter 5 Infections was approved and an update to blood glucose meters (Chapter 6 Endocrine).

Several SBARs in response to MHRA drug safety updates were also discussed and the actions taken/proposed in NHS Fife agreed.

Dr Griffith highlighted current gaps in Committee membership, in particular haematology/oncology Pharmacy representation and paediatric Clinical representation (Dr Sean Ainsworth is stepping down from the Committee due to retiral). It was suggested that Mr Reid discuss with Dr John Morrice, AMD for Women & Children Services. **ER**

The ADTC noted the update report from the Fife Formulary Committee and supported the recommendations made.

6.2 MSDTC

It was noted that the next MSDTC meeting has been re-scheduled to 27 April 2021.

6.3 Antimicrobial Management Team

Dr Griffith introduced the update report and minutes on behalf of the Antimicrobial Management Team and highlighted key points.

Achievements since the last report include a full review of Formulary Chapter 5, maintenance and update of all antimicrobial prescribing guidelines to reflect changed prescribing practice, including an interim review of paediatric antimicrobial guidance pending publication of national guidance.

The workplan for the next six months includes ongoing guidance review and working with the Scottish Antimicrobial Prescribing Group to promote IV to oral switch in line with national guidance. It was noted that routine activity continues to be affected due to the impact of COVID-19 priorities on the team.

The ADTC noted the update report from the Antimicrobial Management Team.

A discussion ensued about three antibiotics which have not been submitted to the SMC by the Pharmaceutical Company and are therefore not recommended due to non-submission. It was flagged up that if these antibiotics are required in an emergency situation obtaining individual patient approval utilising the SMC Non-Submission Treatment Request process may not be appropriate. It was noted that Dr Alfonzo is producing a paper on a similar issue within her specialty relating to availability of a medicine for emergency treatment of hypercalcaemia. It was highlighted that this is a national issue and Mr Garden agreed to escalate to the Directors of Pharmacy, ADTC-Collaborative, SAPG and the SMC. **SG**

6.4 Realistic Prescribing Group

Mr Reid introduced the update report on behalf of the Realistic Prescribing

Group and highlighted key points.

It was noted that there has been an initial meeting with co-chairs Emma O'Keefe and Nicola McGourity. The pharmacy prescribing lead for the group has changed from Fiona Forrest to Fiona Eastop. There has been a review of the current Care Home LES for year 2020/2021 which includes the addition of advice to utilise Near ME for remote consultations between GP/pharmacist and care home/patient. The workplan for the next six months includes the development of further Frailty prescribing guidance across a range of therapeutic areas focusing on diabetes and lipid management

The ADTC noted the update report from the Realistic Prescribing Group.

6.5 Fife Prescribing Forum

Mr Garden provided a verbal update on progress with the Fife Prescribing Forum.

A pre-meeting was held in October and terms of reference for the group were agreed. The first meeting of the Forum was planned for February but following discussion with stakeholder members of the group it was agreed that due to pressures of the COVID-19 pandemic it should be postponed to April. An update on progress to be brought to the ADTC in due course.

7 SBARs

7.1 Newly Licensed Medicines Policy

Mr Reid introduced the updated Policy on the introduction, availability and safe and effective use of medicines, including newly licensed medicines. The Policy has been updated to include Early Access to Medicines Schemes and pre-Health Technology Asessment Free of Charge Pricing Schemes.

Ms Fernie highlighted a potential change required to the terminology around patient engagement. Ms Fernie to liaise with Donna Hughes, Head of Person Centred Care, Patient Relations, to clarify the up-to-date terminology. **CF**

A discussion followed about the lack of patient/patient group involvement in the local Formulary submission process. Mr Garden, Mr Reid and Ms Fernie to discuss further. **SG/ER/ CF**

The ADTC approved the updated Policy on the introduction, availability and safe and effective use of medicines, including newly licensed medicines. To be added to the ADTC website.

7.2 COVID-19 Vaccination

Mr Garden provided a verbal update on progress with the roll-out of the COVID-19 vaccination programme. The main focus of the update was on the background to the introduction of national protocols to enable non-

registrants to administer COVID-19 vaccinations and the implementation of these in NHS Fife. The ADTC was assured that there are robust processes in place to support the implementation of the protocols in NHS Fife.

The ADTC noted the update. The protocols to be brought to the next ADTC meeting. **SG**

8 RISKS DUE FOR REVIEW IN DATIX

Mr Reid took the ADTC through the risks scheduled for review and agreed current risk levels and review dates.

Risk 1504 - Lack of Central IT Repository
Already discussed under item 3. Current risk level to remain. To be brought back to the ADTC for review in June 2021.

Risk 1621 - National Medicine Shortages
A return has been submitted in response to the Scottish Government communication on cost implications of COVID-19 and a response is awaited. Risk 1621 to remain at its current level and brought back to the ADTC in August 2021.

Risk 522 - Prescribing Budget
Mr Reid is meeting with finance representatives to discuss the New Medicines Fund and ongoing pressures on the medicines budget. Current risk level to remain. To be brought back to the ADTC in April.

Risk 1347 - Shared Care
It was noted that there is a preferred candidate for the shared care pharmacist post. It is anticipated that this individual will be in post and have had initial discussions with Dr Hellewell and Chair of the Shared Care Group prior to the June ADTC meeting. Current risk level to remain. To be brought back to the ADTC in June.

Risk 1442 - Single National Formulary/East Region Formulary
A workshop between the Directors of Pharmacy and Formulary teams is scheduled for early March. Current risk level to remain. To be brought to the ADTC in April for review.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

None for consideration.

10 EFFECTIVE PRESCRIBING

10.1 Early Access to Medicine Scheme - Pemigatinib

The ADTC noted the EAMS operational guidance for Pemigatinib monotherapy for the treatment of adults with locally advanced or metastatic cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or rearrangement that is relapsed or refractory after at least one line of

systemic therapy.

11 HEPMA Update

Mr Garden advised that the HEPMA business case has been signed off. The three year implementation plan is on track to commence from April 2021 onwards. Recruitment to posts is continuing and the Head of Digital Innovation is taking the plan forward pending appointment of a Programme Manager.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items for escalation to the Clinical Governance Committee. It was suggested that the review of the New Medicines Policy be highlighted for noting. Mr Garden confirmed that COVID-19 would be included in his vaccination update to the Clinical Governance Committee. **CMcK**

14 ANY OTHER COMPETENT BUSINESS

Dr Gourley highlighted an issue with prescribing of CNS stimulant medicines. It was noted that this was being addressed through the appropriate governance routes.

Other Information

a Minutes of MCN Prescribing Groups - none for noting.

b Date of Next Meeting

The next meeting is to be held on **Wednesday 14 April 2021 at 12.30pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 1 April. Provisional apologies from Dr McKenna – Mr Garden to Chair.

Fife Health & Social Care Integration Joint Board
Supporting the people of Fife together

CONFIRMED MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE FRIDAY 26TH FEBRUARY 2021, 1000hrs - MS TEAMS

Present:	Councillor Tim Brett (Chair) Christina Cooper, NHS Board Member Martin Black, NHS Board Member Councillor David J Ross Councillor Jan Wincott
Attending:	Dr Helen Hellewell, Associate Medical Director Cathy Gilvear, Quality Clinical & Care Governance Lead James Crichton, Divisional General Manager (Fifewide) Lynn Barker, Associate Director of Nursing Scott Garden, Director of Pharmacy & Medicines Lynn Garvey, Interim Divisional General Manager (West) Fiona McKay, Interim Divisional General Manager
In Attendance:	Jennifer Cushnie, PA to Dr Hellewell (Minutes)
Apologies for Absence:	Wilma Brown, Employee Director Nicky Connor, Director of Health & Social Care Kathy Henwood, Chief Social Work Officer

NO	HEADING	ACTION
1.0	**CHAIRPERSON'S WELCOME & OPENING REMARKS** The Chair welcomed everyone to the meeting and hoped the meeting to be shorter in duration that the previous. He stated there would be an update briefing regarding Covid and added, at the full FC meeting the day before, there was a motion on the independent review of Adult Social Care, which he encouraged reading. He advised that NC will be arranging an IJB Development Session relating this topic	
2.0	**DECLARATION OF MEMBERS' INTEREST** There were no declarations of interest.	
3.0	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4.0	**MINUTES OF PREVIOUS MEETING** Cllr Brett requested a change to the minutes of 29.01 as follows: 6.6 Child Protection Annual Report – "AS gave a background to the format of tereport where all Working Group Chairs have contributed to the event." Take out "to the event".	**J Cushnie**

NO	HEADING	ACTION
4.0	**MINUTES OF PREVIOUS MEETING (Cont)** **Decision –** With this change implemented, the Committee agreed to approve the Minute of 29.01.21.	
5.0	**ACTION LOG**	
	Action *(1) LG to come back to the Committee with a report on Urgent Care*. LG advised, the report will be submitted to SLT and is expected to come to the next C&CGC meeting on 31.03. Lisa Cooper will present this paper. MB asked for deadlines be decided, rather than "ongoing" where no definite decision around timing has been taken. Agreed. Person stories will come back once pressures of the pandemic ease.	**LG** **ALL** **NC**
6.0	**GOVERNANCE**	
6.1	**Covid Position Update**	
	HH advised numbers are improving, however, all aspects of work continue to be balanced whilst responding to Covid, thus preventing remobilisation at a greater pace. The SAER and LAER processes have restarted which were previously paused during a surge in Covid cases, these are being prioritised where there is the most learning. LB advised, all wards are now open. Letham is the final ward to be deep cleaned. Five staff members have tested positive and 7 Care Homes are currently closed, although one is not Covid related. LG stated, all inpatient vaccinations have commenced and all Care of Elderly wards were immunised last week (w/c 15.02), Mental Health and Learning Disability wards will be next week (01.03). Cllr Ross asked when Care Home visiting will restart. FMcK advised, the SG guidance, published the day before, is being worked through and a meeting with all Homes is taking place on Mon 01.03. Visits will be 2 people per household, in full PPE, up to 1 hour in length. These visits are expected to commence 8th March, provided the Home is open. Funding is available from SG to support Care Homes re-opening to visitors. MB asked if private Care Homes must also follow guidance? FMcK advised, yes this was the case. Cllr Brett asked if the wards will remain with a reduced number of beds or, at the end of pandemic, will bed numbers increase again? LG stated, there is no plans to increase beds until the end of the pandemic, at which time the situation will be fully assessed. LB added, a short life	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.1	**Covid Position Update (Cont)** learning group will consider all implications before any changes take place. JC advised, Mental Health wards will be slightly different, strategic needs going forward will be considered, along with bed configuration.	
6.2	**Lateral Flow Testing**	
	LG gave assurance Lateral Flow Testing has been rolled out. She advised, there has been a good uptake of test kits across inpatient areas. Rhona Waugh is the Board Lead for this initiative. As a comparison to other Boards in Scotland, Fife are outlying a little due to a problem with recording, however, this is being addressed. LG reported the positivity rate is very low. This has given staff re-assurance when working within clinical areas, they are safe to deliver care to patients. FMcK stated LFTs and PCR tests have been rolled out across Social Care. PCR tests are within Care at Home, which was a SG decision. LFT has been introduced into Care Homes, along with PCRs. Staff are being tested 3 times a week, and this is now rolled out across voluntary and independent providers in Care at Home. SG are endeavoring to look at numbers from the Private Sector, with HSCP supporting this work. This continues to be promoted, as it involves voluntary participation. Cllr Brett asked how often staff are self-testing. LG advised twice weekly, with an uptake of ~90%. Cllr Wincott queried asymptomatic testing sites, these were discussed and the various locations were indicated. CC asked if Care Homes, from the Independent Sector, are using a consistent recording tool and are Partners more on board than initially, in relation to testing? FMcK advised the TURA site is used, which all staff have access to, and Care Homes are prompted by a member of FMcK's staff, if they fail to record data. SG uses this data to inform intelligence. Regular meetings are held with the Care Homes where this message is reiterated.	
6.3	**Winter Update**	
	LG gave a brief update covering actions and performance: • A Delayed Discharge Group has been established • Primary prevention is a focus, avoiding unnecessarily admissions • Support to stay at home through ICASS Team, H@H, High Health Gain Team and Palliative Care Teams • Launch of Whole System Capacity Modelling tool described	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.3	**Winter Update (Cont)**	
	Performance in delay has reduced by 40 patients from last winter to this winter. LG reported this is the lowest ever seen in Fife and is improving month on month. There is a 36% improvement in length of stay from last winter through focus on Home First and the Prevention Strategy. LG felt it is a continual journey, progressing well but can still improve. Cllr Brett asked if it was felt this can be sustained going forward, not just for winter but all year round. LG advised the ambition is to have as close to no unnecessary delay as possible and through a system overhaul and all Teams working collaboratively, this can be achieved. CC queried the position with Guardianship throughout the pandemic. FMcK stated this is being progressed through discussion with Scottish Courts. She advised, she is also looking to engage an organisation within the Voluntary Sector, to support families through the AWI process. Happy to feedback progress at a later Committee meeting.	
6.4	**Pharmaceutical Care Services Report 2020/21**	
	SG advised, as a reflection of everything which is currently being dealt with, it was unrealistic to produce the report for 2020/21, due to its comprehensive nature. The existing report has been referenced to establish if there are any material changes of the service provision, which there are not. Any information requested of NHS regarding Contact information can be provided. It was felt, through consultation with the Area Pharmaceutical Committee and Professional Advisory Group, the risk was low. SG stated he will be working to change the focus of this report going forward. SG told of a newly established Community Pharmacy Core Group which will be key to the development of this report. Cllr Brett invited SG to give an update regarding Covid vaccinations. SG updated as follows: • Programme is progressing well with over 100,000 vaccines delivered to patients. • Cohorts 1-5 have been offered 1st dose vaccine. • Looking at cohort 6, started Tues 23.02, very complex (underlying health conditions, unpaid carers). • Vaccine supply has reduced, increase in AstraZeneca vaccine is expected mid-March. • Complex time when 1st and 2nd doses are being given. • Workforce and training are in a good position. • Smaller number of larger sized venues being looked at. • Everyone 50yrs + by mid-April.	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.4	**Pharmaceutical Care Services Report 2020/21 (Cont)**	
	• Under 50's - this is where larger venues will be mostly utilised • EQIA being reviewed and how we best meet these needs Questions regarding Community Pharmacy performance, vaccine cohort breakdown and accessibility of the large vaccine centres were posed to SG. He responded to each question in good detail.	
6.5	**Care Home Update**	
	LB introduced the Care Home Update SBAR. She advised, in May 2020, the role and remit of the Executive Nurse Director for Care Homes, in Boards across Scotland, changed. This made them responsible for the provision of high-quality nurse leadership, support and guidance within the Care Homes and for quality care assurance within the Care Home sector. LB stated Fife has had a very positive experience and enjoys a very good relationship with the vast majority of Care Homes along with Fiona's teams, Infection Control and Health Protection colleagues. Turas Care Management tool was launched in August 2020 and has been implemented by all 76 Care Homes in Fife. The Homes input daily to the system, from testing, to staffing, to residents being unwell. The data is used to provide: • An overview of individual Care Homes for Care Home managers and Health and Social Care Partnerships to understand activity and any areas of risk. This will enable earlier warning on emerging trends and issues, allowing timely intervention and mitigation to be put in place. • A clearer national picture of Care Homes and any emerging issues that require a national response. • Easier reporting, to free up Care Home resources. There is a Care Home hub with a small team meeting regularly with MDT and external colleagues, ensuring all staffing needs are met. Assurance visits continue through collaborative working. Cllr Brett queried acronyms used in the report, these are interpreted as follows: TBPs - Transmission Based Precautions NIPCM - National Infection Prevention Control Manual SCIPs - Standard Infection Prevention and Control Precautions	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.6	**NHS/HSCP Inspection Visits**	
i.	**Hollyview Ward, Stratheden Hospital**	
	JC gave a summary of the MWC visit to Hollyview Ward, Intensive Psychiatric Care Unit at Stratheden Hospital, which took place in December 2020. This was a very positive visit with no recommendations for improvement from MWC. JC described the Ward, which he felt is well designed. The encouraging feedback from MWC reflects a change of leadership within the unit, both clinically and in nursing, with very good teamwork. A full-time Occupational Therapist is now allocated to the ward and activity is better structured and documented. Also, there is evidence of patient's rights being discussed and shared with them. There was discussion around the importance of patient's care plans including an array of activities and the good practice around this. JC explained a change in Consultant cover for the ward and clarified several points in the report,	
ii.	**Tarvit and Glenrothes Ward 2 (LB)**	
	LB stated there were 2 visits by Health Improvement Scotland to Community Hospitals within East Division, Fife. Glenrothes 7-9 July 2020 and Tarvit at Adamson Hospital, 27-28 October 2020. LB reported both issues were very similar, relating to documentation - the disconnect between electronic and paper versions and the identification of equipment requiring assessment and reviewed. Cllr Brett asked if the Committee would normally receive copies of the reports and the actions being taken to address any issues. LB confirmed this should happen. JC will circulate all related reports to Committee members.	**J Cushnie**
6.7	**Mental Welfare Commission Annual Report / Update on MWC End of Year Meeting**	
	JC introduced the MWC Annual Report and touched on the end of year Fife MWC visit. Key issues within the annual report were: • Colin Mackay retired as Chief Executive, Julie Paterson came into post from August 2020 • Covid-19 is a key feature of the report • Covid-19 advice notes have been introduced • Review of eating disorders with recommendations	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.7	**Mental Welfare Commission Annual Report / Update on MWC End of Year Meeting (Cont)**	
	• Focus on rehabilitation, concern around average length of stay • Functional mental illness wards – difference between functional and organic • Psychological support for older people • MWC investigation process has been reviewed and updated. The End of Year Visit was positive and was the last in 10 visits over the year, which resulted in 24 recommendations. JC advised of a project team, led by Chris McKenna, which is looking at refurbishment of the estate/buildings and facilities at Stratheden Hospital. FMcK described a Strategy which is being developed in conjunction with Housing, considering the way forward for long-stay patients in hospital, funding has been made available for this. Alert system in Lomond Ward is not reliable, funding is available for an upgrade to this system. Door exit system and patients absconding – this is a fire door which cannot be locked. JC advised the fence issue in the garden area of this ward has been addressed, this has reduced abscondence in this area. Staff are monitoring the risk through the ward. This has come down in the last 6 months. Continuing to have dialogue. Cllr Brett commented he enjoyed reading these reports and would like to discuss separately with JC.	
6.8	**Records Management Annual Report**	
	FMcK introduced the report, which is the first Records Management Annual Report provided. The report is a huge piece of work carried out by Lesley Gauld. The report is an update of the Management Plan approved in November 2019. In summary, good progress of the actions has been made with 13 activities completed. Only 4 are still being progressed, the Pandemic having caused resources to be temporarily diverted elsewhere. However, there is scope within the Plan to expand timescales to 2022. FMcK confirmed, this approach has been agreed by National Records of Scotland. FMcK expanded some of the key activities completed which are: • Records Management training for IJB members • Data Process Agreement • Governance Arrangements	

NO	HEADING	ACTION
6.0	**GOVERNANCE (Cont)**	
6.8	**Records Management Annual Report (Cont)**	
	It was asked if the Progress Update Review was suitable, FMcK advised it was and the template is being used as an exemplar for other areas. MB queried item 11 "all Boards will go onto Share" FMcK clarified, IJB Board Papers will be available on Sharepoint, this is an internal electronic system which will enable sharing across the Services. All Committee Papers will be held within Sharepoint.	
7.0	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	No reports.	
8.0	**ITEMS FOR ESCALATION**	
	Cllr Brett commented on the good progress being made in relation to the fight against Covid-19 and the MWC reports are also worthy of noting.	
9.0	**ANY OTHER COMPETENT BUSINESS**	
	No other competent business	
10.0	**DATE OF NEXT MEETING –** Wednesday 31st March 2021, 1000hrs MSTeams	

Unconfirmed Meeting Note of NHS Fife Clinical Governance Oversight Group
On Thursday, 25th February 2021 at 0930 via MS Teams

Present

Lynn Barker (LB)	Associate Director of Nursing, Health and Social Care Partnership (HSCP)
Lynn Campbell (LC)	Associate Director of Nursing, Acute Services Division (ASD)
Gemma Couser (GC)	Head of Quality & Clinical Governance, NHS Fife
Pauline Cumming (PC)	Risk Manager, NHS Fife
Scott Garden (SG)	Director of Pharmacy, NHS Fife
Cathy Gilvear (CG)	Quality, Clinical & Care Governance Lead, HSCP
Aileen Lawrie (AL)	Head of Midwifery/Nursing Women and Children's Directorate
Dr Chris McKenna (CM)	Medical Director, NHS Fife **(Chair)**
Elizabeth Muir (EM)	NHS Fife Clinical Effectiveness Coordinator

In Attendance

Dorothy Gibson (DG)	Clinical Governance Administrator (Admin Support)

Apologies:

Dr Sue Blair (SB)	Consultant in Occupational Health, NHS Fife
Helen Buchanan (HB)	Board Director of Nursing, NHS Fife
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance & Education Training

Item		Action
1	**Apologies**	
	Apologies for absence were **noted** from the above named members.	
2	**Minutes of previous meeting held on Thursday, 16 July 2020 at 14.00, MS Teams.**	
	The team confirmed that the note from the meeting held on Thursday, 16 July 2020 was a true reflection of what was discussed.	
3	**Action List**	
	Mental Welfare Commission LB informed the group that there is now a process for communicating actions following inspection visits. LB informed the group that she will bring a report/update on progress to give assurance to the next meeting on the 22.4.2021.	**LB/CG**

	Clinical Governance Strategy GC will be working on the Clinical Governance Strategy in consultation with colleagues across Fife. An update on progress will be brought back to the April meeting.	**GC**
	Clinical Governance Oversight Group ToR SG advised that discussion in regards to pharmacy representation is work in progress and regular updates will be provided at meetings going forward. CMcK asked for the terms of reference of the group to be circulated again for comments /amendments. The ToR will be brought back to the next meeting for approval.	**DG/ALL**
	Deteriorating Patient Group LC advised that the above group had been reconstituted to take a Fife wide approach with Dr Simpson chairing. The group would like to see the ToR for the Group. LC will speak with Dr Simpson and they will come to the next meeting of the group.	**LC**
	Following discussion around the governance of the group, LC agreed that she will ask Dr Simpson for updates to be provided to the Group at every second meeting commencing 23rd June 2021.	**LC**
4	**QUALITY**	
4.1	**NHS Fife Integrated Performance & Quality Report (IPQR) – January 2021** GC asked the group if we could review this report further i.e. the matrix that is used to present the performance against SAERs and LAERs. GC advised that it would be good to have an offline discussion with colleagues noting the number of major and extreme incidents and bring a report back on the data for discussion in April. CMcK noted instead of discussing the detail and the structure of the IPQR at this meeting, we should use this group to inform any changes that we would propose to the IPQR)rather than the actual detail within each individual report. CMcK advised that the data that is presented is not for this group; it is information for Board Committees, and we need to take a view on what information Board Committee's see. CMcK noted that there was a related debate last year and Board Committee push back that they liked what they were currently receiving. GC advised that the IPQR data was discussed at a meeting with GC , PC and Internal Audit in relation to implementation of actions from SAERs and LAERs and the percentage of those actions that have been implemented following a review in terms of risk to the organisation.	**GC**

	GC asked if it would be helpful if herself PC, EM, Bryan Archibald were to meet and pull together a report on the data and share with the Group with a view to bring back to the next meeting. CMcK agreed and highlighted that this detail isn't required for the IPQR but may be required as a separate report to Clinical Governance as a result of the audit.	**GC**
4.2	**H&SCP Clinical Quality Report – January 2021** CM highlighted that this report is only for noting by the group. No further action required.	
5	**GOVERNANCE ITEMS**	
5.1	**NHS Fife Activity Tracker** EM advised the group that the tracker is for information. EM advised that she had recently received an email regarding the National Guidance that has come out from the National Hub for Reviewing and Learning from the Deaths of Children and Young People. EM mentioned that page 7 of the guidance document outlines the governance arrangements expected of Boards; this new process is due to start from 1st of April 2021. AL raised that this project is going to entail a massive amount of work and it will be too much for one person to manage and a discussion will need to take place to progress this going forward. CMcK asked the group what needs to be considered in light of the guidance that has been circulated. CMcK suggested that in the first instance, Aileen Lawrie and Dr. Morrice should review the report and consider what content. Following review of the guidance a report will be sent to Janette Owens and Dr McKenna giving some recommendations prior it coming back to the next Oversight Group meeting. CMcK highlighted that this review needs to be done fairly quickly. PC agreed with AL, indicating that there will also be a requirement for a Governance Group to be established or to designate responsibility to an existing group. PC asked if the guidance should be considered at the Adverse Events Group meeting in April 2021 as it does link to this group's work. CG mentioned that Heather Bett has had sight of the paper and she is liaising with NHS Lothian as they were the pilot site. CG mentioned that Heather Bett has a call logged with NHS Lothian to find out how it was initially progressed. CG mentioned that the conversation isn't taking place in April it may take place a bit later. CG advised that Heather Bett is looking to link in with other people but wanted to get some learning from NHS Lothian in the first instance.	**AL**

	LB advised that she will be available to provide support for AL to take this forward. LB advised that she was unaware of Heather Bett's involvement but it is helpful that she has taken action by pulling things together and looks forward to seeing an overview of how this will be taken forward. AL highlighted again the magnitude of the work and that it will be inclusive of every child and young person by board regardless of reason for death. AL noted that significantly this will be up to and including the age of 18. AL advised that AL/CG should meet to link in with Heather Bett and get an overview of the up to date position. AL advised that this will need to be a Fife Wide Approach and not necessarily only a service approach. CMcK agreed with AL that this isn't just about one part of the system, it is part of a broader spectrum. CMcK asked EM to circulate the paper to everyone today and once received CM will send an email to Heather Bett copying the most relevant members of staff and ensure that everything is being brought together under one umbrella. This needs to be done quite quickly to make sure we know what we have to do going forward. CM advised that a paper needs to go to the Clinical Governance Committee (meeting after next) as a report including an SBAR explaining what we are doing.	**AL/EM**
	NHS Fife Clinical Policy & Procedure update 14/12/2020	
5.2	EM provided an update from the meeting on the 14/12/2020. We now have 84 Clinical Policies and Procedures for NHS Fife. An update provides new policies that have been introduced since the group last met. We have an Interpretation of Translation Policy and Procedure, a Fife Wide Procedure for Making Meal times Matter and a Procedure for the Organisation of events during Covid 19 and a new procedure for staff travelling during Covid 19. Since the update on the 14/12/2020, the group met on 22/02/2021 and there is another new procedure being introduced and this is for Virtual Visiting and this should be available to staff on staff links shortly. CMcK asked where policies are being held. EM advised that all the policies and procedures are held on Staff Link. CMcK followed on to ask if there is policy management software that automatically updates to advise us when the policy is due for update requirements etc. At present Fife doesn't have a document management system that automatically highlights when policies are ready for updating. EM advised that the document management system had been looked at as NHS Lothian has this in place which is excellent. GC asked if Q-pulse would be a system that could be looked at again as it has been used in Labs. EM advised that when she viewed it for policy control it wasn't the best system to use for this purpose. GC wondered if it would be worth revisiting Q-Pulse just in case there have been any advancements in system software. SG advised that there is a large piece of work being done with this and it has looked at taking what Labs had and at a more system wide contract. The	

	information team had contacted all the services and only a handful of services advised that they were interested in using it e.g. Pharmacy was one of them. SG advised that this wasn't supported by EDG at that time; SG believes that there is a gap in the organisation and Q-Pulse would be a very useful resource for the organisation. GC is happy to take the Q-Pulse action forward with EM and the Clinical Governance Team to find out if this would be an option going forward. EM advised that Gillian McIntosh would be another person to get in touch with for this piece of work.	**GC**
5.3	**National Hub for Reviewing and Learning from the Deaths of Children and Young People – Scottish Government Letters** EM highlighted that this agenda item has been superseded by item 5.1 following the circulation of National guidance around the National Hub for Reviewing Learning from Deaths and of Children and Young People.	
5.4	**Clinical Effectiveness Register Flash Report/Projects by ASD Service** EM advised that this report provides an oversight of all the projects that have been registered on the Clinical Effectiveness Register. EM noted this register supports the Acute Services Division and Health and Social Care Partnership and is for sharing with this group. EM informed the group that bi-monthly updates are prepared for Clinical Directors to share with their Clinical Governance Leads and the specialties of projects that have been completed and we ask them to take these forward through their Directorate reports to the Clinical Governance Committee. EM advise the team are working closely with Heads of Nursing and Clinical Directors to ensure that all pieces of improvement, audit and service evaluation projects are registered. CMcK suggested that moving forward that we would like to see how the projects that have been registered link back to the improvement actions around adverse events.	**GC/PC/EM**
6	**MINUTES FROM LINKED GROUPS**	
6.1	**NHS Fife Adverse Events and Duty of Candour Group- 17/12/2020** The meeting note and cover sheet were noted by the group.	
6.2	**NHS Fife Clinical Policy & Procedure Coordination and Authorisation Group- 14/12/2020** The minutes were noted by the group.	

6.3	**In Patient Falls Steering Group 12/08/2020** LC advised that the In Patient Falls Group has had a number of meetings cancelled but met last week and have an updated work plan. The group noted some increase in falls with harm and have acknowledged the overall challenges in relation to environment and staff being deployed from their own areas. Learning from COVID and strategies to mitigate are included as part of the work plan as we move forward. The minutes were noted by the group.	
6.4	**NHS FIFE Point of Care Testing Committee 02/12/2020** The minutes were noted by the Group.	
6.5	**NHS FIFE RESUSCITATION COMMITTEE 13/01/2021** The minutes were noted by the Group.	
6.6	**NHS Fife Tissue Viability Working Group 19/11/2020** The minutes were noted by the Group.	
7	**AOCB**	
	The group confirmed there was no further business to discuss.	
8	**Date of Next Meeting:** Thursday 22nd April 2021 14.00pm -15.30pm on Microsoft Teams	

FIFE RESEARCH GOVERNANCE GROUP MEETING
MINUTES
Microsoft TEAMS,

	25 MAR 2021	**ACTION**
	Present: Dr Chris McKenna, Medical Director (CMcK) Prof. Alex Baldacchino, R&D Director (AB) Prof.Frances Quirk, R&D Assistant Director (FQ) Prof. Frank Sullivan, Director of Research, University of St. Andrews (FS) Scott Garden. Director of Pharmacy & Medicines (SG) Dr Fay Crawford, R&D Senior Research Advisor (FC) Julie Aitken, R&D Quality & Performance Lead (JA) Tara Graham, Research & Development Psychologist (TG) Dr Grant Syme, Physiotherapist Consultant (GSy) Marie Smith, Library Services Co-ordinator (MS) Aileen Yell, R&D Research Co-ordinator (AY) Gwen Stenhouse, Management Accountant (GS) Angela Scullion, Senior Research Nurse (AS) proxy for Karen Gray Shobna Vasishta, National Project Manager, SHARE (SV) Sarah Ritchie, Deputy Manager, SHARE (SR) 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. **Apologies;** Josie Murray, Consultant in Public Health, Karen Gray Lead Research Nurse Shobna Vasishta thanked the group for the opportunity to present at this group. SHARE presentation.pptx Shobna discussed why SHARE is needed, the process for joining and recruitment. CMcK thanked Shobna for the presentation. FQ asked what the best tips and advice were for advertising SHARE? SV thought it would be a seminar, or on the St. Andrews University and NHS Fife websites. AB noted that Fife had a good public recruitment total with currently 14% of the population registered, the main problem was getting the Clinicians to utilise the resources available to them via SHARE. FS added that there was a need for more research active Clinicians in Fife and maybe a feasibility study should be set up to look to see how SHARE could help them. CMcK noted that there were some good points raised and we will need to work on this more.	**AB/FQ/FS**

2.0	**MINUTES OF THE LAST MEETING** The minutes were accepted as an accurate record. Actions were discussed and the action list updated.	
	STANDING ITEMS	
3.0	**OVERSIGHT OF R&D OPERATIONAL GROUP (OPS) MINUTE** This was reviewed and accepted. CMcK added that it was helpful to see the key issues in the SBAR format.	
	RESEARCH GOVERNANCE	
4.1	**RESEARCH WITHIN GOVERNANCE FRAMEWORK**	
4.1.1	TERMS OF REFERENCE RESEARCH GOVERNANCE GROUP CMcK commented that this document looked inconsistent with other Terms of Reference for similar meetings in terms of layout. FQ added that this is due for review and will be brought to the next meeting in June, there had been significant changes to R&D with the introduction of Innovation and the Library & Knowledge Service and the ToR needed to be updated. CMcK noted that the core membership on the document does not seem like a true reflection as a majority of those on it do not attend this meeting, there needs to be an understanding of how the Boards views research. AB added that other Boards have a Research and Development Steering Committee and that he and FQ would produce a paper regarding membership and structure of the Research Governance group for discussion at Executive level.	**AB/FQ** **AB/FQ**
4.1.2	R&D POLICY, SOP AND WI UPDATES & APPROVALS JA updated from her report that had been attached to the agenda, nothing was required to be escalated. JA asked if the review cycle for these documents could be extended from 2 to 3 years to reduce the burden on the team. AB added that the risk perspective would be minimal. CMcK thought this was a reasonable request and fully supported.	**JA**
4.1.3	EAST OF SCOTLAND RESEARCH ETHICS SERVICE UPDATE BJ was not in attendance, FQ read from her update which was the update that had been sent to the Operational Group meeting on 25th February. There was still an issue with regards to the recruitment of a Clinical Trials Pharmacist member which is needed urgently to enable the review of CTIMPs, a call for help had been issued and as a result three Pharmacists have met to discuss requirements. It was not known if any of the potential candidates had been appointed.	
4.1.4	RISK BASED PROGRAMME OF MONITORING JA advised that there was nothing for escalation, 1 Fife study has been monitored with no issues being identified. The team are conducting a review of the process for prioritising auditing/QC activities for hosted studies. This will be discussed at the next Dunfermline Group meeting to try to get a consensus across all the Boards.	
4.1.5	PHARMACY UPDATE SG advised the group that staffing has proved challenging during this period with two key members of staff leaving the pharmacy clinical trials team (Senior Pharmacist and Senior Pharmacy Support Worker). Both	

	posts have subsequently been recruited to however; there has been a delay for the successful candidates taking up post due to personal circumstances. In the interim, the wider pharmacy team is supporting and will continue to do so until the new staff members are in post and fully trained. This includes: Lead Clinical, Senior Clinical and Lead Cancer Pharmacists supporting protocol review and amendments; previous pharmacy clinical trial staff returning to support (having moved to different posts within pharmacy); sessional input from other experienced staff (pharmacists, pharmacy technicians and support workers).	
4.1.6	PHASE II UPDATE NHS Fife normally undertakes Phase III and above studies. The Research Governance Group previously agreed a pilot of three Phase II studies to establish under what circumstances (if any) Phase II studies can be undertaken in Fife. R&D are now proposing to move from a pilot stage to a change of scope to include Phase II's as everyday practice according to the risk assessment framework and are seeking Research Governance Group approval to do so. SG thought this was a brilliant idea and was fully supportive, AB thought this was really great news. A discussion with regards to whether there were enough core members here to approve this as quorate. CMcK advised that there were enough and it was agreed.	
4.1.7 (I)	SUSPENSION/RESTART/APPROVALS R&D began reviewing applications for Restart on 29 June 2020 and have had regular meetings since then as required to continue these reviews. To date, a total of 50 requests have been received and assessed with 45 of these being approved for restart based on the principles agreed, providing the capacity is there to support the study and with Sponsor permission being in place. Not all studies have required a full R&D review before they can be restarted, around 83% of studies which were originally suspended have now either restarted, gone into follow up or completed. The remainder are not yet in a position to restart but will be reviewed if required at the appropriate time.	
4.1.7 (II)	COVID 19 RESEARCH ACTIVITY AS read from the report that had been attached to the agenda with regards to recent activity. SIREN was initially opened and recruiting staff from the staff surveillance groups only due to pressures on local laboratories to process additional PCR samples. Since the beginning of February SIREN is now open and recruiting to all NHS Fife staff. The original target of 600 is unachievable due to issues with lab capacity,competing priorities for the local labs and the delayed start due to issues with lab processing. NHS Fife has recently secured additional SIREN lab capacity within Lothian. The proposed closure date for recruitment is 31st March 2021. There are currently over 250 participants recruited and hopefully a total of around 400 participants will be achieved before the study closes to recruitment. FQ added that the Research Nurses team have worked solidly over the	

	last 12 months and would like this noted, CMcK absolutely agreed.	
4.1.7 (iii)	CAPACITY/RESOURCES AS advised that despite the incidence of Covid 19 in Fife having fallen significantly the requirement to prioritise Covid UPH badged studies has reduced capacity for non Covid ongoing and existing research activity within NHS Fife, additional restrictive measures such as shielding of staff and remote working practices/ social distancing have also affected our ability to have staff within the hospital and therefore impact our capacity; however, redirecting staff within the department to support priority studies has worked well to mitigate this.	
4.1.8	LIBRARY & KNOWLEDGE SERVICES CMcK welcomed MS to the meeting as this was her first since the Library & Knowledge Service team joined R&D. MS advised that it was nice to be part of the Research Governance Group adding that there has always been strong links between the Library and R&D. MS updated the group from her report which had been attached to the agenda.	
4.2	**PUBLIC PARTNERSHIP WORKING**	
4.2.1	SHARE Recruitment to SHARE was done mostly face to face in clinics which has ceased since March, but Fife are still 2nd largest recruiter.	
4.2.2	R&D/FIFE COMMUNITY ADVISORY GROUP AH advised the group held a virtual meeting on the 15th March 2021. As group membership had fallen, the group decided that its priority was the recruitment of new members from a diverse spectrum of people and age groups. Discussion centred around ways to recruit new members. The group has also begun work on creating its own website. AH added that they were using Facebook and Twitter as well as targeting sports groups, community groups and the University but it was proving difficult to recruit a diverse range of members. CMcK stated the importance of diversity should not be underestimated.	
4.3	**FINANCIAL SUPPORT / RESOURCES**	
4.3.1	R&D BURSARIES & TARGETED CALLS FC advised that the bursary programme has been paused in 20/21 to allow a review of governance, monitoring framework and outcomes to take place. As a strategic initiative 3 Targeted Calls have been implemented. 1.COVID Accelerator Purpose: to support completion/dissemination of projects or data accrued since January 2020 that are COVID focused. To highlight NHS Fife participation in COVID research. Funds will be awarded for items such as, e.g.; statistical support, scientific writing support, Open Access publication fees etc. 2.NRS Fellowship Completing/ed Support Scheme Purpose: for recently completed or completing in 2021 NRS Fellows. Submission of a project proposal that can be conducted in 24 months within a **day a week.**	

4.3.1	3. Aspiring NRS Fellows Support Scheme Purpose: For aspiring Senior Clinicians (medical/non medical) to develop a quality NRS Fellowship application in 2021/22, this will find **one session** per week	
4.3.2	CSO ALLOCATION FQ read from her report that had been attached to the agenda, there was concern that CSO funding would be vastly reduced due to the COVID pandemic and the fact that we could not continue with studies, however the CSO have assured Boards that they have come up with a pragmatic plan using an algorithm to determine Board allocations for 2021/22, this will be discussed further at the Dunfermline Group meeting on 26th March.	
5.0	**CAPACITY BUILDING**	
5.1	**CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AS PART OF ROUTINE PRACTICE**	
5.1.2	COMMUNICATION The March 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 FS advised that there would be a meeting on 26th March to discuss further a joint research office between NHS Fife and St. Andrews university	
5.3	**DEVELOPING RESEARCH KNOWLEDGE/SKILLS OF STAFF**	
5.3.1	R&D EDUCATION PROGRAMME FC updated the group with the details of the SLWG working on a survey of all staff, with a validated tool (Research Capacity and Culture Tool), which would obtain baseline data relating to research capacity and culture in NHS Fife and would allow the assessment of research capacity and culture across the whole organisation. A workplan is in development to progress this activity with an anticipated survey roll out across all staff in June/July. CMcK asked what the prediction of the outcome was? And what other detail was in the survey tool that would drive a change in culture. FC added that there would be a better idea of the demographic of the responder and the sampling frame would be more robust.	
5.4	**ACTIVITIES TO DEVELOP CHIEF AND PRINCIPAL INVESTIGATORS** FC advised that there are ongoing meetings to develop a strategic plan for the development and sustainable growth of CI/PI's and a supporting implementation plan is currently in development. These will be presented at the Operations Group meeting in May and the next Research Governance Group meeting in June.	**FQ/FC/KG**
5.5	**AWARENESS RAISING** AB advised that we need to think of better ways in which we communicate with the Executive Board.	

5.6	**INNOVATION** FQ updated for her report that was attached to the agenda, noting that she has ongoing participation in HISES core meetings (Network Group, Innovation Oversight), Development Day and representing HISES in National meetings/workshops (One Way in Portal, Health Innovation Assessment Panel (HIAP). HISES proposed priorities for 2021/22 are: Mental Health, COPD, Young people with Asthma, Frailty and Cancer. The Kindocoin challenge, for which NHS Fife was a test bed for Phase 1 has funding confirmed for Phase 2 from CanDo (£300K) and all 5 companies will be invited to bid for the Phase 2 challenge. FQ has had internal start up meetings with Digital and Information, Service Redesign, Quality and Clinical Governance re: internal Innovation framework and stakeholder engagement FQ has had meetings with HR and Staffside re: R&D restructure and integration of Innovation. Updated organogram to reflect new structure. AB added his thanks to FQ for taking on this task over and above her day to day job and there is much more that needs to be discussed, thinks FQ is supporting HISES more than they are supporting NHS Fife.	
6.0	**AOCB** AB noted a big thank you to Gwen for supporting the team over the last 7 years as she moves to a 12 month secondment. FQ echoed that sentiment and thanked Gwen for her fantastic help since she took up post last August .	
7.0	**DATE AND TIME OF NEXT MEETING** Thursday 03rd June, 14.00 – 16.00, Microsoft Teams	

UNCONFIRMED Minutes of the Health & Safety Sub Committee held on Friday 12th March 2021 at 12:30 within Microsoft Teams

Present:

Neil McCormick, (NM) Director of Property & Asset Management
Conn Gillespie (CG), Staff Side Representative
Linda Douglas, Director of Workforce

In attendance

Mr Craig Webster (CW), Health & Safety Manager

1. CHAIRPERSON'S WELCOME AND OPENING REMARKS

NM welcomed all to the meeting, he stated that he was delighted to join and chair the meeting.

2. APOLOGIES FOR ABSENCE

Dr Chris McKenna (CM) Medical Director
Mr David Young (minute taker)

3. MINUTES OF PREVIOUS MEETING

Action

3.1. Approval of previous minutes

The minutes of the previous meeting were reviewed by the group and agreed as accurate.

3.2. Actions List Update

NM is aware that CW had responded to the HSE by the 29th January 2021 and the HSE had subsequently replied. Their response will be discussed later in the agenda.

3.2.1 Theatre Locker Rooms

NM is conscious that the Theatre Locker Rooms has become a point of discussion with the HSE and NM noted that CG had been asked to carry out an assessment of the room. CG asked the group if they knew of any evidence relating to the transmission of the virus through clothing. The group discussed the lack of evidence, the guidance and advice that is currently available and how the Organisation should manage the risks involved. LD suggested that any future discussion with the HSE should be driven by evidence and advice presented to the Organisation. LD also suggested that it is important that the organisation should ensure that information should be communicated to staff in order to alleviate any concerns they may have.

NM noted that the Chief Nursing Officer had issued a letter on best practice relating to COVID. The letter mentions changing and changing areas, highlighting the need to manage the number of staff using the area. NM suggested that, if NHS Fife is following national guidance and have assessed the risk, then the organisation should challenge HSE if necessary. NM asked if this should be raised with Clinical Governance to see if they would agree with this approach. LD agreed, stating that Clinical Governance would be able to advise on the best route for the organisation to take. **NM**

CW said that the organisation continues to look for further solutions, but it is difficult due to the physical footprint of the changing areas. The group discussed the current controls implemented in the Theatre Locker Rooms.

3.2.2 Clinical Areas - welfare areas and communal rooms

CW has an action to investigate Covid Management Training for Staff returning to work. CW stated that this is still outstanding **CW**

3.2.3 Laundry

CW advised that the installation of screens has been completed.

3.2.4 Face Fit Testing

NM asked if CW for an update regarding Face Fit Testing. CW stated that there are still some issues highlighted by the HSE regarding the management of local fit testers which needed to be addressed.

An external provider has worked with the H&S team and verified their competency for quantitative fit testing.

A second session to cover issues relating to Qualitative Testing competency was organised but had to be postponed due to adverse weather. A rescheduled session has yet to be organised. **CW**

CW said that he had investigated the action relating to Fit 2 Fit accreditation had decided that it wouldn't have a benefit to the organisation. CW had hoped that members of the H&S Team could be trained as Fit 2 Fit accredited Assessors who would then in turn, be able to accredit local testers. However, this is not the case and the organisation would still need to pay a fee. CW stated that this is not a legal requirement and has no particular benefit to the organisation so this has been closed.

NM asked CW about powered respirators, CW informed the group that an order has been placed and will possibly be located in the Cameron Hospital Kitchens. The respirators will be used for staff that can't get masks to fit..

NM noted that CW had also managed to secure an additional Fit Testing Machine which will help with the number of staff being properly fitted with masks.

3.3. Matters arising not on agenda

Nil

4. COVID 19

4.1. Discussion around H&S issues relating to COVID-19 response and ongoing management.

NM has heard of a few instances where staff who have received either their first or both vaccinations may no longer be adhering to phyisical distancing and wearing appropriated PPE. There is a concern that these staff may be unaware that there is a potential risk that they may still carry the virus even though they have received vaccinations.

NM asked if it was advisable to remind staff that the need to continue adhering to guidelines. LD stated that the Workforce Silver Group, which includes the Staff Wellbeing & Health Bronze Group, is going to reconvene for one or two meetings.

LD is aware that The Staff Wellbeing & Health Bronze Group have been carrying out some work regarding reinforcing these matters to the workforce. Also, Kirsty McGregor's Team has been asked to give prominence to this message. LD is also aware that the Scottish Government have commissioned a campaign to try and manage the staff transmission issue which will begin soon.

NM stressed that most staff are doing a fantastic job and not everyone is becoming complacent. However, NM has heard anecdotally that there are groups of staff not

be maintaining distancing rules and the best way forward is to remind people.

Action: CW to raise issue at the Staff Wellbeing & Health Bronze Group

CG remarked that he thought that staff may be suffering from "COVID fatigue". He also suggested that staff who work shoulder to shoulder in a clinical setting may continue to do so when they are in a non-clinical environment. **CW**

NM asked CW if there was anything else that was being picked up by the HSE other than changing facilities that the organisation should be considering. CW stated that there wasn't anything else that had picked up that we weren't already dealing with but there were issues, such as lack of physical distancing which the organisation could be better at enforcing.

5. GOVERNANCE ARRANGEMENTS

NM said that the diagram was both interesting and complicated. He asked if anyone had thoughts about the terms of reference for the committee?

Clearly the right forum but do we link into all the right places and are there other things we can do to raise awareness of H&S in the workplace.

LD said that the ToR were good but added that some tidying up is required as names have changed. In terms of the governance arrangements structure, she liked the document and found it helpful.

LD noted that there were two points CW might consider;

- Links relating to resilience and resilience forums. LD knows they exist but wondered if they could be more strongly reflected in the diagram and ToR.
- In the future, considering the pandemic, is there anything in the ToR that the committee would want to reflect differently or add because of any lessons learned? **CW**

NM thanked LD for her comments. He remarked that matters such as the powered respirators had been taken to the Executive Directors, so there is an escalation process that isn't documented but could be identified in the review

NM asked CW if the ToR needs to be approved and, if so, when do they need to be approved by?

CW stated that the ToR should be approved by the first meeting of the financial year.

CG asked the group what they thought about the committee? If they thought it contained the right members, was it the right size? Are more members required?

After some discussion, the group agreed that representation was appropriate. The group also felt that it may be worthwhile speaking to Dr McKenna to see if a deputy should be nominated to represent Clinical Governance if he is unable to attend.

NM Summarised;

- TOR requires some tidying up (Names & Job Titles) **CW**
- Governance Review in terms of the way things are going to work post pandemic
- Contact CM to discuss deputy

The group agreed and was happy for revised ToR to be presented to June meeting

LD stated that other Governance committees tend to review ToR in the last month of the financial year so a draft can be presented and approved prior to the new year. LD asked the group if the review date of the committee's ToR should be changed the bring it in line with other committees. The group agreed. **CW**

CW asked if the group were happy with the timings and frequency of the committee meetings or if they needed to be changed. After some discussion, the group decided that the timings/frequency should remain as is.

NM raised the topic of the work plan and asked the group for their thoughts. CW asked if the group were happy with the current format, if they are, CW will review,

update and bring it back as a proposal for the next meeting for 2021 - 2023.

CW said that he was conscious that the work plan was reactive and there may be a need to develop a H&S Strategy a bring that into the workplan. **CW**

Action: CW to review the Work Plan.

Work at Height Procedure. Review required by Jan 2021.CW still to complete. **CW**

The group discussed the Draft Annual Report. CW informed the group that the Annual Report was originally drafted in Feb 2021. CW will amend the report to include today's meeting and make a change to Section 2. 1 (membership) noting that AF was chair until our last meeting, NM has taken over as chair as from today's meeting. CW will also add any business discussed today to the appendices.

CW also informed the group that the Clinical governance Committee has asked that all reports submitted to them should be formatted in the same way so the report has been changed to reflect this.

Action: CW to make relevant changes, circulate by email to the group for approval and submit to the Clinical Governance committee. **CW**

6. NHS FIFE ENFORCEMENT ACTIVITY

NM stated that some of this has already been covered and asked if CW had anything to add. CW said that the only thing to note is that after his last correspondence, He hasn't sent or received letters from the HSE but he is aware that they will be looking for further information regarding the lockers. CW will draft a response based on our last comms this week and circulate around the group, Claire Dobson and Andy MacKay. **CW**

7. POLICIES & PROCEDURE

NM stated that there are a couple of updates relating to polices and procedures.

Working at Height policy has been covered.

Respiratory Protection Procedure. CW informed the group that the policy has been completely revised based on experience and learning from the pandemic. Consultation for the policy closed at the end of last week. CW hasn't received many comments but is waiting on a response from Procurement after which the policy will be ready to go to the Clinical Policies Group then EDG.

8. OTHER BUSINESS

CG informed the group that he had noticed that there was a lack of screen protection for the Security Staff at the main entrance. He has reported this to Paul Bishop and screens have subsequently been ordered.

CW noted that the last agenda mentioned an audit carried out by Internal Audit Service looking at the management of sharps and how the organisation was implementing the sharps policy and procedures. There is an accompanying action plan CW noted that there was slippage due to the pandemic. CW has had a conversation with Internal Audit this week and a revision to the timescale has been agreed. CW will flag any issues to the group. **CW**

9. FOR INFORMATION/ NOTING

Committee Minutes

CW reported that there were no other committee minutes to review at present.

10. Next Meeting

Date, time and venue for June 2021 meeting to be advised. CW/NM

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

MINUTE OF THE FIFE HEALTH AND SOCIAL CARE – INTEGRATION JOINT BOARD HELD VIRTUALLY ON FRIDAY 19 FEBRUARY 2021 AT 10.00 AM

Present	Councillor Rosemary Liewald (RL) (Chair) Christina Cooper (CC) (Vice Chair) Fife Council, Councillors – David Alexander (DA), Tim Brett (TBre), Dave Dempsey (DD), David Graham (DG), Fiona Grant (FG), David J Ross (DJR) and Jan Wincott (JW) NHS Fife, Non-Executive Members – Les Bisset (LBi), Martin Black (MB), Eugene Clarke (EC), Margaret Wells (MW) Chris McKenna (CM), Medical Director, NHS Fife Helen Buchanan, Nurse Director, NHS Fife Amanda Wong (AW), Associate Director, AHP's, NHS Fife Ian Dall (ID), Service User Representative Kenny Murphy (KM), Third Sector Representative Morna Fleming (MF), Carer Representative Paul Dundas (PD), Independent Sector Representative
Professional Advisers	Nicky Connor (NC), Director of Health and Social Care/Chief Officer Audrey Valente (AV), Chief Finance Officer Helen Hellewell (HH), Associated Medical Director, NHS Fife Katherine Paramore (KP), Medical Representative Kathy Henwood (KH), Chief Social Work Officer
Attending	Dona Milne (DM), Director of Public Health Fiona McKay (FM), Interim Divisional General Manager Norma Aitken (NA), Head of Corporate Services Hazel Williamson (HW), Communications Officer Wendy Anderson (WA) (Minute)

NO HEADING **ACTION**

1 CHAIRPERSON'S WELCOME AND OPENING REMARKS

The Chair welcomed everyone to the first Health & Social Care Partnership Integration Joint Board meeting of 2021.

The Chair welcomed Lynn Barker to her first Board meeting since being permanently appointed to the role of Associate Nurse Director and congratulated Helen Buchanan, Nurse Director on her upcoming retirement. The Chair and Nicky Connor both thanked Helen for her unwavering support over the lifespan of the IJB. Helen responded and wished IJB members the best for the future. Jeanette Owens will take over as Nurse Director when Helen leaves.

The Chair then advised members that a recording pen was in use at the meeting to assist with Minute taking and the media have been invited to listen in to the proceedings.

NO	HEADING	ACTION

2 CHIEF OFFICERS REPORT

The Chair handed over to Nicky Connor for her Chief Officers Report.

Nicky advised that the recruitment process for the three Heads of Service posts in the Senior Leadership Team is currently underway. By the next IJB meeting the decisions on these posts will have been taken and an update will be provided.

3 CONFIRMATION OF ATTENDANCE / APOLOGIES

Apologies had been received from Steve Grimmond, Carol Potter, Jim Crichton, Eleanor Haggett, Wilma Brown, Simon Fevre. Lynn Barker and Lynne Garvey.

4 DECLARATION OF MEMBERS' INTERESTS

Having a long-term interest in drug and alcohol issue, Martin Black declared an interest in Item 10.

5 MINUTES OF PREVIOUS MEETING 4 DECEMBER 2020

The Minute of the meeting held on Friday 4 December 2020 was approved.

Dave Dempsey raised a question around an item on page 7 of the Minute. This was an item which Eugene Clarke, Chair of Audit & Risk had put forward for escalation around the Transformation Board. Nicky Connor confirmed that an update on this would be provided to a future Audit & Risk Committee meeting.

6 MATTERS ARISING

The Action Note from the meeting held on 4 December 2020 was approved.

7 COVID 19 / REMOBILISATION UPDATE

The Chair introduced Nicky Connor and colleagues to provide update on Covid-19 and Remobilisation.

Paul Dundas – Care Homes continue to operate and work closely with the partnership. Work is ongoing to understand the implications of the recently published report on the Independent Review of Adult Social Care in Scotland and how this is best supported.

Kenny Murphy – advised that much of the traditional work undertaken by Fife Voluntary Action (FVA) is on hold due to the pandemic, but work continues in areas such as befriending and delivery of food, prescriptions, etc. FVA is working closely with the British Red Cross and public sector partners on supporting the set up and running of vaccination and testing centres along with ensuring the distribution of information.

NO	HEADING	ACTION

7 COVID 19 / REMOBILISATION UPDATE (Cont)

Fiona McKay – updated on the situation within Social Care. Many services have continued throughout the pandemic. Work is ongoing regarding reinstating Respite and Day Services. Staff testing has been introduced for Care at Home and Adult Services staff. Uptake of staff vaccination has been good and good joint working with Care Homes continues.

Dona Milne – Covid-19 numbers are down, clusters of outbreaks in Care Homes have reduced significantly. The Care Home Oversight Group continues to assess the situation. An asymptomatic test centre opened recently in Cowdenbeath, the next centre opens in Kirkcaldy early next week. Other centres will follow in the coming weeks.

Scott Garden – over 95,000 Fife residents have received their first dose of the vaccination to date. 13 community clinics are open. GP's and District Nurses are supporting the vaccination of housebound residents. It is expected that cohorts 3, 4 and 5 will be completed by week commencing Monday 22 February 201. Unpaid carers and those with underlying health issues make up cohort 6 and work will start on vaccination these residents soon. Second doses of the vaccination will commence from 1 March 2021.

Chris McKenna – advised that although January 2021 had been a tough month, the situation within our hospitals was improving. As long as the public continue to follow the advice and regulations this should continue. Plans are being drawn up to remobilise and recover services going forward. The vaccination programme has been an incredible success.

Helen Buchanan – echoed what Chris McKenna had said. Remobilisation of services needs to be done cautiously to ensure the safety of patients, their families and staff.

Helen Hellewell – advised that all GP practices would be issued with lateral flow test kits from next week.

Nicky thanked all of those who provided updates and extended thanks to all staff and colleagues, in all organisations, who have worked exceptionally hard over the last 12 months and thanked the public and communities for their support.

Questions were asked around the siting of mobile test units and the effect the inclement weather had on scheduling of appointments. Scott Garden advised that all appointments which had been missed because of the weather had now been rescheduled.

Board members expressed their praise for the running of the vaccination and testing clinics which had been a complex piece of work.

Discussion took place around mental health issues, how the rise is cases is being dealt with and that mental health is as big a priority as physical health needs. Community mental health teams have worked continuously throughout the pandemic.

8 FINANCE UPDATE

The Chair introduced Audrey Valente who presented this report.

NO	HEADING	ACTION

8 FINANCE UPDATE (Cont)

Audrey updated on the financial position of the delegated and managed services based on 30 November 2020 financial information. The forecast deficit is £5.158m and £6.467m relates to unachieved savings that remain at risk of non-delivery. These are currently within the local mobilisation plans but it remains uncertain whether full funding will be made available by the Scottish Government. This paper reflects the full value of non-delivery of savings included as a pressure within the core projected outturn position. This level of overspend requires urgent management action to ensure that the partnership deliverswithin the approved budget.

Four key areas of overspend are contributing to the financial outturn overspend:-

- Resource Transfer and Other Payments.
- Hospital and Long-Term Care.
- Adult Placements.
- Home Care Services.

Work is ongoing on the budget for the new financial year. Meetings are being held with the Chief Executives and Directors of Finance to finalise information. Once this is available a meeting will be set up to allow Board members to be updated prior to a budget paper being presented to the IJB on 26 March 2021. **NC/AV**

Tim Brett asked if a briefing on Direct Payments could be provided at a future Development Session. This was agreed. **NC/AV**

The Board noted the financial position as reported at 30 November 2020 and noted and discussed the next steps and key actions.

9 PERFORMANCE REPORT – EXECUTIVE SUMMARY

The Chair introduced Fiona McKay who presented this report. This is an executive summary of the full Performance Report which was discussed at the Finance & Performance Committee on 12 February 2021. The summary served to highlight areas of concern which were being continually assessed.

Dave Dempsey questioned where the information contained in the Performance Report was being dissected and looked at in detail to ensure solutions were being sought for issues. Fiona advised that staff across the Health and Social Care Partnership had responsibility for areas of local and national priority and each of these was underpinned with a workplan. Performance was aligned with the Strategic Plan to provide a level of assurance.

Discussion took place around emergency admissions to hospital, which are down on previous levels and how this can be sustained in the future.

9 PERFORMANCE REPORT – EXECUTIVE SUMMARY (Cont)

There has been a reduction in the number of presentations at A&E and Minor Injuries, although there are still peaks of activity eg falls when weather is icy. The Urgent Care Redesign is redirecting people to the correct service which is helping to reduce numbers in A&E/MIU.

The Board noted the information contained within the Performance Report.

10 ALCOHOL & DRUG PARTNERSHIP ANNUAL REPORT 2019-2020 AND ADP STRATEGY 2020-2023

The Chair introduced Kathy Henwood who presented this report, which was the subject of discussion at a Development Session held on Monday 5 February 2021.

Dave Dempsey asked why drug levels are so much higher in Scotland than the rest of the UK and the correlation between Scotland and North East England, which has similar economic issues. Kathy Henwood undertook action to bring back further data to the appropriate governance committee.

The Annual Report provides a synopsis of information from the partnership. Service Level Agreements are in place with service providers and Link Officer and Development Officers from the partnership work closely with each of them.

Discussion took place around evidence to support the long-term impact of the project. The support which is provided is visible, accessible and non-judgemental. There are areas for development and more detailed analysis will be done on these going forward.

Questions were asked about unallocated funding mentioned in the report. Kathy Henwood confirmed that at present funding is almost fully committed.

The Board discussed the content of this report and endorsed the ADP Annual Report 2019-2020 and the ADP Strategy 2020-2023.

11 STRATEGIC RISK REGISTER

The Chair introduced Fiona McKay who presented this report which sets out the risks associated with the partnership. Relevant risks have been discussed at governance committees recently and have been updated by risk owners.

The Board discussed the Risk Register, considered the content and whether any further information was required on the management of any particular risk. The Board then approved the Risk Register.

NO	HEADING	ACTION

12 MINUTES OF GOVERNANCE COMMITTEES / LOCAL PARTNERSHIP FORUM AND ITEMS TO BE ESCALATED

The Chair asked Eugene Clarke, Tim Brett and David Graham for any items from governance committees that they wish to escalate to the IJB.

Tim Brett – Clinical & Care Governance Committee (C&CG) - 13 November 2020 and 29 January 2021

1 Comprehensive update on Covid-19 Vaccination Programme provided by Scott Garden at 29 January 201 meeting.

David Graham – Finance & Performance Committee (F&P) - 11 November 2020 and 15 January 2021

1 F&P are meeting monthly to monitor the financial position.

Eugene Clarke – Audit & Risk Committee (A&R) – 19 November 2020

1 A&R reviewed and approved the External Audit Plan as required by Audit Scotland.

2 Agreed to have dedicated time to look at issues on Risk Register during A&R meetings.

Local Partnership Forum (LPF) - 18 November 2020; 16 December 2020; 20 January 2021

Nicky advised that the LPF is currently meeting monthly. Focus is on staff and workforce issues, staff testing and vaccination and the significant efforts on supporting communications, engagement and health and wellbeing. Senior Leadership Team, Trade Union and Staff Side are represented on the LPF.

13 AOCB

No items were raised.

14 DATES OF NEXT MEETINGS

IJB Development Session – Friday 12 March at 9.30 am

IJB Meeting – Friday 26 March at 10.00 am

Fife NHS Board
CONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON TUESDAY 16TH FEBRUARY 2021, 0900 VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Lesly Donovan	General Manager, Digital & Information
John Chalmers	Clinical Lead, Digital & Information
Philip Duthie	General Practitioner
Margo McGurk	Director of Finance & Strategy
Josie Murray	Clinical Lead Health Protection
Scott Garden	Director of Pharmacy & Medicines
Amanda Wong	Associate Director, AHPs
Jillian Torrens	Senior Manager, Mental Health & Learning Disabilities Service
Miriam Watts	General Manager, Emergency Care

In Attendance:	
Claire Neal	(Minute) PA to General Manager, Digital & Information
Marie Richmond	Head of Strategy and Programmes, Digital & Information
Allan Young	Head of Digital Operations, Digital & Information
Andy Brown	Principal Auditor
Eileen Duncan	Directorate Solutions Manager H&SC
Margaret Guthrie	Data Protection Officer, Digital & Information
Alistair Graham	Head of Digital Strategic Delivery, NHS Tayside
Apologies:	
Claire Dobson	Director of Acute Services
Janette Owens	Director of Nursing
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Nicky Connor	Director of Health & Social Care
Lynn Barker	Associate Director of Nursing
Helen Hellewell	Associate Medical Director

1	**WELCOME AND APOLOGIES**	
	Dr McKenna opened the meeting by welcoming everyone and provided apologies for the short notice for the cancellation of meeting on 19th January. Dr McKenna welcomed Alistair Graham, replacement for Lesly Donovan and a round of introductions were made by each member. Alistair starts with NHS Fife on Monday 22nd February The apologies are listed above and were noted by the Digital and Information Board.	
2	**MINUTE & ACTIONS OF MEETING HELD – 06/10/20**	
	The minutes from the meeting held on 6th October 2020 were reviewed and accepted as a true refection by the Digital & Information Board. The action list was reviewed and updated.	
3	**MATTERS ARISING**	
	3.1 Draft Terms of Reference Oct 20 Dr McKenna introduced the ToR and advised any immediate comments to be raised but was conscious not to go through ToR in major detail within this meeting due to times constraints with a full Agenda, and for group to provide	

	any comments via email. L Donovan highlighted Membership to be more concise with the remit of the new National Digital Strategy being reviewed and the approved NHS Fife Digital Strategy and after discussions with A Brown the ToR covered every aspect. Brief discussion was held regarding the current membership, noting Director of Pharmacy was omitted from list, L Donovan apologised for this oversight. Further discussions are required and to be taken offline to ensure the correct membership and relationship between D&I ToR and IG&S ToR. M McGurk highlighted the ToR and also the Annual Assurance statement require to be completed by this 31st March 2021. L Donovan asked with the ToR should contain a patient representative. It was noted this would be good. **Action** • **C Neal** to organise meeting with C McKenna, M McGurk, L Donovan and A Graham to review current ToR. • **L Donovan** to amend job titles and add S Garden as omitted from membership. ToR to be updated with further discussion on above. No comments were raised	**CN** **LD**
	3.1b – eHealth Board TOR Feb 19 – FOR REFERENCE L Donovan advised ToR was brought to Board as a reference only.	
	3.2 Annual Work Plan 21 -22 L Donovan noted the work plan are there to ensure the Agenda items are considered and sufficient assurance and decision making is in place. With previous item discussions workplan to be updated and reissued. L Donovan suggested taking the item numbers from the ToR and have them listed next to workplan to highlight these are carried out. A Brown also suggested this for the IG&S Groups. **Action** - L Donovan to update workplan with the above suggestions. No comments were raised	**LD**
4.	**PERFORMANCE**	
	4.1 Scorecard A Young presented scorecard for this QTR (Oct – Dec 20) and provided a brief over view of the below: • **End of Life Server removal 2003** - More red colour than would hope, but have requested further information on these reds and shall continue to review and update. • **End of Life Server removal 2008 -** This has been more manageable and is currently green. Great progress has been achieved with GP upgrade. • **SLA's –** More orange and reds are shown, this is due to due to COVID 19 and demands this has had on D&I workload, but this is to be discussed in Item 4.2. L Donovan advised this Scorecard is a work in progress and more information	

	and targets are still to be agreed. No comments were raised.	
	4.2 – SBAR – Challenges in meeting OLS/SLA's A Young provided a brief background to SBAR confirming Operations team had not met the OLA/SLA (Operational/Service Level Agreement) targets due to different ways of working throughout the whole organisation with more demand on digital enablement as a result of COVID 19. A Young presented figures to Board with the increase in calls: • Endpoint Team increased by **17%** • Service Desk increased by **12%** • Hardware Install by **52%** • AST by **68%** A Young advised with all departments work profile changing due to COVID 19, Health Records in particularly have had spare capacity and have provided assistance but as services are remobilising these staff are now required to go back to Health Records. A Young presented a brief background to the different options available and suggested option 3, using fixed term contracts to provide capacity and then look at a Business Case for a more permanent solution. This will then enable us to maintain systems properly and align within the NIS and Cyber essentials. S Garden highlighted the importance of Digital & Information's efforts and how much effort and investment has been required for the Vaccine Rollout Programme and Urgent Care Redesign. Brief discussions were undertaken about how much Digital has progressed in the last 12 months with L Donovan highlighting increase in remote access, increase in network, and supporting of staff. P Duthie also reiterated digital enablement will only grow and this is essential to Clinical Care. M McGurk raised a concern that we need to distinguish between what is BAU and COVID 19 response. Looking into next financial year for this to settle down before looking at BAU needs. **Support** by Board for option 3, but requirement to look into financials and include this in the COVID 19 spend. A Target Operating Model would be developed.	
5	**PROGRAMMES / PROJECTS**	
	5.1 Programmes/Projects update M Richmond presented to Board a brief update, and advised this paper was produced for the cancelled January meeting and many projects have moved on since but largest change was the introduction of Community Testing Project. M Richmond provided a brief update to certain projects: • **HEPMA** - this has now been signed off in November 2019. Contract awarded to EMIS and now looking at how to progress. • **O365** - Working well, next stage is SharePoint. • **Urgent Care Redesign** – Phase 1 now live and moving onto phase 2. • **Vaccination Programme** – really successful, big challenge but very	

	well delivered. • **Test & Protect** – Really good piece of work , working well in Public Health C McKenna thanked M Richmond for the detailed paper and for all the remarkable achievements and projects delivered by the Digital and Information team during the last year - a big thank you. Thanks were echoed from other members of Board. A Graham asked if there were any specific plans around Planned Care, a brief discussion was undertaken and J Chalmers advised this is something to look at hoping for Paperlite. M Richmond advised two Business Analysts were now due to start and the aim for them is to look at Electronic Records, and Digital Health & Care requests. M Guthrie identified a concern with the delivery of SharePoint and the resource required from the IG team to deliver this with National work taking priority. L Donovan confirmed it is a concern across all departments/teams and that the total resource requirements are still to be defined. No comments were raised.	
	5.2 SBAR Community System FBC Addendum M Richmond presented the paper advising this was to update the Board. The original Business Case for Community System also known as Morse which was originally submitted was insufficient to meet the increased demand e.g. increase in staff numbers, infrastructure etc, so an addendum was presented to H&SCP SLT in January for approval, but this was not approved due to funding constraints. M Richmond confirmed there is a risk as the project has not been fully delivered and staff contracts are due to end They have removed some aspects but this needs to continue with funding confirmed. M McGurk notified this has been recognised as a cost pressure and will form part of EDG discussion. C McKenna indicated this needs to be highlight as a significant risk. **Note** this situation to Board.	
6	**BUSINESS CASES / PROPOSALS**	
	6.1 – SBAR Near Me Community Rooms M Richmond presented SBAR advising when Near Me was initially rolled out this was only looking at 3 services initially, then COVID 19 started and Near Me was rolled out to all services. M Richmond is seeking approval for this to go to Business Case for its next phase where is it hoped to be put into Community areas. Brief discussion was undertaken regarding benefits of next phase of Near Me: • Covid secure • Widely used in Highland and successful • Available to widespread Community who don't have access to IT equipment.	

	• Easier to attend and support for family members • Reduction of travel for Clinicians and patients. M Richmond advised Diana Williamson has worked hard to complete an EQIA, with sign language available. Some work still to be done but definitely positives. M Richmond highlighted an update to the application has been released for Near Me, where questions are to be included. This is where a member of the public can ask the right question to Clinician. This option is available for switch on/off. Dr McKenna raised concerns as this is already taking place in NHS Fife under Realistic Medicine and there is a worry these maybe different questions. **Agreed** by Board to take Near Me Community to outline Business Case**.** Agreed **by Board that public questions would be switched off for NHS Fife.**	
	6.2 SBAR Self Booking M Richmond highlighted at previous D&I Board the above paper was supported for progression to Full Business Case with company called Lumeria. Unfortunately Lumeria has ceased trading and is no longer available. Good progress and lessons were learnt from initial stages with the value of self-booking being recognised. It is hoped to be able to seek approval to move to Outline Business Case. **Agreed** by Board to take to outline Business Case**.**	
	6.3 SBAR Business Continuity and Disaster Recovery (BC/DR) A Young provided a background to SBAR advising our Digital Business Continuity and Disaster Recovery (BC/DR) plan for the organisation is out of date. SLT are to review the BC/DR plan and review if they are still fit for purpose in our new digital age. Updating list for recovery in the event of a disaster. NIS regulations and Business Continuity has been taken into consideration but the focus has been on infrastructure. A Young advised there are six parts to a robust BC/DR plan: • **Scope** – Know our services and ensure these are clear to the organisation through a service catalogue. • **Key Services** – Understand their priority when protecting and recovering. • **Critical applications** – Agree with the organisation and establish the order of critically. • **Interdependencies** – Fully understand the connections between Service Catalogue, and those list above. • **Impact Analysis** – Conduct a full Business Impact Analysis to understand the impact of services not available. • **Impact Management** – Put plans in place to manage the impact to services being unavailable and practice recovery procedures. A Young advised there will be temporary resource required to create a business case. L Donovan confirmed here is funding already available for this. Brief discussion was undertaken regarding the above and it was noted as a	

	welcomed approach. No further comments were raised. **Agreed** by Board	
	6.4 SBAR Digital Pathology M Richmond advised they were approached by Digital Pathology to add this Business Case to our Delivery Plan. It was noted this was not part of the Digital Strategy but meets the criteria set out within the strategy and we should try and support if possible. Dr C McKenna highlighted the Business Case has already been forwarded to Scottish Government and were waiting on approval and would need to wait and see where this leads. Review of Cancer process is a priority, this needs to be reviewed by all Boards. Concerns were raised, with more information to be provided but **support** was provided for progression to Business Case with a caveat require to obtain more feedback before end of March. No further comments.	
7	**FINANCE**	
	L Donovan advised this paper was information only to highlight at end of Dec 20 there was an overspend of 70K, but this is a great achievement considering COVID 19 and thanks to S Marshall for keeping such a tight control on the budget. L Donovan advised we are on target for our Capital spend, with ongoing discussions for updating infrastructure, end of life devices, and telephone programme. No comments were made.	
8	**RISKS MANAGEMENT**	
	L Donovan presented paper and advised since the last report 5 risks were closed but 15 red risks are still outstanding of which 5 due to COVID 19 mitigations were unactioned and the board where asked to focus on these 5.: **1338** MS Office 2007, we still have devices that require to use 2007. Although support is no longer available systems like, EMISS, Trak and Office products are still required. Work is required to asses these. This is an issue throughout all Boards. **1393** Patch Management Risk, not been able to proceed with Patch Management Strategy need to look at how we implement on resources available. A Young advised whilst there has been a vast improvement on MS patching all fully automated but issue remains with non MS products. Ongoing work to utilise tool purchased to remedy the above. **1442** Unable to meet NIS & Cyber Essentials compliance, this is being monitored Nationally, ongoing work to review and reduce risk. National programme of audits, 2 audit on 10th March, and will provide a progress report. A Young advised they may never be NIS compliant as suppliers don't update. **1424** End of support lifecycle for Microsoft Server Products, this is being	

	monitored. C McKenna noted would like Risks to be listed higher on the Agenda so these can be reviewed by the Board as part of Assurance and Governance. For this to link with BAF. No further comments were made. **ACTION** - All risks to reviewed and updated appropriately with the above information.	**AY**
9.	**AUDIT / ACTION PLANS**	
	No update reported for this meeting	
10.	**AOCB**	
	10.1 Forensic Medical Service. L Donovan highlighted for information, this is a National Procurement Programme but no information has been provided, no Business Case, and no Implementation Plan but this is due to commence in March. It was noted this was to be kept under review. Dr McKenna advised L Donovan was due to commence in their retirement and this was their last meeting. C McKenna thanked L Donovan for everything that they have achieved in NHS Fife. The great leadership L Donovan has shown throughout their employment but most importantly over the last testing year with COVID. P Duthie offered personal thanks for what L Donovan had achieved for GP's practices. C McKenna thanked all for attending. No further comments	
11	**DATE OF NEXT MEETING** 20TH April 2021.	

NHS Fife

NHS FIFE INFECTION CONTROL COMMITTEE
3RD FEBRUARY AT 10AM
VIA MICROSOFT TEAMS

Present	
Helen Buchanan	Director of Nursing
Julia Cook	Infection Control Manager
Priya Venkatesh	Consultant Microbiologist
Keith Morris	Infection Control Doctor & Consultant Microbiologist
Stephen Wilson	Consultant Microbiologist
Pauline Cumming	Risk Manager
Paul Bishop	Head of Estates
Elizabeth Dunstan	Senior Infection Prevention and Control Nurse
Catherine Gilvear	Patient Safety Programme Manager
Midge Rotheram	Support Services Manager
Lynn Campbell	Associate Director of Nursing
Lynn Barker	Associate Director of Nursing
Margaret Selbie	Lead Infection Prevention and Control Nurse
Fiona Bellamy	Health Protection Nurse Specialist
Aileen Lawrie	Associate Head of Midwifery
Apologies	
Robert Cargill	
Stephen McGlashan	
Jim Rotheram	
Esther Curnock	
In Attendance	
Lori Clark	Notes

1	**APOLOGIES** Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – December 2020** Group approved previous minute as accurate reflection	
3	**ACTION LIST (December 2020)**	**ACTION**
	Group talked through each open action and the actions were closed or completed as appropriate. **Action list updated to reflect.**	
4	**STANDING ITEMS**	
4.1	4.1a HAIRT Board Report With regards to infection control achievements JC updated that IPC are supporting development of the team with a number of staff participating in post graduate study towards MSc Infection Prevention and Control with the University of Dundee. One of our team members is close to completing the course. Two members of the team have been nominated and accepted to complete the Built Environment module with the University of Highlands and Islands which started in January. There will be three new trainee IPCN's joining the team in February also. JC updated that workforce continues to be a challenge for infection control as another 2 members of staff left the service, IPCT workforce has been added to the risk register following the unsuccessful recruitment of a Lead IPCN. A recruitment drive is underway in the hope of filling the vacancies. ED updated that VAD remain the greatest challenge for Hospital acquired SABs but there are ongoing improvement works. UTIs and CAUTIs remain the areas to address to reduce ECB rates and whilst Fife's CDI	

rates are below national rates, the incidence of HCAI must be reduced further to meet targets.

JC updated a key focus for IPC is winter planning and supporting the safe remobilisation of services following the latest COVID wave. IPCT will support by assisting with patient contact tracing, outbreak management, attending PAG/IMT meetings, providing Education and training and supporting the vaccination programme.

ED updated with regards to SABs that in Q4 2020 NHS Fife had 27 SABs with is up from 20 in Q3 2020.
For MRSA there was a marked improvement as NHS Fife achieved 98% compliance with the MRSA in Q4 2020 which is up from 88% in Q3 and above the compliance target of 90%.
ED continued for CDI in Q4 2020 NHS Fife had 7 CDIs which was down from 13 cases in Q3 2020 and for EBC in Q4 2020 NHS Fife had 62 ECBs which is down from 69 cases in Q3 2020.
Hand Hygiene was above 98% compliance which is above the target of 95% and cleaning compliance for Q3 was 95.8% which is up from Q2 with 95.4%.

JC updated that in November and December 2020 there were no closures due to influenza or norovirus outbreaks and there has been baseline activity for both.
JC informed group that the PCR texted positive COVID cases are reported to HPS, JC talked the group through the table of cases over NHS Fife. JC added that since the figures on the table there has been further outbreaks in V41, Glenrothes wards 2 and 3, SGSU, Balcurvie ward, Letham Ward, St Andrews and QMH wards 6 and 7. Screening is now being done on admission and on day , JC added that screening is identifying cases and hopefully preventing larger outbreaks.
HB added that these outbreaks put pressure on all the teams and areas, infection control are stretched as well as other teams such as labs and occupational health. HB thanked the teams for their work around outbreaks and noted that staff seem to be managing some outbreaks to contain so that only bays are to be closed instead of full wards in some cases.
LB noted that east division seems to have most outbreaks but added that the support received has been amazing. JC added that the team support community but somethings cannot be controlled such as the environment, open bays etc. PV added the cases are all multifactorial in the community hospitals. PV also added that there have been 2 complaints and reminded all that duty of candour is very important. HB added that the message not to move can be difficult if it is a relative and the families are fearful and concerned.

ED updated that SSI surveillance is still on hold nationally but locally the team are monitoring data.

With regards to HEI inspection JC updated that Glenrothes received an inspection on 7th to 9th July 2020 and Adamson Hospital on 27th October both unannounced. There was good practice found such as organised and tidy wards, infection control precautions in place, good use of PPE, up to date training records and up to date audits. However, from Adamson there was 2 IPC recommendations one re hand hygiene and the other around decontamination. HB added that these were 2 immaculate reports and the teams should be commended as during a pandemic the important points shone through. HB added that inspections

	have restarted again in the acute settings, Tayside have had a visit so far so they won't be long in visiting Fife. Members **noted** the report.	
	4.1b HAI LDP Update – SABs Reports KM raised that the documents should not be forwarded as they have patient identifiable information on them. KM advised that December was the worst month in 2020 for SABs with 11 cases but it was a good year in total with 82 which is the best year on record. There was no MRSA bacteraemia in 2020 and have now not had one in 24 months which is fantastic. Of the total of 82 there were 37 community SABs, 37 hospital acquired and 8 HCAI. In total the 45 healthcare associated need to be reduced but we are on course to achieve the target. VAD's are still prominent, but only 3 PVC related which is the lowest on record. There were 6 dialysis line infections in 2020; we will work with the renal teams on this. COVID has had an affect with 5 post COVID ventilator associated pneumonias which we haven't seen before. For community skin damage accounted for 12 SABs, PWID had 4 cases in 2020 which is lower than 2019 and there is still ongoing work looking at nurse prescribing for this group. Members **noted** the update.	
	4.1c HAI LDP Update – CDIs Reports PV advised that there are evidence based interventions in place. Also there is new NICE guidance in draft form and some of the recommendations are not in keeping with NHS Fife however we can justify with evidence our process. KM added that Scotland may have its own recommendations that SAPG are feeding into. ED added for CDI there have only been 34 in total for 2020 which is the best year on record. KM added this is a brilliant achievement as there used to be 40 per month. Members **noted** the update.	
	4.1d ECB Surveillance Report ED advised there has been fewer ECB cases in 2020 that in 2018 and 2019. Members **noted** the update.	
	4.1e HAI Update – C Section SSI Reports SSI Surveillance currently paused as a result of CNO letter received. The surveillance team are locally monitoring data. Members **noted** the update.	
	4.1f HAI Update – Orthopaedic SSI Reports SSI Surveillance currently paused as a result of CNO letter received. The surveillance team are locally monitoring data. Members **noted** the update.	
	4.1g Colorectal SSI Surveillance Report SSI Surveillance currently paused as a result of CNO letter received. The surveillance team are locally monitoring data.	

	Members **noted** the update.	
	4.1h CPE Surveillance Report and MRSA Surveillance Nothing to note, information in HAIRT report. Members **noted** the update.	
	4.1i Outbreaks, Incidents and Triggers KM updated on the cases of Endophthalmitis, Ophthalmology have now moved out their previous treatment room and since there moved there has been no further cases. Although there haven't been as many patients it is evidence the room was the issue. The room wasn't big enough and the input vent was above the patient. Members **noted** the update.	
4.2	NHS National Cleaning Services Specification MR advised that NHS Fife in green compliance with 95.4 percent in Q3 which is above Q2 and Q1. The teams have continued audits through the second wave of COVID and any issues picked up are being addressed at the time. NHS Scotland cost to clean is currently £14.56 per m2 but NHS Fife is £12.10 on average. They have been recruiting to the additional hours and are now meeting the extra requirements. There are a huge number of terminal cleans being carried out with more pressure in the community where there are fewer staff. HB noted that the teams have been phenomenal maintaining standard and asked that that the thanks are passed onto the teams. LC echoed this; the domestic teams have been excellent and kept up with the changes in footprint etc. Members **noted** the update.	
4.3	Risk Register PC updated that there are 3 high risks, 2 remain high and the other one has been increased to high. JC added that she has SAB, ECB and CDI risks to review but will keep them on the register as the target dates are still a year away. Members **noted** the update	
4.4	Learning Summaries PC advised that she has brought two learning summaries to the committee. One is CVC for Haemodialysis line and the other PVC but there are no outstanding actions. PC added that the attendance for SAERs have been great the staff are keen to be involved and take on any actions and improvements. Members **noted** the update	
4.5	National Guidance JC advised that the guidance is constantly changing and has added a link to the agenda to the guidance. There are now COVID addendums for acute, care home and community settings. MS added there is also a non-COVID neonatal addendum available. LC added that there are ongoing discussions around patient facing information. JC informed that at a national level they are looking at information for patients on good practice whilst in hospital for mask use etc. JC advised	

	that Lanarkshire have a good leaflet and we can possibly look at this and adapt to NHS Fife, HB agreed with this idea. **ACTION – Create patient mask wearing leaflet** Members **noted** the update	L Clark
4.6	HEI Inspections Covered in HAIRT, report for latest inspection at Adamson hospital attached in agenda. Members **noted** the update.	
4.7	Quality Improvement Programmes CG updated that the UCIG group was cancelled in December and February and the next meeting is due in April but the hope is to bring this forward to March. They are looking at havi9ng care home representation at the meeting and have been working on refreshing the driver diagrams. Members **noted** the update.	
4.8	Infection Prevention & Control Audit Programme JC advised that with increased workload pressures the audit programme was paused for December and January with only follow ups being carried out during this time. With HAI inspections restarted we will restart the audit programme in February. Rosemary Shannon will continue to support this work and she will mentor the new starts in the auditing process. JC advised that auditing will be done by two staff but this is only for training of the new IPC Nurses. Members **noted** the update	
4.9	Prevention and Control of Infection Work Programme 2019-2020 (for noting) JC advised there has been a glitch with the document attached for the meeting and will circulate separately. **ACTION – JC to circulate work programme document.** Members **noted** the update.	J Cook
5.	**NEW BUSINESS**	
5.1	COVID-19 PV raised the need to push for vaccinations for the cohort of patients in the HSCP from an infection control perspective it is important these patients are included in the vaccine roll out as soon as possible to they are in keeping with care homes. HB agreed with this and advised that it has been raised at gold command and also raised with chief executive. LB and Lynn Garvey are looking at how these patients can be vaccinated and there is talk of patients being vaccinated before they can go to care homes. The plan will include inpatients in acute and looking to do over 70's in these areas soon. Members **noted** the update	
5.2	Excellence in Care JC updated that the MDRO tool will be going onto Patientrak, the module has been built and JC will receive a demonstration On Friday 5th February. Members **noted** the update	

5.3	Safe and Clean Audit JC updated that compliant with the safe and clean audits has been higher in some areas than others however COVID pressure and regular ward movements could be a factor in lower rates. JC reminded all that the tool is still up and running and there to use. Members **noted** the update	
6	**NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS**	
6.1	Infection Prevention & Control Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.2	NHS Fife Decontamination Steering Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.3	NHS Fife Antimicrobial Management Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.4	NHS Fife Water Safety Management Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.5	HAI SCRIBES Document attached to agenda lists SCRIBE work carried out recently. Members **noted** the notes of the meeting	
6.6	Quality Reports Quality reports attached to agenda for information. Reports are for **noting** only	
7	**ANY OTHER BUSINESS** MS advised that the team have restarted their weekly outbreaks training sessions on teams, the link is added to Blink weekly for all staff to access and attend training without having to book and at the end of the session they receive a certificate for their attendance. There have been 51 people trained through this online method. The team have also been offering short, sharp sessions in the wards during visits. The team are hoping to have some more videos available to all staff on Blink in the next few months. JC updated that there has been some glitches with ICNet but the team are working with ehealth and ICNet to resolve. We are due an ICNet upgrade in the next quarter although it may mostly be cosmetic changes. HB advised this is her last ICC meeting before she leaves at the end of March. HB expressed the importance of the committee for governance and a time for all issues to be raised. It's also a time to celebrate good practice. HB thanked all for the work they do and for all the great development in the IPC team and this committee. Janette Owens will chair this meeting going forward. Members **noted** updates.	
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held 14th April 2021 at 2pm via Microsoft Teams	

Fife NHS Board

Confirmed

NOTES OF THE PUBLIC HEALTH ASSURANCE COMMITTEE MEETING HELD ON THURSDAY 25 FEBRUARY 2021 AT 2.30PM VIA MICROSOFT TEAMS

Present:	Dona Milne (DM) (Chair)	Director of Public Health
	Olukemi Adeyemi (OA)	Consultant in Public Health
	Lynn Barker (LB)	Associate Nurse Director
	George Brown (GB)	Emergency Planning Officer
	Cathy Cooke (CC)	Public Health Scientist
	Esther Curnock (EC	Consultant in Public Health Medicine
	Josie Murray (JM)	Consultant in Public Health
	Emma O'Keefe	Consultant in Dental Public Health
	Julie O'Neil (JON)	Public Health Service Manager

Apologies:

In Attendance:	Sarah Nealon (SN) (notes)	PA to Director of Public Health

ACTION

1. WELCOME AND APOLOGIES

DM welcomed everyone to the meeting and there was a round of introductions.

2. MINUTE OF THE MEETING HELD ON 20 JANUARY 2021

These were agreed as an accurate record of the meeting.

3. MATTERS ARISING

Withdrawal of HPT TB activity since March 2020 with particular reference to BCG Vaccination and Latent TB Screening clinics

DM reported that she had a follow up conversation with FB. Followed up action about the potential support with Lothian and FB was working on that. JM reported that she has had conversations with Lothian and they now don't have additional capacity to help. There is a risk due to the current backlog, there has been further development with service managers and lead pediatrician. Agreed a process going forward as previously a clinic had to take place where there was paediatric staff and this is now not required. Proposing to hold on to this, so FB can check if any risk requires to be logged. **ACTION FB/JM** **FB/JM**

JON said that she would be happy to work with the Service Manager to produce a business plan. **ACTION: JON to catch up with FB and see what is required.** **JON**

TOR – Meeting has not taken place to go over this to date. **JON/DM**

Annual Workplan

SN said that this was a first draft. It was agreed that some committee minutes should come to this committee for information. **Action: Committee members to send these to SN so they can be incorporated to the plan along with committee dates for the year**. OA said that she found this very useful. **ALL**

5 ANNUAL SCREENING REPORT

CC said that quite a bit of information from this report has already been presented to this meeting before. Data may look out of date but it is the most recent data available. Screening programmes were paused at the end of March 2020. Uptake has gone down and the full impact is not know as it is too early to tell.

EC said that this was a really clear report, nice and straight forward to read. EC asked in relation to inequalities whether the trend in inequality had been looked at over time.

EC noted that in relation to the AAA screening, whilst there was still a socioeconomic gradient Fife are doing better than elsewhere in Scotland in the most deprived areas, is there anything we can transfer from this to other programmes?

CC confirmed that Bowel Screening uptake has improved and that may be because you can do it at home, however it is still encouraging to see the uptake increase. CC mentioned Health Inequalities looking at trend data over time and that is something Fife should be doing. EC mentioned that she was aware that the AAA screening Team were very proactive and they were visiting mens shed and other similar projects.

DM said that it would be quite useful to look at inequality data over time in future reports and thanked CC for the report. This can now be submitted to the Clinical Governance Committee. **Action SN to send template to CC for submission to Clinical Governance Committee**. **SN**

6. ANNUAL IMMUNISATION REPORT

This has not been circulated as it was not ready to be circulated. **Action EC to submit report to the next meeting.** **EC**

EC talked through a paper that was taken to the Area Immunisation Steering Group (AISG) on 19th February.

PHS have been monitoring and reporting on the wider impact of the pandemic, including the impact on the infant and pre-school vaccination programme. Latest data from that monitoring period up to November 2020 is that there is a 10% drop in MMR vaccination uptake at 1 year in Fife, taking Fife below national average. The paper taken to AISG

discusses what may have caused this and the challenges to delivery during this period. There are additional actions the immunisation team are taking forward to follow up those individuals who have not attended for their vaccination during this period.. There is a long term Public Health risk unless a mop up programme is carried out.

HPV Programme – Fife are in a better position than some other areas in Scotland. There was some disruption in vaccination of S1 males planned for Spring 2020 due to administrative problems with consent packs. Teenage vaccination Programmes were then paused due to the pandemic and catch up was arranged in February this year. Due to the scheduling error that caused double-booking of Covid-19 Vaccinations some of the teenage catch-up clinics in February had to get cancelled at short notice to pull staff to assist in the covid vaccination clinics. However, vaccinations were rearranged this week for those that were cancelled in February.

DM thanked EC for her update and asked if anyone had any questions.

OA said that she was encouraged that there has not been any communicable transmission from some of the children that have missed the vaccine. It was noted that there are currently low rates for vaccine preventable diseases in general..

EO'K mentioned the Health Inequalities issue and is there something that this committee should flag up and do we have a duty of flagging inequalities. DM said that everybody has a duty to do that in Public Health.

Timeline for the infant / pre-school catch up programme. EC acknowledged this needs to be clearer before considering if appropriate to go to Clinical Governance as a separate paper or linked to the annual report.

OA mentioned that there is national work going on around screening and inequalities and they will be sharing outcomes from this work.

DM mentioned that Inequalities is mentioned in the Remobilisation Plan this time.

Equalities - EC mentioned that there is a much more structured approach from the covid programme to the EQIA process and subsequent action plan, and there is learning that can come from that for the wider programme.

7. COVID TESTING REPORT

JM talked through this report. Significant expansion over the last quarter, the paper highlights some of the risks due to several large changes.

LFD tests are now available in Fife, they are quick and easy to obtain, but come with some challenges which we are working through.

Programme approach being taken to covid testing, mapping the programme overall and to use capacity effectively across Fife.

JM mentioned that waste water sampling can be used to see where there might be undetected covid. This is used along with other measures to determine where to deploy testing sites and mobile units.

JM asked if anyone had any questions.

EC thanked JM for this paper and asked a couple of things, there are two lines for students in the summary table section 2.3.1. JM said that the Community Testing Team are involved in testing students if their LFD is positive and they have isolated and received a home test kit, if this comes back inconclusive, then the Community Testing Team would go out to test them.

It was noted that Fife laboratory are expanding capacity and overflow will be sent to Lothian. Fife Laboratory have expanded this for patients, but not for Public Health. East Region node, using academic facilities, Fife have an opportunity to use that.

DM asked the Committee if they were happy for this report to be submitted to Clinical Governance Committee. This was agreed.

RISK MANAGEMENT

8. IDENTIFY NEAR MISSES, CRITICAL INCIDENTS & LEARNING

Not aware of any near misses or critical incidents. DM reminded everyone that these should be brought to this committee.

Adverse Reporting – there was a question about a summary provided for this and should this be brought to this committee. DM said that any Significant Event should come to this committee.

There was some discussion around what are strategic risks and operational risks and who has responsibility. This should be clarified at the outset when each risk is agreed.

9. NEW PROSPECTIVE RISKS

SN asked for clarity around risk updates, whether these should be submitted to the committee for approval before being updated on Datix or if they can be updated by the Risk Owner and then come for information. DM confirmed that these should come to the committee for approval or if they require to be updated outwith the meeting then DM would approve these.

9.1 New Prospective Risk Form

SN asked for any comments on the form that she had received from the DATIX Team and asked if the department agree to adopt this template. GB said that he didn't find the direction of the text easy to read**. Action SN agreed to try and adapt the form to make it easier to use.**

10. REVIEW OF CURRENT RISKS ON PUBLIC HEALTH REGISTER

Action still outstanding from last meeting: **JON agreed to liaise with SN regarding governance discussion out with this meeting.** **JON/SN**

Not all updates had been received in advance of this meeting. It was agreed that updates would be sent to SN and SN would seek approval from DM before updating on DATIX. **Action All.** **ALL**

10.1 518 Resilience

Next review due 20/04/21

10.2 528 Pandemic Flu Planning

Next review due 20/04/21

10.3 1729 Suspicion of Malignancy

Next review due 19/03/21

10.4 1873 Pregnancy and Newborn Screening

Next review due 31/03/21

10.5 1904 Coronovirus Disease 2019 (Covid-19) Pandemic

Scottish Government have released a new Covid-19 Strategic Framework Update on 23rd February 2021. This needs to be considered by EDG and the Fife Resilience Partnership to identify the next set of priority actions for Fife. This is likely to continue to be directed by Scottish Government who will control the levels that each geographical area is in, but will require management by public health locally. The Fife strategic framework action plan can now be reviewed.

10.6 1905 Contact Tracing including TTIS Programme

Risk of transmission remains, as evidence for vaccines or therapies remain unsubstantial. R is 0.7-0.9. Lockdown is beginning to ease, however there is an abundance of contact tracer staff available in relation to the case numbers. Policy change to call all contacts has begun. No change in risk levels.

10.7 1906 Contact Tracing including TTIS Programme

Testing programme risks- risk that harm will come as a result of testing. testing is a method used to identify those who should carry out isolation. Testing without adequate support can incur financial, economic and mental health harms. Due to levels and pace of roll out of testing risk is now moderate and very likely.

10.8 1907 Public Health Oversight of Covid-19 in Care Homes

The Open with Care Guidance document was published on 24th February to support meaningful contact in care homes. There have been a series of national workshops for care providers and in Fife we are providing a Webinar session in partnership with Scottish Care to support the care homes with the implementation of this guidance and the resumption of indoor visiting to care homes.

10.9 1908 Handling of Excess Deaths during the Global Covid-19 Pandemic

A meeting of the Fife LRP Mass Fatalities Co-ordination Group took place on the 17th February to review the current arrangements for Excess deaths arrangements in Fife. The group reviewed the dashboard which includes: Body Storage Capacity, Vehicle Availability (to move bodies if required), Staffing of mortuary facilities, Availability of PPE, Availability of body bags, Any issues within the Belief Community and Comms and PR Issues

No issues of concern were noted at the meeting and a further review will take place in the next few months or if there is any change in the situation.

No change to the risk level on this occasion but may consider changing to low at next review.

10.10 2005 Covid Vaccinations – Vaccine Effectiveness

Next review due 15/03/21

10.11 2025 Covid 19 Vaccinations – Long Term Infrastructure

- an external consultant has been jointly commissioned by the DPH and Chief Officer of Fife HSCP to "undertake a review of the immunisation resource and structure (governance, planning and delivery) and make recommendations to NHS Fife in order to meet the increasing demands and expectations for the childhood and adult immunisation programmes in Fife". The review will take place over two months starting week beginning 15th Feb. The consultant will be employed 2 days / week over 10 weeks. The final report will be submitted to the Executive Directors Group.
- Fortnightly meetings between the external consultant, DPH,

Director for Pharmacy & Medicines and the Chief Officer of HSCP are ensuring there is strong executive oversight

- The COVID vaccination programme manager role has gone out to advert and shortlisting will commence w/b 1st March. Planning for the long term infrastructure for mass vaccination in Fife will be a core part of this role.

Given the progress made as outlined above the current risk assessment should be changed from likely (4) to possible (3). The consequence remains extreme (5). This means the overall risk assessment is now 15 so remains high risk.

11. ANY ISSUES TO ESCALATE TO CLINICAL GOVERNANCE

There were none.

12. ANY OTHER COMPETENT BUSINESS

There was none.

13. DATE OF NEXT MEETING

Date to be changed due to diary clash and annual leave. **Action SN to amend and resend meeting invite.**