NHS Fife Clinical Governance Committee

Wed 03 November 2021, 14:00 - 17:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Verbal *Christina Cooper*

14:00 - 14:00
0 min

2. Declaration of Members' Interest

Verbal *Christina Cooper*

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Friday 17 September 2021

Enclosed *Christina Cooper*

Item 3 - CGC Minutes 17 September 2021 - Unconfirmed.pdf (10 pages)

14:00 - 14:00
0 min

4. Matters Arising / Action List

Enclosed *Christina Cooper*

Item 4 - CGC Action List - 3 November 2021.pdf (1 pages)

14:00 - 14:20
20 min

5. COVID-19 UPDATE

5.1. General Covid-19 Update

Verbal *Dr Joy Tomlinson*

5.2. Flu Vaccination & Covid Vaccination (FVCV) Programme Update

Enclosed *Nicky Connor*

Item 5.2 - SBAR Flu Vaccination & Covid Vaccination (FVCV) Programme Update + Appendix 1.pdf (13 pages)
Item 5.2 - Appendix 2 – CMO letter.pdf (9 pages)
Item 5.2 - Appendix 3 – National Delivery Plan Update .pdf (1 pages)

14:20 - 15:10
50 min

6. GOVERNANCE / ASSURANCE

6.1. Board Assurance Framework - Quality & Safety

Enclosed *Dr Chris McKenna / Janette Owens*

Item 6.1 - SBAR Board Assurance Framework - Quality & Safety.pdf (10 pages)
Item 6.1 - Appendix 1 - Board Assurance Framework - Quality & Safety .pdf (2 pages)
Item 6.1 - Appendix 2 - Quality & Safety linked operational risks.pdf (2 pages)

6.2. Board Assurance Framework - Strategic Planning

Enclosed *Margo McGurk*

- Item 6.2 - SBAR Board Assurance Framework - Strategic Planning.pdf (3 pages)
- Item 6.2 - Board Assurance Framework - Strategic Planning.pdf (1 pages)

6.3. Board Assurance Framework - Digital & Information

Enclosed *Alistair Graham*

- Item 6.3 - SBAR Board Assurance Framework - Digital and Information.pdf (4 pages)
- Item 6.3 - Appendix 1 - Board Assurance Framework - Digital & Information.pdf (2 pages)
- Item 6.3 - Appendix 2 - Digital & Information linked operational risks.pdf (4 pages)

6.4. Internal Audit Report - Clinical Governance Strategy & Assurance

Enclosed *Dr Chris McKenna*

- Item 6.4 - Internal Audit Report - Clinical Governance Strategy and Assurance.pdf (14 pages)

6.5. Annual Internal Audit Report 2020/21

Enclosed *Margo McGurk*

- Item 6.5 - SBAR Annual Internal Audit Report 2020-21.pdf (3 pages)
- Item 6.5 - Annual Internal Audit Report 2020-21.pdf (34 pages)

6.6. Annual Workplan

Enclosed *Gemma Couser*

- Item 6.6 - Clinical Governance Committee Annual Workplan 2021-22 .pdf (3 pages)

15:10 - 16:00
50 min

7. STRATEGY / PLANNING

7.1. Strategic Planning & Resource Allocation 2022/23

Enclosed *Margo McGurk*

- Item 7.1 - SBAR Strategic Planning & Resource Allocation 2022-23.pdf (4 pages)
- Item 7.1 - Appendix 1 - Strategic Planning and Resource Allocation Letter from CE.pdf (4 pages)
- Item 7.1 - Appendix 2 - Strategic Planning and Resource Allocation Template.pdf (7 pages)

7.2. Redesign of Urgent Care

Enclosed *Dr Chris McKenna*

- Item 7.2 - SBAR Redesign of Urgent Care.pdf (12 pages)

7.3. Clinical Governance Strategy

Presentation *Dr Chris McKenna*

7.4. Primary Care Improvement Plan - MOU2 Update

Enclosed *Nicky Connor*

- Item 7.4 - SBAR Primary Care Improvement Plan - MOU2 Update.pdf (7 pages)
- Item 7.4 - Appendix 1 - General Practice Division Letter.pdf (3 pages)

16:00 - 16:25
25 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance & Quality Report

Enclosed *Dr Chris McKenna / Janette Owens*

- Item 8.1 - SBAR Integrated Performance & Quality Report.pdf (3 pages)
- Item 8.1 - Integrated Performance & Quality Report.pdf (46 pages)

8.2. Health Associate Infection Report (HAIRT)

Enclosed *Janette Owens*

- Item 8.2 - SBAR HAIRT Report.pdf (6 pages)
- Item 8.2 - HAIRT Report.pdf (16 pages)

8.3. National Hub for Reviewing and Learning from the Deaths of Children & Young People

Enclosed *Janette Owens*

- Item 8.3 - SBAR National Hub for Reviewing and Learning from the Deaths of Children and Young People .pdf (9 pages)
- Item 8.3 - Appendix 1 - Guidance National Hub for Reviewing and Learning from the Deaths of Children and Young People.pdf (31 pages)
- Item 8.3 - Appendix 2 - Terms of Reference Short Life Working Group.pdf (2 pages)

16:25 - 16:40
15 min

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1. Volunteering Annual Report 2020/21

Enclosed *Janette Owens*

- Item 9.1 - SBAR Volunteering Annual Report 2020-21.pdf (12 pages)

9.2. Complaints Report

Enclosed *Janette Owens*

- Item 9.2 - SBAR Complaints Report.pdf (16 pages)

16:40 - 16:50
10 min

10. ANNUAL REPORTS

10.1. Medical & Appraisal Revalidation Annual Report 2020/21

Enclosed *Dr Chris McKenna*

- Item 10.1 - SBAR Medical Appraisal Revalidation Report 2020-21.pdf (3 pages)
- Item 10.1 - Medical Appraisal Revalidation Report 2020-21.pdf (8 pages)

10.2. Prevention & Control of Infection Annual Report 2020/21

Enclosed *Janette Owens*

- Item 10.2 - Prevention and Control of Infection Annual Report 2020-21.pdf (42 pages)

10.3. Organisational Duty of Candour Annual Report (Interim)

Enclosed *Dr Chris McKenna*

- Item 10.3 - Organisational Duty of Candour Annual Report (Interim).pdf (20 pages)

16:50 - 16:55
5 min

11. LINKED COMMITTEE MINUTES

11.1. Acute Services Division Clinical Governance Committee

Enclosed *Aileen Lawrie*

Item 11.1 - SBAR Acute Services Division Clinical Governance Committee Minutes.pdf (1 pages)
Item 11.1 - Acute Services Division Clinical Governance Committee Minutes - Unconfirmed.pdf (16 pages)

11.2. Fife Area Drugs & Therapeutics Committee

Enclosed *Dr Chris McKenna*

Item 11.2 - Fife Area Drugs & Therapeutics Committee Minutes - Unconfirmed.pdf (8 pages)

11.3. Fife Health & Social Care Partnership Clinical and Care Governance Committee

Enclosed *Nicky Connor*

Item 11.3i - Fife Health & Social Care Partnership Clinical and Care Governance 04.08.21 - Confirmed.pdf (9 pages)
Item 11.3ii - Fife Health & Social Care Partnership Clinical and Care Governance 08.09.21 - Confirmed.pdf (7 pages)

11.4. Digital and Information Board

Enclosed *Dr Chris McKenna*

Item 11.4 - Digital and Information Board Minutes - Confirmed.pdf (6 pages)

11.5. Health & Safety Sub-Committee

Enclosed *Dr Chris McKenna*

Item 11.5 - H&S Sub-Committee Minutes - Unconfirmed.pdf (4 pages)

11.6. Infection Control Committee

Enclosed *Janette Owens*

Item 11.6 - Infection Control Committee Minutes - Unconfirmed.pdf (7 pages)

11.7. Area Medical Committee

Enclosed *Dr Chris McKenna*

Item 11.7 - Area Medical Committee Minutes - Confirmed.pdf (4 pages)

11.8. Cancer Governance and Strategy Group

Enclosed *Dr Chris McKenna*

Item 11.8 - Cancer Governance & Strategy Group Minutes - Unconfirmed.pdf (9 pages)

11.9. Research, Innovation & Oversight Group

Enclosed *Dr Chris McKenna*

Item 11.9 - Research, Innovation & Oversight Group Minutes - Unconfirmed.pdf (5 pages)

11.10. Public Health Assurance Committee

Enclosed *Dr Joy Tomlinson*

Item 11.10 - Public Health Assurance Committee Minutes - Confirmed.pdf (8 pages)

16:55 - 17:00
5 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPR & Chair's Comments

Verbal *Christina Cooper*

17:00 - 17:00
0 min

13. ANY OTHER BUSINESS

17:00 - 17:00
0 min

14. DATE OF OF NEXT MEETING - THURSDAY 13 JANUARY 2022

Fife NHS Board

UNCONFIRMED

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON FRIDAY 17 SEPTEMBER 2021 AT 9.30AM VIA MS TEAMS

Present:
C Cooper, Non-Executive Member (Chair)
M Black, Non-Executive Member
S Braiden, Non-Executive Member
Cllr D Graham, Non-Executive Member
C Potter, Chief Executive
S Fevre, Area Partnership Forum Representative
A Lawrie, Area Clinical Forum Representative
Dr C McKenna, Medical Director
J Owens, Director of Nursing
J Tomlinson, Director of Public Health

In Attendance:
G Couser, Head of Quality & Clinical Governance
S Garden, Director of Pharmacy & Medicines
A Graham, Associate Director of Digital & Information
H Hellewell, Associate Medical Director
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
N McCormick, Director of Property & Asset Management
M McGurk, Director of Finance & Strategy
A McKay, Deputy Chief Operating Officer *(deputising for C Dobson)*
F McKay, Divisional General Manager *(deputising for N Connor)*
E Muir, Clinical Effectiveness Co-ordinator
H Thomson, Board Committee Support Officer (Minutes)

The Chair welcomed everyone to meeting.

The Chair thanked our workforce for their incredible ongoing commitment. Over the past few weeks', the pressures across the system in response to the pandemic have increased significantly and the Chair acknowledged how hard this is for our teams across the organisation. The well-being of our teams is a priority so that they can deliver the best for our patients, and work is underway to identify how we can address the pressures across the system.

1. Apologies for Absence

Apologies were noted from members R Laing (Non-Executive Member) and attendees L Campbell (Associate Director of Nursing), R Cargill (Consultant Cardiologist), N Connor (Director of Health & Social Care), C Dobson (Director of Acute Services), L Douglas (Director of Workforce) and S Fraser (Associate Director of Planning & Performance).

A McKay (Deputy Chief Operating Officer) was welcomed to the meeting, deputising for C Dobson, and Fiona McKay (Divisional General Manager) was welcomed as deputising for Nicky Connor.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting

3.1 The Minute of the meeting held on 7 July 2021

The Committee formally **approved** the minute of the last meeting.

3.2 The Minute of the Extraordinary meeting held on 2 September 2021

The Committee formally **approved** the minute of the Extraordinary meeting, following a slight re-wording to section 3 to clarify it is the third dose of Covid-19 being offered and a first for Seasonal Flu.

4. Matters Arising / Action List

The Committee **noted** the updates provided and the closed items on the Action List.

5. Covid-19 Update

The Director of Public Health provided a verbal update on Covid-19 activity around testing and progress.

Positive Covid-19 cases have seen a dramatic increase, with around 752 cases per 100,000 of population, in Fife. There has also been an escalation in the number of tests carried out. A total of 30,041 Lateral Flow Tests (LFT) were carried out from the period 6 – 12th September 2021, and this is the highest amount, to date. Polymerase Chain Reaction Tests (PCR) in the same time period numbered 25,438. The largest increase in PCR testing is in the community testing, which is mainly covered by the UK laboratories and is just under 18,000. It was noted we are very heavily reliant on UK laboratories testing.

The uptake of testing has resulted in almost full capacity, and intermittently there are challenges around the turnaround time due to the volumes. Technical challenges were outlined.

It was advised there has been significant change around staff contacts and conditions for returning to work, which now includes an additional negative PCR test and also a daily negative LFT for ten days. The importance of carrying out these tests was highlighted, as it minimises workforce absences and should retain safe staffing levels.

Equity remains a concern within the teams and ensuring good access across the population in terms of geography and other control factors, to effectively manage self-isolation. NHS Fife are working closely with Fife Council to ensure test sites are in the most accessible areas possible to promote attendance.

There are challenges within the workforce and the large number of staff required for fixed sites, as it has been difficult to fully expand the testing units. There are also recruitment challenges, particularly with fixed rate contracts.

Testing for staff and families is ongoing at Cameron Hospital, however, there is little capacity now in that area. Additional capacity is being sought through pre-admission testing at the asymptomatic site in Dunfermline, which will improve access for residents in West Fife and NHS Fife Staff.

It was reported active conversations are taking place at national level on the future of testing capacity. It was noted our system is working well, particularly with a large volume of testing.

Following a question, it was advised testing is being escalated as much as it can be and there is a meeting scheduled with Directors of Public Health to discuss further. A balance going forward is required, and to determine the capacity that is going to be required.

It was noted all age groups are coming forward for testing, and it is difficult to identify groups who are not coming forward, as reluctance can be attributed to many different reasons.

An overview was provided on the significant impact and pressures on our clinical services, and it was reported the increase in community numbers will always lead to a level of people requiring hospital care, whether they have been vaccinated or not vaccinated. The numbers of people requiring hospital level care at this current level of community transmission is different from what it would have been pre-vaccination. At the level that it currently sits at, it is leading to a significant submission and a strain on our Acute Services, and subsequent pressure across the whole system, including our critical care facilities. Discharge planning is a key area, due to longer stays in hospitals. It was advised delivery of non-urgent and elective healthcare is just as important to our health care services going forward.

It was confirmed pausing of elective procedures and outpatient activity has been very selective, due to clinical prioritisation, and as much patient activity delivery is taken place as possible. In the previous week, some non-urgent outpatient and elective activity has been paused in order to support the urgent and emergency response, mainly due to safety reasons and to deliver a large-scale critical response. It was noted the critical response is manageable and being monitored on a day-to-day basis. Planning for over the winter period is crucial.

Assurance was provided to the Committee on work being done to maintain the clinical services, and through clinical prioritisation, particularly around staffing levels. Regular communication is taking place with the Scottish Government to mitigate risks. It was noted NHS Fife are over performing against other Health Boards, and clear plans are in place to raise activity levels.

The Committee **noted** the update and current position, taking assurance from the actions described.

6. GOVERNANCE / ASSURANCE

6.1 Board Assurance Framework – Quality & Safety

The Medical Director provided an update on the NHS Fife Board Assurance Framework (BAF) for Quality & Safety and advised work is still ongoing on its revision.

In terms of the current situation, two linked risks have been removed: Overcapacity in Assessment Unit and Capacity Planning – Boarding of Patients, as the issues within those risks are not applicable due to a change of circumstances in refiguring the hospital. Alternative risks as a result of our response to Covid-19 will be identified through development of risks in Acute Services moving forward. It was noted, the temperature control fluids risk has been downgraded due to changes in the infrastructure with regards to temperature control for fluids.

Full updates are being collated for each of the high risks from each area of the organisation, and a comprehensive update with recommendations will be provided at the next Clinical Governance Committee meeting and include assurances on associated links.

Action: Medical Director

The Committee **noted** the content and current position of the quality and safety component of the Board Assurance Framework.

6.2 Board Assurance Framework – Strategic Planning

The Director of Finance & Strategy provided an update on the NHS Fife Board Assurance Framework (BAF) for Strategic Planning.

Assurance was provided to the Committee the Population Health & Wellbeing Strategy is progressing, including progress on engagement with the population and staff.

The Committee **noted** the current position in relation to the Strategic Planning risk.

6.3 Board Assurance Framework – Digital & Information

The Associate Director of Digital & Information provided an update on NHS Fife Board Assurance Framework (BAF) for Digital & Information.

The BAF reports a small change from previous reports and a linked operational risk has been removed, as detailed in the paper. An improved position is expected in the next report.

The Committee **noted** the content and current assessment of the Digital & Information BAF.

7. STRATEGY / PLANNING

7.1 NHS Fife Population Health & Wellbeing Strategy Progress

The Director of Finance & Strategy gave an update on the progress of the NHS Fife Population Health and Wellbeing Strategy development, the briefing paper on which has been provided to the Committee for assurance.

The Executive Directors Group propose to take forward a portfolio approach to developing and delivering the strategy. It will initially focus on the development of a new 5 – 10 year strategy and will inform our deliverable plans and projects, which will be monitored through a newly established Portfolio Delivery Programme Board (PDPB). It is anticipated that the PDPB will report directly into the new Public Health & Wellbeing Governance Committee being established by the Board.

The portfolio will be aligned directly to the four national care programmes that the Scottish Government have initiated.

It was advised that the first stage of the EQIA stage assessment has concluded and is now moving to stage two.

The design of the strategy is being progressed through communications and engagement with wider stakeholders and members of the public. More detail on the communication with wider stakeholder was requested, and it was advised a further update will be provided at the next meeting.

Action: Director of Finance & Strategy

The Committee **noted** the establishment of the Population Health and Wellbeing Portfolio Board and progress of the development of the strategy.

7.2 Joint Remobilisation Plan 2021/22 (RMP)

The Director of Finance & Strategy provided an update on progress of the Joint Remobilisation Plan for 2021/22.

The Scottish Government (SG) have approved the previous iteration of the RMP3 and have acknowledged that planning is an ongoing activity. A delivery planning template has been issued from the SG for completion by the end of September 2021 and this will be completed as part of the RMP4. The RMP4 will include key deliverables agreed within the RMP3, and any additional actions or material changes envisaged in terms of those being delivered towards the latter part of 2021.

SG have not requested a separate winter plan, and thus this will form part of the RMP4 submission. Discussions are underway to form the winter plan element, and this will be developed in the context of the current level of challenges within the services, particularly social care, and staff workforce capacity.

An action tracker is being developed with key actions and progress on deliverables, and updates will be provided to the Executive Teams, Committees and to the Board (by exception only).

The Committee **noted** the Joint Remobilisation Plan 2021/22 and process in place for production of the RMP4.

7.3 Review of Health & Social Care Integration Scheme

The Divisional General Manager provided an update on the Review of the Health & Social Care Integration Scheme and noted a full review has been carried out, with detailed input from partners over a timescale that had been lengthened by Covid pressures.

No significant changes to the scheme were required, and it is now required to be approved by NHS Board and Fife Council Board.

More clarification was requested on the financial implications in terms of the risk sharing arrangement. It was advised that the Finance, Performance & Resources Committee have scrutinised the financial aspects and recommended approval to the NHS Board, and that this area is not within the remit of the Clinical Governance Committee. The Director of Finance & Strategy nevertheless provided assurance and advised significant progress had been made in terms of moving risk share positions, and it was agreed the historic resource transfer will not form part of the risk share. It was advised more timely financial planning has been written into the agreement, and an early indication of funding year-on-year should be provided and agreed by both parties by the Quarter 3 of the financial year, to limit the use of the risk share arrangement in future. It was noted the risk share is split and is more closely aligned to level of contribution from each of the partners.

The Committee **recommended** the revisions to the Integration Scheme to enable NHS Fife Board to formally approve this prior to it being submitted to Scottish Government for Ministerial approval.

7.4 Robotic Assisted Surgery Assurance Report

The Medical Director provided a comprehensive update on the Robotic Assisted Surgery Assurance Report and outlined the benefits and enhancement to the patient experience.

It was emphasised the Robot is to be used only to enhance the patient experience and recovery and will not form part of every operation.

One surgeon from each speciality is expected to be authorised for Robotic surgery in the coming week, and it was reported this is positive progress. To date, the Robot has been used during 12 operations, and this has resulted in a significant reduction to the patient's length of stay.

Following a question on financial sustainability, and continuing and developing with the plans, it was advised more work is required in developing the Robot, and the financial aspect will be discussed further through the Finance, Performance & Resources Committee. A fuller understanding of the longer-term costs is required, which would incorporate how often it is used, and savings made. The Director of Finance & Strategy advised the Finance, Performance & Resources Committee endorsed the full business case for the Robot. An explanation was provided on the Robot being procured whilst the business case was in development, due to the time-limited availability of government funding, and further detail is provided in the paper.

In terms of capital funding support, additional Robots may be available. The detailed financial strategy will come to the Clinical Governance Committee for assurance on the patient-related aspects.

Following a question on safeguarding for sterilisation and instruments, it was advised procedures are in place anytime the Robot is out of order, and patients will continue

to get a standard level of care, even if their surgery does not make use of the device. It was noted national capital to support the business case is being explored for robotic decontamination and instruments, in Fife. A National Group are looking at decontamination across Scotland, and a representative from NHS Fife sits on the Group.

It was highlighted one of the key benefits of the business case is the offering of the robotic service and enhanced staff training in Fife. If this was not offered, there is a risk that specialist staff will go to another Health Board where that training is available.

The Regional position with Robotic surgery was provided and noted a strong business case was provided to bring a Robot into Fife. It was noted there are four Robots in the Region.

The Committee commended all involved in the work of establishing robotic assisted surgery.

The Committee **noted** the assurance from the Medical Director regarding the introduction of Robotic Assisted Surgery in NHS Fife and **endorsed** the Robotic Assisted Surgery Clinical Governance Assurance report.

8. QUALITY / PERFORMANCE

8.1 Integrated Performance & Quality Report

The Medical Director provided an update on the Integrated Performance & Quality Report (IPQR) and advised there were no areas of concern, with some areas under close observation.

The Director of Nursing advised there is an improvement in falls, and a Falls Champion Network is being developed.

The importance of maintaining communication to complainants in delays to responses was highlighted. Due to the pressures on the workforce, it has been agreed to pause some complaint activity. The Clinical Services are committed to continue dealing with complaints and have been advised they can pause if required due to pressures. The Patient Relationships Department have been communicating with complainants on extending response times. Recording in Datix is being carried out when an extension to a response has been provided. It was advised all Health Boards are in a similar position. It was also advised the Scottish Government are content with the current position on complaints.

The Committee **examined** and **considered** the NHS Fife performance.

8.2 Healthcare Associated Infection Report

The Director of Nursing provided an update on the Healthcare Associated Infection Report (HAIRT) and reported NHS Fife is below the Scotland comparison in healthcare associated infection, and this is a testament to the hard work of the teams.

An inspection was carried out in May 2021 at Victoria Hospital and the report was positive. Two requirements were reported: testing of patients within five days and

equipment and state of repair in the Ward in the Tower Block. Both requirements have now been addressed, and an action plan is in place.

Following a question, it was advised the National programme of Surveillance for Surgical Site Infections is still currently on pause nationally.

The Committee **noted** the HAIRT report.

9. DIGITAL / INFORMATION

9.1 Digital Strategy 2019-2024 Update

The Associate Director of Digital & Information provided an update on the Digital Strategy 2019-2004 paper, which focusses on the delivery plans to implement the strategy.

Delivery of each of the strategic ambitions - Modernising Patient Delivery, Joined Up Care, Information and Informatics, Technical Infrastructure and Workforce and Business Systems - were outlined

The Digital and Information Team were thanked for their hard work in supporting and protecting staff to deliver in a safe environment.

The Committee **noted** the Digital Strategy 2019-2024 update.

9.2 Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme

The Director of Pharmacy & Medicine provided an update on the HEPMA Programme and advised the final version of the HEPMA Programme is expected in October 2021.

The status of the programme has been moved from green to amber, due to delays in contractual negotiations, as described to members.

An update on progress was provided, including project actions, which are ongoing; communication and engagement strategies across the organisation; patient journey mapping; and change management activity. Key leadership posts are outlined in the paper.

Background to the programme is outlined in the paper, and it was reported delivery of timelines is being closely monitored. The overall transformation benefits of HEMPA were highlighted.

Following a question on NHS Orkney supporting the HEPMA Programme Board with procurement tasks since June 2021, it was advised this support is continuing to ensure consistency of approach. There has been a number of vacancies in the NHS Fife procurement function for some time, and work is being carried out to scope out different roles to attract more candidates.

The Committee **noted** the update on the Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme.

9.3 Safer Management of Controlled Drugs

The Director of Pharmacy & Medicine outlined the report on the Safer Management of Controlled Drugs Report, which covers the period April 2020 – March 2021. The paper is provided to the Committee for an update on the situation and to provide members with assurance.

It was reported a Regional Controlled Drugs Local Intelligence Network has been established, and the benefits are already visible due to the sharing of information.

It was advised an independent pharmacy audit is carried out every six months in all clinical areas that hold drugs, and action plans developed. 100% compliance was reported in all areas audited and it was a noted the audit is extensive.

Work has been carried out to ensure there is sufficient authorised witnesses for the destruction of controlled drugs. Standing operating procedures have been improved, which provides clarity and easier training.

External regulator inspections for Community pharmacies are carried out from the General Pharmaceutical Council. Their focus is on new premises and where standards have not been met previously.

It was advised there has been a decrease in the reporting of incidents compared to previous year, and the potential causes are described in the paper.

Challenges around administration were reported, and a lot of work has been carried out in terms of education, training and follow ups to improve in that area.

It was reported an extensive review is being carried out over the next six months on the safer use and management of controlled drugs. A newly developed tool will support recording of performance. It was advised monitoring and the usage of data around controlled drugs has matured.

Following a question on how medicines are prescribed and the generic name versus the branded name, it was advised this is challenging and generic prescribing is being encouraged.

The Committee **noted** the ongoing activity and developments to support the safer management of Controlled Drugs in NHS Fife.

10. LINKED COMMITTEE MINUTES

All items under this section were taken without discussion and the Committee **noted** the following Committee Minutes.

10.1 Acute Services Division Clinical Governance Committee *(dated 21/07/21)*
10.2 Fife Drugs & Therapeutics Committee *(dated 11/08/21)*
10.3 Fife IJB Clinical and Care Governance Committee *(dated 02/06/21)*
10.4 NHS Fife Clinical Governance Oversight Group *(23/06/21)*
10.5 Digital and Information Board *(dated 20/04/21)*
10.6 Infection Control Committee *(dated 02/06/21)*
10.7 Public Health Assurance Group *(dated 08/06/21)*

10.8 Area Medical Committee *(dated 08/06/21)*
10.9 IRMER Board Minutes *(dated 20/08/21)*

11. ITEMS TO NOTE

11.1 Internal Audit Report: Digital & Information Governance Arrangements

The Committee **noted** the findings of the Internal Audit Report for Digital & Information Governance Arrangements.

11.2 Internal Audit Report: Manual Handling Training

The Committee **noted** the findings of the Internal Audit Report for Manual Handling Training.

11.3 Excellence in Care

The Committee **noted** the conclusions of the Excellence in Care paper.

11.4 Health Promoting Health Service Report

The Committee **noted** the conclusions of the Health Promoting Health Service Report.

11.5 Corporate Calendar / Committee Dates

The Committee **noted** the proposed meeting dates for 2022/23.

11.6 Clinical Governance Committee Workplan

The Committee **noted** the up-to-date Clinical Governance Committee Workplan for 2021/22.

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

It was **agreed** to commend the work in introducing Robotic Assisted Surgery to the NHS Fife Board. The committee also **agreed** to commend the significant progress in relation to the Digital Strategy.

13. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Wednesday 3 November 2021 at 2pm via MS Teams.

KEY:	
	Deadline passed / urgent
	In progress / on hold
	Closed

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Wednesday 3 November 2021

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	17/09/21	**Board Assurance Framework – Quality & Safety**	Full updates are being collated for each of the high risks from each area of the organisation, and a comprehensive update with recommendations will be provided at the next Clinical Governance Committee meeting and include assurances on associated links.	**CM**	November 2021	22/10/21 – Closed. On Agenda at meeting on 3 November 2021.	Closed
2	17/09/21	**NHS Fife Population Health & Wellbeing Strategy Progress**	More detail on the communication with wider stakeholder will be provided at the next Clinical Governance Committee meeting.	**MM**	November 2021	22/10/21 – Closed. This item has moved to the new Public Health & Wellbeing Committee	Closed
3.	07/09/20	**Situation report for combining of key plans and programmes**	Executive Directors' overview, when completed, to be brought back to the Committee to understand how things will be managed across the Health Board & H&SCP.	**SF**	To remain on Action List until Pandemic settles.	18/08/21 - Oversight and Leadership of the key programmes in Fife will be given by the newly established Population Health and Wellbeing Portfolio Board. The governance of this board is proposed to the newly formed Public Health and Wellbeing Committee. 15/10/21 – Closed. The Remobilisation Plans have brought together all the plans into one action plan. Escalation of any action that will not be delivered on time will be through EDG and Committees.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**FVCV Programme Delivery Update**
Responsible Executive:	**Nicky Connor, Director of Health and Social Care**
Report Author:	**Lisa Cooper, Immunisation Programme Director**
	Emma Strachan, FVCV PMO Project Manager

1 Purpose

This is presented to the Clinical Governance Committee for:

- Information
- Discussion

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

National programme board updates, JCVI and CMO guidance directs the effective planning and delivery of the FVCV programme Tranche 2 now known nationally as the Autumn/Winter Vaccination Programme. NHS Fife Clinical Governance Committee is asked to review and consider in regard to this, the delivery models for the population of Fife detailed within this paper.

2.1.2 Flu / Covid 19 Booster/Third Dose Delivery (Tranche 2)

Advice from the Joint Committee on Vaccination and Immunisation (JCVI) has now been received regarding the time period for Covid -19 Booster vaccinations.

The time period of 182 days between second doses and boosters/third doses as originally guided, has now changed to 24 weeks (168 days), the vaccine product will be Pfizer and

evidence indicates that co-administration of both vaccinations is safe, well tolerated and does not reduce the immune response.

2.2 Background

While the COVID-19 vaccination continues to progress with newly identified cohorts in Tranche 1, the Board has now begun both Flu and Covid-19 booster vaccinations across Stage 1 of Tranche 2 which commenced Monday 6th September.

Following the recent direction from Scottish Government and guidance received from JCVI, the Board has been able to formalise a number of planning assumptions for ongoing Tranche 1 and progressing to Tranche 2 delivery as outlined below.

Autumn/Winter Vaccination Programme

2.2.1 Tranche 1 Delivery:

All adults over the age of 18 have been offered a first dose of COVID vaccine and this was completed 18 July 2021.

The programme has been effective so far for the population of Fife and at time of writing has now delivered 560k doses now administered in Fife with 12217 individuals having received their full course + booster

The programme has three remaining key priorities:

- Ensuring second doses are given at 8 weeks for those who have received first doses
- Ensuring first doses are to continue for the following groups
    - Those recovering from COVID (as vaccination cannot be administered until 28 days' post infection)
    - Ensuring there is an 'Evergreen' option – allowing those who for whatever reason have not previously been vaccinated or come of age during the programme, to ensure they receive a full course. This is being offered through a series of pop ups and outreach activity

- Children/young people in the following groups

    - **All children aged 12 to 15 years of age not known as a universal offer**

      The universal offer for children continues and at time of writing 9179 (55%) of 12-15s have accessed their first dose by attending either a drop in or scheduled appointment. This is in line with national averages. Ongoing drop in will be scheduled and an in reach school programme is being planned but cognisance of consent issues and how to manage these need to be factored within planning.

    - **All children aged 16 to 17 years of age**

      At time of writing 5616 (72%) have accessed their 1st dose and 818 (10%) have accessed a second dose. There were accessed via scheduled appointments, drop ins and a bespoke in reach programme to all secondary schools and colleges across Fife. Drop ins and appointments will continue

- Children and young people aged 12 years and over who are household contacts of persons (adults or children) who are immunosuppressed.

Nationally there are issues to extract the detail of this cohort specifically so they are reported within the other relevant age group cohorts.

2.2.2 Tranche 2 Delivery:

A two-stage approach has been instructed in delivering COVID-19 booster/third doses and flu vaccinations, resulting in several cohorts, originally delivered independently of each other, being grouped together, and delivered concurrently.

The two stages are:

Stage 1 (offered a third dose of COVID-19 vaccine and the annual flu vaccine, as soon as possible from September 2021):

- adults aged 16 years and over who are immunosuppressed
- those living in residential care homes for older adults
- all adults aged 70 years or over
- adults aged 16 years and over who are considered clinically extremely vulnerable
- frontline health and social care workers

Stage 2 (offered a third dose COVID-19 vaccine as soon as practicable after Stage 1, with equal emphasis on deployment of the flu vaccine where eligible):

- all adults aged 50 years and over
- all adults aged 16 – 49 years who are in an influenza or COVID-19 at-risk group
- adult household contacts of immunosuppressed individuals

Planning for delivery for all cohorts within stage 1 of Tranche 2 is complete and detailed further. Planning for stage 2 is at an advanced stage and remains based on the planning assumptions provided nationally with workstreams being anticipatory as possible ensuring a cohesive and joined up approach to planning and agreeing models for delivery.

Recent direction and guidance received, has allowed the Board to proceed with formalising planning based on scenario one which was previously presented and key aspects are outlined below.

Appendix one details the Tranche 2 delivery plan submitted to National Programme Board 24/09/2021. This is evolving in line with national direction and planning assumptions.

Appendix 2 contains the CMO letter SGHD/CMO(2021)28 providing further information and guidance relating to the seasonal flu immunisation programme.

2.2.3 Stage 1

Prioritisation of the cohorts within this stage remains aligned with the initial cohorts 1-9 advised by the JCVI. Delivery of vaccine will be via co-administration to all priority groups before 24th October 2021, due to wider public groups becoming eligible at this point for co-administered vaccinations. The directive has been extended by SG from 06/12/2021 and complete flu vaccinations are now to be completed by 19th December 2021.

In consideration of the timescale for delivering Flu and national working assumptions of 80% uptake, it has been identified that a total number of 185,882 citizens are eligible for receiving a Flu vaccination. Those eligible in stage 1 will receive both vaccinations at the same appointment. This presents significant efficiencies and Fife has recruited a substantive workforce which would be sufficient to staff community clinics and the HSCWs clinics.

2.2.4 Scheduling

There are various methods for which stage 1 cohorts will be appointed. Some will be appointed locally e.g. care homes residents, housebound and some people within the over 80s group (dependant on the delivery plan aligned to their general practice). The remaining cohorts will be appointed via lettering from NVSS excepting Health and Social Care staff as advised in next paragraph.

The national scheduling system is now being used for staff, with registration via an online portal which was released 21st September for staff to register. This is a change to the previous model which involved local scheduling. For members of the public, the existing national scheduling system will be used with local teams responsible for preparation of cohort files, and resolving any operational issues. Venues for staff and public clinics have been identified, incorporating learning from the COVID programme and including appropriate accessibility for the target groups.

Appendix one details how each cohort will be appointed.

A recent national change in direction for stage 2 cohorts including appointing models has been agreed and circulated. This is available to view in **appendix 3.** The main points to be aware off are that appointments for cohort age 60-69 and aged 16+ who are considered clinically extreme vulnerable will be via national lettering and not the online portal initially proposed. The main reason for change was to manage agreed risks to delivery plan and dates which a mixed model for appointing may create for these cohorts. The Programme team are supportive of this approach and planning is now being adjusted to manage this with no risks perceived.

2.2.5 Communications

Communications are closely linked into the national direction applying national toolkits provided with adaption locally and the team have established a range of channels, with lessons learned from the COVID programme to ensure effective, timely and targeted communications.

Further communications specific to staff vaccinations have now being agreed by programme leads and distributed via available channels to ensure there is clarity for all staff on the registration process and eligibility criteria.

Stage 1 Delivery Progress

2.2.6 Childhood Flu Vaccinations

The vaccination of this cohort commenced 3rd September. Some challenges have been experienced due to significant high levels of pupil absence within schools. Uptake therefore is currently not as high as expected at this stage with only 7858 children and

1205 teaching staff (30%) of those having responded from the overall cohort size, having been vaccinated to date. A high level breakdown of this data is as follows,

- Children 2-5 years old: 1382
- Primary School Children: 2919
- Secondary School Children: 9875
- Primary School Teaching Staff: 288
- Secondary School Teaching Staff: 1300

Vaccinations for Secondary School children is due to complete early November with the 2-5 age group and Primary School children due to be completed early December. Due to the current challenges with absence, extended mop up sessions will be required to ensure all children are vaccinated. As SG have extended target completion date now till 19/12/2021 the programme team are assured that working assumptions are achievable and are reviewing detailed delivery plans to target areas of reduced uptake.

2.2.7 Care homes

Care home vaccinations for residents and staff commenced 27th September and completed 15th of October. There are **2293** individuals within this cohort and a dedicated workforce team is in place to deliver the vaccinations. To date, a total of **4333** vaccinations have been delivered, split by **2278** Flu vaccinations and **2055** Covid-19 boosters. This equates to approx 94% of the care home resident population having received both vaccines and is well above current national average. This is suggested as excellence in care to ensure a targeted approach to vulnerable members of our society. Mop up sessions will continue for those who were unable to be vaccinated at time of writing.

2.2.8 Frontline Staff

Flu and Covid-19 booster vaccinations commenced 28th September with an expected completion date of 29th October. An overall cohort size of 20016 was anticipated, based on those vaccinated during Tranche 1. Staff have been invited to self-register via the national online portal for their vaccinations. This is applicable for all Frontline healthcare and social care workers aged 16 and over, providing staff with the opportunity to check their eligibility and book an appointment immediately.

Currently, a total of 16230 vaccinations have been administered split by 8199 Flu Vaccinations and 8031 Covid-19 vaccinations.

There are known national issues with the online portal registration for HSCWs with no resolution identified as yet. To manage this locally the team have offered local bespoke drop in staff sessions and leaders and managers across health and social care have acted as the conduit alongside other established comms channels to reach out to all staff to encourage uptake. Assurance is given this focused approach to scheduling and comms will continue to encourage uptake for all staff eligible for either covid, flu or both vaccines.

The programme team seek ongoing support of leaders and managers across health and social care to ensure that access to the Autumn/Winter flu programme for HSCWs remains a high priority.

2.2.9 Severely Immunosuppressed

JCVI guidance advises people with a condition which means there are severely immunosuppressed (SI) are to be invited to access a Primary 3rd dose of a Covid vaccine.

Following national agreement, this cohort was identified as a subset of the previous shielding list. Following national lettering and appointing via NVSS, vaccination of this cohort commenced 2nd October with completion the following day on the 3rd October. The overall cohort size was 2954. Following a review from JCVI of persons eligible as classed as SI, a SLWG is now being convened led by the Immunisation Coordinator to liaise with clinicians locally and ensure all persons within this cohort who will required a 3rd dose as per JCVI guidance are invited to receive one.

The Fife programme leads identified a recording issue within the electronic system being used nationally regarding correct record keeping for those accessing a 3rd primary dose as opposed to a booster. Should JVCI guidance advise a booster for this cohort, there is a perceived risk with digital identification. Fife now have a local repatriation process agreed and are linking with the national programme board to share learning.

2.2.10 Over 80s population

Extensive and complex yet highly effective engagement work has taken place with GP practices to agree vaccination of the over 80's group. Three options were proposed to GP practices and programme leads have worked through and agreed a detailed plan for delivery which is now live.

The three options are that the practice itself wholly delivers all vaccines, option 2 is a blended model shared between the practice and the health board and option 3 if the practice for various reasons has no capacity to support delivery it will be delivered wholly by the board.

For those patients of practices that have chosen a blended or Board delivery model, appointing is via NVSS lettering or local appointing. A person centred approach has been taken during the venue selection process to ensure vaccination appointments are assigned to individuals within a location as close to their GP practice as possible.

Vaccine supply for Covid-19 booster doses will be managed by the Board and ordered via a pack down service offered by NSS for those GP practices choosing to deliver vaccinations themselves. Flu vaccine supply will be ordered by GP practices directly from Movianto.

It should be noted that it has been agreed within the Programme that those GP Practices delivering their patient vaccinations can also administer vaccinations to their staff. For those practices unable to vaccinate their patients or opting for a blended model, staff will be guided to book their vaccinations via the national self-registration portal and attend one of the community clinics for their vaccinations.

A summary of the status of GP practice option response and the vaccination delivery plan for the over 80s cohort is detailed in table 1 below.

Table 1

Option 1: Delivering Vaccinations in Practice	
No. of Practices	23 practices have selected this option. Please note that this includes those practices who have 2 branches to accommodate. There are approximately 6760 patients within this option to be vaccinated.
Timescale	Clinics commence early October with majority of activity completing by early to mid-November. Some mop up clinics have been planned for late November and into December to accommodate the time period between doses for some patients.
Progress	• 20 practices have confirmed their clinic dates and vaccine supply requirements • Vaccine supply ordering commenced 24th September
Option 2: Blended Model - Delivering vaccinations with support from Board	
No. of Practices	8 practices have selected this option. There are approximately 1817 patients within this option to be vaccinated.
Timescale	Clinics commence early October with activity currently planned to be completed by mid-November.
Progress	• 5 practices have confirmed their clinic dates and vaccine supply requirements with work being finalised with remaining 3 practices • Vaccine supply ordering commenced 24th September
Option 3: Board delivering vaccinations	
No. of Practices	25 practices have selected this option. There are approximately 6000 patients within this option to be vaccinated.
Timescale	Clinics commence early October with activity currently planned to be completed by mid-November
Progress	• 23 practices have now responded with their patient data to allow for local or national appointing of their patients • Venues and clinic dates for those 23 practices have now been assigned • Appointing methods and patient data currently being worked through for all patients across the practices

The NHS Fife communication team have worked closely with the FVCV programme team, primary care and general practice colleagues to ensure a detailed bespoke communication plan as it was realised that there was risk around public awareness and expectation. The NHS Fife website is now updated with a specific over 80s delivery page with detailed information for each practice. The link below provides more detail. Each practice is also updating their telephone messaging accordingly with a consistent approach to scripting being lead by the programme team in conjunction with primary care colleagues.

Over 80s COVID-19 vaccination booster | NHS Fife

2.2.11 Housebound

The programme is working closely with community nursing teams and the vaccination teams to facilitate vaccinations for persons within the housebound group with plans now complete to enable and assure safe delivery. Flu and Covid-19 booster vaccinations will be decoupled for this cohort with District Nursing teams delivering Flu vaccinations and Covid-19 booster vaccinations being delivered by a dedicated workforce team.

The rationale for decoupling is primarily due to the logistical challenges posed by administration of Pfizer vaccine and the impact and risk to community nursing capacity. A dedicated team to administer the Covid -19 vaccine will mitigate this risk. Overall there is no perceived clinical risk to decoupling and this has been considered and assured via clinical leads within the programme board.

Expected cohort size is 4209 based on GP practice data received to date with delivery planned through October. It is currently planned for the vaccination of this cohort to be completed by end of October.

Stage 2

It is planned for as many co-administered vaccination appointments to be offered, as possible, before the 19th December 2021 taking the JCVI guidance of 24 weeks (168 days) between second doses and boosters/third doses into consideration.

It is important to note that individuals who will require to be 'de-coupled' due to their Covid booster not being due until after the expected flu completion date, will have their flu vaccination appointment brought forward to ensure flu delivery timescales can be achieved planning is allowing this to be a focused approach within a specific week of the programme.

2.2.12 Vaccine Administration

It has now been confirmed that Flu and COVID-19 boosters/dose 3 can be administered during the same appointment however JCVI advice to delivery teams has stated that both should be administered at the earliest possible time. This could result in both vaccines being administered independently of each other and this is being considered within planning assumptions.

JCVI guidance released has also confirmed that COVID-19 boosters/third doses should be administered 24 weeks (168 days) after the second dose.

2.2.13 Vaccine Product

Clinical guidance from JCVI is confirmed on the vaccine product which will be administered for COVID-19 booster/third dose. Guidance received has indicated that Pfizer should be administered for all boosters/third doses within Fife, regardless of vaccine product received for doses one and two. It has been confirmed nationally that the 15-minute waiting period will remain for Pfizer vaccinations administered as a booster.

2.3 Assessment

2.3.1 Quality/ Patient Care

At time of writing, the Board has now exceeded 562k total doses administered in the COVID vaccination with a focus currently on the 16-17 and 12-15 groups and those under 40 still to access 1st and 2nd dose within tranche 1. The outreach programme continues with a number drop in clinics continually in operation across the community. Drop ins are planned to continue to allow ongoing open access for Tranche 1 vaccine delivery e.g. those still to

access 1st or 2nd dose. Drop ins will be scheduled at times when planning activity allows and advertised via current channels including NHS Fife website. It is anticipated that drops ins will not be available for Tranche 2 delivery at this time in line with national programme board guidance. An assessment of these is ongoing to determine the future approach to pop up and outreach activity to ensure uptake and results are maximised.

Work is now completed involving General Practice and good engagement with the Local Medical Committee to mitigate concerns regarding the over 80s cohort and support flu and Covid vaccine delivery close to home. These are transitional arrangements supported by National Temporary and Direct Enhanced Service agreements while the Vaccination Transformation Programme (VTP) is progressed to completion.

2.3.2 Workforce

The board currently has 217 Healthcare Support Worker Vaccinators (band 3) recruited, trained, and actively administering across our community clinics under the supervision of registered nursing staff working within national protocols. The clinics have operated well due to the implementation of strong clinical leadership ensuring structure and stability throughout the programme. This approach has been considered as part of the workforce planning assumptions for FVCV with activity currently focused on the future workforce modelling to identify potential recruitment requirements.

There are agreed risks regarding the sustainability of the workforce in the longer term: many are contracted to March 2022. Workforce planning is at an advanced level, with focus currently on specialised sub groups for individual cohorts including, housebound and inpatients.

Military Aid to Civil Authority (MACA)

Military Aid to Civil Authority (MACA) support has also been offered via the national programme board to assist with the programme due to the recent new guidance released. This could include registrants, health care support worker equivalents and venue support.

22 vaccinators have been requested to cover two of the larger venues which includes a leadership role for each site. Expected date of commencement is 28th October with a review planned every 5 weeks. This has been agreed in principle however official confirmation and approval has yet to be given by the UK Government. Indemnity cover has been provided at board level and was drafted locally with input from Central Legal office, Chief executive sign off has been completed and submitted accordingly to the National Board and Ministry of Defence.

2.3.3 Financial

The programme continues to work closely with Finance colleagues to track and report on expenditure. Additional costs identified throughout the planning stages of the FVCV programme will be reported accordingly. This is complex to manage and a cohesive approach to ensure effective financial governance of all programmes is evolving.

2.3.4 Risk Assessment/Management

There are currently 29 risks identified for the FVCV programme, with only one of those currently carrying a high risk level. A robust risk review process is in place where risks are reviewed fortnightly across key leads of the programme.

The direction from Scottish Government notes that the 2021/22 flu season in the UK could be up to 50% larger than typically seen, and may also begin earlier than usual. This highlights the importance of a robust and early approach to vaccination.

One of the primary risks identified locally has been use of the national vaccination scheduling system, which has encountered a range of operational difficulties over the last 7 months. The direction nationally is to continue use of this system. Local resilience around its use will continue to be a focus however from a governance perspective the use of the NVSS system is recognised as best practice nationally and locally to support effective appointing

2.3.5 Equality and Diversity, including health inequalities

A robust EQIA was established within the COVID-19 programme through strong links with Public Health and partner organisations. The Fife approach to inclusivity and resulting EQIA was noted as an example of best practice at the National Programme Board. Assessment of the EQIA for the FVCV programme is underway by utilising the strong links already established and developed accordingly for the wider immunisation programme. The established inclusivity group will continue to lead delivery of EQIA actions. A full review is important given the move towards further cohorts being eligible.

2.3.6 Communication, involvement, engagement and consultation

Weekly communications continue to be issued to elected members and monthly communications are now issued to NHS Fife staff. Communications pathways have been established and documented within the programme and work is underway to assess these pathways, ensuring strong relationships are maintained and continue to work effectively within the FVCV programme.

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.

- Executive Directors Group – 4 October 2021

2.4 Recommendation

NHS Fife Board Clinical Governance Committee is asked to **note** the detail in the paper regarding the assurance for ongoing planning and delivery of the Autumn/Winter Vaccination plan, **discuss** and **support** the Programme team in the delivery of this.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Health Delivery Plans – September 2021
- Appendix 2 – CMO letter SGHD/CMO(2021)28
- Appendix 3 – National delivery plan update 14/10/21

Report Contact
Lisa Cooper
Immunisation Programme Director
Email Lisa.Cooper@nhs.scot

Appendix 1

Health Board Delivery Plans – September 2021
Autumn / Winter – Flu & Boosters

Cohorts	**Delivery Setting** • Please confirm how you will deliver each cohort, for example, mass vaccination / GP / Community Pharmacy	**Appointing Method** (if applicable) • NVSS letter, other letter, online booking, Other (please specify)	**Start Date**	**Projected Completion Date**	**Cohort Size**
2-5 Flu	Nursery	Locally	13 September	6 December	
Childhood Flu (Primary)	Primary School	Locally	13 September	6 December	28,354[(1)]
Childhood Flu (Secondary)	High School	Locally	20 September	5 November	21,591[(1)]
12-15 (at risk)	Local Clinics	Locally	August	24 September	289[(2)]
12-15 (universal offer)	Vaccination Clinics	NVSS	2 October	11 October	17,242[(2)]
Severe Immunosuppressed	Vaccination Clinics	NVSS	2 October	3 October	2,954[(2)]
Care Home residents	Care Homes	Locally	27 September	15 October	2,266[(2)]
Housebound Patients	Domiciliary	Locally	5 October	22 October	4,209[(3)]
Frontline H&SCW	Vaccination Clinics	NVSS Online Booking	29 September	29 October	*20,016* *(4 see footer)*
Over 70's	Vaccination Clinics & GP's	NVSS (under 80s and some over 80s) Locally (variable dependent on GP Practice)	9 October	14 November	60,162[(2)]
All adults aged over 16 with underlying health conditions / Adult	Vaccination Clinics	NVSS	25 October	21 November	Underlying heath conditions - 26,251[(2)] Household Contacts – 15,957[(5)]

household contacts of immunosuppressed individuals					
50 years old or over	Vaccination Clinics	NVSS Online Booking	25 October	6 December for coupled vaccinations January for those returning for COVID Boosters	107,177[2]
Non Frontline HSCW's (Flu Only)	Vaccination Clinics	NVSS Online Booking	29 September	6 December	*20,016[4 see footer]*
Teachers, Nursery Teachers, School staff	School Settings / Pharmacy	Locally Arranged or visit Pharmacy	In line with school delivery	In line with school delivery	unknown
Prison population	n/a				

Projected Volumes per week

	W/k 20/9	W/k 27/9	W/k 4/10	W/k 11/10	W/k 18/10	W/k 25/10	W/k 1/11	W/k 8/11	W/k 15/11	W/k 22/11	W/k 29/11	W/k 6/12
Flu		**15300**	**12896**	**16110**	**9000**	**28521**	**23500**	**33650**	**46442**	**7441**	**7400**	**3496**
Covid		**12912**	**19778**	**14978**	**10369**	**24265**	**18989**	**30250**	**250**	**31250**	**24750**	**15250**

1. https://www.gov.scot/publications/school-level-summary-statistics/ - 2020 total p1-p7 for primary, s1-s6 for secondary for schools in Fife local authority area
2. From NCDS cohort lists
3. Collated lists of Housebound from each GP practice. Responses received from 35/54 totalling 2,728 housebound so overall total includes projection.
4. Total vaccinated at staff clinics during Tranche 1, not possibly to distinguish front line from other roles.

Appendix 2

Chief Medical Officer - final version - SGHD

Appendix 3

National Delivery plan update 14.10.21

Chief Medical Officer Directorate

E: SeasonalFluProgramme@gov.scot

The Scottish Government

Dear Colleagues

SEASONAL FLU IMMUNISATION PROGRAMME 2021/22

1. We are writing to provide you with further information about the adult and childhood seasonal flu immunisation programmes for 2021/22.

2. We would like to begin by thanking you for your exceptional work in delivering the COVID-19 vaccination programme. We understand the extreme challenges faced by colleagues in NHS Boards and social care across Scotland in developing plans to deliver the largest scale vaccination programme ever planned and delivered here.

3. You are already aware that Scottish Ministers have extended the eligibility of the seasonal flu immunisation programme this winter.

4. Given the ongoing impact of COVID-19 on the most vulnerable in society, it is imperative that we continue to do all that we can to reduce the impact of flu and COVID-19 on those most at risk, through vaccination. With the enormous success of the COVID-19 vaccination programme, as we enter flu season, it is more important than ever that we build on the success from last year's vaccination programme. These efforts will help us to prevent ill health in the population and minimise further impact on the NHS and social care services.

Planning and Delivery

5. We recognise that delivering the flu vaccination programme this year will be an immense challenge because of the impact of COVID-19 on our health and social care sector. We appreciate that you will draw on your experience with

From Chief Medical Officer
Interim Chief Nursing Officer
Chief Pharmaceutical Officer
Dr Gregor Smith
Professor Alex McMahon
Professor Alison Strath

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7 October 2021

SGHD/CMO(2021)28

For action
Chief Executives, NHS Boards
Medical Directors, NHS Boards
Nurse Directors, NHS Boards
Primary Care Leads, NHS Boards
Directors of Nursing & Midwifery, NHS Boards
Chief Officers of Integration Authorities
Chief Executives, Local Authorities
Directors of Pharmacy
Directors of Public Health
General Practitioners
Practice Nurses
Immunisation Co-ordinators
CPHMs
Scottish Prison Service
Scottish Ambulance Service
Occupational Health Leads

For information
Chairs, NHS Boards
Infectious Disease Consultants
Consultant Physicians
Public Health Scotland
Chief Executive, Public Health Scotland
NHS 24

Further Enquiries
Policy Issues
Vaccination Policy Team
seasonalfluprogramme@gov.scot

Medical Issues
Dr Syed Ahmed
St Andrew's House
syed.ahmed@gov.scot

Vaccine Supply Issues
nss.vaccineenquiries@nhs.scot

COVID-19 and be mindful on how best to deliver a vaccination programme that is prioritised towards protecting the most vulnerable.

6. It is a key priority to encourage greater uptake amongst health and social care workers, including Independent Contractors (GP, dental and optometry practices, community pharmacy teams, laboratory staff (working on COVID-19 testing) including support staff, who are delivering patient facing services. An innovative timely approach is required and is critical to safeguard staff, whilst also protecting those in their care.

7. To further increase flu vaccine uptake across all eligible groups, we encourage NHS Boards and social care colleagues to utilise all marketing and learning materials to the greatest extent with particular focus on those who are aged 65 years and over; those aged under 65 years old in an at-risk group, as well as pregnant women (at all stages of pregnancy).

8. NHS Boards are encouraged to use their local and clinical judgement, in line with the Green Book, to vaccinate people experiencing homeless in temporary accommodation, rough sleeping as well as people experiencing drug and alcohol addiction. It is likely that a significant proportion of these people will have underlying chronic medical conditions and are at high risk of flu related complications. NHS Boards have the support of the Scottish Government in doing so.

9. We continue to work closely with the Scottish Immunisation Programme Group to develop vaccination service delivery to ensure that all who will benefit most from the flu vaccine will have the opportunity to receive it in a timely manner, whilst maintaining Infection Prevention & Control practices and appropriate physical distancing. The provision of appropriate Personal Protective Equipment (PPE) to those involved in the delivery of the flu vaccination programme remains an important part of the programme planning. Please refer to the COVID-19 guidance available at: HPS Website - Infection prevention and control (IPC) guidance in healthcare settings (scot.nhs.uk).

10. GPs will participate on an optional basis where NHS Boards have not fully transferred influenza and pneumococcal vaccinations as part of the Vaccination Transformation Programme. This should only be where NHS Boards cannot directly deliver vaccinations through NHS Board employed or engaged staff. GP practices are not the preferred delivery model for vaccinations. This will enable GPs to focus their time on expert medical generalism, whilst ensuring that patients' needs are met through services which will make the best use of the mix of skills in primary care. GP - GP contractual information / payments – link to the Temporary Enhanced Service (PCA(M)(2021)07 - Temporary Enhanced Service - seasonal influenza and pneu. disease - 2021-22) might be useful: Influenza & pneumococcal temporary enhanced service (scot.nhs.uk).

JCVI Advice on Co-Administration

11. The advice from the Joint Committee on Vaccination and Immunisation, on a COVID-19 vaccine booster programme this winter, alongside the vital annual seasonal flu vaccination programme was published on 14 September 2021. People who are eligible for both flu and COVID booster can be given both vaccines at the same appointment where at least 24 weeks has passed since they received their second COVID dose. The details can be found here: JCVI issues updated advice on COVID-19 booster vaccination - GOV.UK (www.gov.uk)

12. The latest information on co-administration of the COVID-19 vaccines with other vaccines can be found in the Green Book, chapter 14a Greenbook chapter 14a COVID-19 (publishing.service.gov.uk).

Other Vaccinations: Pneumococcal and Shingles Vaccination Programmes

13. The Pneumococcal vaccine (PPV23) can be given at any time in the year, whereas flu vaccine must be given within a short period during the winter months. We therefore suggest that maximum efforts should be directed in optimising flu uptake rates and providing timely immune protection of eligible individuals over the winter period.

14. The Shingles vaccination programme for the year 2021/22 commenced on 1 September 2021, as in previous years, and eligible individuals can be immunised from this time. Shingles vaccinations do not have to be delivered at a particular time, and participating practices can deliver these vaccinations at a time which protects their capacity. It is important to note that some of these patients may also be eligible for other vaccines, and staff should take the opportunity to offer these vaccines opportunistically, if appropriate. The Shingles CMO letter can be accessed here: CMO(2020)21 - Details of the shingles (herpes zoster) vaccination programme (scot.nhs.uk). Further information about the programme will be issued shortly.

Working Assumptions

15. Seasonal Flu Immunisation Programme 2021/22 uptake working assumptions are:

Cohort	Uptake Working Assumption
65 and over	90%
Children Aged 2-5	70%
Primary School Aged Children	80%
Secondary School Age Children less than 18 years	80%
Under 65 years old in an at-risk group	65%
Pregnant women(with & without risk factors)	70%
Health & Social Care Staff	80%
Unpaid and young carers	75%
Independent NHS Contractors, (GP, dental and optometry practices, community pharmacists, laboratory staff working on COVID-19 testing) including support staff	80%*
Teachers, support staff, Prison staff and support staff operating the detention estate.	60%*
Prison population (Fluctuates daily – approximate figure provided. Population may also be included in cohorts above.)	60%
50-54 not at risk	65%
55-59 not at risk	65%
60-64 not at risk	65%

* Guidance on how NHS Boards are to record uptake figures for these cohorts, due to each of the Boards using different delivery settings, will be shared shortly.

Key Assumptions

16. To ensure the protection of those most at risk from flu this winter, the flu vaccination programme remains a strategic and Ministerial priority. This is to ensure that the impact of potential co-circulation of flu and COVID-19 is kept to an absolute minimum again this season. The above working assumptions are not official flu vaccination targets, and have been put in place for internal Scottish Government purposes, and to ensure that sufficient vaccine stock is procured to protect those most at risk of flu.

17. For the 2021/22 adult flu vaccination programme an online registration and booking service went live on 21 September 2021 and is available for Health and

Social Care Workers. This service which, offers co-administration bookings where possible. The portal can be accessed here: Vaccinations for health and social care workers | NHS inform. This is in response to last winter's low uptake in this group and an early offer of flu vaccination at the start of the programme may increase uptake.

18. Based on the final JCVI advice regarding COVID-19 boosters published on 14 September 2021, eligible cohorts will be offered co-administration of flu and COVID-19 boosters wherever possible and a CMO letter giving further details is available here: CMO(2021)25.pdf (scot.nhs.uk)

Vaccine supply

19. We have procured additional vaccine to support higher uptake, however, ongoing and effective management at a local level is essential to the success of the programme. NHS Boards and social care services should fully consider the needs of their eligible cohorts and plan appropriately and timeously in order to successfully deliver the programme.

20. In our previous letter, vaccine ordering and delivery arrangements were included and these are set out in Annex A.

    I would ask that NHS Boards and social care colleagues refer to this information for this flu season.

21. To allow us to be responsive to the changing context this winter, we will review the availability of vaccine after uptake levels become clear within existing and expanded cohorts. The Scottish Government will remain in regular dialogue with delivery partners through the Scottish Immunisation Programme Group and will update on any significant developments.

Health and Social Care Workers

22. Timely immunisation of eligible health and social care workers in direct contact with patients/clients remains a critical component in our efforts to protect the most vulnerable in our society.

23. Influenza viruses are notoriously unpredictable, therefore, it is essential that we maintain focus on delivery to achieve higher vaccine uptake, especially in the health and social care worker cohort. This will help to protect individual staff members, but also reduce the risk of transmission of flu viruses within health and social care settings, contributing to the protection of individuals who may have a suboptimal response to their own immunisation. Furthermore, it will help to protect and maintain the workforce and minimise disruption to vital services that provide patient/client care, by aiming to reduce staff sickness absence.

24. Senior clinicians, NHS Managers, Directors of Public Health, Local Authorities and Integration Authorities should ensure this work aligns with the prioritisation already being given to our COVID-19 response to the care sector as a means to prevent transmission of the flu viruses in an already vulnerable group.

Communication materials and Resources

25. Integration Authority Chief Officers and Local Authorities are asked to work closely to communicate and promote the flu vaccination programme and encourage uptake across all cohorts especially in the social care workers group who are providing direct personal care, and to ensure that they are fully supported to access the service.

26. The national media campaign (TV, radio, press, digital and social media) has been developed and further details will be circulated in due course. The childhood flu vaccination campaign commenced on 19 August.

27. Public Health Scotland has developed a toolkit to encourage the promotion of the flu vaccine that will support NHS and Social Care colleagues. Flu immunisations - Immunisations - Our areas of work - Public Health Scotland.

28. Public Health Scotland has developed and published a range of national accessible information materials to support informed consent for all eligible cohorts. The flu vaccine (nhsinform.scot).

29. The public should be signposted to Flu vaccination - Immunisations in Scotland | NHS inform for up to date information on the programme.

30. The COVID-19 Helpline 0800 030 8013 has been extended to include flu enquiries. The helpline will be available from 8am – 8pm (7 days a week).

31. The National Vaccination Scheduling System has been developed and will be used to schedule Flu and COVID-19 appointments. A Self-Registration Portal has been developed to allow greater access to vaccinations and will include the ability to book suitable appointments.

32. Vaccination events should continue to be recorded on the Vaccination Management Tool unless agreed by exception.

Workforce Education

33. NHS Education for Scotland (NES) and Public Health Scotland have worked closely with stakeholders this year to develop and make available a range workforce education resources/opportunities. These are available on the NHS Education for Scotland TURAS Learn website https://learn.nes.nhs.scot/14743/immunisation/seasonal-flu.

Resources

34. NHS Boards are asked to ensure that immunisation teams are properly resourced to develop and deliver the extended programme.

35. Any additional costs related to adapting immunisation programmes to meet COVID-19 requirements (e.g. physical distancing, PPE) should be recorded in

NHS Boards' Local Mobilisation Plans, now called Covid-19 finance returns. This is in the form of a single row figure in the return.

36. A template was issued by Scottish Government Finance on 11 June 2021 to NHS Board Finance leads and returns should be fed back to your Finance Teams. Please ensure that costs are not double counted for services already delivered. NHS Boards are asked to ensure that immunisation teams are appraised of this information.

37. We would like to recognise and express our gratitude for your professionalism and continuing support in planning and delivering this important vaccination programme. Thank you for all your hard work in these most challenging of circumstances.

Yours sincerely,

Gregor Smith	*Alex McMahon*	*Alison Strath*
Gregor Smith Chief Medical Officer	Alex McMahon Interim Chief Nursing Officer	Alison Strath Chief Pharmaceutical Officer

Annex A

ORDERING INFORMATION

Flu vaccines for 2021/22

Vaccine ordering and delivery arrangements

1. Information on ordering and delivery arrangements for the flu vaccine will be provided within further correspondence. Details of the supply arrangements for community pharmacies supporting this year's immunisation programme has been shared directly via relevant NHS Boards.

2. Orders for the flu vaccine should be placed on the Movianto online ordering system - Marketplace: https://marketplace.movianto.com/. Log-in details used in previous seasons remain valid and should continue to be used.

3. If you have any issues with log-in arrangements or if you have new staff who require access to the system please contact Movianto Customer Services on 01234 587 112 for assistance.

4. NHS Boards and GP practices participating in the programme should plan appropriately and place the minimum number of orders needed, taking into consideration available fridge capacity. NHS Boards are charged for each delivery made to practices participating in the programme.

5. NHS Boards and GP practices participating in the programme must ensure adequate vaccine supplies before organising vaccination clinics.

6. When placing orders for the vaccines in Marketplace, practices should search for the type of vaccine required. For example, if vaccines are required for patients aged 18 to 64 these can be found in Marketplace by entering the search term "QIVc" or on the 'Orders' screen. If vaccines are required for patients aged 65 or over, these can be found by searching for "aQIV".

7. To make it simpler for front line staff in the coming season, all NHS Boards will be allocated the same type of vaccine for each cohort e.g. QIVc for most cohorts. Only aQIV should be ordered for individuals aged 65 years and over. Only QIVc should be used for 50-64 year olds, not otherwise eligible due to underlying health condition or employment. Those who are egg-allergic should be offered the QIVc vaccine as detailed above.

8. Vaccines are available in packs of 10. On the ordering platform, please read the vaccine information carefully and order the number of packs required rather than the total volume of individual vaccines – for example, if the vaccine is available in packs of 10 and the practice wants to request a delivery of 500 vaccines, an order should be placed for 50 packs of 10.

9. Patient information leaflets for vaccines are supplied in packs of 10 will be provided separately to the vaccines. These will be automatically added to orders by Movianto.

10. A small volume of QIVe (Sanofi) has been procured for children aged 6 months to under 2 years and a small amount of QIVr for order for at-risk adults including pregnant women aged less than 65 years of age. QIVe will be supplied via Vaccine Holding Centres and ordering arrangements for QIVr will be shared in due course.

Further information and support

11. As with last year, NHS National Procurement will act as a link between participating GP practices and Movianto to ensure any potential allocation or delivery issues can be minimised and swiftly resolved. Contact details for the Procurement Officer are as follows: nss.vaccineenquiries@nhs.scot.

For queries linked to ordering and deliveries, please contact the Movianto Customer Service Team on 01234 587 112. If any delivery service issues cannot be resolved satisfactorily through dialogue, the issue should be escalated to NHS National Procurement (contact details as above) in the first instance and thereafter the Immunisation Co-ordinator within the NHS Board. If you require contact details for your NHS Board Immunisation Coordinator please email: immunisationprogrammes@gov.scot.

National Delivery plan update received 14/10/2021

Who	What	When	How - Invite	Where
• Children aged 6 months to 2 years with certain underlying health conditions* • Children aged 2-5 and not in school yet • Primary School Children (P1-7) • Secondary School Children (S1-6)	• *Injectable Vaccine QIVe (egg based) • Flu Vaccine (LAIV - nasal spray)* 'porcine gelatin' free alternative available	• From September onwards	• Via postal invite • Via school invite – consent pack home in bag	• Health centre clinics • Schools
• All young people 12 -15 years	• 1st dose of Covid-19 vaccine	• Sept-October; • Rolling offer until at least Spring 2022 for those turning this age	• Via postal invite • Consent pack from school • NHS Inform	• Local community clinics • School • Open access clinics
• Young people 12-15 – with certain underlying health conditions	• Course of Covid-19 vaccine (2 doses min 8 wks apart)	• Sept-October; • With rolling offer until at least Spring 2022	• Via postal invite • Consent packs from school • NHS Inform	• Local community clinics • Schools • Open access clinics
• Severely Immunocompromised (aged 12+)	• 3rd dose of Covid-19 vaccine – 8 wks after 2nd dose • Flu vaccine • Co-admin where possible	• Now until end of October/early November	• Via postal invite • or via GP contact • or Specialist contact	• A local vaccination centre • Or relevant clinical setting depending on condition
• Adults in care homes for older adults • Frontline Health and Social Care Workers (HSCWs) • People who have the highest health risk (CEV) • People who are 70 years and above	• flu vaccine • Covid-19 vaccine booster (if >24 wk gap since 2nd primary) • Co-admin if possible	• Now until late Oct/early November	• Care home organised • Via postal invite • Via GP contact • For HSCWs via on-line booking system (or via phone line)	• Delivered in care homes • Domiciliary visits for housebound • Local community clinics • GP practice • Workplace clinic.
• Adults age 60-69 years • Adults 16+ with underlying health conditions (includes pregnant women with underlying conditions)	• flu vaccine • Covid-19 vaccine booster (if >24 wk gap since 2nd primary) • Co-admin if possible	• Appointments running from late Oct/ Nov	• Via postal invite	• Local community clinics • Domiciliary visits for housebound
• Adults 50-59 years • Unpaid carers aged 16+ • Adult (16+) household contacts of immunosuppressed people (Covid-19 only)	• flu vaccine (not household contacts) • Covid-19 vaccine booster (if >24 wk gap since 2nd primary) • Co-admin if possible	• Mid November and December	• Self-booking portal - opens from mid-November (people may get a letter after a few weeks if they have not self-boked)	• Local community clinics
• Pregnant women** • Non frontline NHS workers • Frontline Education workers & pupil facing support staff • Frontline prison officers & support staff	• Flu vaccine only • ** if a pregnant women has not had her 1st and 2nd Covid-19 – this should be offered	• From September onwards • Education and Prison frontline can use HSCW portal from late October	• Via midwifery care • Self-Booking portal (or via national phone line)	• If pregnant, via your midwife. • A local vaccination centre • Workplace clinic/session

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**NHS Fife Board Assurance Framework - Quality & Safety**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Pauline Cumming, Risk Manager, and Gemma Couser, Head of Quality and Clinical Governance**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to an:

- Annual Operational Plan
- Emerging Issue
- Government Policy / Directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to update the Committee on the BAF for Quality and Safety and associated linked risks.

The Committee has a vital role in scrutinising the risks and where indicated, the Committee chair will seek further information from risk owners. This report provides the Committee with an update since the last report on 17 September 2021.

2.2 Background

The BAF brings together key information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions. It should:

- identify and describe key controls and actions in place to reduce or manage the risk
- provide assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- link to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following on receipt of each update on the BAF:

- 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?

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor the organisation's performance in relation to quality and safety; details of linked high level risks are set out in Appendix 1 and 2. Further information on quality and safety performance is provided in the Board Integrated Performance & Quality Report.

Linked Risk Changes since Last Committee

Since the last report to the Committee, Risk 1296: Emergency Evacuation, VHK Phase 2 Tower Block, has reduced its rating from a High risk (20) to a High risk (15). This is due to the likelihood having reduced from Likely to Possible.

There are no changes to the level of the remaining linked risks detailed in Appendix 2.

Review of the Quality and Safety BAF

A commitment was made at the last meeting, to provide the Committee with a review of the BAF. The rationale for doing this was to ensure that it fulfils its function i.e. to reflect the principal risks to the Board's strategic priorities, along with corresponding operational risks as defined at corporate, service and directorate level.

This review has now been undertaken and it revealed the following:

- The risk description has not changed since the BAF's inception in 2017.
- The current risk rating has not changed since inception.

- There has been no change to the rationale for the current risk rating.
- The current performance statement has not changed since inception.
- It is necessary to review the current linked risks and identify any new or other existing risks that should be included in the BAF.
- Some components of the BAF have been updated over time in line with local and national developments, i.e. Controls, Gaps in Control and Assurances. Focused work is needed to improve the quality of this content and to strengthen the assurances provided. This will require to be an interative process.

Review of BAF Risk

It is necessary to review the wording of the risk description associated with this BAF and in particular, to ensure that it reflects the risks associated with the impact of the pandemic. The table below summarises options which have been discussed:

Table 1

	Option	Wording	Comments
1	Status Quo - current wording	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.	Does not reflect risks associated with COVID -19
2	New risk developed	There is a risk that the effects of the COVID - 19 pandemic, including reduced elective & non essential services, clinical prioritisation, patients' ability/ willingness to attend for consultation / treatment, restricted capacity due to enhanced infection control measures, and workforce pressures, will impact on the quality & safety of patient care and service delivery resulting in: Short - Medium term: backlog of demand, patients waiting beyond national timescales for appointments, increased mortality & morbidity due to delayed diagnosis & treatment, including deterioration in long term conditions, later presentations of health problems and increased treatment needs. The longer term impacts on quality of	Does not capture the fundamental principles which are essential to provide assurance that safe, quality and effective care are being delivered

		care, patient safety/and experience require to be assessed.	
3	Combination of Options 1 and 2	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". In particular, in the current context, there is a risk that the effects of the COVID - 19 pandemic, including reduced elective & non essential services, clinical prioritisation, patients' ability/ willingness to attend for consultation / treatment, restricted capacity due to enhanced infection control measures, and workforce pressures, will impact on the quality & safety of patient care and service delivery resulting in: Short - Medium term: backlog of demand, patients waiting beyond national timescales for appointments, increased mortality & morbidity due to delayed diagnosis & treatment, including deterioration in long term conditions, later presentations of health problems and increased treatment needs. The longer term impacts on quality of care, patient safety/and experience require to be assessed.	Captures both risks under the umbrella of Quality & Safety
4	Create new BAF for COVID -19 and maintain existing BAF		Captures both but does not link COVID 19 to Quality & Safety which is a fundamental.

Discussions so far support Option 3 as the preferred way forward, however discussion and input from the committee would be welcome.

Summary of Current Linked Risks

Table 2

ID	Title	Initial Risk Rating	Current Risk Rating	Target Risk Rating	Date Risk Opened
1652	Medical Capacity in Community Paediatrics	25	25	12	12/11/2019
43	Vascular Access for Haematology/Oncology	20	20	12	24/03/2012
529	Information Security Risk	15	16	4	02/10/2012
1365	Cancer Waiting Times Access Standards	15	15	9	15/06/2017
1296	Emergency Evacuation, VHK Phase 2 Tower Block	20	15	5	22/08/2016

Overall, the linked risk ratings have reduced marginally, with the length of time risks have been in existence ranging from approximately 2 years to more than 9 years.

Review of Linked Risks

Risk owners and handlers reviewed the linked risks in conjunction with colleagues in the service and produced a detailed SBAR report approved by senior managers. The purpose of doing this was to update the Medical Director and the Director of Nursing, and to confirm if these still present a risk to the Board achieving its strategic priorities and corporate objectives on quality and safety, and so be retained on the BAF, or inform a different approach.

The tables below summarise the reviews, along with recommendations for change. Consideration should be given to the acceptance and / or level of monitoring of the risks.

Table 3

Medical Capacity in Community Paediatrics Risk 1652	
Risk Summary	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 with many received from MSPs and local councillors.
Date Risk Opened	12/11/2019
Assessment	The risk remains very high and will remain so until consultant posts are filled.
Recommended changes	None at present. Retain on BAF.

Table 4

Vascular Access for Haematology/Oncology Risk 43	
Risk Summary	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.
Date Risk Opened	24/03/2012
Assessment	The following interventions have improved the service: increase in the interventional radiology service delivered to Fife from NHS Tayside has improved waiting times for these procedures short term funding secured until end of 21/22 to trial portacath service within radiology (an alternative to Hickmann or PICC). This has improved access to service for Fife patients. Further bid has been put forward to the Scottish Government to continue funding for service. agreement has been made with the Planned Care Directorate to fund an anaesthetic session which would provide a dedicated session for vascular access for haematology and oncology patients. The likely start date for this is late November 2021.Recent feedback from staff indicates that access to this service has improved. Despite the above, the risk remains high. There have been occasions when patient treatment has been delayed due to waiting for this procedure. The Directorate believe that full implementation of the above will allow the risk to reduce. This will be considered at the next review.
Recommended changes	Retain pending review and discussion with Senior Leadership Team.

Table 5

Information Security Risk 529	
Risk Summary	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.
Date Risk Opened	02/10/2012
Assessment	The risk as described would have the potential to be debilitating to our ability to facilitate patient care within a very short time span.
Recommended changes	In order to better understand the component parts of the risk and the corresponding mitigations, it is proposed that this risk is reviewed, split into 3 as outlined below and scored accordingly. The outcome of this exercise will determine if any of the risks should be linked to this BAF. New Risk 1 - 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. (Assign to Information Security Manager). New Risk 2 - 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 a malicious attack designed to damage or steal electronic data or affect essential services. (Assign to Cyber Security Manager). New Risk 3 - 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 loss, theft or misuse of paper-based records during transportation, clinical processes or storage. (Assign to Information Governance).

Table 6

Cancer Waiting Times Access Standards Risk1365	
Risk Summary	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.
Date Risk Opened	15/06/2017
Assessment	NHS Fife successfully achieves the 31 day Cancer Waiting Times standard however performance against the 62 day standard is variable.
Recommended changes	It has been determined that this risk has materialised and so should be closed and a new risk raised which reflects the current position in relation to delivery of performance standards. The new risk should be considered for linkage to the BAF.

Table 7

Emergency Evacuation, VHK Phase 2 Tower Block Risk 1296	
Risk Summary	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.
Date Risk Opened	22/08/2016
Assessment	While risk likelihood has reduced from likely to possible, risk remains high and will remain so until the Elective Orthopaedic Centre opens and inpatient services transfer out of the tower block.
Recommended changes	Consider removal from this BAF and manage through Property & Asset Management Risk Register and governance structures

Summary of Recommendations Further to Review of Risks

The following changes are recommended:

Table 8

	Recommended Changes
1.	**BAF Risk:** Consider rewording in line with options above and invite discussion.
2.	**Medical Capacity in Community Paediatrics (1652):** Note risk assessment and confirm the risk's continued linkage to this BAF.
3.	**Vascular Access for Haematology/Oncology (43):** Following the next review and assessment of this risk, consider if it requires to be linked to the BAF or can be managed through the Emergency Care Directorate Risk Register and Acute Services Division governance structures.

4.	**Information Security Risk (529):** Split into 3 new risks as described above, risk assess, and then determine if any risks should be linked to this BAF.
5.	**Cancer Waiting Times Access Standards Risk (1365)**: Close risk and raise a new risk which reflects the current position regarding delivery of performance standards. Consider new risk for linkage to the BAF.
6.	**Emergency Evacuation, VHK Phase 2 Tower Block (1296):**Note the current risk assessment and consider if the risk should be unlinked from this BAF and managed through the Property & Asset Management risk register and related governance structures.

New Risks to be linked to the BAF

The Committee was previously advised that risks associated with the impacts of the pandemic on the quality and safety of patient care and service delivery should be identified and considered for linking to this BAF. These should reflect the risks in the Scottish Government Remobilisation Plan (RMP4), associated with balancing the response to COVID - related demand, with the provision of non COVID - related services throughout the remainder of 2021/22 and beyond; these are likely to include:

- Increase in waiting lists for elective care as a consequence of the pandemic
- Mental Health service provision, estate, and increase in waiting times, including CAMHS and Psychological Therapies
- Risk to population health following 18 months of reduced levels of healthcare
- Reputational risk
- Strategic planning considerations for the evolving Population Health and Wellbeing Strategy for NHS Fife

In summary:

The review described above has informed further work required to refresh the BAF. It is proposed that this redevelopment is carried out, specifically to :

- renew the risk description
- review and update all components of the BAF to align with the new description and strengthen content
- identify existing and new risks which ought to be considered for linking to this BAF

An update will be presented to the Committee on 13 January 2022.

Next steps:

- Review all existing high risks to identify which should be linked to this BAF
- Sessions with Operational Directors and Senior Leadership Teams to be arranged to determine key risks to operational delivery and ensure these are reflected on the appropriate risk registers and linked as appropriate to the BAF.

2.3.1 Quality/ Patient Care

Effective risk management underpins the delivery of high quality, person - centred care. Highlighting relevant risks to the Committee, allows for appropriate scrutiny, challenge and monitoring of risks to the delivery of quality health and care services.

2.3.2 Workforce

Optimal staff health and well being can contribute to enhanced performance, improved patient experience and increased job satisfaction. Please see Appendix 2 for specific impacts on staff where applicable.

2.3.3 Financial

Please see Appendix 2 for specific financial impacts where applicable.

2.3.4 Risk Assessment/Management

Please refer to Appendices 1 and 2.

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

The process involved risk owners, handlers, senior managers and directors.

2.3.8 Route to the Meeting

This paper has been developed through discussions with the Head of Quality and Clinical Governance, the Medical Director, the Director of Nursing, and the EDG.

2.4 Recommendation

The Committee is invited to:

- **Consider** the questions set out above;
- **Approve** the updated quality and safety component of the BAF;
- **Approve** the recommendations outlined in section 2.3

3 List of appendices

Appendix 1, NHS Fife Board Assurance Framework (BAF) Quality & Safety to NHS Fife CGC 031121 V1.0
Appendix 2, BAF Risks - Quality & Safety - Linked Operational Risks to NHS Fife CGC 031121 V 1.0

Report Contact

Gemma Couser
Head of Quality and Clinical Governance
Email gemma.couser2@nhs.scot

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																											
16	Clinical	17/03		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	5	20	High	5	5	25	High	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Chief Nurse	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact 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 3 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 requires review, update & plan for implementation.	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 HIS 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, risk management,clinical effectiveness 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems 7. Review our position against the Quality of Care Framework and understand our state of readiness for a review. 8. Further develop the culture of a person centred approach to care. 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives'. 10. Align the developing Clinical Governance Framework with the NHS Fife Corporate Objectives and the developing Population Health & Wellbeing Strategy . 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks. 13 .Build risk culture which links the identification of risk to organisational objectives and strategic priorities. 14.Identify and implement an electronic system/ quality management system …	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. External 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 9.Compliance and monitoring of policies & procedures to ensure these are up to date 9. Locally designed subject specific audits. 10. National audits	1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Opinion 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	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 and monitoring of actions from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews. 3.We require additional assurances that there are systems in place for oversight of operational and strategic 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	5	10	High	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

for managing policy and procedures to improve efficiency and assurance of document management

15.Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of CG Framework

16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of organisational themes

17. Further develop and monitor implementation of NHS Fife governance and reporting structure for the review of deaths and young people ensuring a pan organisational approach with clear reporting lines taking into consideration existing review groups e.g. groups for suicide and peri-natal deaths

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
43	Vascular access for haematology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
528	Pandemic Flu Planning	Active Risk	Moderate Risk	12	Brown, George
637	SAB LDP standard	Active Risk	Moderate Risk	9	Cook, Julia
1670	Temperature within fluid storage room within critical care.	Active Risk	Moderate Risk	12	Morgan, Belinda
356	Clinical Pharmacy Input	Closed Risk	High Risk	15	McKenna, Christopher
521	Capacity Planning	Closed Risk	Very Low Risk	1	Watts, Miriam
1287	Overcapacity in AU1 Assessment Unit	Closed Risk	Very Low Risk	3	Shepherd, Angie
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk	Moderate Risk	10	Lowe, David
1366	T34 syringe drivers in the Acute Division	Closed Risk	Low Risk	6	Savage, Shirley-Anne
1502	3D Temperature Monitoring System (South Lab)	Closed Risk	Moderate Risk	12	Campbell, Ken
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk	High Risk	15	Garden, Scott
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Closed Risk	High Risk	15	Anderson, Jane
1524	Oxygen Driven Suction	Closed Risk	High Risk	20	McKenna, Christopher
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk	High Risk	25	Dobson, Claire

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
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	New Consultant started in post 22/3/21 and Specialty Doctor post is currently out to advert again. Conversations regarding ADHD Service have still to take place with Divisional Manager Fife wide HSCP regarding governance and improvement actions required across HSCP and Community Paediatrics	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	Dobson, Claire	Galloway, Donna	17/06/2021	31/12/2021
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	Discussions between ECD and PC regarding Theatre space this is planned to commence September/October 21 and will be supported by Radiology.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12	Savage, Shirley-Anne	Davidson, Dr Kerri	02/08/2021	01/11/2021
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 and the creation of an Information asset register, but this involves significant effort to retrospectively complete, this is work in progress. There has been discussion between the ISM (Information Security Manager) and the Head of Information Governance 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 once regular meetings are established. The NIS regulations audit has been carried out and we as a board improved by 16%, this report has been used to build an action plan of progression towards addressing the information security objectives. ISM and Cyber Security Manager (once appointed), will develop a framework of baseline acceptable standards and documentary requirements that will address information and cyber security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks: 217,220,221,225, 226,233,234,537,538,541,5421410,1569,2109.	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	18/08/2021	27/10/2021

ID	1296	1365
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register	Acute Services - ACUTE SERVICES DIVISION RISK REGISTER, NHSFBD - Cancer Services Risk Register, NHSFBD – COVID-19 Risk Register
Opened	22/08/2016	15/06/2017
Title	Emergency Evacuation, VHK Phase 2 Tower Block	Cancer Waiting Times Access Standards
Description	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.	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.
Likelihood (initial)	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	5 - Extreme	3 - Moderate
Risk level (initial)	High Risk	High Risk
Rating (initial)	20	15
Current Management Actions	JR - 22/06/2021 - Current management actions still apply. The fire safety advisors have visited ward 10 and all staff have completed recent fire training. An exercise to upgrade/repair all the compartment doors is underway and a survey to check for any breaches in compartmentation is also underway.	25/10/21 Cancer Performance & Audit Team carry out daily tracking with local escalations as required. Patient Tracker List (PTL) weekly review with Service Managers and business coordinator continues to ensure robust escalations for patients that are not moving through their pathways. Participation in local and national review of pathways to improve and sustain performance as part of the Cancer Recovery Plan. Current priorities are prostate* and lung. Implementing the Scottish Government (SG) Effective Cancer Management Framework which was rolled out in September 202 1 with SG visit being arranged. Contributing to national discussions with collaborative working with Boards through Cancer Managers' Forum. The Cancer Strategy and Governance Group is now overseeing local performance and taking forward the Cancer Recovery Plan.
Likelihood (current)	3 - Possible - May occur occasionally - reasonable chance	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	5 - Extreme	3 - Moderate
Risk level (current)	High Risk	High Risk
Rating (current)	15	15
Likelihood (Target)	1 - Remote - Can't believe this event would happen	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	5 - Extreme	3 - Moderate
Risk level (Target)	Low Risk	Moderate Risk
Rating (Target)	5	9
Risk Owner	McCormick, Neil	Couser, Gemma
Handler	Ramsay, Jimmy	Nicoll, Kathleen
Previous Review Date	15/09/2021	25//10/2021
Next Review	29/01/2022	15/11/2021

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**NHS Fife Board Assurance Framework - 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:

- Assurance

This report relates to a:

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 accurate and timely assurances to the 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, the Committee will seek further information from risk owners.

This report provides the Committee with the next version of the NHS Fife BAF 5 on 23.09.21.

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.

Following discussion at previous committees, previous risks have remained on the BAF until the new Strategy is produced. The BAF and risk also describes how

- the Strategic Priorities form part of the strategic planning direction going forward for NHS Fife.
- Work is progressing in the development of the Population Health and Wellbeing Strategy. The public and staff survey will be the start of the development phase.
- The process for SPRA for 2022/23 is about to commence with a view to reporting in Quarter 4 of 2022/22.

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.

2.4 Recommendation

The Committee is invited to:

- **Discuss** the current position in relation to the Strategic Planning risk.

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	23/09/2021	30 November 2021	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. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 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.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Director of Finance	Margo McGurk Director of Finance Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 1.Progress has been made setting up the PHW Portfolio Board 2. Public and Staff Survey being developed for PHW Stragy and will be released in November 21 assuming sign off. 3. SPRA for 22/23 is planned for distribution in October 2021	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	23/9/21 PHW Portfolio Board is being established and will meet monthly. TOR ready for sign off. Governance route will be Public Health and Wellbeing Committee 27/5/21 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 responsible 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 session 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 committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance.	Corporate Objectives agreed for 21/22. SPRA process 22/23 will commence in October 21 and will inform the strategy and corporate objective for 22/23. RMP4 due to be submitted on 30 September 21.	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce.

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				

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**NHS Fife Board Assurance Framework - Digital and Information**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham – Associate Director of Digital and Information**

1 Purpose

This is presented to the Committee for:

- Assurance

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 is 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

In addition, the BAF recognises the opportunity to integrate digital capability as part of the work relating to the development of the Population Health and Wellbeing Strategy.

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 an update on NHS Fife BAF in relation to Digital & Information (D&I) as at 4 October 2021.

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 risks are set out in the BAF, together with the current risk assessment and the mitigating actions.

Changes since the last report to the Committee are as follows: -

New Linked Operational Risks:

Following the completion of the Internal Audit report, B23/21 (Information Technology Infrastructure Library (ITIL) Processes), an additional operational risk (2192) has been linked to the BAF. Due to the scale and complexity of an ITIL framework implementation, the risk has been assessed as high. By mitigating this risk, there is an opportunity to develop operational processes focused on service and value and further support the Digital Strategy (2019-2024) delivery.

Previously Linked Operational Risks:

During the period, 1 risk has been removed as Linked Operational Risk (1927). This risk, relating to the deliberate and unauthorised misuse of system access by internal users, has been reassessed as a moderate risk level.

The BAF current risk level has been assessed as 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 are continuing to identify and quantify the key financial exposures that present risks to be able to operate within the agreed budget. D&I looks to identifying additional funding allocations and changes to operating models to mitigate the levels of financial exposure and await confirmation following requests made to Scottish Government.

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

The BAF was presented to EDG on 7 October 2021

2.4 Recommendation

- **Assurance** – the content and current assessment of the Digital & Information BAF is provide to the committee for assurance.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - BAF Digital & Information 20211004
- Appendix 2 - Digital & Information linked operational risks

Report Contact
Alistair Graham
Associate Director of Digital & Information
Email alistair.graham1@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	17/09/2021	11 October 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 current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	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 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 Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with assurance activity plans reviewed by Steering Group and Improvement measures agreed 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 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 – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the Digital Strategy, inline with the current baseline of D&I Operating Costs Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems 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- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 October 2021) 2. Updated baseline of current operating financial commitments and assessment of financial implementation of Digital Strategy. (Target completion October 2021) 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Target completion October 2021) 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance. (Target completion February 2022)	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. External Assurance on Delivery Plan by Scottish Government 12. Update to Assessment following June 2019- Digital Maturity Assessment 13 Periodic Benchmarking for areas of focus	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 October 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. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to 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). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adopt ion of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	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. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	2 – Unlikely – Not expected to happen – potential exists	5 - 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.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
885	Digital & Information Financial Position	Active Risk	High Risk	20	Graham, Alistair
1338	NHS Fife is at increased risk to a targetted cyber intrusion - due to legacy systems	Active Risk	High Risk	20	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	20	Graham, Alistair
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	Graham, Alistair
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
1576	Risk of not meeting SaMD full compliance	Active Risk	High Risk	16	McKenna, Christopher
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
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1393	Patch Management Risk	Active Risk	Moderate Risk	12	Young, Allan
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1927	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Active Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Active Risk	Moderate Risk	12	Young, Allan
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

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
885	NHSFBD - Digital and Information Directorate Risk Register	31/10/2014	Digital & Information Financial Position	There is a risk that D&I will not be able to provide funding for new IT initiatives due to flatlined or reducing budgets. This is due to the need to ensure the current production infrastructure is appropriately maintained, support contracts paid for and vulnerable equipment upgraded in order to remain safe & secure. The D&I financial position is heavily reliant on non-recurring money issued to the Board by Scottish Government eHealth Directorate. This funding is always subject to reduction and designed to support enablement and innovation within NHS Boards. However NHS Fife uses a significant proportion of this funding to run the operational digital service, thus restricting the Board's ability to embark on redesign / service developments, innovation and strategic aims. The D&I department is forced to carry persistent high/red risks due to ever-competing funding challenges, which impact the ongoing ability maintain safe operations.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	15/9/21 - Quantification of financial exposure for 2021-22 presented to Finance and await confirmation from SG regarding allocation to NHS Fife. This includes ADEL funding, National Funding for projects - Impact on deliver of Digital Strategic complete and presented to EDG and CGC September 2021 Full financial planning for 5 years period to be completed by October 2021	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Graham, Alistair	Marshall, Shelley	31/08/2021	01/10/2021
1338	NHSFBD - Digital and Information Directorate Risk Register	23/02/2017	NHS Fife is at increased risk to a targeted cyber intrusion - due to legacy systems	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.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	Low Risk	4	Young, Allan	Faichney, Brian	02/03/2021	10/01/2022
1996	NHSFBD - Digital and Information Directorate Risk Register	17/11/2020	Office 365 - Unknown Financial Consequence and so risk to licence availability	There is a risk that the cost to NHS Fife of adopting O365 is not able to be fully quantified, following the year 4 deal agreed nationally resulting in a user not being assign the correct Office 365 licences within the NHS Scotland tenancy and so are unable to access Teams, Outlook and other Office 365 tools.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	3/8/21 - Update provided by National O365 Team. They are developing a implementation plan that details where adoption of O365 features would incur additional costs. Risk requirement to be reviewed at this stage as financial risk of adopting O365 not fully known. Business Case creation ongoing (September 2021) Request made by NHS Boards for more user admin rights within the O365 tenancy.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	1 - Negligible	Very Low Risk	2	Graham, Alistair	Granger, Claire Louise	03/08/2021	24/09/2021

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
2192	NHSFBD - Digital and Information Directorate Risk Register	15/09/2021	Risk that Digital & Information Service Management activities are not aligned to ITIL	There is a risk (As supported by IA ReportB23-21) that the lack of governance and procedures aligned to the maintenance of ITIL standards will result in increased periods of system unavailability and adverse impact to clinical and corporate functions in NHS Fife	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	A cost benefit analysis will be prepared for consideration at the Digital and Information Board - October 2021 The cost benefit analysis will include consideration of the ITIL standards for all IT service management areas e.g. Labs and Radiology - October 2021 Consider the opportunity presented through the implementation of Service Now supports improved change management processes - September 2021	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	2 - Unlikely - Not expected to happen - potential exists	3 - Moderate	Low Risk	6	Graham, Alistair	Young, Allan		30/09/2021
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	May 21 - Current NISD audit results received (69%) and action planned created. Action plan being progressed in line with NISD recommendations/priorities.	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	Graham, Alistair	Young, Allan	13/09/2021	11/10/2021
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

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
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 and the creation of an Information asset register, but this involves significant effort to retrospectively complete, this is work in progress. There has been discussion between the ISM (Information Security Manager) and the Head of Information Governance 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 once regular meetings are established. The NIS regulations audit has been carried out and we as a board improved by 16%, this report has been used to build an action plan of progression towards addressing the information security objectives. ISM and Cyber Security Manager (once appointed), will develop a framework of baseline acceptable standards and documentary requirements that will address information and cyber security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks: 217,220,221,225, 226,233,234,537,538,541,5421410,1569,2109.	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	18/08/2021	27/10/2021
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	09/09/21 - Await outcome for funding requests from SG to support network resilience improvement work.	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	06/09/2021	11/10/2021
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	09/09/21- Agreement for Associate Director of D&I, Director of Pharmacy and Medicines and Director of Finance to meet to discuss and approach for medical devices/Software as a Medical Device.	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	13/09/2021	11/10/2021

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
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	31/08/2021 Training has been provided on how to use Outlook. 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	09/03/2021	31/12/2021
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	09/09/2021 - Await outcome from funding request made of SG to provide coverage for replacement and upgrade of LAN switches throughout Fife and replacement of any end of life appliances as 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

FTF Internal Audit Service

Clinical Governance Strategy and Assurance

Report No. B19/21

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance and Strategy

Chris McKenna, Medical Director and Executive Lead for Clinical Governance
Gemma Couser, Head of Quality and Clinical Governance

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Audit and Risk Committee
Clinical Governance Committee
External Audit

Contents

Draft Report Issued	26 August 2021
Management Responses Received	31 August 2021
Target Audit & Risk Committee Date	16 September 2021
Final Report Issued	**14 September 2021**

CONTEXT AND SCOPE

1. The NHS Fife Strategic Framework includes key aspirations of providing services that are clinically excellent and objectives '*to embed patient safety consistently across all aspects of healthcare provision*' and '*to ensure that NHS Fife's environment is clean, tidy, well maintained, safe and something to be proud of*'.

2. The NHS Fife Board Assurance Framework (BAF) for Quality and Safety describes the following risk which could threaten the achievement of these strategic objectives – '*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.*' This review did not review this risk in detail, although we would highlight that our Annual Internal Audit Report did comment on the need for serious consideration the content and scoring of this risk, which does not appear to reflect the increased risks created by the covid pandemic.

3. The current actions recorded in the Quality and Safety BAF to mitigate this risk include:

    - '*Clinical Governance structures and operational governance arrangements*'
    - '*Clinical and Care Governance Strategy*'.

4. A number of internal audit reports on Clinical Governance Strategy and Assurance dating back to 2017 highlighted a range of potential improvements to the Clinical and Care Governance Strategy and associated structures, assurances and arrangements. Review of the Clinical and Care Governance Strategy has been delayed and no agreement has yet been reached on arrangements for delegated functions.

5. Given the time pressures on officers and Directors, and the need for swift review, this audit focussed on what arrangements should become, applying existing assurance and Health and Social Care Integration Governance principles to the development of the strategy, with Internal Audit advising on the application of these principles and assessing detailed arrangements as they developed.

6. A high level follow-up of the recommendations made in Internal Audit Report – Clinical Governance Strategy and Assurance (B15/17 & B18/18). Its findings are therefore now entirely superseded this report.

AUDIT OPINION

7. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

Development of Revised Clinical and Care Governance Strategy and Follow-up of Internal Audit Report B15/17 & B18/18 – Clinical Governance Strategy and Assurance

8. A complete revision of the Clinical Governance Strategy and the relationship between the different committees and groups in it has been initiated. This is being led by the Head of Quality and Clinical Governance and includes an engagement process to ensure that all stakeholders are heard during the development of the strategy. The strategy will be known as the Clinical Governance Framework.

9. The outline timetable for the development of the strategy (see appendix 1) schedules presentation of the revised framework to the Clinical Governance Committee for approval in January 2022.

10. The approach being taken to the development of the framework, including the engagement process, was presented to the Clinical Governance Oversight Group on 22 April 2021 and a paper on the framework development plans is to be presented to the NHS Fife Clinical Governance Committee in due course. Progress towards the development of the revised Clinical Governance Framework is to be reported to the Executive Directors Group on a bi-monthly basis.

11. The engagement process includes gathering information on current clinical governance structures and activities from a variety of stakeholders in clinical governance (see appendix 2) as well as a self assessment of these structures and activities and reflections on how well current clinical governance meetings contribute to the achievement of objectives.

12. Initial engagement has taken place with responses received from some key stakeholders. A workshop based approach is to be taken forward to engage with stakeholders who have not responded thus far to ensure that their input is captured.

13. The development of the Clinical Governance Framework has not halted changes being made within Clinical Governance and work has been initiated in a number of areas including:

    - Adverse Event Process and Policy Review
    - Establishment of an Organisational Learning Group
    - Collating all previous Internal Audit Findings in preparation for assurance to be provided to CGC that the revised Framework addresses these

14. We conducted a high level review regarding whether the findings in our previous report on this topic had been addressed. Overall we found that of the 13 findings in B15/17 & B18/18 - 4 had been addressed, 2 had been superseded by events and 7 were outstanding. The issues that remain to be addressed are:

    - Ensuring that the strategy and framework are fully consistent and provide a clear vision of clinical governance responsibility across NHS Fife including services delegated to the IJB
    - Refining assurance reporting routes for clinical governance, using the committee governance and integration principles, including assurance regarding clinical governance in services delegated to the IJB
    - Reflecting that ownership of operational clinical risks associated with services delegated to the IJB rests with Fife NHS Board in the revised Clinical Governance Framework and embedding this in relevant documentation including the risk management strategies of the IJB and the Health Board

- Developing the assurance provided by the Clinical Governance Oversight Group to add routine and annual assurance reporting to the CGC in addition to providing its minutes to the CGC as is the case currently
- Adding responsibilities for providing assurance to Fife NHS Board regarding Information Governance to the Terms of Reference for the CGC
- For Information Governance assurance regarding services delegated to the IJB - clarifying roles and responsibilities, in particular the role of the IG&SSG, and reflecting this in the Clinical Governance Framework
- Reviewing annual assurance provision from sub-groups of the CGC, again using committee governance principles as a guide, to ensure that annual assurance reports are received, within the required timescale, from all sub-groups that the CGC relies upon to agree its own annual assurance report and statement
- Developing a Clinical Governance Framework Implementation Delivery Plan and reporting on its implementation to the CGC.

15. We are aware that it is intended to address these and other issues in the revised Clinical Governance Framework, which is not yet available for review, but include recommendations in this report to allow these to be monitored through the audit follow-up process. This report therefore entirely supersedes B15/17 & B18/18 – Clinical Governance Strategy and Assurance.

16. The Head of Quality and Clinical Governance has also initiated a review of the findings and recommendations included in all Internal Audit reports related to Clinical Governance over the past four years to confirm that these have either been addressed or been superseded by events. A collaborative approach is to be undertaken with Internal Audit so that the new Clinical Governance Framework is developed in a manner that addresses the findings in these reports.

Scottish Patient Safety Programme – The 10 Essentials

17. As this review replaced a scheduled review of how the Scottish Patient Safety Programme's 10 essentials are complied with in NHS Fife we conducted a brief overview of their implementation within this audit.

18. Our previous report on this topic (B19/18 – Patient Safety Programme published in January 2018) concluded that in the Acute Services Division the 10 essentials had become embedded into normal practice and were included in relevant Clinical Policies and Procedures whilst implementation of the 10 essentials in the Health and Social Care Partnership was at an earlier stage. Our findings from this review are that the 10 essentials continue to be embedded in normal practice in the Acute Services Division and the applicable essentials are becoming embedded in the Health and Social Care Partnership. A table showing the Clinical Policies and Procedures that include the practices associated with the 10 essentials is included at appendix 4 of this report.

19. The focus of reporting related to patient safety is on outcome measures and where the monitoring of these shows potential performance issues these are investigated and consideration given to compliance with policies and procedures as well as whether the policies and procedures need to be amended to improve performance and/or prevent recurrence of harm caused.

20. Developments regarding improving patient safety continue with NHS Fife currently working to understand how the latest guidance package from the Scottish Patient Safety Programme – Essentials of Safe Care can be used to best affect across NHS Fife and the

Health and Social Care Partnership. A Deteriorating Patient Group has also recently been established with a scope covering NHS Fife and the Health and Social Care Partnership.

B08/20 Internal Control Evaluation – Finding 4 re External Reporting

21. As part of this review we also followed up on action plan point 4 from our 2019/20 Internal Control Evaluation (B08/20), required to remedy a lack of assurance to the NHS Fife Clinical Governance Committee on the implementation of actions arising from issues identified in external reports. Our associated recommendation asked for:

    - A summary of external reports to be provided to the CGC at year-end along with an indication of whether any findings would require to be included as disclosures in the Board's Governance Statement
    - Triangulating significant findings from external inspections with the issues identified by internal control systems
    - Undertaking a review to understand why internal control systems did not identify the issues reported by external inspectors.

22. The NHS Fife CGC Annual Assurance report includes reference to the External Reports related to NHS Fife Clinical Governance that have been published during the year and high level assurance regarding action being taken to address issues identified. External reports have also been presented to CGC in 2020/21 including HIS unannounced inspections of Glenrothes and Adamson Hospitals and the Ionising Radiation Medical Exposure Regulations (IRMER) Final Report on Victoria Hospital. This satisfied the first part of the recommendation above.

23. The second and third parts of the recommendation related to triangulation/comparison of findings of external reports with internal data to assess the reliability of internal assurance systems. These have been partly addressed through the establishment of the Organisational Learning Group but the group is in its infancy and has not undertaken any such reviews thus far. We have therefore not been able to evidence the triangulation and internal control analysis and we include a related finding and recommendation in this report which therefore supersedes recommendation 4 from B08/20 for follow-up purposes.

ACTION

24. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

25. We would like to thank all members of staff for the help and co-operation received during the course of the.

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

Seven of the 13 findings from our previous report on this topic (B15/17 & B18/18 – Clinical Governance Strategy and Assurance) have not yet been addressed. The current process initiated to revise the Clinical and Care Governance Strategy offers the opportunity for these outstanding findings to be addressed.

Audit Recommendation:

Action has not yet been taken to fully address the findings and recommendations in Internal Audit Report B15/17 & B18/18 – Clinical Governance Strategy and Assurance. Given the time that has passed since the publication of this report, and our awareness that a process is in place to develop a revised Clinical Governance Framework, we have updated the outstanding actions in this report which now entirely supersedes our previous report (B15/17 & B18/18).

From the 13 findings in B15/17 & B18/18 4 had been addressed (Ref. 3, 6, 7 & 9), 2 had been superseded by events (Ref. 5 & 11) and 7 were outstanding (Ref. 1, 2, 4, 8, 10, 12 & 13).

The development of the Clinical Governance Framework should:

a Ensure that it is fully consistent and provides a clear vision of responsibility for clinical governance across NHS Fife's span of responsibility including clinical areas delegated to the Integration Joint Board (Ref 1)

b Specifically consider the clinical governance reporting routes in NHS Fife including the services delegated to the IJB using the committee governance principles, endorsed by the Audit and Risk Committee in May 2021, and integration principles, agreed with the Scottish Government, to guide this review (Ref 2)

c Reflect that ultimate ownership of operational clinical risks associated with services delegated to the IJB rests with Fife NHS Board and embed this in relevant documentation including the risk management strategies of the IJB and the Health Board (Ref 4)

d Develop the assurance provided from the Clinical Governance Oversight Group to the CGC so that:
- It provides an assurance report as well as minutes to each CGC
- It provides a year-end annual assurance report and statement, reflecting on delivery of an agreed workplan for the group, to the CGC (Ref 8)

e Ensure that responsibilities for providing assurance to Fife NHS Board regarding Information Governance are included in the Terms of Reference of the CGC (Ref 10)

f For Information Governance assurance regarding services delegated to the IJB - clarify roles and responsibilities, in particular the role of the IG&SSG, and reflect this in the Clinical Governance Framework. There must be absolute clarity on roles and responsibilities in this key area (Ref 10)

g Review the sub-groups that report to the CGC and determine, using the committee assurance principles as a guide, which of these sub-groups is required to provide an annual assurance report and statement in a time frame that allows these to be considered by the CGC before it finalises its own annual assurance report and statement.

The rationale for this decision making should be recorded and provided to the CGC.

Currently D&I Board, H&S Sub-Committee and the Information Governance & Security Steering Group along with the C&CGC provide annual assurance reports and

statements in a timeframe that allows these to be considered by the CGC before it finalises its own annual assurance report and statement.

Other sub-groups provide annual reports but the timing of these does not allow them to be considered by CGC before agreeing its own (Ref 12)

h Include development of a delivery plan for implementation of the Clinical Governance Framework and regular reporting on implementation progress in to CGC (Ref 13).

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

Recommendations will be addressed through the development of the Clinical Governance Framework and associated delivery plan.

Action by:	Date of expected completion:
Gemma Couser, Head of Quality and Clinical Governance	**31 January 2022**

Action Point Reference 2	
Finding:	
The recommendations associated with action plan point 4 from our 2019/20 Internal Control Evaluation report (B08/20) have been partly implemented but due to the Organisational Learning Group being in its infancy we have not yet been able to evidence triangulation or analysis of internal control systems following publication of external reports.	
Audit Recommendation:	
Following publication of external reports (eg HIS inspection reports) the Organisational Learning Group should undertake: • Triangulation of internal data with external report findings to get to the root cause and to identify appropriate action to address issues across all areas they relate to • Analysis of internal control systems to identify why these did not identify the issues highlighted by external reports to allow changes to be made so that these issues are highlighted internally earlier in future.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
Terms of Reference for the Organisational Learning Group are to be finalised in August and presented to the Clinical Governance Oversight Group in October. The points raised above have been noted and are contained within the draft terms of reference. Monthly Organisational Learning meetings scheduled. Would anticipate the group will have developed an approach to address this recommendation by November 2021 and the impact of this visible from early 2022.	
Action by:	**Date of expected completion:**
Gemma Couser, Head of Quality and Clinical Governance	**31 March 2022**

Section 3 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Section 3 Definition of Assurance and Recommendation Priorities

Assessment of Risk

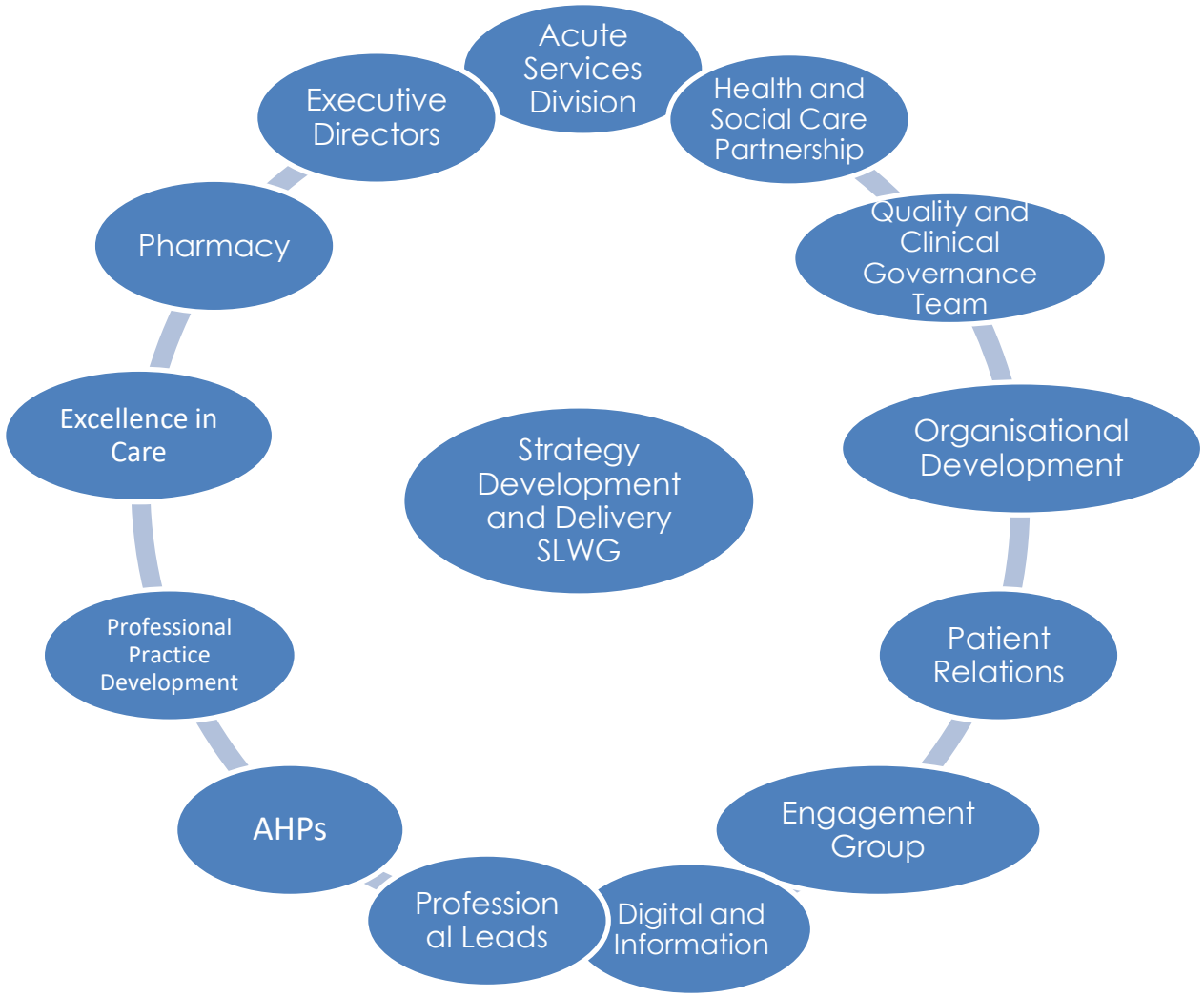
To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	**One** **Action Point 1**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**One** **Action Point 2**

Clinical Governance Framework Development Outline Timetable

Action	Deadline
Confirm Executive Priorities	September 21
Launch of Strategy Refresh- Assessment of where we are today	September 21
Clinical Governance Oversight Group	April 21
Review of Strategy Driver Diagram	August 21
Engagement Meetings	Sept/Oct 21
Review of Internal Audit Findings	November 21
Establish Working Group with cross section of staff	September 21
Update Clinical Governance Oversight Group	June 21 & Ongoing
Draft Strategy Shared	December 21
Present to Clinical Governance Committee	January 2022
Development of Annual Work Plan to support Delivery of Y1	January 2022

Engagement – Stakeholders



Scottish Patient Safety Programme - Ten Patient Safety Essentials

10 Essentials	Policy/procedure/checklist that includes the related practice – Acute Services Division	Policy/procedure/checklist that includes the related practice – Health and Social Care Partnership
Hand Hygiene	NHS Fife Prevention & Control of Infection Manual	NHS Fife Prevention & Control of Infection Manual
Leadership walkrounds	These were discontinued in 2017.	Senior Leadership Walkround SOP [FHSCP/CCG/SOP6]
Surgical Pause and Brief	Pre-operative Patient Identification: the identification and preparation of patients undergoing operative and invasive procedures [ASD - POPI-01] which includes the Perioperative safety checklist.	N/A
General Ward Safety Brief	Pro-forma safety brief checklists.	Pro-forma safety brief checklists based on a standard template with specific questions added for different services.
ICU Daily Goals	Pro-forma Nursing Care Plan and Doctors Medical Notes prompt the recording of the ICU Daily Goals.	N/A
Ventilator Associated Pneumonia	The format of the 24 hour chart used for each patient in ICU includes provision for the recording of the Ventilator Associated Pneumonia bundle checks.	N/A
Early Warning Scoring Bundle	Acute Procedure for Recording of Patients' Clinical Observations using Fife Early Warning Score (FEWS) [ASD-COFEWS-01].	FEWS is now operating in H&SCP and the ASD Procedure is to be updated to become a Fife-wide procedure covering ASD and H&SCP.
Central Venous Catheter Insertion and Maintenance Bundles and Peripheral Venous Cannulla	Fife-Wide –– Procedure for the Insertion, Care, Maintenance and Removal of Midline Venous Catheters in Adults [FWP-MVCA-01].	Fife-Wide –– Procedure for the Insertion, Care, Maintenance and Removal of Midline Venous Catheters in Adults [FWP-MVCA-01].

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Annual Internal Audit Report 2020/21**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Committee for:

- Assurance

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

The purpose of this report is to present the final 2020/21 Annual Internal Audit Report to the NHS Fife Clinical Governance Committee.

2.2 Background

This annual report provides details on the outcomes of the 2020/21 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2020/21.

2.3 Assessment

Based on work undertaken throughout the year the auditors concluded that:

- The Board has adequate and effective internal controls in place;
- The 2020/21 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, they did not advise management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

The overall audit opinion was that:

- The Board has adequate and effective internal controls in place
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

The report noted the following key themes:

- As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. The auditors welcomed the progress with the Strategic Allocation and Resource Process which has informed the annual plan (RMP3).
- The development of the Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, is due to be presented to the Board for approval in March 2022.
- Strong communication within the Board, in challenging times, with Staff Link providing a constant feed of news and a Weekly News Roundup via email, which provides Operational, Clinical, Workforce, Staff Health & Wellbeing and Research & Development updates, as well as a useful links and updates from the Health & Social Care Partnership (HSCP) Director.
- Highlighted changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains comments aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. They noted the progress with the update of the Digital and Information, Strategic Planning and Financial Sustainability BAFs.
- The Quality and Safety BAF is planned for review as part of ongoing with the Assurance Mapping work and the auditors highlighted the importance of this in ensuring effective management of clinical risk.
- The reported noted positive improvements in a number of areas and specifically highlighted those in relation to Information Security and Information Governance.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

Individual internal audit assignments identify the key risks at the planning stage and are designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and the Deputy Director of Finance.

2.3.8 Route to the Meeting

The report was reviewed by the Audit and Risk Committee.

2.4 Recommendation

The Clinical Governance Committee is asked to:

- Take assurance from this annual report and specifically note the aspects pertinent to this committee.

3 List of attachments

The following attachment is included:

- Annual Internal Audit Report 2020/21

FTF Internal Audit Service

Annual Internal Audit Report 2020/21

Report No. B06/22

Issued To: Carol Potter, Chief Executive
Margo McGurk, Director of Finance and Strategy
NHS Fife Executive Directors Group

Gillian MacIntosh, Head of Corporate Governance and Board Secretary

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	30 August 2021
Management Responses Received	08 September 2021
Target Audit & Risk Committee Date	16 September 2021
Final Report Issued	09 September 2021

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2020/21 internal audit and my opinion on the Board's internal control framework for the financial year 2020/21.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place.
- The 2020/21 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work.
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected.
- The format and content of the Governance Statement in relation to the relevant guidance.
- The disclosure of all relevant issues.

ACTION

4. The Audit and Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2020/21 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Appendix 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit and Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued January 2021, was informed by detailed review of formal evidence sources including Board, Standing Committees, Executive Directors Group (EDG), and other papers. The ICE noted actions to enhance risk reporting and clinical governance arrangements, with progress in improvements in Information Governance arrangements. Internal Audit concluded that NHS Fife's assurance structures were adequate and effective and made 6 recommendations for improvement by year end. The status of previous recommendations is summarised in table 1 below.

9. During the year we worked with management to review and update outstanding internal audit recommendations to take account of Covid19, including those arising from the previous ICE report.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid19 and the governance arrangements in place during the year, taking into account developments since year-end where relevant. Some areas for further development were identified and will be followed up in the 2021/22 ICE and, where applicable, our detailed findings have been included in the NHS Fife 2020/21 Governance Statement.

11. Our assessment of the progress taken to address ICE recommendations is detailed in table 1 on page 11. NHS Fife has demonstrated good progress with only minor slippage on some actions, despite the continuing difficulties caused by Covid. Several of the more strategic actions are not yet due for completion but are progressing well. We will comment on the effectiveness of the action taken in the 2021/22 ICE.

12. For 2020/21, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as whole, which would therefore include activities under the direction of IJBs.

13. The Board has produced a Governance Statement which states that:

    'During the 2020/21 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control'.

14. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum and this, combined with a sound corporate governance framework in place within the Board throughout 2020/21, provides assurance for the Chief Executive as Accountable Officer.

15. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place.
    - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, this process has been enhanced with guidance on content provided by the Director of Finance and Strategy. These assurances have been reviewed and no control issues, breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19 and the work to remobilise. The Governance Statement includes details of the Board performance and risk profile and future changes to Strategy Development and Strategic Planning and Resource Allocation. The risk management section of the Governance Statement is particularly helpful in describing the enhancements required to the risk arrangements and profile of the organisation. All elements of the Governance Statement have been considered by Internal Audit.

Key Themes

18. As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. We welcome the progress with the Strategic Allocation and Resource Process which has informed the annual plan (RMP3).

19. We are pleased to note that new Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, is under development and due to be presented to the Board for approval in March 2022.

20. We highlight the strong communication within the Board, in these challenging times, with Staff Link providing a constant feed of news and a Weekly News Roundup via email, which provides Operational, Clinical, Workforce, Staff Health & Wellbeing and Research & Development updates, as well as a useful links and updates from the Health & Social Care Partnership (HSCP) Director.

21. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains recommendations aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. We note the progress with the update of the Digital and Information, Strategic Planning and Financial Sustainability BAFs. The Quality and Safety BAF is planned for review as part of the work ongoing with the Assurance Mapping Group.

22. Whilst there have been positive improvements in a number of areas, we would highlight in particular Information Security and Information Governance, where the Board's own systems have identified issues in addition to those highlighted by Internal Audit and made the improvements necessary to achieve minimum standards.

Key developments since the issue of the ICE included:

- The third iteration of the Remobilisation Plan, RMP3 covering the period April 2021 – March 2022, was submitted to the Scottish Government on 26 February 2021 and presented to the Board, as soon as possible, in May 2021.
- Corporate Objectives have been developed and were approved at the 27 July 2021 Board Meeting.

- Overall, there has been good progress on recommendations from the ICE. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.
- The development of the Health and Wellbeing Strategy and timetable agreed.

23. During 2020/21 we delivered 28 audit products to the NHS Fife Audit and Risk Committee (May 2020 to June 2021 meetings). These audits reviewed the systems of financial and management control operating within the Board and provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

24. A number of our reports, including the ICE and Sustainability work, have been wide ranging and complex audits which have relevance to a wide range of areas within Fife. These should provide the basis for discussion around how NHS Fife can best build on the very good work already being done to improve and sustain service provision.

25. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Internal Audit have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit and Risk Committee. In March 2021, Internal Audit carried out a review of outstanding recommendations and removing from the Audit Follow Up system actions which had been completed, or were consolidated and superseded by recent audit products. As reported to the 17 June 2021 Audit and Risk Committee, of the 49 audit actions remaining, 33 had date extensions, 6 were overdue and 10 were not yet due.

ADDED VALUE

26. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

    - Examining a wide range of controls in place across the organisation.
    - In conjunction with Local Authority Internal Auditors, providing advice and support during 2020/21.
    - Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
    - Continuing to liaise with management and providing ad-hoc advice on a wide-range of governance and control issues.
    - Provision of Committee Assurance principles and risk guidance which were considered and endorsed by the Audit and Risk Committee for adoption by Standing Committees. We continue to engage with national groups to ensure that our approach is congruent with forthcoming SGHSCD developments.
    - Assurance mapping and risk advice, in particular on Digital and Information risks.
    - Consideration of how best to provide Directors' assurances required under the Scottish Public Finance Manual and production of a potential template for use in future years.

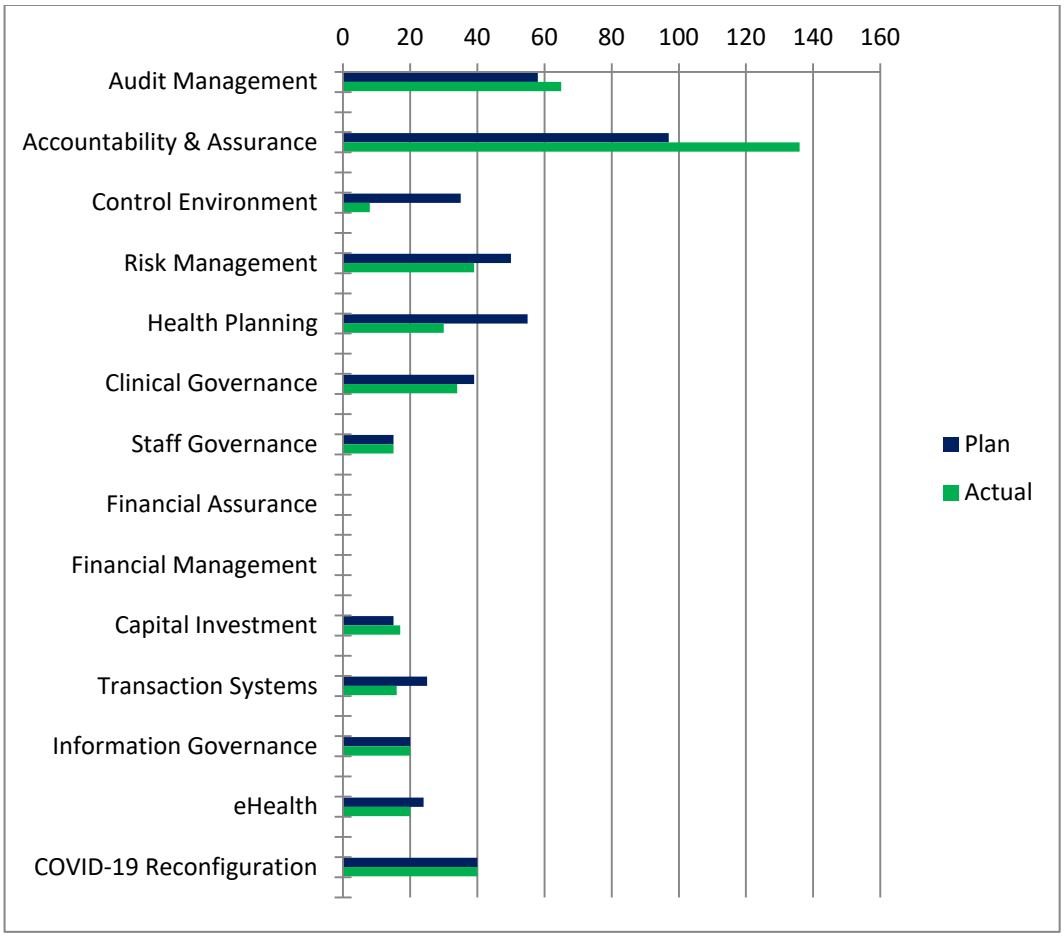
- Advice provided to the process maps for agency nurses and authorisation of invoices, etc.
- Initial review of NHS Fife's proposed approach to strategic planning and resource allocation.
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Suggested amendments to the draft Integration Scheme and preparation for assumption of the Chief Internal Auditor role for Fife IJB from April 2021 onwards.

27. Internal Audit have also used any time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

- Revision of the internal audit reporting protocol and flowchart.
- Development of a revised client quality questionnaire.
- Update and enhancement of the FTF Intelligence Library.
- Review of internal documentation and processes including analytical review and performance review, again to ensure we add value wherever possible.
- Review and update of our risk assessment categorisation.
- Ongoing development of the FTF website.
- Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.

INTERNAL AUDIT COVER

28. **Figure 1: Internal Audit Cover 2020/21**



29. Figure 1 summarises the 2020/21 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 13 July 2020. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit and Risk Committee approved amendments in March 2021. We have delivered 439 days against the available 473 days.

30. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2020/21 audits for inclusion in the 2021/22 plan.

31. A summary of 2020/21 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

32. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2020/21. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF Client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2020/21 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

33. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

34. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

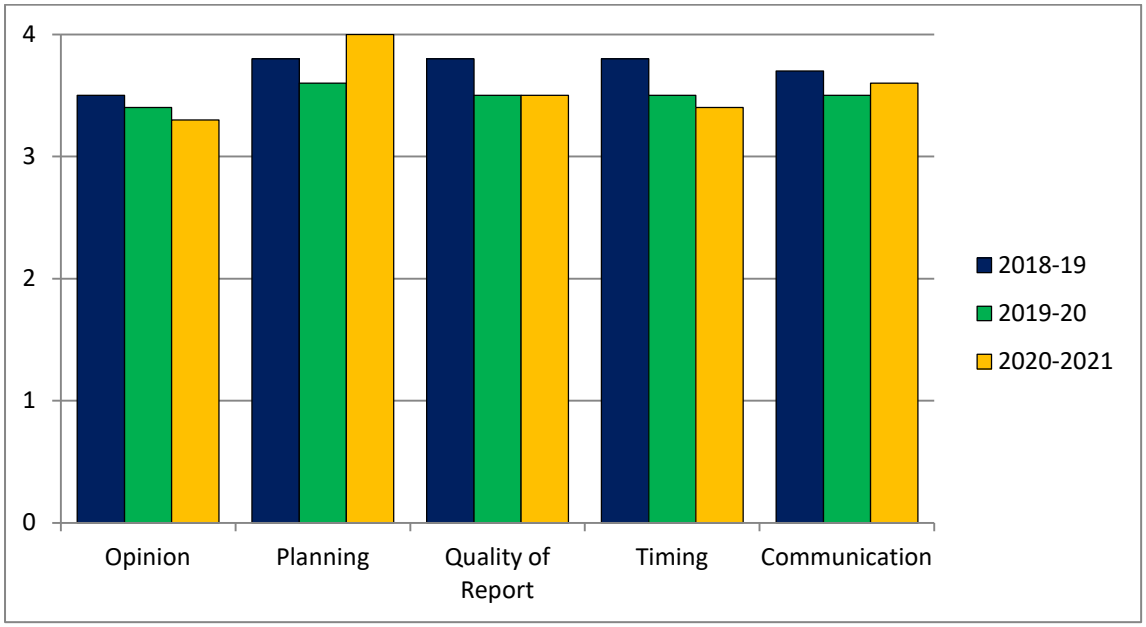
35. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

36. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Fife Internal Audit Service in 2018/19, concluded that *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment and this will be reported to the NHS Fife Audit and Risk Committee in early 2021/22.

37. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

38. **Figure 2: Summary of Client Satisfaction Surveys**

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



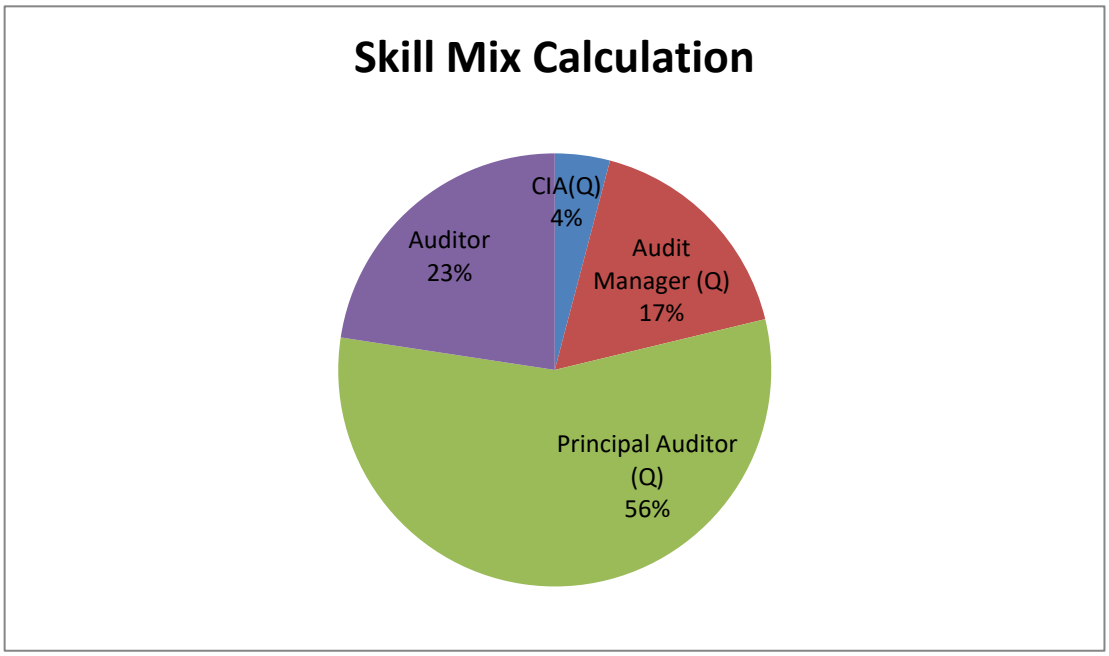
39. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

40. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2020/21 the audit was delivered with a skill mix of 77%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

41. **Figure 3: Audit Staff Skill Mix 2020/21**

Audit Staff Inputs in 2020/21 [days] Q= qualified input.



ACKNOWLEDGEMENT

42. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

43. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance and Strategy, the Board Secretary, EDG and the Audit and Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (B08/21) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the SPRA as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive***	• The Board noted and approved the RMP 3 at the May 2021 Board meeting. • The Board has been kept informed of the development of the Strategy through a number of updates including a Board Development Session on the progress of the Population Wellbeing Strategy for Fife on 27 April and an update on Strategy Development on 29 June 2021. • An update on the Strategic Planning & Resource Allocation Process (SPRA) was presented to the 12 January 2021 meeting of the Finance Performance & Resources Committee (FP&RC). The SPRA process was planned to support the development of an organisational strategy and 3 year financial and strategic plan. However, disruption caused by Covid has necessitated a more fluid and agile approach to planning this year. The Remobilisation plan RMP3 has been informed by the SPRA process and was approved by the Board in May 2021. A Remobilisation Forum has been established to update the tracker for the RMP3. This will also be used to track progress with RMP4, which is due to be submitted to the Scottish Government in September 2021. • The update on SPRA presented to the 12 January 2021 FP&RC meeting included a timetable the submission of directorate templates by 31 March 2021. • The SBAR to the FP&RC meeting held on 16 March 2021 stated 'the *output from the SPRA process will*	 **On track**

	be part of the development of the new Health and Wellbeing Strategy following on from the Clinical Strategy. This is due to be presented to the Board in March 2022'. The reporting on progress of the RMP3, is through a Tracker which will be monitored by the EDG and Remobilisation Forum. The FP&R Committee receive updates on the SPRA. The RMP3 is also monitored through the ESIPQR performance reporting to the Board.	
2. Governance and Year end Assurances Coordination of the year-end governance reports and statements of assurance is well underway. This will conclude in the normal timeframes – **June 2021,** specifically • Adoption of Assurance Mapping principles **– June 2021** *Action Owner: Director of Finance and Strategy*	• Templates were produced for year end assurances and governance reports and statements have been provided. • Year End Review shows significant progress, with workplans for Standing Committees being reviewed, to ensure that they are fit for purpose in a covid related environment. • Year-end governance reports and statements were comprehensive and meaningful. • Significant progress has been made with the implementation of Assurance Mapping principles. The Committee Assurance Principles for best practice, produced by Internal Audit were presented to the March 2021 meeting of the Audit and Risk Committee and were considered and endorsed. The Environmental Sustainability & IJB BAFs require an update on narrative and Covid risks.	 **On track**
3. Clinical Governance Framework Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration Principles. ***Action Owner: Medical Director***	• As per internal audit report B19/21 the Clinical Governance Strategy and Framework are being revised. A consultation process, including evaluation of the current governance reporting lines, is underway and an outline timetable is in place with a final version of the revised strategy scheduled to be presented to the CGC and Fife NHS	 **On track**

	Board towards the end of 2021/22. • The approach to presentation of the BAFs and corporate risks are currently being reviewed by the Director of Finance & Strategy (Executive Lead for RM) with full involvement of EDG.	
4. Whistle Blowing • An annual report from the Whistleblowing Champion (WBC) cannot be provided until a WBC is appointed to NHS Fife. In the absence of a WBC a report is being presented to the Board which includes whistleblowing data. The SGC action plan 2021/22 will include the reporting requirement from the Whistleblowing Champion – **March 2021** ***Action Owner: Director of Human Resources***	• The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and their replacement attended their first Staff Governance meeting as a member on 1 July 2021 and provided an update to the Staff Governance Committee on the role of the Whistleblowing Champion at the September meeting. • Fife NHS Board was updated, on 31 March 2021, regarding the new Whistleblowing Standards, which came into effect on 1 April 2021 and provided the 2020/21 annual report. The update stated that that no Whistleblowing concerns had been raised in the financial year to 31 March 2021. Future reports will facilitate discussion around whether this indicates whether staff are sufficiently encouraged/facilitated staff to raise concerns. • The SGC Workplan for 2021/22 includes 'Whistleblowing – Reporting of Incidents/Data' will be reported quarterly to the SGC which started September 2021 with the first quarter 1 April to 30 June 2021. • The report template of annual and quarterly assurance reports is being further developed to include the statistical information, analysis and conclusions required by the standard in order to allow a conclusion on the adequacy and effectiveness of whistleblowing arrangements.	 On track

5. Property Management Strategy • Property and Asset Management Strategy (PAMS) is on the Agenda for the NHS Board in March 2021. • We anticipate that there will be a requirement for an East Regional PAMS report in the near future. The data in this document represents NHS Fife position as at 1 April 2020. • The 2020 PAMS document is largely retrospective and represents the pre-Covid19 landscape, the Impact of Covid19 will be further considered as part of the 2021 full PAMS which will be compiled between April and July 2021 by NHS Fife and likely submitted as part of an East Regional PAMS report – August 2021 ***Action Owner: Director of Property and Asset Management***	• The interim PAMS for 2020 was presented to the FP&RC in March 2021 and reflected the position from 1 April 2020 to March 2021. Currently the target for approval of the NHS Fife PAMS document by the NHS Board is November 2021 following scrutiny by EDG, FCIG and FP&RC. NHS Fife is currently reviewing any requirement for a regional component of PAMS going forward.	 On track
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group ToR • Digital and Information Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and	• Annual Assurances were received by the CGC from the Information Governance & Security Steering Group and the Digital and Information Board. The IG&SSG statement recognised the requirement to '*further enhance and develop suitable controls in some areas*'. This is consistent with our report on D&I Governance Arrangements (B28/21) which followed up this ICE recommendation. • Additional assurance reporting has been included in the Clinical Governance Committee Annual Workplan with IG&S reporting to the Committee in July 2021 with a follow up to be agreed later in the year. • The risk regarding affordability of the NHS Fife D&I Strategy was reflected in the most recent iteration of the D&I BAF and	 On track

Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital***	included in the D&I Strategy Update provided to the June Clinical Governance Committee meeting.	

Corporate Governance

BAF Risks:

- **Risk 1675 – Strategic Planning - 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.**
- **Risk 1676 – Integration Joint Board - There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.**

Strategy

The ICE report highlighted the opportunity to build on the strong foundation of existing reconfiguration and remobilisation processes, in order to produce an overarching strategy which allows effective prioritisation and creates sustainable services allowing for the changes to demand, resources and modes of operation created by Covid19.

The Strategic Planning Resource Allocation (SPRA) Framework was created to inform both a medium term strategy and support the development of a longer term organisational strategy. The Directors discussed and agreed the output of the SPRA process on 22 February 2021, where three key objectives were identified. The output of the SPRA process was presented to the March 2021 meeting of the Finance, Performance and Resources Committee:

- Minimise transmission of Covid19 and support health protection
- Improve whole system capacity and flow to ensure timely and appropriate access to health care when required
- Support the actions required to reduce health inequalities

The SPRA process also informed the key objectives for NHS Fife for 2021/22. An EDG workshop was held in March 2021 where key Strategic Priorities for the organisation were agreed, prior to Board approval on 27 July 2021 and represent the key objectives for delivery in 2021/22. These priorities, each aligned to a Executive Director, will be used as the framework to provide assurance to the Board on delivery of the Corporate Objectives:

1. To Improve Health and Wellbeing
2. To Improve the Quality of Health and Care Services
3. To Improve Staff Experience and Wellbeing
4. To Deliver Value and Sustainability

The SBAR presented to the July 2021 meeting of the CGC provided assurance that the objectives for 2021/22 are aligned to NHS Fife Strategic Priorities and will be aligned to the 'in development' Population and Wellbeing Strategy which is due to be presented to the Board in March 2022, with progress monitored by the EDG and the recently established Population Health and Wellbeing Committee.

Covid19 & Governance

NHS Fife has continued to monitor and adapt governance arrangements whilst taking account of the pressures on management and the need to free operational staff to prioritise the response to Covid19. Covid reporting to the Board has continued and covers: Covid19

Vaccination, Test and Protect and Covid19 Testing in Fife.

A revised Code of Corporate Governance was approved by the Board in May 2021, which includes the recently revised remits of the Board Committees. The SBAR presented to the Board noted that further changes to the Code are likely to be required to reflect the work underway for the implementation of the NHS Scotland Blueprint for Good Governance.

Assurance Mapping

The Chief Internal Auditor, working with officers from NHS Fife and other Client Health Boards, developed a set of Committee Assurance Principles, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them. These were recommended for use by Standing Committees at the May 2021 Audit and Risk Committee. B12/21 Assurance Framework, provided assistance to the Board in developing an assurance map for key aspects of the Digital and Information Governance BAF.

Remobilisation

The draft NHS Fife Remobilisation Plan - April 2021 to March 2022 (RMP3) was submitted to Scottish Government (SG) on 26 February 2021. Feedback and sign off from SG was received on 2 April 2021 and the RMP3 was presented to the Board for formal approval at the May 2021 Board Meeting which was the earliest opportunity following the Scottish elections.

The ICE 2020/21 report recommended establishing greater formality of reporting of remobilisation progress through governance structures. An action tracker has been developed by the Executive Directors Team (EDG). A Remobilisation Plan Forum has been re-established to review the Action Tracker, which will be updated every 2 months, in preparation for presentation to the EDG. The update on RMP3 due in July was not taken through the EDG and Standing Committees but we have been informed that subsequent updates will be presented to the EDG and on to the Standing Committees of the Board. The RMP3 activity template is an integral part of the performance reporting to the Board and is included within the Fife Integrated Performance & Quality Report Executive Summary. The Associate Director of Strategic Planning has advised that the Remobilisation Plan Forum will meet every two weeks in preparation for the submission of the RMP4 to the Scottish Government for 30 September 2021. The RMP4 is planned for presentation to the Board in November 2021. We note the extremely challenging ambition within Fife's response to RMP4 guidance and the intention to increase elective output above pre-covid levels.

Risk Management

As reported within the B08/21 ICE 2020/21 report, a number of BAFs have been updated for Covid19; however the Board has not received an overall Covid19 risk or been informed on how these will be incorporated into the BAF. The Quality and Safety BAF will be reviewed as part of B11/22 Assurance Framework. As noted previously, the IJB BAF and the Environmental Sustainability BAF still require review and update to reflect the current risks and mitigating actions.

The risk profile remained largely static throughout the year, again as noted within the ICE, with the exception of both the Financial Sustainability and Strategic Planning BAFs risk ratings which were updated appropriately.

During the year, a high level covid risk register of the highest organisational risks was developed via the Emergency Command structures which were considered by the EDG, although they were not presented to the Board or a Standing Committee nor were they incorporated into the BAF. Standing Committees and the full Board were however presented with regular updates on the activities and risks included in the ongoing response to the

Covid pandemic.

The SBAR presented to the June 2021 Audit and Risk Committee advised that the Corporate Risk Register (CRR) will be presented to the EDG, where all escalated active high risks or operational risks will be considered for inclusion on the CRR and/or as a linked risk on the BAF; this is still ongoing. Draft Internal Audit report B13/21 - Risk Management Strategy Standards and Operations Phase 1 identified key areas for improvement for the revised Risk Management Framework. We were pleased to note that the Executive Lead for Risk Management has agreed to secure a short-term resource to undertake a risk maturity assessment of the organisation and review and improve risk management arrangements, priorities and risk structures including the development of detailed improvement plans and focussed reporting.

Performance

The Board was presented with the Integrated Performance Quality Report Executive Summary (ESIPQR) at the July 2021 meeting.

Highlights include that NHS Fife has continued to exceed the Cancer 31-day Diagnostic Decision to first Treatment (DTT) target and inpatient falls with harm. Drug and Alcohol Treatment Waiting Times are also above target performance.

The Patient Treatment Time Guarantee (TTG), New Outpatients and Diagnostics are all performing below target, although they are all well above the Scotland average.

There are continued challenges with meeting targets for the following key indicators: 4 Hour Emergency Access, where current performance is 3.1% under the target of 91.9% although over the Scotland average of 88.7%; Complaints (stage 2 closure rate) where current performance is 21.6% with a target of 65%; 18 weeks RTT where current level is 69.2%, slightly below the Scotland average of 75.9%; the Sickness Absence rate is currently 5.07% with a target of 4.0%. It was noted that Covid19 related absence affected approximately 1.52% of the NHS Fife workforce in March and 0.62% in May.

NHS Fife are successfully delivering against the remobilisation plan for TTG Inpatient/Daycase Activity; New OP Activity; Elective Imaging Activity; A&E Attendance; Emergency Admissions; Urgent Suspicion of Cancer; CAMHS and Psychological Therapies. The Board has been less successful meeting the projected targets for Elective Scope Activity and 31 Day Cancer – First Treatment and the challenges are likely to increase given the ambitions around elective activity and the likely backlog of unrecognised need and higher case mix in relation to both targets.

Integration

An update on the review of the Integration Scheme was presented to the March 2021 Board meeting. The Scottish Government indicated that due to the constraints placed on Boards caused by the Pandemic, they are content that local reviews are concluded with an indicative timescale provided on the planned conclusion. The revised Scheme will be considered for approval by the Board in September 2021, before being submitted to Scottish Government for final sign-off.

Clinical Governance

BAF Risks:

- **Risk 1674 – Quality and Safety - 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.**

Annual Report

The Clinical Governance Committee (CGC) annual report provided a reflective and nuanced conclusion that the Committee had fulfilled its remit and that adequate and effective clinical governance arrangements were in place throughout NHS Fife during the year. The narrative in the report includes detailed reflection on key areas including nosocomial covid infection, the risk based approach taken to service pause during the pandemic and mitigating action taken to minimise the impact of this on patient treatment and diagnosis.

Pandemic

The CGC received reports on Shielding, Testing, Care Homes, PPE, Medicines Availability, Remobilisation of Clinical Services, Nosocomial Related infections and the Covid Vaccination Programme during 2020/21.

During the year, the Board experienced significant challenges initially in delivering the seasonal flu programme. The Chief Executive commissioned an independent review which made 9 recommendations. The CGC in January 2021 was informed that 4 actions had been completed and the remainder were on track, although no subsequent reports were produced to provide assurance that the remaining actions were complete.

An external review of all immunisation programmes in NHS Fife subsequently made recommendations to allow NHS Fife to meet the increasing demands and expectations for childhood and adult immunisation programmes. Recommendations were approved by the EDG at their 6 May 2021 meeting and are due to be presented to an extraordinary meeting of CGC in September 2021, which will consider the forthcoming flu and Covid19 booster immunisation programmes.

Clinical and Care Governance Strategy and Framework

A revised Clinical Governance Strategy, now to be referred to as the Clinical Governance Framework, is in development. This will contain reference to the integration framework which is also in development. An engagement process has been established with the finalised strategy scheduled to be presented to the NHS Fife Clinical Governance Committee and Fife NHS Board by January 2022. There are also a number of contributing Workstreams underway which will enable and inform the Framework development including:

- Adverse Event Process and Policy Review
- Development of an Organisational Learning Group
- Review of Internal Audit Findings
- Review of the Risk Management Framework.

Internal audit report B19/21 followed up previous internal audit reports on Clinical Governance Strategy and Assurance. Most recommendations had been implemented or superseded although there is still a need to ensure that the revised strategy and framework provide a clear vision of responsibility for clinical governance across NHS Fife's span of

responsibility including clinical areas delegated to the Integration Joint Board. Clearly, the Clinical Governance Framework will need to align with the development of other NHS Fife strategies including the Population Health and Wellbeing Strategy for NHS Fife.

CGC Governance and Assurance

The workplan is reviewed following each meeting to assure the committee that key business has been covered and to track any delayed items.

The work being undertaken to develop the new Clinical Governance Framework will consider all groups and committees in the framework to ensure that appropriate assurance reporting and scrutiny is provided as efficiently as possible. The committee and integration assurance principles prepared by Internal Audit will be used as a guide in this process.

Risk Management

The scoring and information on the 3 BAFs considered by the CGC (Strategic planning, Quality and Safety, and Digital and Information) did not significantly change during 2020/21, despite enormous changes to the risk environment and to the application of a number of key controls. A complete review of all BAFs and corporate risks is underway being led by the Executive Director for Risk Management (Director of Finance and Strategy) and will include integrating risk management in the strategic planning process. A commitment was made at CGC to specifically consider combining remobilisation, transformation and strategic planning into one BAF and responsibility for this BAF has transferred from the Medical Director to the Director of Finance and Strategy.

Our work in internal audit B11/22 will include providing guidance regarding assurance mapping and will specifically consider the Quality and Safety BAF.

Risk management arrangements are continuing to evolve, with dedicated senior Leadership from the Risk Manager and Adverse Events now managed separately.

Pandemic related risks were considered via the Bronze, Silver and Gold command structure. However the risk associated with interruptions to treatment and diagnostic services and resultant patient harm were not recorded overtly even though it has the potential to be one of, if not the most significant threat to the wellbeing of patients. Whilst we are aware that some controls are in place, it is of concern that this key risk has not been included within the risk register nor discussed with the CGC, which would provide the opportunity to assess and assure the adequacy and effectiveness of these key controls.

We recommend the development of a specific risk, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. This would allow the CGC to understand the quantum of the risk and also to monitor the controls already in place to mitigate it, for example, the clinical prioritisation and remobilisation framework developed in line with Scottish Government guidance.

External Review

The NHS Fife CGC Annual Assurance Report now includes reference to the External Reports related to NHS Fife Clinical Governance that have been published during the year and high level assurances on action being taken to address issues identified. We previously highlighted the need to triangulate data and information from different sources in order to assess the reliability of internal assurances; this has not yet been implemented but will be considered as part of the revised internal control framework for Clinical Governance and developed further through the Organisational Learning Group.

Significant Adverse Events

A full review is currently being undertaken of the processes associated with recording and investigating adverse events and for ensuring the required actions are implemented in all areas of the organisation they apply to. A Short Life Working Group (SLWG) is being established to take this forward and will consider the overall process, the triggers for LAERs and SAERs and the education, learning and communication required related to the process. The SLWG is to commence its work in September 2021 and will report to the Adverse Events & Duty of Candour Group and the Clinical Governance Oversight Group with a paper detailing the outcome to be presented to the Clinical Governance Committee when the work is complete.

Organisational Duty of Candour

The Organisational Duty of Candour Annual Report for 2020/21 is on the Clinical Governance Workplan for November 2021. In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement.

Clinical Policies and Procedures

The latest report to the Clinical Governance Oversight Group in April 2021 indicated that 100% of Clinical Policies and Procedures had been reviewed by their scheduled review date.

Other Areas

Inpatient falls with harm have increased during the pandemic. Improvement work has been undertaken in those areas that have seen the largest spike in numbers and the Inpatient Falls Steering group are refreshing their workplan to include learning from experiences during Covid and how care needs to adapt.

Efforts are underway to address the backlog of complaints caused by the pandemic and to bring response timescales back in line with legislative timescales.

Action Point Reference 1 - Increased Risk of Harm

Finding:

Pandemic related risks were considered via the Bronze, Silver and Gold command structure. However there are major risks associated with SGHSCD mandated interruptions to treatment and diagnostic services. These have the potential for significant resultant patient harm which have not been recorded overtly even though they have the potential to be one of, if not the most significant threats to the wellbeing of patients. Whilst we are aware that some controls are in place, it is of concern that this key risk has not been included within the risk register nor discussed overtly as a risk with the CGC, which would provide the opportunity to assess and assure the adequacy and effectiveness of these key controls.

Audit Recommendation:

A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. This would allow the CGC to understand the quantum of the risk and also to monitor the controls already in place to mitigate it, for example, the clinical prioritisation and remobilisation framework developed in line with Scottish Government guidance.

The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect:

- The key priorities and aims for 2021/22 within the current remobilisation plan.
- Other relevant controls, such as implementation of RCS guidelines
- A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates.
- Identified requirements to redesign services.

Assessment of Risk:

Significant  Weaknesses in control or design in some areas of established controls.
Requires action to avoid exposure to significant risks in achieving the objectives for area under review.

Management Response/Action:

The development of a risk as recommended above will form part of the review and update of the Quality & Safety BAF. This review will take account of the short, medium and longer term impact of the pandemic on service provision and consider the corresponding controls and assurances that require to be in place, linking to the evolving Population Health and wellbeing Strategy.

Action by:	Date of expected completion:
Head of Quality and Clinical Governance	**November 2021**

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy.**

Governance

The April 2021 Staff Governance Committee (SGC) received a self-assessment by members of the operation of the committee together with improvement actions including number of attendees, role and contribution; agenda management; and report content and related actions.

The SGC Annual Statement of Assurance concluded that the Staff Governance Committee fulfilled its remit and that adequate planning and monitoring arrangements were in place.

Pandemic

Regular updates on Staff Health and Wellbeing were presented to SGC in 2020/21 which included assurances regarding staff resourcing, induction and learning, communications & guidance, staff wellbeing hubs and psychological support for staff but no information on PPE, Social Distancing or Home Working, which were key risks at that time. The HSE issued a 'Notice of Contravention' following their spotcheck of Covid Management at Victoria Hospital in November 2020. This was considered by the December 2020 Health and Safety Sub Committee (and reported to the January 2021 SGC) with assurance that an official response would be provided to HSE by the end of January 2021 by which time most actions would have been implemented. The HSE closed the Contravention Notice on 31 March 2021. It is not clear that the committee received comprehensive, overt internal assurances on the impact of Covid19 on staff throughout the year.

Risk Management

The Workforce Sustainability BAF was considered at SGC meetings other than 4 March 2021.

The content of the Workforce Sustainability BAF has not altered significantly during 2020/21 and the current risk rating remains high. The Director of Workforce informed the July 2021 SGC that the development of the Workforce Strategy 2022-2025 will provide the opportunity for a thorough review of the BAF.

Staff Governance Action Plan

No specific year-end assurance provided to SGC on the Staff Governance Action Plan as work on this was paused due to the pandemic. The SGC Annual Statement of Assurance states that '*A particular strand of the Staff Governance standards is reviewed at each meeting, ensuring full coverage over the year's meeting schedule'.* Although papers relating to each strand of the Staff Governance were discussed throughout the year, their strand to which they relate was not always highlighted in the papers, agenda or minutes and there was no year-end summary to demonstrate coverage achieved. However, it is included in the 2021/22 workplan going forward and will be made overt in future papers.

The action lists from SGC meetings held in 2020/21 record the pausing of the Staff

Governance Action Plan.

Staff Governance Standard Annual Monitoring Return 2020/21

Scottish Government has requested returns from all Boards by 24 September 2021. The NHS Fife return, which focuses on the five individual strands of Staff Governance as well as staff experience and culture, has been developed and presented to Executive Directors Group, Area Partnership Forum, and the Staff Governance Committee. The Return will be signed by the Chair of Staff Governance Committee and the Employee Director will endorse the Return in September 2021 prior to being submitted to Scottish Government.

Workforce Strategy, Planning and Delivery

SGC were updated at their 1 July 2021 meeting that the NHS Fife Workforce strategy refresh will be completed in conjunction with the development NHS Fife Population Health & Wellbeing strategy. Consultation and engagement timescales for the Workforce Strategy development will therefore progress in parallel.

The Operational Workforce Planning Group, with oversight from the Strategic Workforce Planning Group, is in the process of reviewing the extant Workforce Strategy and associated action plans prior to March 2022. Service leads have been asked to update action plans produced as part of the 2019-2022 Workforce Strategy, confirming the status of each commitment, the results of which will be summarised at a future Staff Governance Committee. The review is being led by the development of the new NHS Fife Population and Wellbeing Strategy and is considering short term issues such as current capacity and staffing requirements as well as longer term prognoses for need and provision.

A draft Interim Joint Workforce Plan 2021/2022 was presented to SGC on 29 April 2021 prior to submission to the Scottish Government. The plan includes an emphasis on the staff wellbeing agenda, focusing on the ongoing implications of Covid delivery in terms of test and protect, staff and patient testing, vaccination, occupational health and infection control.

Whistleblowing

The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and the newly appointed Whistleblowing Champion attended her first Staff Governance meeting as a member on 1 July 2021.

The March 2021 Board was informed of the implementation of the Whistleblowing Standards, which came into effect on 1 April 2021 and the June Audit and Risk Committee was informed that regular Whistleblowing reports would be provided in future. No Whistleblowing concerns were raised in first quarter of 2021/22. A report on implementation of the standards has been presented to the SGC and future reports will contain the data required by the new national standards as they evolve.

Performance Development Plans

The SGC was updated regarding the completion of Performance Development Plan Reviews at its September 2020 and January 2021 meetings. To reflect the impact of the pandemic, the target was reduced from 80% completion target to 55%. However, year-end completion was only 36% as noted in the Staff Governance Annual Report.

Medical Revalidation and Appraisal

The General Medical Council deferred revalidation for a year for all those due 16 March 2020 - 31 March 2021 and medical appraisal was paused across Scotland from 16 March 2020 - 1 October 2020. In Fife there was an additional pause at the beginning of January 2021 for 6 weeks. Many medical staff were given exemptions for 2020/21 as a result. It is

anticipated that 2021-22 will see a partial return to normal practice, although there are likely to be some technical difficulties with some aspects of required experience.

Attendance Management

Papers to SGC in 2020/21 indicate that efforts continue to be made to reduce staff absences including staff wellbeing activity such as mindfulness sessions, staff wellbeing hubs and access to psychological support.

The average percentage of staff absent in 2020/21 was 5.06% which is an improvement on the 2019/20 figure of 5.85% but still significantly higher than the notional national target of 4%.

Covid19 related absences are not included in the absence data quoted above and for 2020/21; the average percentage of hours lost due to Covid19 related absences within NHS Fife was 2.27%.

Remuneration Committee

The Remuneration Committee met on 5 occasions in 2020/21. The self assessment also considered that the operation of the committee during the pandemic had continued without interruption and that assurance could continue to be given to the Board on the areas under its remit.

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy.**

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The SGC Annual Statement of Assurance concluded that the Staff Governance Committee fulfilled its remit and that adequate planning and monitoring arrangements were in place.

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Risk Management

The Workforce Sustainability BAF was considered at SGC meetings other than 4 March 2021. The content of the Workforce Sustainability BAF has not altered significantly during 2020/21 and the current risk rating remains high. The paper presented to the 1 July 2021 SGC indicated that the development of the Workforce Strategy 2022-2025 will provide the opportunity for a thorough review of the BAF.

Staff Governance Action Plan

No specific year-end assurance provided to SGC on the Staff Governance Action Plan as work on this was paused due to the pandemic. The SGC Annual Statement of Assurance states that '*A particular strand of the Staff Governance standards is reviewed at each meeting, ensuring full coverage over the year's meeting schedule'.* The agenda and minutes of the SGC do not specifically highlight the papers presented relevant to each strand of the Scottish Government standards and no table illustrating this was included in its annual statement of assurance but a review of the papers indicates that papers relevant to each strand were discussed at the meetings. The action lists from SGC meetings held in 2020/21 record the pausing of updating the Staff Governance Action Plan.

Staff Governance Monitoring Return 2020/21

Scottish Government has requested returns from all Boards by 24 September 2021. The NHS Fife return, which focuses on the five individual strands of Staff Governance as well as staff experience and culture, will be completed and presented to Area Partnership Forum for approval in September 2021 prior to being submitted to Scottish Government.

Workforce Strategy Development and Delivery

SGC were updated at their 1 July 2021 meeting that the NHS Fife Workforce strategy refresh will be completed in conjunction with the development of the NHS Fife Population Health & Wellbeing strategy. Consultation and engagement timescales for the Workforce Strategy development will therefore progress in parallel.

The Operational Workforce Planning Group, with oversight from the Strategic Workforce Planning Group, is in the process of reviewing the extant Workforce Strategy and associated action plans prior to March 2022. Service leads have been asked to update action plans produced as part of the 2019-2022 Workforce Strategy, confirming the status of each commitment, the results of which will be summarised at a future Staff Governance Committee. The review is being led by the development of the new NHS Fife Population and Wellbeing Strategy and is considering short term issues such as current capacity and staffing requirements as well as longer term prognoses for need and provision.

An action plan to underpin the strategy is being developed by the Operational Workforce Planning Group which will include commitments within the Joint Interim Workforce Plan for 2021/2022, the Remobilisation Plan and other service review programmes.

Workforce Planning

A draft Interim Joint Workforce Plan 2021/2022 was presented to SGC on 29 April 2021 prior to submission to the Scottish Government. The plan includes an emphasis on the staff wellbeing agenda, focusing on the ongoing implications of Covid delivery in terms of test and protect, staff and patient testing, vaccination, occupational health and infection control.

Whistleblowing

The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and their replacement attended their first Staff Governance meeting as a member on 1 July

2021.

The March 2021 Board was informed of Whistleblowing standards, which came into effect on 1 April 2021 and the June Audit and Risk Committee was informed that regular whistleblowing reports would be provided to the NHS Fife Board in future. No whistleblowing concerns were raised in first quarter of 2021/22 and no report was provided to the Board. A draft quarterly whistleblowing report template was presented to the EDG on 5 August 2021 but Internal Audit have noted that it did not contain provision for recording much of the information required by the new standards.

Performance Development Plans

The SGC was updated regarding the completion of Performance Development Plan Reviews at its September 2020 and January 2021 meetings. To reflect the impact of the pandemic, the target was reduced from 80% completion target to 55%. However, year-end completion was only 36% as noted in the Staff Governance Annual Report.

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Attendance Management

Papers to SGC in 2020/21 indicate that efforts continue to be made to reduce staff absences including staff wellbeing activity such as mindfulness sessions, staff wellbeing hubs and access to psychological support.

The average percentage of staff absent in 2020/21 was 5.06% which is an improvement on the 2019/20 figure of 5.85% but still significantly higher than the national target of 4%.

Covid19 related absences are not included in the absence data quoted above and for 2020/21; the average percentage of hours lost due to Covid19 related absences within NHS Fife was 2.27%.

Remuneration Committee

The Remuneration Committee met on 5 occasions in 2020/21. The self assessment also considered that the operation of the committee during the pandemic had continued without interruption and that assurance could continue to be given to the Board on the areas under its remit.

Financial Governance

BAF Risk:

- **Risk 1671 – Financial Sustainability - There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.**
- **Risk 1672 – Environmental sustainability - There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation**

Financial Targets and Savings

As reported to the 27 July 2021 Board, the draft financial outturn position to 31 March 2021 subject to external audit review, was:

- A surplus of £0.377m against a Revenue Resource Limit of £870.979m.
- 99.98% of total capital allocation spent against Capital Resources of £17.315m.
- 2020/21 savings delivered of £11.766m, of which £5.430m (46%) are recurring. Also received £8.3m support from Scottish Government in relation to Covid19 savings delays.

Financial Planning 2020/21

NHS Fife considered the Financial Plan as part of its draft Annual Operational Plan for 2020/21 – 2022/23 at the March 2020 meeting of the FP&RC, noting that plans will be subject to constant review. The Plan set out a position to deliver financial balance, and the savings requirements, over the next 3 year period. The plan was based on NHS Fife's continuing response to the pandemic, recovery and remobilisation priorities.

The Financial Plan for 2021/22 is a part of the RMP3 for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership, with this plan to be the Annual Operational Plan for 2021/22. Key financial assumptions were included as part of the overall financial plan.

Savings

Initial savings targets were set out in the 2020/21 financial plan. Savings in 2020/21 have come largely from unsustainable non-recurring sources which will increase the financial gap in future years. The gap in plan before efficiencies for 2021/22 is £21.837m with planned savings of £8.181m, which will make achieving financial balance in 2021/22 extremely difficult. In the longer term, financial sustainability will only be achieved through a combination of securing full NRAC parity, review of external commissioning costs and levels and the redesign of services with very clear priorities, which should arise from the new Health and well-being Strategy and the SPRA process.

Financial Reporting

Finance reporting to Board and FP&RC has been transparent and the Director of Finance has consistently and clearly articulated financial challenges, including the need for confirmation

of allocations to cover Covid19 costs and the delay in delivering anticipated savings in 2020/21. We are aware of the ongoing discussions on potential IJB risk share options with Scottish Government and respective partners.

Capital Plan and Property Strategy

An Interim Property & Asset Management Strategy (PAMS) update for 2020 was provided to the March 2021 PRC. This followed Scottish Government reporting requirements and forms part of a 'state of the nation' report. An update was also provided to the July 2021 PRC around the production of the PAMS report for the year to 31 March 2021. This report is not mandatory but NHS Fife have decided to produce. Delays have been experienced due to the late release of the templates by the Scottish Government with the target for approval of the NHS Fife PAMS document by the NHS Fife Board in November 2021. It would be beneficial for the PAMS produced to have clear links to the Health and Wellbeing Strategy development.

The FP&RC receive regular updates on current major capital projects and property transactions including the impact of Covid19. The Business Case for the Orthopaedic Centre was approved by the FP&RC in November 2020.

Best Value

Internal Audit has previously recommended application of the Audit Scotland Best Value Tool Kit. However, given the pressures on officers due to Covid19 response, we do not consider this a priority for the Board at this time, especially as best value and effective allocation of resources are a key element of the new SPRA process.

BAF – Financial Sustainability

The Financial Sustainability BAF, as reported to the FP&RC during 2020/21, recognised the ongoing financial challenges facing Acute Services, the pressures within Health & Social Care Partnership, specifically in relation to social care budgets and the ongoing work to review the risk share arrangement and the impact of Covid19 in delivering savings.

Information Governance

BAF Risk:

- **Risk 1677 – Digital and Information - 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 Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.**

Governance Arrangements and Assurance Reporting

During 2020/21 the governance arrangements for Digital and Information Governance have been reviewed and revised with newly formed Information Governance & Security Steering and Operational Groups and the evolvement of the eHealth Board into the Digital and Information Board. Annual Assurance reports from Digital and Information Board and the Information Governance & Security Steering Group were presented to the CGC and included assurance on the key activities of both groups.

Recently issued audit report B28/21 - Digital and Information Governance Arrangements concluded that '*although the IG&S Operational Group has only recently started to meet, and much of the time at the meetings of the IG&S Steering Group held to date has necessarily been taken up with agreeing the new governance arrangements, assurance reporting has begun and is anticipated to evolve in 2021/22*'. The most recent report presented to IG&SSG on 1 June 2021 (IG&S Activity Tracker 2021-22) and the update provided to the Clinical Governance Committee on 7 July 2021 show an improving position regarding the quality of assurance provided with plans to further enhance.

B08/21 ICE 2020/21 notes that the work plan for the Clinical Governance Committee presented to its 30 April 2021 meeting, did not include provision for regular assurance reporting on Information Governance.

Pandemic

Several projects and programmes of work were accelerated to allow remote working and new projects added regarding the management of Covid19. All work was undertaken at pace with high level risk assessments taking the place of documented Data Protection Impact Assessments, Information Sharing Agreements and System Security Policies which are now being addressed retrospectively.

Digital and Information Strategy

The Digital and Information Strategy 2019-24 was approved by Fife NHS Board on 30 September 2020 and updates on the impact of the pandemic on the Digital and Information Strategy Delivery Plan were provided to CGC on 7 September 2020 and 7 July 2021. The later update considered the strategy's robustness and highlighted areas of reprioritisation.

The latest Digital and Information BAF presented to CGC on 7 July 2021 includes a revised risk description which recognises the risk to D&I Strategy implementation posed by lack of financial investment. This addresses a previous internal audit recommendation on this topic.

A paper on the funding challenges facing Digital and Information was presented to the Digital and Information Board on 21 July 2021 and highlighted areas of operating costs that require further consideration by NHS Fife. A financial plan is in development to address the significant challenges and we will consider this as part of our 2021/22 Internal Control

Evaluation work.

Risk Management

Internal Audit have continued to work with the lead for eHealth around improvements to the Digital and Information BAF. Initial changes were made and a full risk review within Digital and Information was undertaken and an improved Digital and Information BAF was presented to CGC on 7 July 2021.

Improvement to risk reporting to IG&SSG and Digital and Information Board have been made progressively throughout 2020/21 with the latest Risk Report presented to Digital and Information Board on 21 July 2021 including a new risk categorisation model and a new format of reporting including detailed analysis of one high risk and introducing the concept of 'risk velocity'.

The CGC Annual Assurance Report recognises that further work is required on Digital and Information risks and those related to transformation programmes noting that work on strategy development will bring an overall focus and direction to individual strands of work.

External Review

The Competent Authority NISR Audit Report was published 26 April 2021, with Compliance in 2021 audit at 69% (compared to 53% in 2020) which was recognised as 'a significant achievement especially in the midst of a pandemic'.

Internal Audit note the commitment made within the Medical Director's Annual Assurance letter that states *'the outcome and subsequent action plan will be considered by the IG&SSG in 2021/22, with intention to share, where appropriate, updates on the delivery of this plan with the Clinical Governance Committee*'.

Information Governance Incidents

During the financial year 2020/2021, 11 incidents were reported to the Information Commissioner's Office (ICO), with no further action required for 9 of the incidents. The ICO has since responded regarding the other 2 incidents reported in March 2021 indicating that no further action is required.

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by April 30th	Yes	No (June 20)	No (July 21)
2	Annual Internal Audit Report presented to Audit & Risk Committee by June	Yes	Yes	No
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	95%	79%
4	Draft reports issued by target date	75%	76%	59%
5	Responses received from client within timescale defined in reporting protocol	75%	57%	68%
6	Final reports presented to target Audit & Risk Committee	75%	76%	47%
7	Number of days delivered against plan	100% at year-end	101% at year-end	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	76%	77%
9	Skill mix	50%	72%	77%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	One
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	None

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							
Population Health and Wellbeing Strategy Development	DoF&S/ADPP		✓	✓	✓	✓	✓
Corporate Objectives	DoF&S/ADPP		✓				
Cancer Strategy	MD	TBC Jan					
Clinical Governance Strategy	MD/ Head of Q&CG			`	✓		✓
Redesign of Urgent Care	MD				✓		
Quality and Performance							
Integrated Performance and Quality Report	DoF&S/ADPP	✓	✓	✓	✓	✓	✓
Winter Plan and Performance	DoN	✓			✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	DoN	✓	✓	✓	✓	✓	✓
Safer Management of Controlled Drugs	DoPh			✓			
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	✓	✓	✓	✓	✓	✓

Updated 25-October-21

	Lead	May	July	September	November	January	March
Committee Self-Assessment Report	Board Secretary						✓
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 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					✓	
Research, Innovation and Knowledge Annual Report	MD					✓	
Linked Committee Minutes							
Acute Services Division Clinical Governance Committee	ASD AMD	✓	✓	✓	✓	✓	✓
Area Clinical Forum	Chair of Forum	✓	✓	✓		✓	✓
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, Innovation and Knowledge Oversight Committee	MD	✓	✓			✓	✓
Health and Safety Sub-Committee	Chair of Sub-Com	✓	✓		✓	✓	✓

Updated 25-October-21

	Lead	May	July	September	November	January	March
Infection Control Committee	DoN	✓	✓	✓	✓	✓	✓
Public Health Assurance Group	DoPH	✓	✓	✓	✓	✓	
Ionising Radiation Medical Examination Regulations Board (IRMER)	MD		✓				
Information Governance and Security Steering Group	DoF&S		✓			✓	
Area Medical Committee	MD			✓	✓	✓	✓
Cancer Governance and Strategy Group	MD				✓		

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Strategic Planning and Resource Allocation 2022/23**
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:

- Assurance

This report relates to:

- Strategic Planning and Resource Allocation Process

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The Strategic Planning and Resource Allocation (SPRA) Process for 2022/23 is now underway.

The SPRA process is intended to create a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the 5-year financial and strategic plan to support the delivery of the Population Health and Wellbeing Strategy.

At the beginning of October 2021, a revised template was sent to all directorates of NHS Fife for completion. This paper describes the SPRA process and provides an update on the submission process.

2.2 Background

This is the second year of the Strategic Planning and Resource Allocation process which brings together the planning of services with financial and workforce implications of service delivery and change. Template has been revised and is similar to template provided by Scottish Government for RMP4.

2.3 Assessment

Templates have been distributed and once returned, submissions will be collated and reviewed to report back to EDG on the list of service changes and programmes that will be discussed and then prioritised. These service changes and programmes will be considered in terms of the overall objectives, quality of care as well as financial and workforce implications.

Once completed, the governance of this work will be to provide a paper on the organisation's priorities to the committees and through to the Board.

Key dates:

11 October	SPRA Templates distributed to Directors
12 November	Deadline for SPRA submissions
16 December	Summary of submissions to EDG followed by prioritisation
21 December	Board Development Session
11 January	SBAR to Finance, Performance and Resource Committee
12 January	SBAR to Staff Governance Committee
13 January	SBAR to Clinical Governance Committee
29 March	Final SPRA report to Board

2.3.1 Quality/ Patient Care

The main aim of SPRA process is to continue to deliver high quality care to patients.

2.3.2 Workforce

Workforce planning is key to the SPRA process.

2.3.3 Financial

Financial planning is key to the SPRA process.

2.3.4 Risk Assessment/Management

Risk assessment is part of SPRA process and will be part in the prioritisation of key objectives

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is integral any redesign based on the SPRA process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation throughout the SPRA process.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The Committee is asked to:

Note the update to the Strategic Planning and Resource Allocation methodology and the timeline for delivery.

3 List of appendices

Appendix 1: Strategic Planning and Resource Allocation Letter from CE

Appendix 2: Strategic Planning and Resource Allocation Template

Report Contact

Susan Fraser

Associate Director of Planning and Performance

Email susan.fraser3@nhs.scot

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy
Fife KY2 5AH
Telephone: 01592 643355
www.nhsfife.org

Executive Team
NHS Fife

Date
Your Ref
Our Ref
Enquiries to Susan Fraser
Extension 07557 481351
Email Susan.Fraser3@nhs.scot

Dear Colleague

Strategic Planning and Resource Allocation 2022/23 – 2026/27

As we continue to manage our organisational response to the impact of COVID, there is understandably a primary focus on maintaining delivery of our operational services and ensuring robust plans are in place to address the significant challenges of the winter period. However, in parallel to that, it is important that we also protect time to look to the longer terms, as we develop the Population Health and Wellbeing Strategy and our underpinning SPRA process. To deliver the latter successfully, I am seeking your support and collaboration across the directorates and strategic programmes for this second year of our SPRA process. To ensure completeness, the Health and Social Care Partnership will contribute through sharing their planning documentation.

Each director has a role to ensure that the knowledge and insights gathered from their individual or collective engagement with various national groups and key stakeholders, as well as their operational areas of responsibility, are reflected in the SPRA process and used to guide and inform our planning approach.

The process and documentation from 2021/22 has been reviewed and revised by Planning, Workforce and Finance colleagues to create more effective linkage between key objectives and any implications on workforce and finance and any associated risks.

Each Directorate is asked to provide a plan that articulates the scope of work which requires to be done to deliver our 4 recently agreed strategic priorities. It will be important that in developing these plans this is done collaboratively with clinical leaders and operational managers.

The SPRA timeline has been extended to 5 years rather than 3 to align with the developing Population Health and Wellbeing Strategy. Understanding the scope and the potential phasing of activity will support the overall prioritisation process required to create a deliverable 5-year plan. Whilst it is likely that there will be more detailed knowledge in relation to 2022/23, I am proposing that we provide as much information as possible for the remaining 4 years. This will

also ensure that the resources available to us are targeted to those prioritised objectives over time.

Each Directorate should review the key objectives that were agreed through the SPRA process for 2021/22, providing a mid-year update on progress as at the end of September 2021. It will be important that as an Executive Team we can report through our governance committees and the Board on both progress against our objectives for 2021/22 and our proposals for 2022/23 and future years.

The template for completion has changed with directorates being asked to provide the following information in detail for 2022/23 and in summary for 2023/24 to 2026/27.

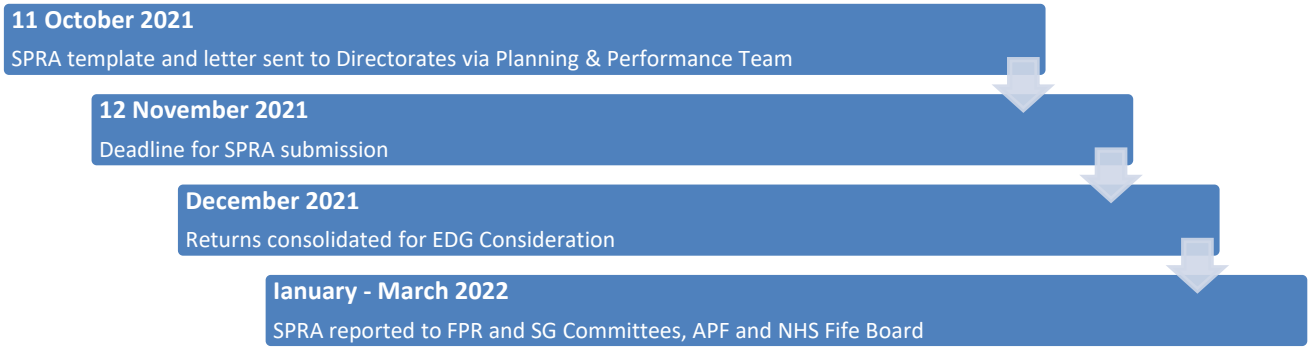
For each Key Objective

- Summary of activities
- Timescales
- Risks and controls
- Outcomes
- Links to strategies, plans and programmes
- Digital and innovation requirements and opportunities
- Property and asset management requirements
- Workforce profile and planning assumptions
- Finance profile and planning assumptions
- Efficiency savings plan

More detailed plans should be held within each service area.

Directorates should liaise closely with their relevant Finance Business Partner or Management Accountant to complete the Finance section and with Workforce colleagues in relation to staffing plans. Directorates should detail proposals/plans to address the legacy recurring savings gap from 2021/22 as well as the efficiency target for 2022/23.

The SPRA template should be completed by each Directorate within Acute Services and all Corporate Directorates. Templates should be returned by 12 November 2021 to be consolidated for full EDG consideration in December 2021. Progress on the process will be reported to Finance, Performance and Resources Committee, Staff Governance Committee and Area Partnership Forum in January 2022. Final proposals and report from the process will be considered by EDG during January and February 2022 and presented to Finance, Performance & Resources Committee, Staff Governance Committee, Area Partnership Forum and NHS Fife Board in March 2022.



This approach will allow enhanced scrutiny of SPRA plans, transparency of proposed service changes and seek to support more effective assurance on all aspects of planning and performance. It will facilitate development of corporate and individual objectives for 2022/23 and support delivery of future Remobilisation Plans. A mid-year review will take place in September/October 2022 to assess progress.

The SPRA Template should be submitted to Planning & Performance Team (fife.planningperformance@nhs.scot) no later than 12 November 2021.

As highlighted, support for completion of the SPRA template is available and contact can be made with Susan Fraser (ext. 20875, Susan.Fraser3@nhs.scot) to arrange this.

This important annual planning exercise will inform how we manage the Covid19 pandemic alongside our collective priorities for the coming years. The NHS Board is committed to the delivery of the new strategy by March 2022, the work on our SPRA will provide a foundation upon which we will deliver this.

Carol Potter
Chief Executive
NHS Fife
For Action:

Executive Team

Janette Owens, Director of Nursing
Chris McKenna, Medical Director
Scott Garden, Director of Pharmacy & Medicines
Joy Tomlinson, Director of Public Health
Claire Dobson, Director of Acute Services
Nicky Connor, Director of Health & Social Care
Margo McGurk, Director of Finance & Strategy
Neil McCormick, Director of Property & Asset Management
Linda Douglas, Director of Workforce

For Information:

Other Members of Executive Directors Group

Susan Fraser, Associate Director of Planning & Performance
Gillian MacIntosh, Head of Corporate Governance and Board Secretary
Kirsty MacGregor, Head of Communications
Wilma Brown, Employee Director

Guidance for completion

Review 21_22

Please provide an update to key objectives agreed from SPRA for 2021/22.

RAG Status	assign status as at end of September 2021(based on key in top left)
End Date	proposed date that objective will be delivered, denote whether objective is to be carried forward into 2022/23
Progress against objective	outline progress made up until end of September 2021
Outcomes	denote outcome(s) of objective on once delivered
Strategies, plans & programmes	denote any strategy/plan/programme that the objective relates to

1YR 22_23

Articulate the key objectives for your directorate to be delivered during 2022/23 which can be shared with staff and stakeholders.

5YR 26_27

Articulate the key objectives for your directorate to be delivered by 2026/27 which can be shared with staff and stakeholders.

For both tabs, outline the summary of activities, associated risks and state other requirements/dependencies/implications for each objective:

- Digital requirements
- Property and Asset Management dependencies
- Workforce implications
- Financial implications
- Interdepencies - affects on other services

Workforce

Opening Position

Staff establishment information

Increases/Decreases

Please provide narrative and values around anticipated increases and decreases to the staff establishment over the next 3 years. The changes could be for example service redesign, skill mix or posts no longer required.

Safe Staffing

Please provide narrative and values on staffing requirements in order to meet safe staffing levels legislation.

Financial Plan

Opening Position

Full year budget information

Significant Cost Pressures

Please provide narrative and cost information for significant cost pressures affecting over the next 3 years.

Planned Reductions

Please provide narrative and cost information for any anticipated reductions over the next 3 years.

Efficiency Savings

Each directorate/programme should set out the level of planned efficiency savings for each of the 3 years of the plan. This should include a move to generate a significant proportion of recurring savings initiatives. For this initial stage in the planning process an assumption should be made that a minimum of 3% will be required.

NHS Fife – Review of Strategic Planning & Resource Allocation (SPRA) for 2021/22

Unlikely to complete on time/meet target
At risk - requires action
On Track
Complete/ Target met

RAG Status	**Objective** *these can be qualitative or quantitative*				**Risks** *list key risks to delivery and controls/mitigating actions*		**Outcomes** *include outcomes if possible – add multiple outcomes if required*	**Strategies, plans & programmes**
Sept 21 Status	Key Objective - Description (sample)	End Date	Carried over to next year? Y/N	Progress against objective	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the objective relates to
	Deliver a medium-term financial Strategy for NHS Fife							
	Support the development of the strategic plan that captures the NHS Fife vision on what it wants to deliver in Fife							
	Ensure that departments with procurement responsibility deliver consistent application of best procurement practice and Board Standing Financial Instructions to support the optimisation of savings							
	Support delivery of Strategic Planning and Resource Allocation							
	Develop and expand Programme Management Office (PMO) to create resource to progress transformation and change programmes at pace across the organisation							

Objective *these can be qualitative or quantitative*				**Delivery Area**	**Risks** *list key risks to delivery and controls/mitigating actions*		**Outcomes** *include outcomes if possible – add multiple outcomes if required*	**Strategies, plans & programmes**	**Digital Requirements**	**Property & Asset Management Dependencies**	**Workforce Implication**		**Financial Implication**			**Inter-dependencies**
Key Objective - Description	Summary of activities etc	Proposed Start Date	End Date	Delivery Area	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the objective relates to	Summarise below	Summarise below	summarise below, provide detail on Workforce template	Cost	summarise below, provide detail on Financial Plan template	Capital / Revenue	Cost	Please provide any detail of impact on other services

Objective *these can be qualitative or quantitative*				**Delivery Area**	**Risks** *list key risks to delivery and controls/mitigating actions*		**Outcomes** *include outcomes if possible – add multiple outcomes if required*	**Strategies, plans & programmes**	**Digital Requirements**	**Property & Asset Management Dependencies**	**Workforce Implication**		**Financial Implication**			**Inter-dependencies**
Key Objective - Description	Summary of activities etc	Proposed Start Date	End Date	Delivery Area	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the objective relates to	Summarise below	Summarise below	Summarize below, provide detail on Workforce template	Cost	Summarize below, provide detail on Financial Plan template	Capital / Revenue	Cost	Please provide any detail of impact on other services

Workforce Plan	Key Objective	2021/22	2022/23	2023/24
		WTE	WTE	WTE
Opening Position				
Nursing & Midwifery				
Medical & Dental				
Admin & Clerical				
Medical Dental Support				
Healthcare Sciences				
Allied Health Professionals				
Personal Social Care				
Support Services				
Other Therapeutic				
Total		-	-	-
Workforce Plan		2021/22	2022/23	2023/24
		WTE	WTE	WTE
Increases/Decreases				
* Please give detail as appropriate				
Total		-	-	-
Workforce Plan		2021/22	2022/23	2023/24
		WTE	WTE	WTE
Safe Staffing in-year				
* Please give detail as appropriate				
Total		-	-	-
Workforce Plan		2021/22	2022/23	2023/24
		WTE	WTE	WTE
Summary Overall Position		-	-	-

Financial Plan	Key Objective	2021/22	2022/23	2023/24
		£'000	£'000	£'000
Opening Position				
Pay				
Non Pay				
Purchase Of Healthcare				
Total		0	0	0
Financial Plan		2021/22	2022/23	2023/24
		£'000	£'000	£'000
Significant Cost Pressures				
* Please give detail as appropriate				
Total		0	0	0
Financial Plan		2021/22	2022/23	2023/24
		£'000	£'000	£'000
Planned Reductions				
* Please give detail as appropriate				
Total		0	0	0
Financial Plan		2021/22	2022/23	2023/24
		£'000	£'000	£'000
Summary Overall Position		0	0	0

Efficiency Savings Plan	Recurring / Non Recurring	Key Objective	2021/22	2022/23	2023/24
			£'000	£'000	£'000
Total			**0**	**0**	**0**

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Redesign of Urgent Care**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Authors:	**Belinda Moran, General Manager ECD** **Chris Conroy, Clinical Services Manager (Primary and Preventative Care Directorate)** **Rose Robertson, Assistant Director of Finance** **Stephen McNamee, Portfolio Manager (Interim)**

1 Purpose

This is presented to the Committee for:
- Assurance

This report relates to a:
- Redesigning Urgent Care Programme

This aligns to the following NHS Scotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summaries

2.1 Situation

2.1 Situation

This paper is presented to the NHS Fife Clinical Governance Committee to provide an update on the delivery of the Redesigning Urgent Care Programme; outline the new governance arrangements in place; and to seek guidance on the establishment of an appropriate delegated budget. This is set against the backdrop of a system-wide redesign supported by some dedicated new non-recurring funding and a wider context of existing funding aimed at managing the increasing system wide demands for urgent and unscheduled care. Boards and HSCP's have been asked to develop a model where urgent care demand can be scheduled and delivered closer to home to ensure the right care is provided at the right place and right time. This Programme aligns with the new Scottish Government NHS Recovery plan.

2.2 Background

2.2.1 Phase Two Governance Structure

A new governance structure (outlined in Appendix A) in support of our Redesign of Urgent Care programme comprises 4 workstreams and replaces the phase 1 model:

- Specialist Care Workstream
- Mental Health Pathways
- Urgent Care Access Workstream
- Urgent and Emergency Care – Footprint of the VHK

There are a further 2 tiers: RUC – Operational Group, chaired by Dr Rob Cargill; and the (to be established) Integrated Unscheduled Care Programme Board, chaired by Dr Chris McKenna. In addition, a core group is being established with stakeholders responsible for the operational delivery of urgent care within ASD and HSCP -linking directly to both SLTs.

2.2.2 Engagement & Feedback

Over an 8 week period people attending ED were asked to take part in a Patient Pathway Survey. 378 responses were gathered. A full output from the Survey is attached as Appendix B of this report. Noteworthy findings from the survey are as follows:

- Over 50% of respondents were aged under 30 years
- There were a wide range of reasons for attendance with the highest grouping by far being Minor Injury attendances
- 55% of respondents came direct to ED having had no contact with other health services e.g.GP, NHS24, 111, Pharmacy, etc.)
- 25% of respondents had contacted NHS24 on their 111 number prior to attendance
- 13.5% had been in contact with their General Practice prior to attendance.
- Over 90% or respondents came because of two main factors:
  - They believed their attendance was appropriate for the Emergency Department
  - The Emergency Department was their closest service
- Only 25% of respondents were aware of changes in how Urgent Care is accessed in Scotland

Feedback suggests that more needs to be done around national public messaging on the redesign of urgent care. We also need to build on and increase our local messaging in support of the national message. Our communications strategy should pay particular attention to the under 30s as a target group.

2.2.3 GP Admissions Pathway

As part of ongoing improvement work within AU1 and the early planning for phase 2 of RUC it was recognised that in terms of patient flows into the VHK that the FNC centre could play a crucial role in being a single point of access for assessing and navigating GP Medical admissions. As such, a short life working group was convened to develop acute admission pathways into Victoria Hospital Kirkcaldy. The aim for the short life working group was for the FNC clinical team to become the expert team to assess and navigate GP medical admissions to the most appropriate pathway, which would include non-admission to AU1. This would also include working closely with other services to support GPs accessing non acute admission pathways (i.e. H@H, ICASS, ECAS), whilst also supporting direct admission clinical discussions with Acute Specialty teams. Figure.1 below illustrates where the FNC assessment and navigation sits within the medical admission pathway.

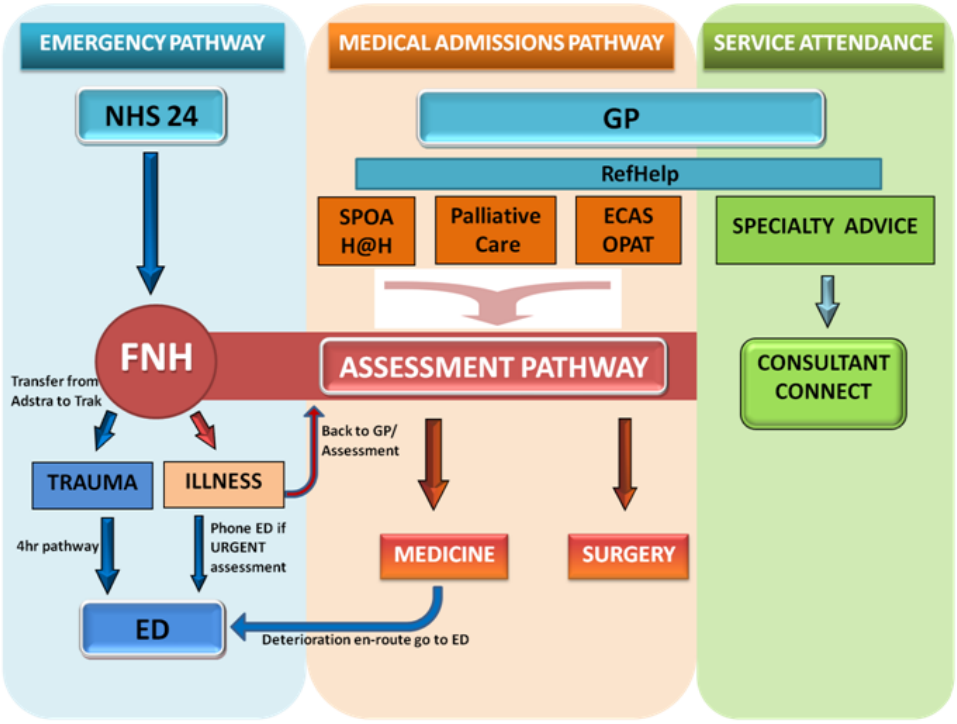


Figure 1 - NHS Fife Urgent Care System Schematic

Since 12th July 2021, acting as a single point of access for GP's across Fife, the FNC has commenced triaging all GP calls prior to direct admission to AU1 between the hours of 8-1, 7 days a week. Early results from the Test of Change show several improvements can be seen (first 6 weeks), with:

- A 32% redirection rate away from AU1 – of 435 people, 140 were redirected (18% prior to 12th July)
- A 24% non-admission rate (with some patients admitted directly to a specialist ward)
- An extensive suite of measures to allow for constant amendments to processes
- Good engagement from GP's with all practices utilising the model
- Extensive engagement with all key stakeholders, including staff surveys and regular MDT meetings
- Co-produced guidelines and pathways with GPs and Clinical Specialties
- A comprehensive handover to AU1 team which supports a more seamless triage and assessment process reducing duplication of information

From the end of September, FNC will fully transition to triaging all GP calls 24/7. Further developments are optimising H@H and social care pathways directly from the FNC single point of contact to reduce GP contacts with additional services. These developments will also look at whether there are opportunities to support Surgical admissions flows into VHK.

Workforce

In terms of nursing recruitment, it was recognised that there was an opportunity to make the operation of the FNC more attractive to the ANP workforce we wish to recruit whilst at the same time mitigating the risk that different services compete for that limited ANP resource. The aim is to have an integrated core workforce of ANP's directly managed within FNC management structures but who would rotate between Acute AU1/MIU's and

FNC. This will have several benefits; increasing ANP capacity within AUI/MIU's, support skills and competencies and develop a sustainable and resilient workforce who can work seamlessly between HSCP and ASD. This will further enhance and strengthen relationships supporting teams to work collaboratively to enable us to deliver the best care for the population of fife.

Recruitment is currently under way for 6 substantive ANPS, with 9 applicants shortlisted for interview. Supported via the ANP cohort currently covering admission referrals and a joint development plan between AU1 and Urgent Care Services, new recruits will commence at the beginning of October.

2.2.4 Operational Update

Demand for Urgent and Emergency services continues at challengingly high levels. Emergency Department attendances have returned to or surpassed pre-Covid levels as outlined in Fig 2 below which provide a previous 6-month activity snapshot over the last 3 years. This demonstrates that whilst changes to how we delivery Urgent Care Services is changing, demand for overall unscheduled care services is increasing, therefore reinforcing the need to continue the delivery of the RUC Programme at pace.

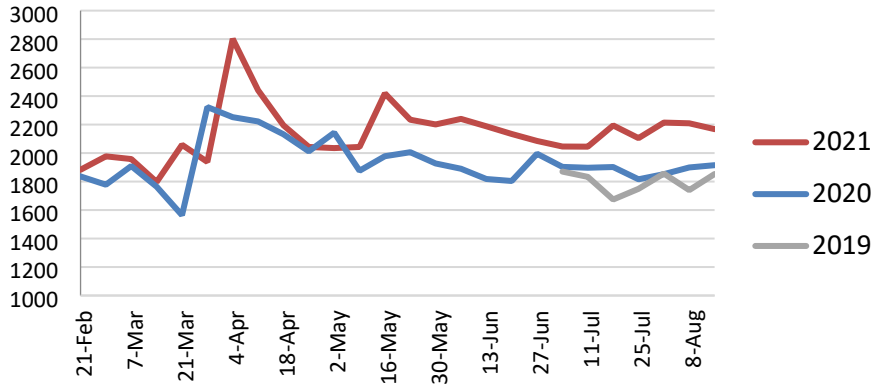
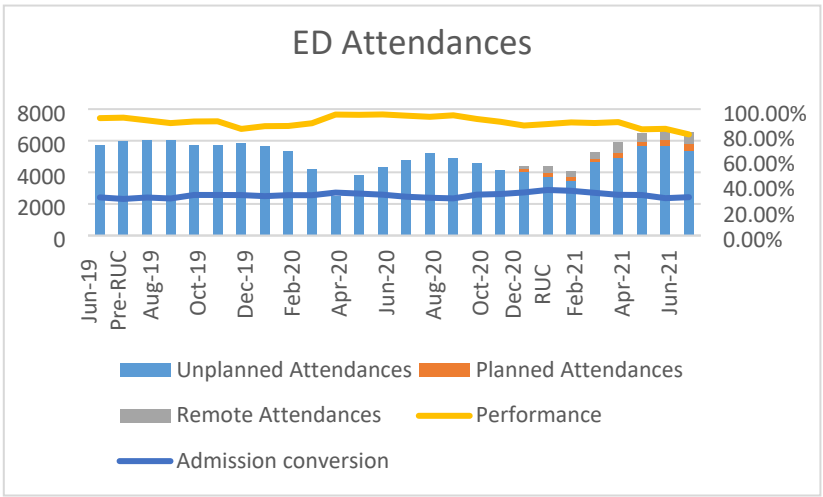


Figure 2 - ED activity from June 2019 – July 2021.



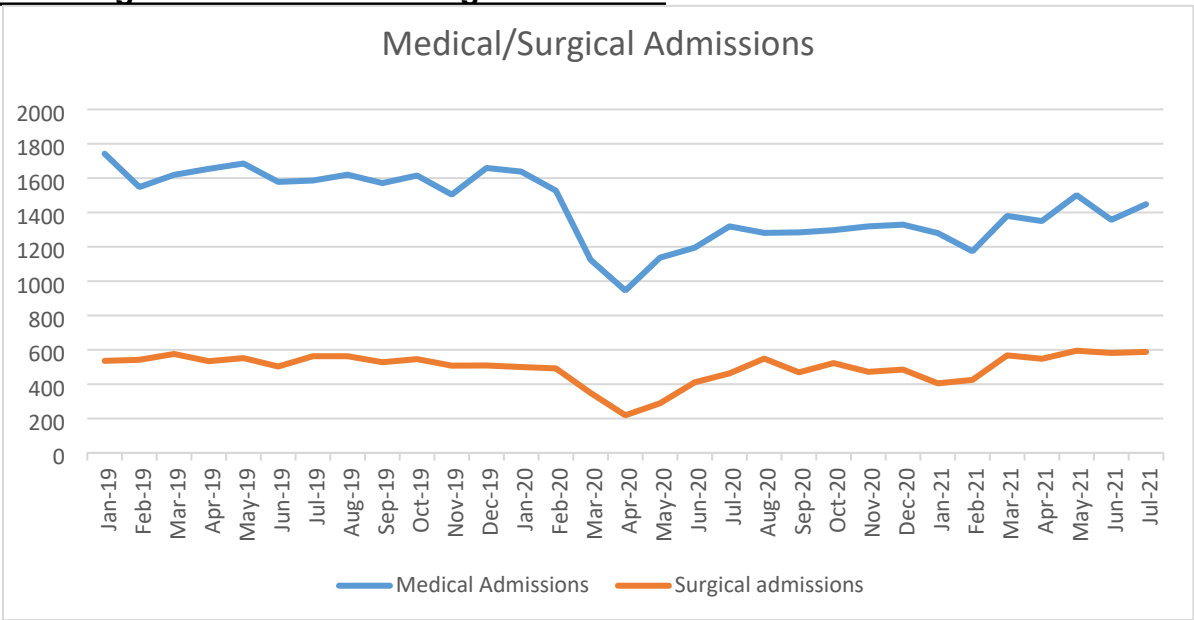
Overall ED activity: has increased over the last five months. Between July 2019 and July 2021 there has been a 9.1% increase in overall activity. Planned attendances have increased month on month with July 21 recording the highest activity to date (434 attendances). Similarly, remote consultations have increased month on month but have

seen a steeper increased in the previous 4 months (an increase from 394 pts in March to 747 in July).

Unplanned attendances: continue to make up the majority of ED's attendances. Attendances over the previous 4 months have increased however are still lower than recorded in both the summer and winter of 2019. Unplanned attendances in July 21 were 10.8% lower than that of July 2019.

Remote consultation: A number of patients who have a remote consultation attendance will also then go on to have another attendance (recorded as a planned attendance). Meaning there may be more than one attendance for one clinical incident. Since the introduction of RUC in Dec 20 the average percentage of patients who have a telephone triage appointment and then go on to have a face-to-face appointment is **70.3% (average of 186 pts/month).**

Medical & Surgical Admissions through front door:



The data: This data (provided by information services and based on the speciality of the patient on admission) demonstrates the trend of both medical and surgical admissions that have come into VHK through either AU1 or AU2 (Via ED and GP Referral).

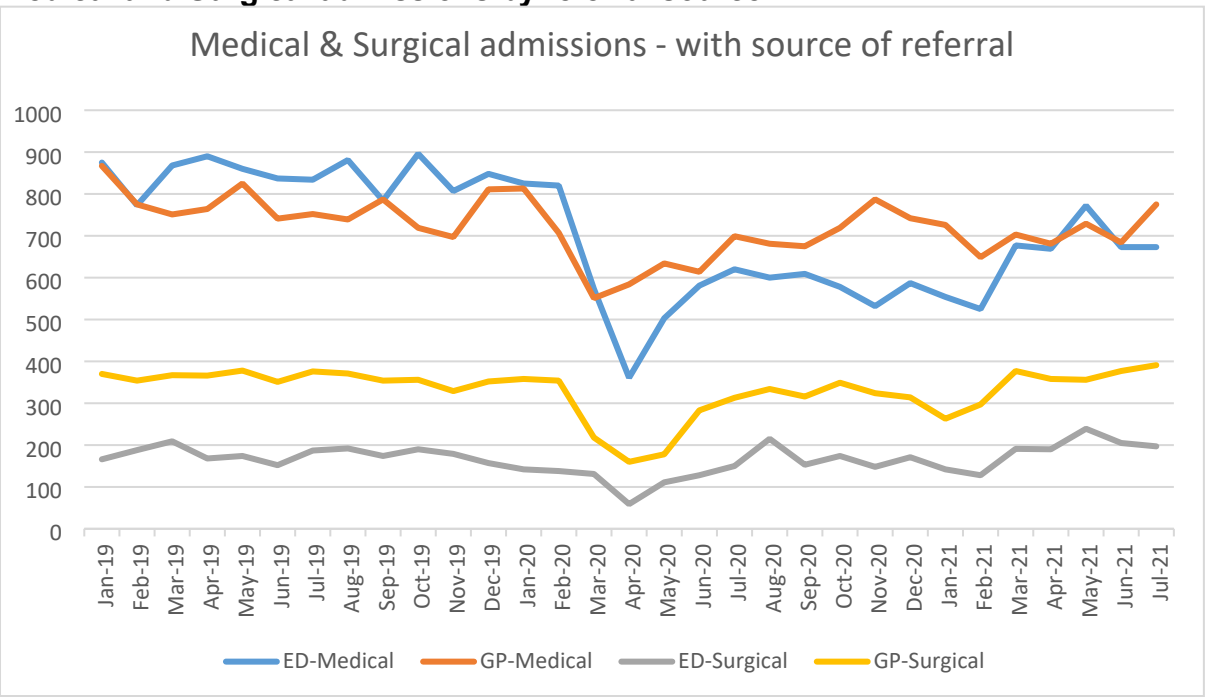
Medical admissions: In July 2019 there were an average of 51 medical admissions per day. While the number of daily admissions has risen over the previous months, the number of medical admissions in July 2021 were on average 47 per day.

Surgical admissions: In July 2019 there were an average of 18 surgical patients admitted per day. July 2021 has exceeded the number of surgical admissions in 2019 with an average of 19 patients per day. The last three months (May, June & July 21) have seen surgical admissions rise and maintain at a level higher than seen in the previous two winters.

Medical/ Surgical Admissions – Heat Map

Admission Date	Medical admissions	Admission Date	Surgical admissions
Jan-19	1742	Jan-19	536
Feb-19	1548	Feb-19	542
Mar-19	1619	Mar-19	576
Apr-19	1654	Apr-19	534
May-19	1685	May-19	552
Jun-19	1578	Jun-19	503
Jul-19	1586	Jul-19	563
Aug-19	1620	Aug-19	563
Sep-19	1571	Sep-19	528
Oct-19	1615	Oct-19	546
Nov-19	1504	Nov-19	508
Dec-19	1659	Dec-19	509
Jan-20	1638	Jan-20	500
Feb-20	1527	Feb-20	492
Mar-20	1124	Mar-20	349
Apr-20	945	Apr-20	219
May-20	1137	May-20	289
Jun-20	1195	Jun-20	411
Jul-20	1319	Jul-20	463
Aug-20	1281	Aug-20	549
Sep-20	1284	Sep-20	469
Oct-20	1297	Oct-20	523
Nov-20	1319	Nov-20	472
Dec-20	1329	Dec-20	485
Jan-21	1280	Jan-21	405
Feb-21	1174	Feb-21	425
Mar-21	1380	Mar-21	568
Apr-21	1350	Apr-21	548
May-21	1501	May-21	595
Jun-21	1357	Jun-21	582
Jul-21	1448	Jul-21	588

Medical and Surgical admissions by referral source



The data: This data (provided by information services and based on the speciality of the patient on admission as well as linking patient data to ED attendance to define the source of admission) demonstrates the trend of both Medical and Surgical admissions that have come into VHK through either AU1 or AU2 and where the source of that admission came from.

Medical Admissions: Medical Admissions via ED have remained significantly lower than pre Covid. In July 19, the average number of medical admissions from ED were 27 patients per day, in July 21 this was an average of 22 patients per day.

Medical admissions via GP have remained relatively stable with numbers only slightly below that of pre Covid. July 19 had an average of 24 patients a day while July 21 had a small increase with an average of 25 patients per day.

Surgical Admissions: Surgical admissions via ED have been increasing since the beginning of 2021 with a peak in May of 239 patients admitted. That number exceeds all previous months looked at in this data set, higher than either of the previous two winters.

GP admissions have remained at similar levels to pre-covid. March to July 21 have seen increased numbers with July 21 again seeing the highest number of admissions compared to the previous two winters.

2.2.5 Financial Update

In Autumn 2020 we were asked to provide a 3-year plan to inform our funding requirements for the Redesign of Urgent Care. This submission highlighted the part year cost for 2020/21; and the full year costs for each of the 3 years 2021/22 to 2023/24 of c£2.1m for each of the years. This has since been updated a number of times at the Urgent Care Redesign Group chaired by Dr Chris McKenna. The full year costs for each of the 3 years estimated at c£1.6m.

Funding received in 2020/21 was an NRAC share of a national £10m augmented by general Covid-19 funding. The actual costs incurred on this programme in 2020/21

was £0.260m. This informed a year end IJB earmarked reserve of £0.935m which was carried forward for use in 2021/22.

NHS Fife has received a funding letter (May 2021) highlighting the funding allocation for NHS Fife's programme of work as follows:

2021/22 Funding Letter	Funding £'000
Redesign of Urgent Care	681
Unscheduled Care: Building Capacity to Support Recovery (6 Essential Actions)	456
Winter Planning	661

The unscheduled care funding is non-recurring and has historically been allocated to Emergency Care within ASD who have historical committed spend in excess of the available funding. This extends to Local Improvement Team resource, agreed additional surge activity, and discharge vehicles.

Winter funding received each year is always significantly less than the anticipated spend. Over the last 2 financial years funding has been distributed on a 50/50 basis to Health Board retained and HSCP.

2.2.6 Developments - Ref Help Improvement work

There is an organisational priority to review, update and augment the information we have locally on our Ref Help pages by specialty. A team of colleagues have been brought together to support clinical leads (or their delegates) in the rapid review of current Ref help content on Blink. A 3-hour block of time can be accessed in which Blink, Lothian's Ref Help pages for that specialty as well as national resources and information leaflets are brought together to augment specialty pages on Ref Help in Fife.

This team will have a mix of administrative, design, process mapping and digital skills. At the end of the session the team will draft the changes into a non-live set of pages for final amendment and approval. This content can then be made live on the Blink pages for your specialty. A review process and associated clinical governance assurances are currently in development.

It is intended that a launch and associated training / messaging will happen in November for the refreshed Ref Help content on Blink.

2.2.7 Developments - Clinical Peer-to-Peer Messaging System

NHS Fife Digital and Information have identified a need to augment FNC triage calls with a digital solution to enable clinicians to communicate safely and effectively directly. The current process for instant referrals is either for unsolicited calls to be made to a specialty, sometimes without the use of a recorded advice line or for calls to be made into a recorded advice line with on occasion messaging peer to peer on personal devices. While all three have the patient's welfare at the forefront, they open the patient, clinician, and Board up to a significant degree of risk in particular around data protection and incomplete and therefore inappropriate referrals. A digital communication solution will ensure there is an auditable, clear, and efficient way to refer, query or obtain advice from the correct specialty in relation to a patient's care.

An Options Appraisal has been carried out by Digital & Information with scoring based on specific functional and non-functional requirements. Through analysis of available systems and the scoring process two applications have been identified and the next steps will be to hold further demonstration workshops with both the suppliers (individually) and a select group of internal clinical stakeholders. Invitations have been issued to ascertain availability.

The workshops will describe the product and will work to allay existing concerns raised through the analysis process, the workshop will be facilitated by Digital and Information colleagues. This is designed to alleviate concerns and allow for a final joint decision to be made on the preferred option that will meet the functional, operational, and strategic requirements of NHS Fife.

2.3 Assessment

2.3.1 Quality/ Patient Care

To enable us to deliver person centred care within urgent care we must ensure people receive the Right Care, at the Right Time and in the right place. The approach being taken in Fife to reduce demand on ED and schedule unscheduled care through the RUC Programme, has seen the following outcomes:

- Approximately 25% of patients who have a local assessment via ENP/ANP clinical team whilst seeking to access ED are signposted to another service out with VHK
- When patients need to attend ED or MIU, 24% are scheduled
- 32% of medical admissions coming via FNC are redirected away from AU1

Whilst making these changes consideration has also been given to the following:

- Inequity of provision (digital access to support digital consultation) - action plan created following publication of EQIA stage 2
- Consequences of delaying/denying treatment – Review of re-admissions, Datix and complaints highlight no concerns

2.3.2 Workforce

This programme is being delivered in the main within the existing staff profile of both organisations with the following posts recruited to directly to aid delivery:

Staff role	Contribution	Number of Staff
Dispatchers	The Dispatching team are key navigators within the FNC, following clear protocols to make sure patients follow the correct pathways and facilitating the scheduling element of the pathways.	**6.9 WTE**
Senior Dispatchers	This role will oversee and provide leadership and development to the dispatch team and play a crucial role in maintaining governance over current and future processes and protocols	**1.6 WTE**
ENP	This role will support the local clinical assessment of 4-hour minor injury pathway patients	**3.2 WTE**
ANPs	This role will support the local clinical assessment of	**6 WTE**

	4-hour minor injury pathway patients and medical admission pathway patients.	
Senior Decision Maker	This role, along with programme lead for the FNC workstream, will provide live time SCDM support to the ANP team	**1 WTE**
GPSI	This role will support the ED team in releasing ED Consultant time to allow them to support the SCDM role for all 4-hour patients	**1.7 WTE**

Whilst the FNC model will support all 5 strategic areas outlined within Phase 2 of the RUC programme, it is clear that the model will evolve over the next 2-3 years and should constantly be reviewed as the detail around the 5 workstreams become clearer, both nationally and locally.

2.3.3 Financial

Covered in Finance section above.

2.3.4 Risk Assessment/Management

A Programme Risk Register is maintained on DATIX. The main programme risk remains around the financial sustainability of the programme as there is no recurring funding associated with the programme. Work is ongoing with Scottish Government to ascertain future financial plans.

2.3.5 Equality and Diversity, including health inequalities

An EqIA has been completed for this programme.

2.3.6 Communication, involvement, engagement and consultation

Communications
A programme communications and engagement plan has been developed to work in conjunction to a national communications plan.

Patient engagement and experience
A working group is currently developing a patient experience plan to build on the learning from pervious ED and FNH led surveys.

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:

- HSCP SLT
- ASD SLT

2.4 Recommendation

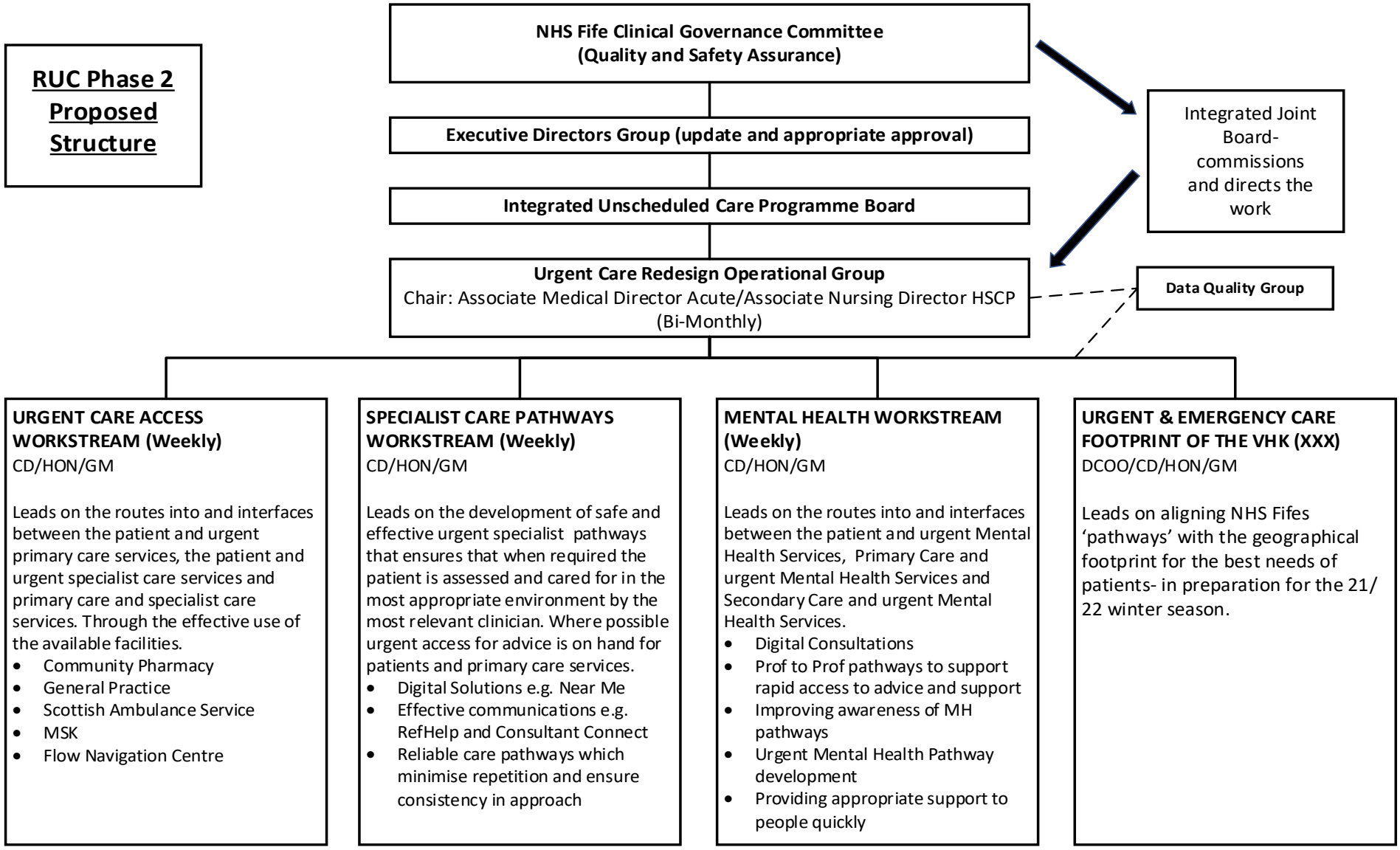
NHS Fife Clinical Governance Committee is asked to note the contents of this paper and agree the new governance structure with links to both SLT's

3 List of appendices

Appendix A – RUC Governance diagram

Report Contact
Stephen McNamee, Portfolio Manager (Interim)
stephen.mcnamee2@nhs.scot

Appendix A – RUC Governance diagram



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Primary Care Improvement Plan: MOU2 Risk Paper**
Responsible Executive:	**Nicky Connor, Director of Health & Social Care**
Report Author:	**Bryan Davies Head of Primary & Preventative Care Services.** **Dr Helen Hellewell Associate Medical Director**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is being brought to NHS Fife Clinical Governance Committee to provide an update on the risks associated with the 2018 GMS Contract Implementation Memorandum of Understanding 2 (MOU2) published on 30 July 2021 (**Appendix 1**).

2.2 Background

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

The aim is to enable GPs to do the job they train to do and enable patients to have better care. GP and GP practice workload will reduce and refocus under the proposals, as the wider primary care multi-disciplinary team is established and service redesign embedded by the end of the planned transition period. People presenting to general practice will be seen by the right professional to meet their needs.

The contract proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. Sustainable general practice is critical for better care for patients.
A Memorandum of Understanding (MOU), between Integration Authorities, SGPC, NHS Boards and the Scottish Government covered an initial 3 year period 1 April 2018 to March 2021, and sets out agreed principles of service redesign (including patient safety and person-centred care), as well as ring-fenced resources to enable the change to happen. The scope of this programme is to deliver all priorities defined in the General Medical Services Contract (2018) and associated Memorandum of Understanding.

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

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

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

A revised MoU (MOU2) covering the period 2021-2023 was recently agreed between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities and NHS. MOU2 recognises what has been achieved to date, but also that there is still a considerable way to go to fully deliver the GP Contract offer and commitments intended to be delivered by April 2021. It also reflects the impact of the Covid-19 pandemic and clarifies expected deliverables and timescales.

2.3 Assessment

The MOU2 states ‘implementation of multidisciplinary team working should remain underpinned by the seven key principles outlined in the previous MoU: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money. All six MoU areas remain areas of focus for the MoU signatories. However, following the joint SG/SGPC letter of December 2020, the parties acknowledge that the focus for 2021-22 should be on the following three services’:

Vaccination Transformation Programme

GP practices will not provide any vaccinations under their core contract from 1 April 2022.

- All vaccines provided under Additional Services will be removed from the Additional Services Schedules of the GMS Contract and PMS Agreement regulations in October 2021.
- The National Travel Health sub-group will re-convene and determine a 'Once for Scotland' travel health solution with substantial input from local areas by October 2021, and put in place by April 2022
- GPs will retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration.

Position: It is anticipated vaccinations will transfer from Fife GP Practices to NHS Fife by 1 April 2022.

Pharmacotherapy

NHS Boards are responsible for providing a pharmacotherapy service to patients and practices by 1 April 2022.

Whilst the Contract Offer and Joint Letter emphasise implementing the level one pharmacotherapy service, there are interdependencies between all three levels that require focus on the delivery of the pharmacotherapy service as a whole. NHS Directors of Pharmacy, supported by National Education Service for Scotland, will support the delivery of national workforce plans that will reflect the staffing requirements of the pharmacotherapy service, in particular what is required for delivery of a level one service for each practice, and the appropriate use and mix of skills by pharmacy professionals. This information has not been agreed/published as yet.

Position: Although Pharmacotherapy aim to deliver a full level 1 service to all 54 GP Practices by 1 April 2022, this is very unlikely due to workforce availability and short timescale to implement. This will result in the need for a transitionary arrangement with some Fife GP Practices for level 1 pharmacotherapy services from 1 April 2022. However detailed work has been undertaken to allow understanding of the workforce required. There is a plan to recruit in a phased way to at least the minimum level of staffing needed to deliver level 1 pharmacotherapy to minimise the time spent in transitionary arrangements. During transitionary arrangements General practice will continue to deliver this service to patients.

Community Care and Treatment (CTAC)

NHS Boards are responsible for providing a Community Treatment and Care (CTAC) service from 1 April 2022. Services will be designed locally, taking into account local population health needs, existing community services as well as what brings the most benefit to practices and patients. Including, but not limited to:

- Phlebotomy service
- Minor injuries and dressings service
- Ear syringing service
- Suture removal service
- Chronic disease monitoring and related data collection
- Other services

Position: CTAC services will not be delivered in full by 1 April 2022 and will require transitionary arrangements and payments with Fife GP Practices. CTAC will be delivered in two phases.

Phase 1 will deliver 60% of CTAC services by 2021/22. The proposal is based on the assumption that the service would be able to recruit a high number of AFC Band 5 Registered Nurses quickly, which could be challenging over winter months and put pressure on nursing teams across the Health Care System.

Phase 2 will deliver 100% of CTAC service by 2022/23.

Transitionary Arrangements

Following Regulation change, HSCPs and Health Boards will be responsible for providing vaccination, pharmacotherapy and CTAC services to patients and GP practices.
GP practices will support HSCPs and Health Boards to provide MoU services in two ways to help ensure patient safety:

The treatment of patients requiring medical care that is immediately necessary such as an immediate need for wound care, phlebotomy or repeat prescriptions. HSCP/Health Board MoU service provision must minimise the need for immediately necessary support from GP practices.
Temporary support of routine MoU services, where necessary, under transitionary service arrangements from 1 April 2022.
SG and SGPC will negotiate transitionary service and payment arrangements where practices and patients still do not benefit from nationally agreed levels of HSCP/HB vaccination, pharmacotherapy, and CTAC services after 1 April 2022. Transitionary service arrangements are not the preferred outcome or something seen as a long-term alternative. All parties locally should remain focused on the redesign of services and delivery of the MoU commitments and transitionary arrangements should not be seen as a desired alternative. A set of principals for how transitionary services and payment arrangements will work is awaited from Scottish Government and SGPC

Recent experience of seasonal Flu Vaccinations not transferred by 1 October 2021 is that Scottish Government make amendments to the GMS contract and PMS agreement regulations removing the service from GP contracts with effect from a specified date. A guidance circular is then issued to health boards advising how to serve notice to practices who are required to continue providing the service not transferred by the deadline.

2.3.1 Quality/ Patient Care

The programme team in collaboration with Fife GP Clusters and Fife LMC/GP Sub Committee work closely to ensure equity of service provision and deployment of GMS Contract resources based on GP Practice/GP Cluster priorities and demographic need, to ensure equal access for Fife citizens and reducing health inequalities.

Full delivery of Multidisciplinary Teams is expected by 2023/24. Further advice from MOU parties on the delivery of Additional Professional Roles (including mental health roles) is expected by the end of 2021.

GP practices will support HSCPs and Health Boards to provide MoU services in two ways to help ensure patient safety:

The treatment of patients requiring medical care that is immediately necessary such as an immediate need for wound care, phlebotomy or repeat prescriptions. HSCP/Health Board MoU service provision must minimise the need for immediately necessary support from GP practices.

Temporary support of routine MoU services, where necessary, under transitionary service arrangements from 1 April 2022.

2.3.2 Workforce

The Primary Care Improvement Plan requires some staff previously employed by GP Practices to TUPE over to NHS Fife employment. There is the potential for clinical/staff opposition to the transfer of GP Practice employed staff over to NHS Fife. The Primary Care Nursing Transformation Group will revisit the TUPE scoping exercise undertaken in 2019/20 to understand the current position.

The majority of staff appointed to Fife GMS Contract roles have been internal candidates, not new staff. This creates pressures elsewhere in the system. However phased recruitment has mitigated this risk and more recently we have started to attract some external candidates.

The pipeline/lead time for qualified clinical roles such as Advance Nurse Practitioners and Pharmacotherapy staff is approximately 18 months. Many of the staff appointed to Fife GMS Contract roles are in training, and require GP supervision/mentoring further impacting on GP and GP Practice capacity.

2.3.3 Financial

The cost to fully implement the GMS Contract in Fife based on models of care approved by the GP Clinical Quality Group and GMS implementation Group is estimated to be approximately £23m. The 2021/22 (Year 4) Primary Care Improvement Fund (PCIF) allocation is £10.5m. A gap in funding of £12.5m. A detailed plan for the use of PCIF reserves should be developed in order to part fund MOU2 implementation for the next two years. However further consideration of the financial consequences and associated risks will need to be explored, once the details of transitionary arrangements are received and further discussion with Scottish Government has taken place, to ensure full implementation of the primary care improvement plan as detailed in MOU 2 can be achieved.

2.3.4 Risk Assessment/Management

There is a joint financial and reputational risk between NHS Fife and Fife HSCP if CTAC, Vaccinations or Pharmacotherapy services do not transfer in full by April 2022 because there is insufficient Primary Care Improvement Funding, resulting in the need for transitionary agreements and payments to Fife GP Practices.

There is a joint financial and reputation risk between NHS Fife and Fife HSCP because there is insufficient premises for workforce and services to operate from.

There is a risk if the roles and responsibilities of the directors involved in the implementation of the primary care improvement plan under the terms of MOU2 are not clear then this will lead to a lack of clarity around governance and decision making and escalation of risks and issues for action.

In order to mitigate this in line with the corporate objectives The Director of HSCP is the lead director for " Supporting the primary care providers reform service delivery for people of fife in line with Primary care transformation plan and MOU " and is therefore leading on this work all other directors are critical contributors. The Director of Pharmacy and Medicines is leading on the

development and delivery of a pharmacotherapy service and will be responsible for the development and delivery of the pharmacotherapy service in line with national direction and GMS contract. The Medical Director is leading on collaborate and redesign urgent care to which this work needs to closely align and has responsibility to ensure that there are safe effective primary medical services for the people of fife.

2.3.5 Equality and Diversity including Health Inequalities

An EqIA has not been completed at this time, we are still awaiting national guidance on whether this is necessary for this programme. We will continue to consider the need for this.

2.3.6 Other impact

None

2.3.7 Communication, involvement, engagement and consultation

There has been no engagement or consultation with stakeholders on MOU2 in the preparation of this paper due to reporting timescales.

2.3.8 Route to the Meeting

This report is an amalgamation of reports submitted to the following groups:

- GMS Implementation Group
- HSCP SLT
- EDG

2.4 Recommendation

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

- Assurance is sought from the finance meeting with Scottish Government. Once this is obtained, it is recommended that the required posts in order to deliver CTAC and VTP and pharmacotherapy be recruited to on a permanent basis.
- PCIF funding reserves should be utilised in order to implement MOU2 phase 2 for the next two years.
- The financial consequences and associated risks from full PCIP implementation be further explored with Partners once transitionary payment details are received.

3 List of appendices

The following appendices are included with this report:

Guidance to Health
Boards to serve notic

Report Contact:

Bryan Davies Head of Primary & Preventative Care Services
Helen Hellewell Associate Medical Director
Email bryan.davies2@nhs.scot Helen.hellewell@nhs.scot

PCA(M)(2021)10

Primary Care Directorate
General Practice Division

Addresses

For Action
Chief Executives NHS Boards
Chief Officers for Health and Social Care Partnerships
GP Practices
NHS National Services Scotland

For Information
Scottish General Practitioners Committee
Primary Care Leads NHS Boards

Policy Enquiries to:
Michael Taylor
Primary Medical Services
1 East Rear
St Andrew's House
Edinburgh
EH1 3DG

Tel: 0131-244-5483
Michael.Taylor@gov.scot

28 September 2021

Dear Colleagues

GUIDANCE TO HEALTH BOARDS TO SERVE NOTICE TO PRACTICES TO CONTINUE TO DELIVER VACCINATIONS
DEADLINE FOR RURAL FLEXIBILITY AND OPTIONS APPRAISAL

1. Vaccinations which are still in the core GP contract under the Additional Services Schedule will be removed by October 2021.

2. Following negotiations with SGPC, the amendment regulations that will give effect to this commitment have been laid before the Scottish Parliament, with a view to coming into force from 18 October. These can be found at https://www.legislation.gov.uk/ssi/2021/302/contents/made

3. These regulations are complicated and only form part of the picture of what is changing. It is important to understand that they will be accompanied by Scottish Government directions which we have agreed with SGPC and will contain a number of elements:

    - From October 18th, the Vaccination & Immunisations and Childhood Vaccination Additional Services will be removed from regulations. Boards will however be able to serve notices (under regulation 33A of the amended GMS regulations) to practices that will require them to continue to deliver vaccinations that were providing these additional services from October to April 2022.

    - **We anticipate boards serving notices to every practice that was previously providing vaccinations under the Additional Services Schedule. It is important to understand that these notices will require practices to continue providing these vaccinations but only until 1 April 2022 at the latest. Funding will continue under the core GP contract.**

- Boards will also be able to serve notices (under Schedule 2A of the amended GMS Regulations) to practices to continue delivering these vaccinations in the longer term beyond this where the Boards remain unable to deliver these vaccinations from April 2022. Comprehensive Directions will be issued such that any ongoing practice involvement in these vaccinations beyond 1 April 2022 will only be under the terms of the transitionary service arrangements (including additional payment arrangements) which we are working to negotiate and agree with SGPC or for those remote rural practices where it has been assessed in an options appraisal that practice-delivery is the only option for vaccine delivery (we are also negotiating service and payment arrangements for these practices with SGPC). Under no other circumstances will practices provide vaccinations under national regulations from April 2022. The options appraisal process was established in 2019 and, where it is sought by HSCP partners and has not been completed already, should be completed as soon as possible (see below). The directions will set a final date by which initial options appraisals must be carried out before practices can be served notice to continue delivering vaccinations due to their exceptional remote rural situation.

- Practices currently have the ability to opt-out of Additional Services and the directions that will accompany these regulations will set out similar arrangements that will apply going forward.

4. This is a complicated process and the publication of these regulations is only one piece of whole process, but we will share details of the other components when we are in a position to do so.

RURAL FLEXIBILITY AND OPTIONS APPRAISAL

5. In 2019 the Scottish Government issued guidance to HSCPs about the exceptional circumstances where some remote or rural GP practices would continue to deliver one or more MOU services that would otherwise be transferring to Health Board employed staff as part of the implementation of the 2018 GP Contract.

6. The guidance sets out that an options appraisal should form part of the PCIP process and the National GMS Oversight Group will have a role reviewing PCIPs and trackers to ensure a consistency of approach to the process. As part of this role, they will also review the decisions and supporting evidence to ensure this process has been followed.

7. As with the options appraisal for vaccinations it is important to give both GP practices and the wider system certainty of what services will not transfer as an outcome of the rural options appraisal process. The Scottish Government and SGPC will negotiate a separate arrangement including funding for these practices who will continue to provide services after 1 April 2022.

8. We would therefore request that all options appraisal exercises, including those for vaccinations, are completed by HSCPs and shared with the National GMS Oversight Group by 31 December 2021.

Enquiries

9. Any enquiries resulting from this letter should be raised with Michael Taylor.

Yours sincerely

Naureen Ahmad

Deputy Director and Head of General Practice Division

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 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 Committee for:

- Discussion

This report relates to the:

- Joint Fife Remobilisation Plan for 2021/22 (RMP3)

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 August 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.

2.3 Assessment

The IPQR has been refreshed in appearance for FY 2021/22. While the content is unchanged in terms of measures covered, the presentation of information has undergone a number of cosmetic changes in order to provide clearer information, particularly in the drill-down section. Some measures have revised targets for FY 2021/22, reflecting performance and challenges in the previous year.

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. NHS Fife is working according to the Joint Fife Remobilisation Plan for 2021/22 (RMP3), and the IPQR provides a high-level activity summary on Page 4. This will be updated monthly as the year progresses, and forecasts have changed to reflect the additional funding available from the Scottish Government. A further iteration of the plan (RMP4) was submitted to the SG in late September, and will supersede RMP3 from the November IPQR onwards.

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. Discussions around a target for Adverse Events are continuing, against a background of reviewing the overall policy.

Measure	Update	Local/National Target	Current Status
HSMR	Quarterly	1.00 (Scotland average)	Above Scottish average
Falls	Monthly	7.68 per 1,000 TOBD	Not achieving
Falls With Harm	Monthly	1.65 per 1,000 TOBD	Achieving
Pressure Ulcers	Monthly	0.42 per 1,000 TOBD	Not achieving
CS SSI [1]	Quarterly	2.5%	Not achieving
SAB (HAI/HCAI)	Monthly	18.8 per 100,000 TOBD	Achieving
ECB (HAI/HCAI)	Monthly	33.0 per 100,000 TOBD	Not achieving
C Diff (HAI/HCAI)	Monthly	6.5 per 100,000 TOBD	Not achieving
Complaints (S1)	Monthly	80%	Not 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 June 2021

[2] Following discussion with the Nursing Director, we agreed to work towards achieving the 65% target by March 2021. The impact of the second wave of the pandemic has severely affected progress, and we initially agreed the target should be extended to March 2022, with a mid-year target of 50%. A decision has been made to pause certain aspects/areas of complaints handling due to the current situation in the Acute Hospital, and this is reflected in the performance.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

Not applicable.

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.

The October IPQR will be available for discussion at the round of October/November Standing Committee 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 21 October. 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

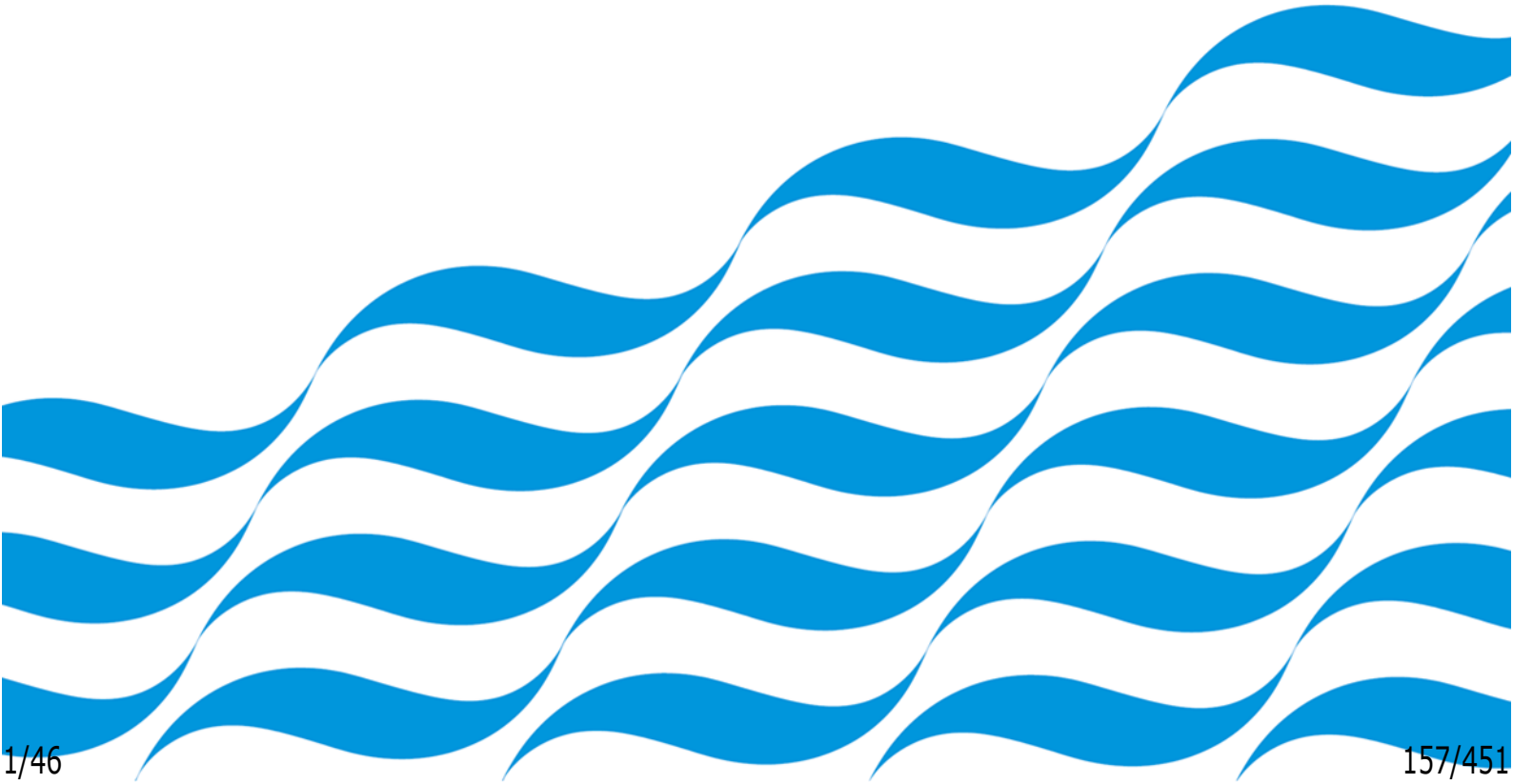
3 List of appendices

None

Report Contact
Bryan Archibald
Head of Performance
Email bryan.archibald@nhs.scot

Fife Integrated Performance & Quality Report

Produced in October 2021



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. Remobilisation Summary

e. 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.

Health Boards are planning the recovery of services following the first and second waves of the COVID-19 Pandemic. NHS Fife has agreed its Joint Remobilisation (RMP3) for 2021/22, and this effectively replaces the previous 1-year or 3-year Annual Operational Plans. It will be superseded by RMP4, addressing the status and forecasts for the second half of the FY from next month. Both the current RMP3 and the forthcoming RMP4 include forecasts for activity across key outpatient and inpatient services, and progress against these forecasts is included in this document by two methods:

- Update of monthly activity (Remobilisation Summary)
- Enhancement of drill-downs to illustrate actual v forecast activity

The RMP provides a detailed, strategic view of how NHS Fife will approach the recovery, while the IPQR drills down to a level where specific Improvement Actions are identified and tracked. In order to provide continuity between the IPQR from version to version (year to year), Improvement Actions carry a '20', '21' or '22' prefix, to identify their year of origin. They are shaded in **BLUE** if they are assessed as being complete or no longer relevant.

Action completion dates appear in **RED** text if they have slipped, but will revert to BLACK text in the next issue of the report, provided no further slips have been reported.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 6 (21%) classified as **GREEN**, 5 (17%) **AMBER** and 18 (62%) **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:

- Cancer 31-Day DTT – above Standard for the 16th successive month (with no breaches for the third time in the last 6 months)
- CAMHS – very close to the 90% LDP Standard for the first time since this measurement was introduced
- Psychological Therapies 18-Weeks RTT – highest monthly performance ever recorded (the second successive month when this has been the case)

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 9 (31%) within upper quartile, 13 (44%) in mid-range and 7 (25%) in lower quartile.

There are indicators where national comparison is not available or not directly comparable.

c. 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	Measure	Target 2021/22	Reporting Period	Year Previous		Previous		Current			Trend	Reporting Period	Fife		Scotland
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Aug-20	31	Jul-21	28	Aug-21	39	↓		N/A			
	HSMR	N/A	Year Ending	Mar-20	1.01	Dec-20	1.01	Mar-21	1.02	↓		YE Mar-21	1.02	●	1.00
	Inpatient Falls	7.68	Month	Aug-20	7.25	Jul-21	7.45	Aug-21	8.14	↓		N/A			
	Inpatient Falls with Harm	1.65	Month	Aug-20	1.56	Jul-21	1.45	Aug-21	1.61	↓		N/A			
	Pressure Ulcers	0.42	Month	Aug-20	1.11	Jul-21	1.22	Aug-21	1.21	↑		N/A			
	Caesarean Section SSI	2.5%	Quarter Ending	Jun-20	2.2%	Mar-21	2.7%	Jun-21	3.6%	↓		QE Dec-19	2.3%	●	0.9%
	SAB - HAI/HCAI	18.8	Quarter Ending	Aug-20	15.1	Jul-21	4.9	Aug-21	10.8	↓		QE Jun-21	6.3	●	18.7
	SAB - Community	N/A	Quarter Ending	Aug-20	7.4	Jul-21	7.4	Aug-21	7.5	↓		QE Jun-21	8.6	●	10.9
	C Diff - HAI/HCAI	6.5	Quarter Ending	Aug-20	5.5	Jul-21	8.5	Aug-21	8.4	↑		QE Jun-21	10.0	●	14.6
	C Diff - Community	N/A	Quarter Ending	Aug-20	6.4	Jul-21	6.4	Aug-21	4.2	↑		QE Jun-21	4.3	●	5.4
	ECB - HAI/HCAI	33.0	Quarter Ending	Aug-20	52.1	Jul-21	46.1	Aug-21	46.8	↓		QE Jun-21	37.6	●	38.2
	ECB - Community	N/A	Quarter Ending	Aug-20	39.2	Jul-21	38.3	Aug-21	41.5	↓		QE Jun-21	32.2	●	41.9
	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Aug-20	72.6%	Jul-21	71.6%	Aug-21	69.4%	↓		2019/20	71.5%	●	79.9%
	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Aug-20	36.1%	Jul-21	32.0%	Aug-21	30.0%	↓		2019/20	35.7%	●	51.8%
Operational Performance	IVF Treatment Waiting Times	90%	Month	Aug-20	100.0%	Jul-21	100.0%	Aug-21	100.0%	↔		N/A			
	4-Hour Emergency Access	95%	Month	Aug-20	95.4%	Jul-21	84.7%	Aug-21	83.6%	↓		Aug-21	83.6%	●	77.8%
	Patient TTG (% of Total Waits <= 12 Weeks)	100.0%	Month	Aug-20	30.0%	Jul-21	67.7%	Aug-21	68.2%	↑		Jun-21	69.3%	●	38.6%
	New Outpatients (% of Total Waits <= 12 Weeks)	95%	Month	Aug-20	50.0%	Jul-21	60.7%	Aug-21	58.6%	↓		Jun-21	62.1%	●	53.1%
	Diagnostics (% of Total Waits <= 6 Weeks)	100%	Month	Aug-20	78.3%	Jul-21	84.9%	Aug-21	81.2%	↓		Jun-21	90.7%	●	62.6%
	18 Weeks RTT	90%	Month	Aug-20	64.0%	Jul-21	72.5%	Aug-21	72.2%	↓		QE Jun-21	68.0%	●	74.7%
	Cancer 31-Day DTT	95%	Month	Aug-20	96.1%	Jul-21	99.1%	Aug-21	100.0%	↑		QE Jun-21	99.0%	●	98.1%
	Cancer 62-Day RTT	95%	Month	Aug-20	84.3%	Jul-21	92.5%	Aug-21	91.3%	↓		QE Jun-21	80.3%	●	84.1%
	Detect Cancer Early	29%	Year Ending	Dec-19	25.0%	Sep-20	19.0%	Dec-20	19.4%	↑		2018, 2019	26.1%	●	25.6%
	Freedom of Information Requests	85%	Quarter Ending	Aug-20	78.2%	Jul-21	75.2%	Aug-21	74.8%	↓		N/A			
	Delayed Discharge (% Bed Days Lost)	5%	Month	Aug-20	7.8%	Jul-21	10.1%	Aug-21	10.3%	↓		QE Mar-21	5.6%	●	4.6%
	Delayed Discharge (# Standard Delays)	N/A	Month	Aug-20	54	Jul-21	81	Aug-21	99	↓		Aug-21	32.76	●	24.80
	Antenatal Access	80%	Month	Jun-20	92.1%	May-21	88.4%	Jun-21	88.5%	↑		FY 2019/20	89.0%	●	88.3%
	Smoking Cessation	473	YTD	Jun-20	31.4%	May-21	62.0%	Jun-21	57.6%	↓		FY 2019/20	92.8%	●	97.2%
	CAMHS Waiting Times	90%	Month	Aug-20	57.8%	Jul-21	80.9%	Aug-21	88.8%	↑		QE Jun-21	73.7%	●	72.6%
	Psychological Therapies Waiting Times	90%	Month	Aug-20	77.9%	Jul-21	86.9%	Aug-21	87.4%	↑		QE Jun-21	80.4%	●	82.7%
	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%
	Drugs & Alcohol Treatment Waiting Times	90%	Month	May-20	86.8%	Apr-21	91.0%	May-21	87.1%	↓		QE Mar-21	94.5%	●	95.6%
	Dementia Post-Diagnostic Support	N/A	Annual	2018/19	93.4%	2019/20	92.8%	2021/21	97.2%	↑		2018/19	93.7%	●	75.1%
	Dementia Referrals	N/A	Annual	2018/19	61.0%	2019/20	58.3%	2020/21	50.0%	↓		2018/19	60.9%	●	43.4%
Finance	Revenue Expenditure	(£13.822m)	Month	Aug-20	N/A	Jul-21	(£7.037m)	Aug-21	(£8.884m)	↓		N/A			
	Capital Expenditure	£29.207m	Month	Aug-20	N/A	Jul-21	£4.290m	Aug-21	£5.790m	↑		N/A			
Staff Governance	Sickness Absence	3.89%	Month	Aug-20	4.58%	Jul-21	6.03%	Aug-21	5.95%	↑		YE Mar-21	4.77%	●	4.67%

d. NHS Fife Remobilisation Summary – Position at end of September 2021

Better than Projected | Worse than Projected | No Assessment

(NOTE: Better/Worse may be higher or lower, depending on context)

		Quarter End	Month End			Quarter End	Quarter End	Quarter End
		Jun-21	Jul-21	Aug-21	Sep-21	Sep-21	Dec-21	Mar-22
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,981	1,000	1,000	1,120	3,120	3,394	3,716
	Actual	3,260	988	942	1,004	2,934		
	Variance	279	-12	-58	-116	-186		
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	17,100	6,227	6,259	6,639	19,125	22,925	24,441
	Actual	19,488	6,154	6,749	7,239	20,142		
	Variance	2,388	-73	490	600	1,017		
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,801	611	611	611	1,833	1,833	1,833
	Actual	1,406	484	547	475	1,506		
	Variance	-395	-127	-64	-136	-327		
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,850	3,750	3,750	3,750	11,250	11,250	11,250
	Actual	12,971	4,324	4,221	4,084	12,629		
	Variance	2,121	574	471	334	1,379		
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	17,110	6,280	6,590	6,240	19,110	18,370	18,490
	Actual	20,728	7,052	7,192	6,866	21,110		
	Variance	3,618	772	602	626	2,000		
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	8,040	2,830	2,800	2,690	8,320	8,680	8,830
	Actual	10,085	3,355	3,367	3,346	10,068		
	Variance	2,045	525	567	656	1,748		
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	Projected	5.82				5.85	5.63	5.73
	Actual	5.54				6.16		
	Variance	-0.28				-0.28		
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,450	870	870	870	2,610	2,610	2,610
	Actual	2,885	996	1,001	1,051	3,048		
	Variance	**435**	**126**	**131**	**181**	**438**		
31 Day Cancer - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	415	145	145	145	435	435	435
	Actual	305	110	109				
	Variance	-110	-35	-36				
CAMHS - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	306	84	103	104	291	346	298
	Actual	411	110	107	121	338		
	Variance	105	26	4	17	47		
Psychological Therapies - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	1,369	514	471	437	1,422	1,905	1,780
	Actual	1,816	605	565				
	Variance	447	91	94				

		Month End	Month End			Month End	Month End	Month End
		Jun-21	Jul-21	Aug-21	Sep-21	Sep-21	Dec-21	Mar-22
Standard Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	37	35	36	36	36	42	43
	Actual	81	81	99	83	83		
	Variance	44	46	63	47	47		

[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

e. Assessment – Clinical Governance

		Target	Current
HSMR		**1.00**	**1.02**

The HSMR for NHS Fife for the year ending March 2021 rose slightly in comparison to the rate for the year ending December 2020, and was above the Scotland average. The rate for VHK alone was 1.03.

Inpatient Falls (with Harm)	*Reduce falls with harm rate by 10% in FY 2021/22 compared to rate in FY 2020/21*	**1.65**	**1.61**

The significant challenges facing inpatient services continue alongside ongoing workforce challenges and as noted previously an increased usage of supplementary staffing. Staff continue to use the extant falls bundle and local support is being given to areas where falls with harm have increased noting a slight increase in some areas.

Pressure Ulcers	*50% reduction by December 2020, continued for FY 2021/22*	**0.42**	**1.21**

Acute: Since January 2021 there has been a shift in the data, with pressure ulcer rates above the median for 8 consecutive months. There has been a reduction in grade 2 and multiple pressure ulcer incidences but an increase in suspected deep tissue injury and grade 3. There have been no grade 4 reported since November 2018.

HSCP: The number of acquired pressure ulcers has reduced slightly from the previous quarter, and four hospitals within the HSCP had no hospital acquired pressure ulcers in August. Over the whole partnership, there has been one hospital acquired pressure ulcer (grade 3) in August and one area has achieved three months with no pressure ulcers. There has been no hospital acquired grade 4 pressure ulcers reported since January 2020.

Caesarean Section SSI	*We will reduce the % of post-operation surgical site infections to 2.5%*	**2.5%**	**3.6%**

All mandatory SSI surveillance remains paused (as per the start of the Covid-19 pandemic) until further instruction from the Scottish Government. However, Maternity Services continue to monitor their Caesarean Section SSI cases and, where necessary (in the case of deep or organ space SSIs) carry out Clinical Reviews. Note that the performance data provided is non-validated and does not follow the NHS Fife Methodology, and that no national comparison data has been published since Q4 2019.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**18.8**	**10.8**

NHS Fife is continuing to achieve the trajectory for the 10% reduction target, to be met by March 2022. There was one PVC associated SAB in August, but there have been no CVC SABs since March.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**6.5**	**8.4**

NHS Fife is above the local improvement trajectory for a 10% reduction of HCAI CDI by March 2022, although the incidence rate has improved since May and remains below average national comparator. There have been 4 recurrences to date in 2021, an improvement from 6 for the same time period in 2020. Reducing the incidence of CDI recurrence is pivotal to achieve the HCAI reduction target, and continues to be addressed.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2022*	**33.0**	**46.8**

The target for NHS Fife is to achieve a 25% reduction of HCAI ECBs by March 2022. For August, NHS Fife was above the trajectory line to achieve this target. In the month, there were 4 CAUTIs and 11 ECBs due to another urinary source. Reducing CAUTI incidence remains the quality improvement focus.

Complaints – Stage 2	*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*	**65%**	**30.0%**

There continues to be an ongoing challenge to investigate and respond to Stage 2 complaints within the national timescales due to the ongoing response to COVID-19 and current service pressures. There is an increase in the complexity of complaints received and numbers received continue to be high. Although reduced slightly, PRD has responded to a high number of concerns and Stage 1 complaints relating to COVID-19 vaccination appointments. We anticipate an increase in calls, enquiries and complaints as the programme team start to deliver third vaccines.

e. Assessment (cont.) – Operational Performance

		Target	Current
4-Hour Emergency Access	*95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer*	**95%**	**83.7%**

The high attendance trend has continued which has impacted on the 4-hour access target, a theme across mainland health boards. Access pathways through the Flow and Navigation hub is being increased further for managing GP admissions for early redirection where possible. Embedding of the Assessment pathways in AU1 continues, but is challenged by high occupancy and demand for bed capacity. The Emergency Department has successfully remodelled the Resus area, providing increased capacity accommodating both red and amber pathways.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**68.2%**

Performance in August has plateaued with 68.2% waiting less than 12 weeks compared to 67.9% in June. NHS Fife continues to be one of the best performing Board in Scotland for TTG. Theatres are now fully remobilised however the continued increase in unscheduled care activity is impacting on our ability to undertake elective inpatient surgical activity as planned and slowing improvement. After a period of stability the waiting list in August has risen to 3,401 which is 6% greater than in August 2019 pre-covid. There is a continued focus on clinical priorities whilst reviewing long waiting patients. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government to deliver the plan.

New Outpatients	*95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment*	**95%**	**58.6%**

Performance in August has deteriorated slightly with 58.6% waiting less than 12 weeks compared to 62.4% in June. The waiting list has continued to rise and at 21,955 is 53% higher than in August 2019 pre-covid. Particular attention continues to be focused on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks. Activity continues to be restricted due to the need for social distancing and enhanced infection control procedures. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government to deliver the plan.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**81.2%**

Performance continues to be under significant pressure, decreasing to 81.2% from 90.6% in June waiting less than 6 weeks. The waiting list has stabilised and at 4,779 is 9% higher than at the end of August 2019 pre-covid. The referrals for CT and Ultrasound remain high with significant pressures from unscheduled care activity and staffing absence resulting in increased routine waits for these modalities. Particular attention continues to be focused on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. A recovery plan is being implemented and additional resources have been agreed with the Scottish Government 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%**	**91.3%**

We saw improvement in 62-day performance in August, however this will remain variable due to an increasing backlog of patients who have breached with no treatment date. The number of USC referrals remains high, consistently exceeding pre pandemic numbers. Breaches are attributed to routine staging and investigations, delays to surgery due to increasing numbers and consultant leave and radiotherapy treatment, while Oncology capacity remains an issue. The majority of breaches continue to be prostate due to the challenging pathway. The range of breaches were 5 to 27 days (average 12 days); the range of maximum days breach has improved.

FOI Requests	*At least 85% of Freedom of Information Requests are completed within 20 working days*	**85%**	**74.8%**

There were 49 FOI requests closed in August, 11 of which were late, a closure performance of 77.5%. The performance figure above (71.2%) reflects the performance for the 3-month period ending August.

Due to staff turnover in the FOI Role, the Information Governance and Security Advisors are overseeing the administration of FOI requests.

		Target	Current
Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay is to reduce*	**5%**	**10.4%**

The number of bed days lost due to patients in delay continues to rise and has remained above the target 5%. Increased hospital activity over the recent months has resulted in more people requiring social care; this demand has been unable to be met due to social care services experiencing significant workforce pressures. H&SCP have surged 62 downstream beds over the last 4 months to mitigate against the lack of home care, and this is resulting in the increase in the % of bed days lost which is being reported. Bed days occupied by Code 9 (51X) patients, while not counted in the IPQR measure, accounts for approximately 30-35% of beds days lost.

Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**68**

Service provision has continued to be delivered remotely by phone and Near Me appointments. Staffing levels are improving, with two staff members returned from maternity leave (albeit now using accrued annual leave). Continued local training is being delivered to new staff members and refresher training for others. There is an ongoing challenge and potential risk to the LDP Target with supply shortage of Champix (varenicline tartrate) across all doses and presentations which looks set to continue until the new year. Two new staff members have completed their competencies and are now competent and confident practitioners.

CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**88.8%**

Referral to Treatment (RTT) performance remains high, reflecting the ongoing prevalence of urgent and priority referrals to CAMHS and the allocation of the majority of the workforce to meet this need. Longest waits has been sustained (despite staff employed to address this group leaving post) by reallocating core staff to target those waiting the longest. Recruitment process is ongoing - 6 of the available 8 posts to increase capacity have been appointed with the remaining posts at interview stage. The two 'longest wait' posts have been appointed within Clinical Psychology and will start in early 2022. The outstanding (10) posts identified through the Gap Analysis, funded by the Mental Health Recovery and Renewal Fund, are still in the recruitment system.

Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**87.4%**

The overall waiting list continues on a downward trend, and there has been a further reduction in numbers waiting over 52 weeks, with these longest waits being mainly for highly specialised therapy. The trend in referrals remains upward, with the increased referral/self-referral rate for our expanded range of online PTs continuing. Group work has increased. Recruitment to new posts (and current vacancies) is ongoing.

e. Assessment (cont.) – Finance

		Target	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**(£13.822m)**	**(£8.884m)**

Month 5 financial position

The revenue position for the 5 months to 31 August reflects an overspend of £8.884m. This comprises a run rate overspend position of £1.908m; unmet core savings of £1.286m (to be delivered over the remaining months of the year); and underlying unachieved 'long Covid' savings of £5.690m.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£29.257m**	**£5.961m**

The overall anticipated capital budget for 2021/22 is £29.257m. The capital position for the period to August records spend of £5.79m. Therefore, 19.8% of the anticipated total capital allocation has been spent to month 5.

e. Assessment (cont.) – Staff Governance

		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**3.89%**	**5.95%**

The sickness absence rate in August was 5.95%, a decrease of 0.08% from the rate in July. The average rate for COVID-19 related special leave, as a percentage of available contracted hours for the financial year to date was 1.14%.

II. Performance Exception Reports

Clinical Governance

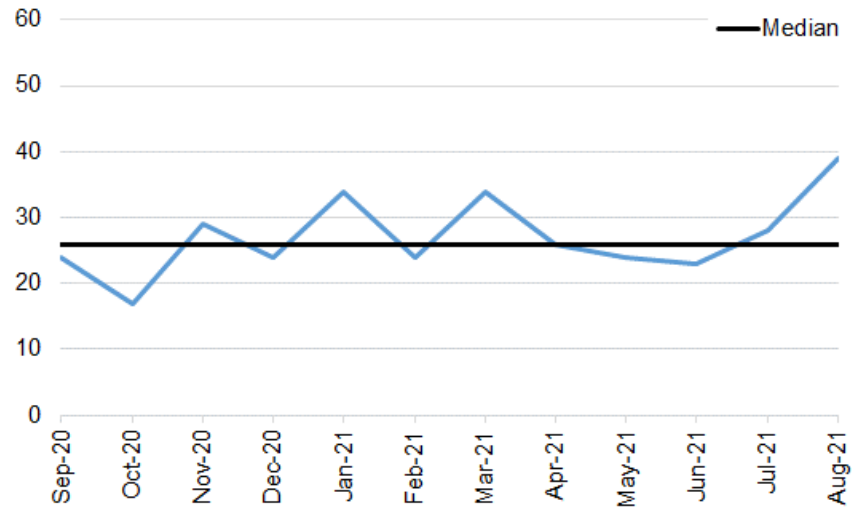
Finance, Performance & Resources: Operational Performance

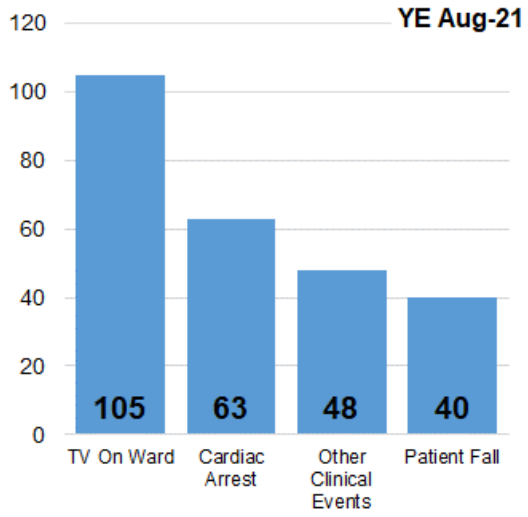
Finance, Performance & Resources: Finance

Staff Governance

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2020/21							2021/22				
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
ALL	NHS Fife	1288	1340	1307	1249	1288	1210	1363	1355	1370	1349	1413	1432
	Acute Services	607	558	640	601	573	531	628	592	646	606	625	605
	HSCP	639	748	635	621	694	653	707	724	682	694	740	791
	Corporate	42	34	32	27	21	26	28	39	42	49	48	36
CLINICAL	NHS Fife	925	903	955	928	904	855	952	934	1009	935	1005	943
	Acute Services	559	509	596	558	534	495	586	545	597	548	566	542
	HSCP	348	378	341	360	359	346	352	371	388	365	412	382
	Corporate	18	16	18	10	11	14	14	18	24	22	27	19

Commentary

Levels of reporting have increased marginally, with August having the highest number of incidents reported in the past 12 months. There was also an increase in major and extreme incidents reported, with the most notable increase in events relating to patient falls.

Focused improvement work continues in areas where there has been an increase in falls with harm. A proportion of the increase is attributable to the reporting of events related to infrastructure, specifically in relation to staffing and environment.

Overall, the reported number of tissue viability events (pressure ulcers developing on ward) has reduced in August with systems in place continuing to monitor, review and respond appropriately.

Specific activities are as follows:

- Baseline mapping of the current Adverse Events process is complete
- New Lead for Adverse Events starts in post in November and will provide dedicated leadership to drive forward the review of Adverse Event Policy and Procedure including system learning from events
- Terms of Reference for a new Organisational Learning Group have been drafted; this group will identify thematics and learning from events and other clinical governance data to support system wide improvement
- Increased number of Executive Sponsors now in place to support timely review of Significant Adverse Event Reviews to ensure learning and actions are implemented

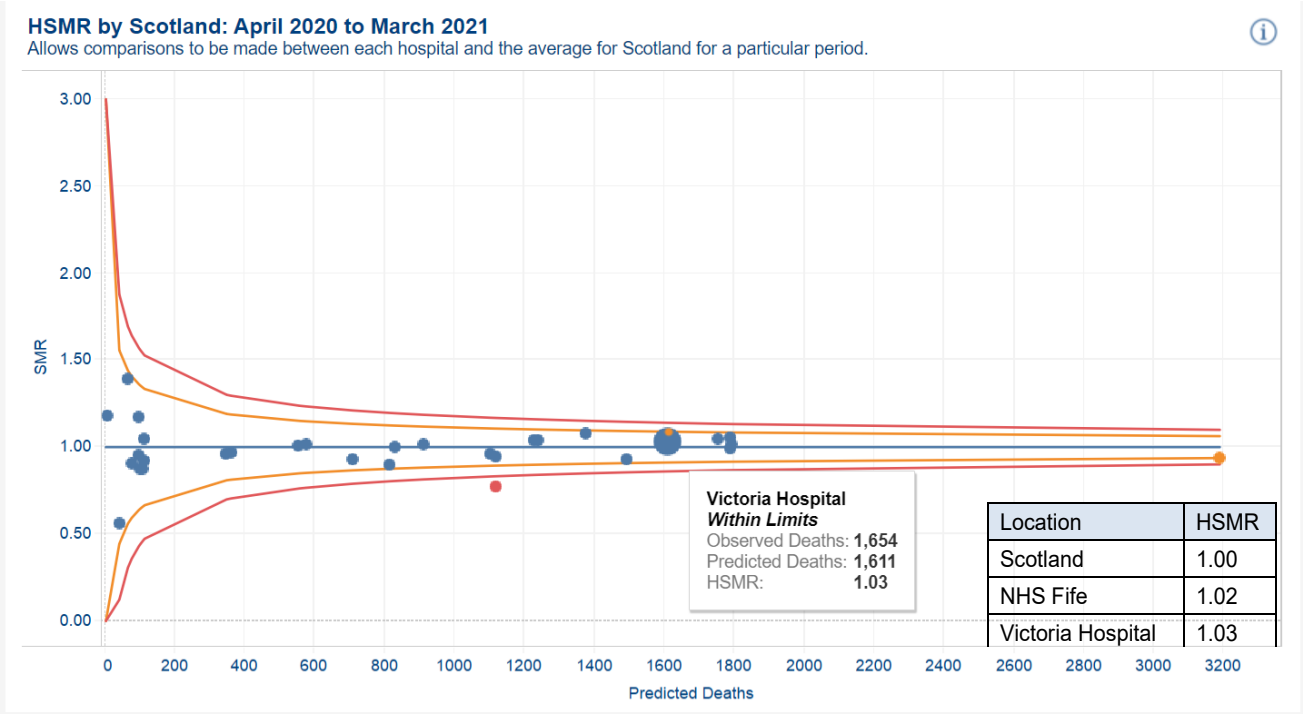
HSMR

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; April 2020 to March 2021[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	1.02
Victoria Hospital	1.03

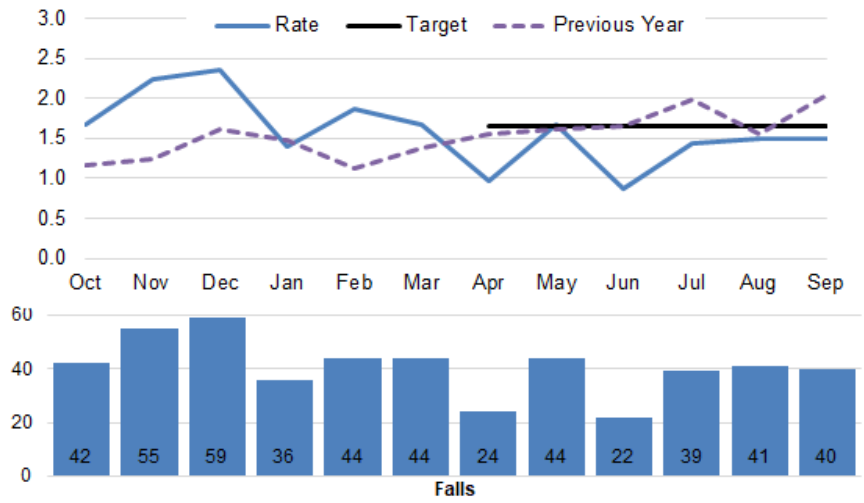
Commentary

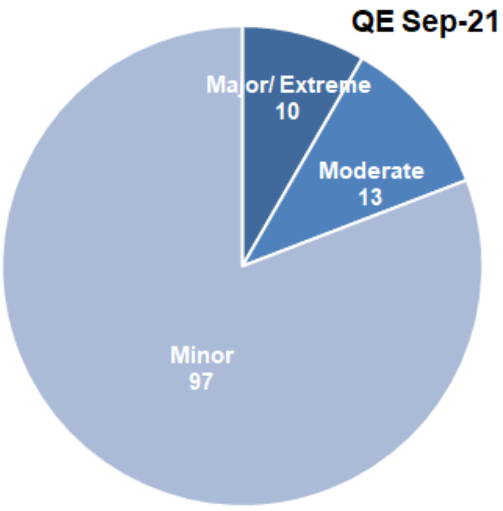
The HSMR for NHS Fife has remained slightly above the 1.00 mean for all periods since the measure was changed two years ago. This should be seen as normal variation, but we will continue to monitor this closely. The difference between actual and predicted number of deaths in the year ending March 2021 produced a ratio of 1.02 with VHK alone being 1.03).

Inpatient Falls with Harm

Reduce Inpatient Falls with Harm rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2022) = 1.65 per 1,000 OBD

Local Performance





Performance by Service Area

		2020/21							2021/22				
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
With Harm	NHS Fife	2.03	1.68	2.24	2.35	1.39	1.87	1.68	0.98	1.68	0.86	1.45	1.61
	Acute Services	1.37	1.11	1.54	1.67	1.24	1.18	0.98	0.35	0.88	0.41	0.79	1.41
	HSCP	2.62	2.17	2.88	2.96	1.53	2.47	2.29	1.54	2.40	1.27	2.03	1.79

KEY CHALLENGE(S) IN 2021/22

- Continued challenges in in-patient settings with patient placement, social distancing
- Ongoing combined challenges of the dynamic nature of provision of care while ensuring COVID measures are firmly in place, and remobilisation of services
- Re-establishing the Falls Champion Network across all in-patient areas to support local work and support how to address the challenges noted

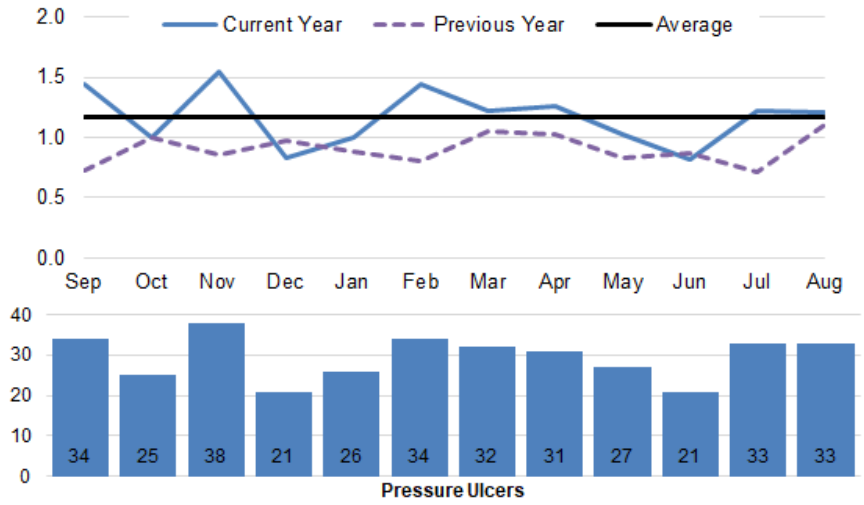
IMPROVEMENT ACTIONS

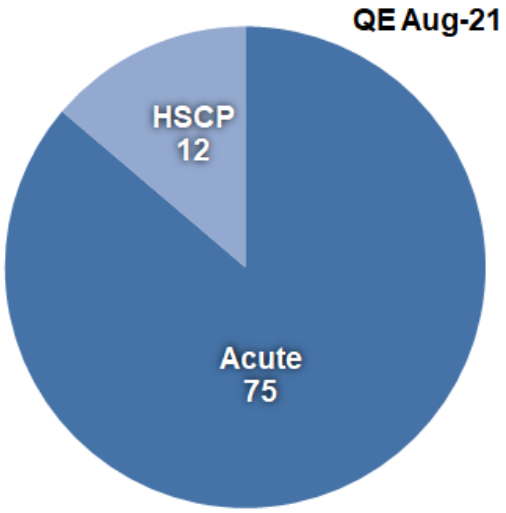
20.3 Falls Audit	***By Feb-22***
A new national driver diagram and measurement package have still to be finalised and as already reported have been tested in four boards across Scotland in May and June. Due to current challenges NHS Fife documentation will be reviewed in early 2022 and an audit will then follow.	
20.5 Improve effectiveness of Falls Champion Network	***By Jan-22***
This work has been significantly delayed and opportunities to refresh are further hampered with workforce challenges. This will continue to be an area of focus for the group but with an amended target date for completion.	
21.2 Falls Reduction Initiative	***By Nov-21***
A Falls Reduction Initiative has taken place in three Mental Health Inpatient wards. QI work commenced in early March with support from CCGT and ongoing tests of change were implemented. Early indication has highlighted that falls have decreased, and work will now take place to ensure improved sustainability. The improvement team meet fortnightly to review ongoing tests of change and we continue to evaluate and review the weekly quality data to inform decisions and strategy. A review of outcomes will take place towards the end of the year.	
21.3 Integrated Improvement Collaborative	***By Jan-22 (interim report Nov-21)***
A Collaborative involving three community inpatient wards was introduced last September but was paused as a result of COVID. The work will now continue until January 2022. A further two wards are participating in the collaborative with the main focus being on reducing patient falls and identifying further improvement interventions for reducing medication incidents and hospital acquired pressure ulcers.	

Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2022) = TBD per 1,000 OBD
NOTE: CURRENTLY USING THE PREVIOUS TARGET TO CALCULATE RAG STATUS

Local Performance





Performance by Service Area

		2020/21							2021/22				
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Grade 2 to 4	NHS Fife	1.44	1.00	1.55	0.83	1.00	1.44	1.22	1.26	1.03	0.82	1.22	1.21
	Acute Services	2.73	1.20	2.39	1.17	2.06	2.18	2.12	2.42	1.68	1.58	2.05	2.36
	HSCP	0.32	0.82	0.78	0.53	0.07	0.80	0.43	0.23	0.44	0.15	0.49	0.21

KEY CHALLENGE(S) IN 2021/22

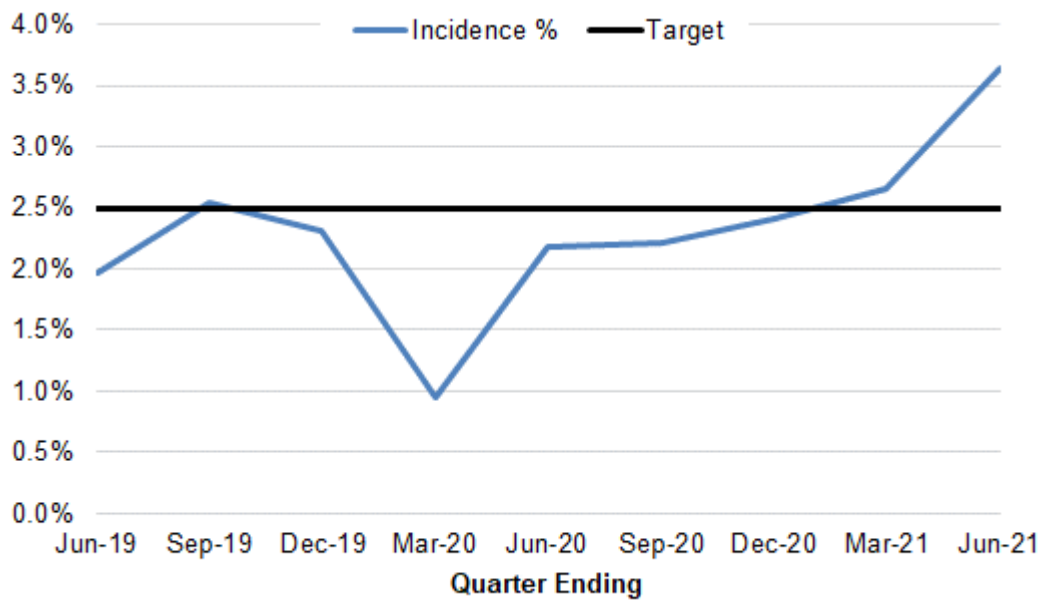
Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

IMPROVEMENT ACTIONS	
21.2 Integrated Improvement Collaborative	**Complete Jun 2021**
21.3 Implementation of robust audit programme for audit of documentation	**Complete Jun 2021**
22.1 Improvement Collaboratives	**By Jan-22**
Community inpatients wards within HSCP are undertaking self-assessment against the Prevention & Management of Pressure Ulcers to enhance good practice and identify opportunities for improvement. The work is currently under review in order to reflect and establish SMART objectives to ensure improvement targets are met.	
22.2 Community Nursing QI Work	**By Nov-21**
One area within Fife HSCP community nursing teams has implemented a focused piece of work involving a number of improvement initiatives. To complement this work, the team have adopted a "back to basics" approach, to ensure that all relevant skin and risk assessments are completed, and this is having a positive impact on patient outcomes. Restrictions within Datix have been identified and discussions are taking place around expanding the speciality list, which would enable better analysis of data and allow the team to identify targeted support and education.	
22.3 ASD Pressure Ulcer Improvement Programme	**By Mar-22**
The commencement of third cohort of the Pressure Ulcer Improvement Programme (PUIP) has been paused due to the current staffing pressures. However QI support has been offered to individual areas on a bespoke basis. Teams involved in cohort 1 and 2 continue to collect process measures data and are encouraged to continue to identify and test change ideas until sustained improvement is achieved.	
22.4 Implementation of Focused Improvement Activities	**By Mar-22**
There are a number of focused improvement activities taking place in a variety of settings. ICU have two projects underway, one aiming to improve the management of moisture related skin damage and a second aiming to improve pressure area care for patients nursed prone. Ward 31 and ED are also carrying out pressure ulcer improvement projects.	

Caesarean Section SSI

Sustain C-Section SSI incidence for inpatients and post discharge surveillance (day 10) below 2.5% during FY 2021/22

Local Performance



National Benchmarking

Quarter	2017/18		2018/19				2019/20				2020/21		
Ending	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20
NHS Fife	4.0%	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%	1.0%	2.2%	2.2%	2.4%
Scotland	1.6%	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%				

KEY CHALLENGE(S) IN 2021/22

Resumption of SSI surveillance (when instructed/agreed) will require a review of the previously established methodology (adopted in Q4 2019 and paused during Q1 2020 due to the pandemic response), with regards to possible subsequent changes both nationally and locally. Then training of staff in the definitions of C-section SSI and the surveillance programme, areas include; Maternity Assessment, Maternity Ward, Observation Ward and the Community Midwives.

IMPROVEMENT ACTIONS	
20.1 Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	**By Mar-22**

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 (LAER) any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop.

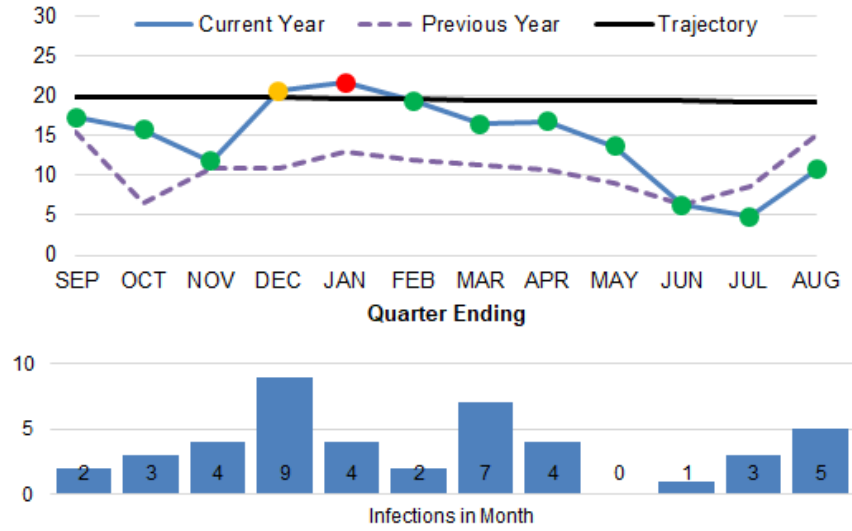
There is currently no date for resumption of SSI surveillance, set by ARHAI (due to the third wave of Covid-19).

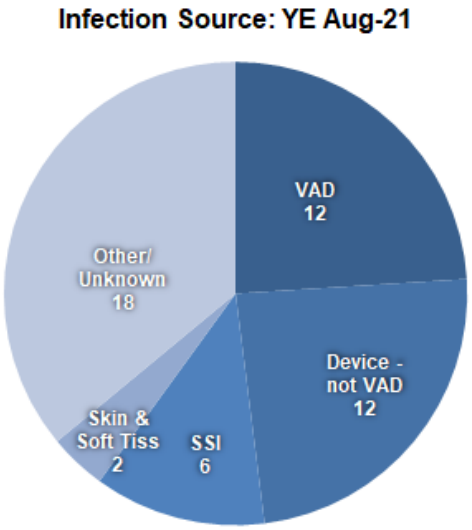
On resumption of the C-section SSI surveillance programme, the IPCT will review the surveillance methodology to capture any practice/patient pathway changes due to the pandemic response and/or any alterations to the case definition. This will ensure that the surveillance methodology remains the most effective means of capturing SSI cases.

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				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	10.9	12.5	6.3	18.7	20.6	17.8	6.3
Scotland	15.2	16.3	20.3	17.3	18.9	18.4	18.7

KEY CHALLENGE(S) IN 2021/22

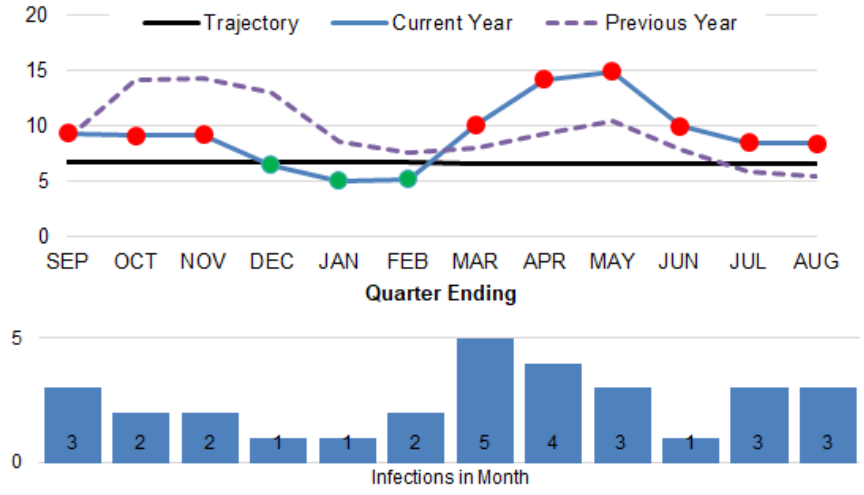
Vascular access devices and medical devices such as urinary catheters are risk factors identified for SAB, and infections in these areas need to be minimised in order to achieve the 10% reduction by March 2022

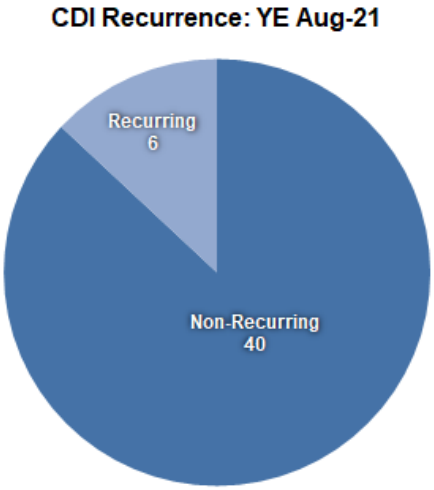
IMPROVEMENT ACTIONS	
20.1 Reduce the number of SAB in PWIDs	***By Mar-22***
The incidence of SABs in PWIDs has continued to reduce, with only 3 cases identified in 2021 to date (compared to 5 in 2020 and 14 in 2019). IPCT continue to support addiction services with the SAB improvement project. The IPCT presentation for wound care training for ANPs has been completed and awaiting dates to deliver sessions from Addiction services. The Addiction outreach team "We are With You" is available to support PWID on a referral basis. The rollout of PGDs for non-medical prescribing of antibiotics by ANPs which was planned for July, is still pending.	
20.2 Ongoing surveillance of all VAD-related infections	***By Mar-22***
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	
20.3 Ongoing surveillance of all CAUTI	***By Mar-22***
Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions regarding catheter and urinary care. The group last met July with the September meeting postponed. The Driver Diagram for the group is currently in the process of being reviewed and updated. This Quality Improvement group is contributed to by the ECB data.	
20.4 Optimise comms with all clinical teams in ASD & the HSCP	***By Mar-22***
Monthly SAB reports distributed with Microbiology comments, to gain better understanding of disease process and those most at risk. 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 displayed for public assurance.	
22.1 Use Electronic insertion and maintenance bundles for PVC, CVC, urinary catheters	***By Mar-22***
Electronic insertion and maintenance bundles for PVCs are completed on Patientrack to support best practice. Compliance is reported weekly to ward Senior Charge Nurses if the ward failed to achieve 90% of all PVC being removed prior to the 72hr breach. There are Quality Improvement (QI) projects to support areas which are not achieving best practice. Similar electronic insertion and maintenance bundles are planned for in-dwelling urinary catheters and CVCs to promote and support best practice, reduce avoidable harm and improve quality of care.	

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				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	13.1	8.0	7.9	9.3	7.7	14.0	10.0
Scotland	15.1	13.6	15.4	17.4	16.4	15.8	14.6

KEY CHALLENGE(S) IN 2021/22

Sustain and further reduce healthcare-associated CDI and recurrent CDI in order to achieve the 10% reduction target by March 2022

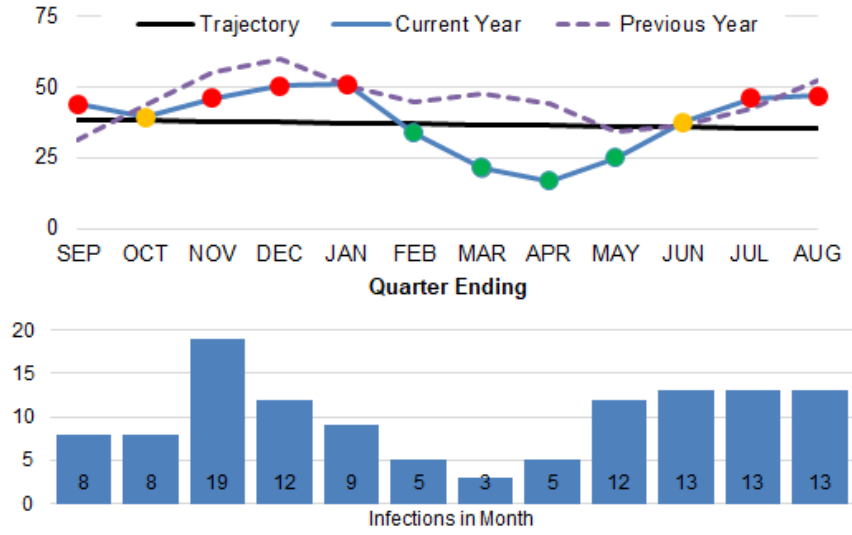
IMPROVEMENT ACTIONS

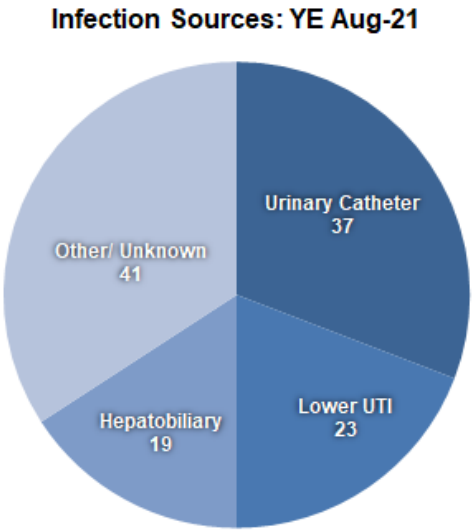
20.1 Reducing recurrence of CDI	***By Mar-22***
Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection. To reduce recurrence of CDI Infection for patients at high risk of recurrent infection, two treatments are utilised in Fife, Fidaxomicin and Bezlotoxumab. The latter is can be prescribed whilst faecal microbiota transplantation is unavailable during the COVID-19 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 and the revised Microguide app has been circulated to all GP practices.	
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. IPCN ward visits reinforce SICPs and transmission-based precautions, provide education to staff to promote optimum CDI management and daily Medical Management form completion. The Ward Dashboard is continuously updated, for clinical staff to access CDI incidence by ward and is also displayed for public assurance.	

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				2021/22
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	60.0	47.9	36.4	45.3	50.3	21.6	37.6
Scotland	40.8	36.4	39.7	42.0	40.9	34.7	38.2

KEY CHALLENGE(S) IN 2021/22

Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTI) remain the prevalent source of ECBs and are therefore the areas to address to reduce the healthcare-associated inflection ECB rate

IMPROVEMENT ACTIONS

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 undergoes IPC surveillance to establish a history. All CAUTI ECBs associated with traumatic insertion, removal or self removal are submitted for DATIX to assist understanding and learning.
As part of the strategy to reduce E.coli Bacteraemia (ECB), a DATIX audit was proposed, with resulting LAERs for all catheter associated ECB (including without trauma) being undertaken by the patients clinical team. However, due to hospital pressures, all LAERs are currently on hold.

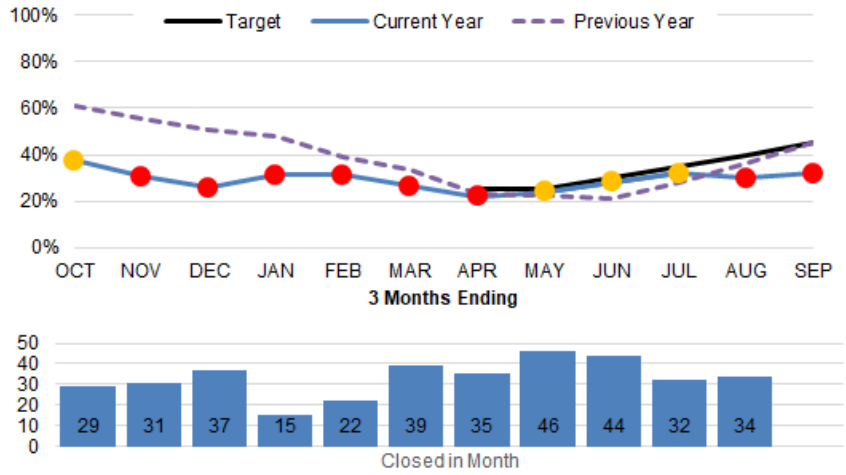
20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG)	***By Mar-22***

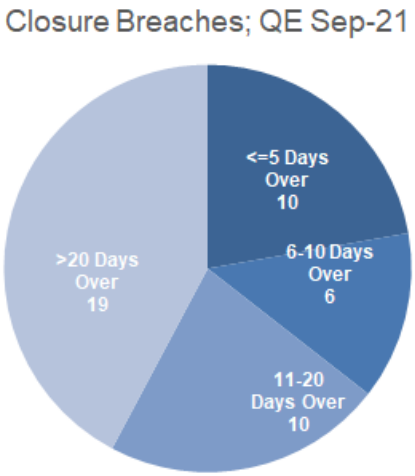
The UCIG meeting last met in July, with the September meeting being cancelled. Initiatives to promote hydration and provide optimum urinary catheter care (including continence care) across Fife continue. They cover analysis and update of process, training/education/promotion and quality improvement work. Work involves the district nursing service and staff in both private and NHS care homes as well as a QI CAUTI programme at Kelty GP Practice.

Complaints | Stage 2

At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)

Local Performance





Performance by Service Area

3-Month Ending	2020/21							2021/22				
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	45.0%	37.3%	30.5%	25.8%	31.3%	31.1%	26.3%	21.9%	24.2%	28.0%	32.0%	30.0%
Ack <= 3 Days (Monthly)	95.5%	93.1%	100.0%	100.0%	93.3%	95.5%	94.9%	100.0%	93.5%	100.0%	96.9%	100.0%
ASD	52.8%	39.6%	34.0%	30.5%	36.5%	35.3%	19.3%	15.9%	15.7%	22.5%	23.5%	25.7%
HSCP	26.1%	26.1%	15.4%	13.9%	20.0%	18.2%	50.0%	38.1%	48.3%	31.4%	38.7%	23.3%

KEY CHALLENGE(S) IN 2021/22

- Service recovery following Covid-19 pandemic
- Improve the quality of complaint handling
- Complex complaints / Multi-Directorate Complaints

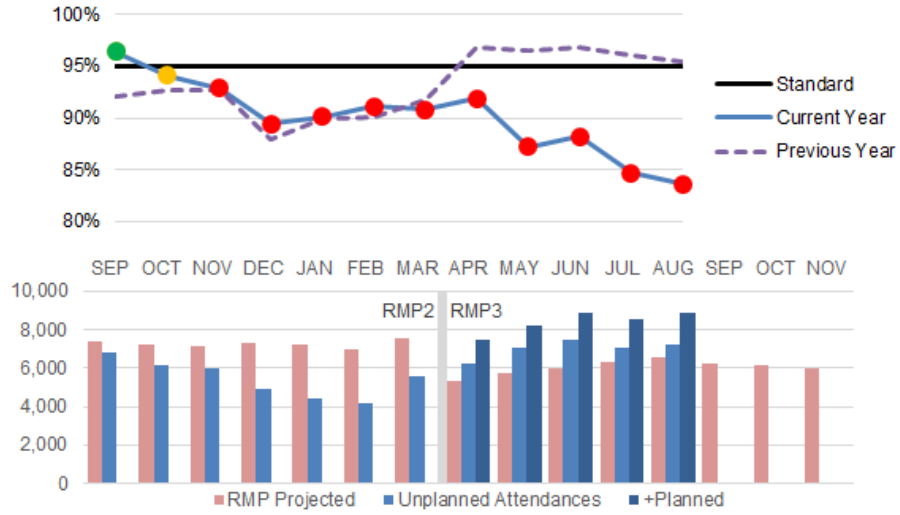
IMPROVEMENT ACTIONS

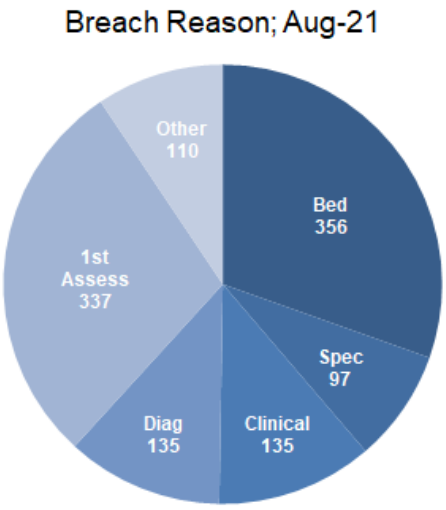
22.1 Review complaint handling process and agree measures to ensure quality	**By Mar-22**
Patient Relations are completing in-house QA checks on draft final responses. A review of the current complaint handling process by Clinical Governance and Patient Relations has started, but is on hold due to the ongoing response to COVID-19 and current capacity issues.	
22.2 Improve education of complaint handling	**By Mar-22**
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. While some training sessions have been delivered virtually, this is on hold due to the ongoing response to COVID-19 and current capacity issues. Bespoke training sessions with Fife Wide & Fife East took place in May and June, and the aim is that this will restart during the remainder of 2021, where there is capacity to do so.	

4-Hour Emergency Access

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

Local Performance





National Benchmarking

Month	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	96.4%	94.1%	92.9%	89.4%	90.1%	91.1%	90.8%	91.9%	87.2%	88.2%	84.7%	83.6%
Scotland	92.1%	89.6%	89.8%	86.4%	86.0%	86.2%	88.5%	88.7%	87.2%	85.0%	81.5%	77.8%

KEY CHALLENGE(S) IN 2021/22

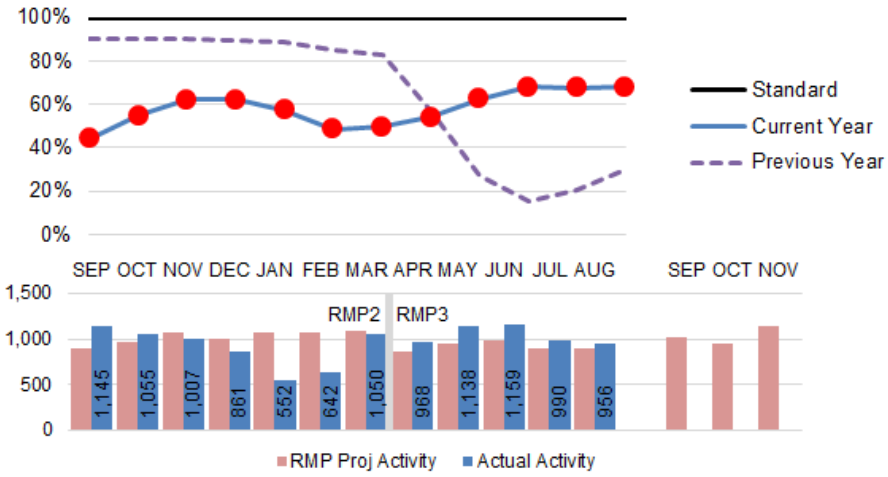
- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

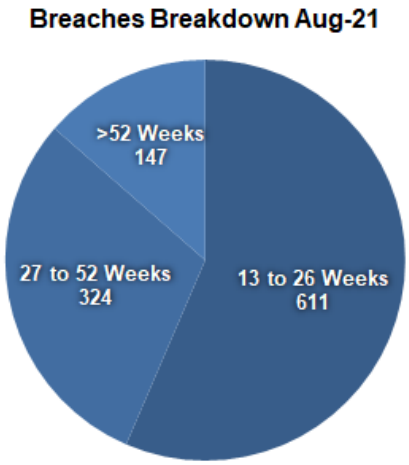
IMPROVEMENT ACTIONS	
21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub	**By Mar-22**
Flow and Navigation appointments to ED are now in place and the hub has expanded to handle GP calls previously taken through acute consultant staff in-hours. Early indication shows decreased referrals towards the end of the week and expansion for 24/7 handling is in planning.	
22.1 Co-produce (with NHS 24) patient criteria for access to ED via 1-hr and 4-hr pathways	**By Nov-21**
Work continues on ED and MIU pathways via working groups. High numbers of presenters to ED continue to be walk ins, and local surveys have been carried out to source intelligence as to public knowledge of pathways and options for treatments.	
22.2 Reduce number of patients breaching at 4 hrs, 8 hrs, and waits for beds	**By Nov-21**
Bed waits continue to be the principal reason for breaches. There has been an increase in 8-hour breaches due to capacity challenges across the site. All directorates are focussed on improvement actions which can improve flow into downstream wards and effectively manage admission demand from front door.	

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

	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	44.1%	54.9%	62.3%	62.3%	57.4%	48.6%	49.7%	54.1%	62.7%	67.9%	67.7%	68.2%
Scotland	30.0%	34.2%	37.4%	37.0%	35.9%	33.5%	34.7%	35.5%	37.2%	38.6%		

KEY CHALLENGE(S) IN 2021/22

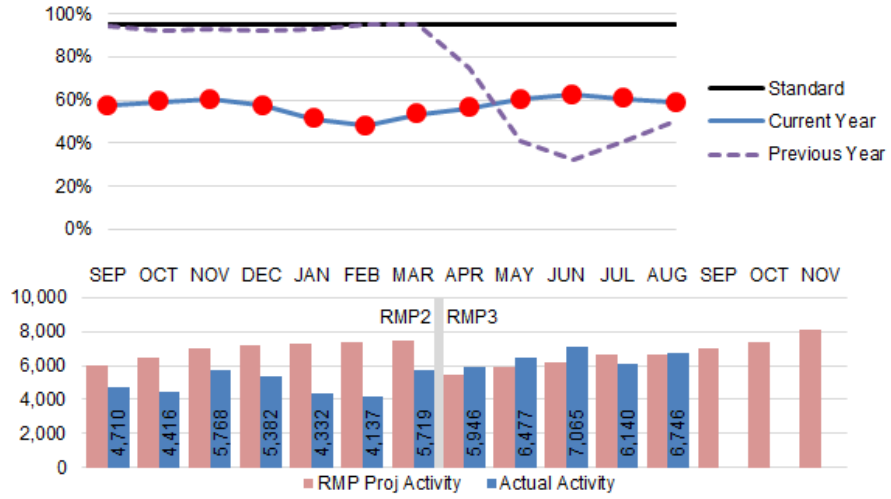
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

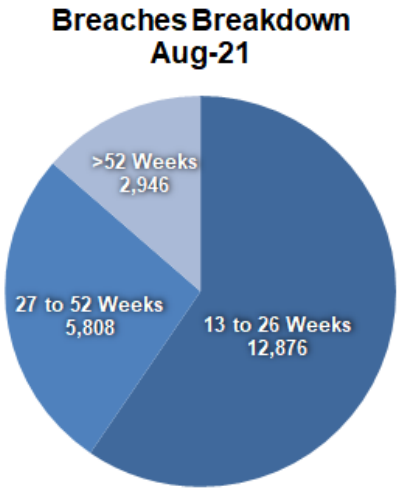
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
Monthly DCAQ monitoring in place, additional funding agreed with Scottish Government and formal review undertaken with revised plan submitted Action complete	
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Mar-22**
Options appraisal to support a digital solution finalised	
22.3 Undertake waiting list validation against agreed criteria	**By Mar-22**
Clinical teams continue to review lists and prioritise patients, Clinical Prioritisation Group meets regularly. This work will continue as clinical prioritisation remains a key activity.	

New Outpatients

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

Local Performance





National Benchmarking

	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	57.4%	59.3%	60.3%	57.5%	51.2%	48.0%	53.4%	56.4%	60.3%	62.4%	60.7%	58.6%
Scotland	46.5%			47.8%	44.5%	43.9%	48.3%	50.4%	52.1%	53.1%		

KEY CHALLENGE(S) IN 2021/22

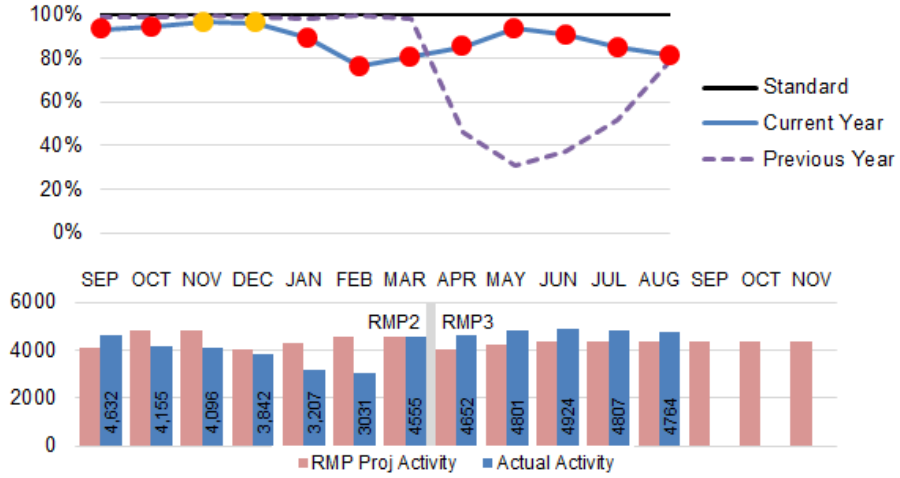
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

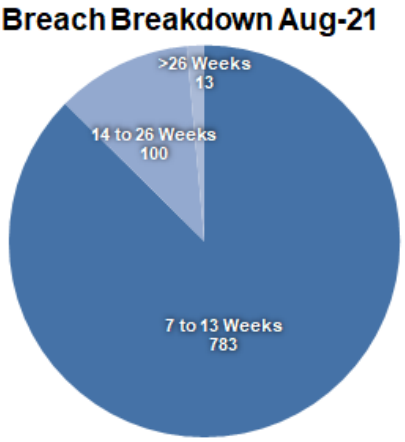
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
Monthly DCAQ monitoring in place, additional funding agreed with Scottish Government and formal review undertaken with revised plan submitted Action complete	
22.2 Deliver appropriate elements of Modernising outpatients and unscheduled care redesign to reduce and manage demand and sustain capacity	**By Mar-22**
ACRT and PIR being progressed in Directorates and waiting list validation continues	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**By Mar-22**
Directorates promoting and supporting initiatives	
22.4 Understand impact of potential changes to guidance on social distancing and actions needed to implement	**By Dec-21**
Remodelling work complete and shared with clinic staff, revised guidance issued however additional Infection Control guidance sought form local team	

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

	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	93.1%	94.3%	96.5%	95.9%	89.2%	76.2%	80.6%	85.3%	93.5%	90.6%	84.9%	81.2%
Scotland	53.3%	52.3%	57.2%	55.9%	52.0%	57.8%	61.4%	61.8%	64.1%	62.6%		

KEY CHALLENGE(S) IN 2021/22

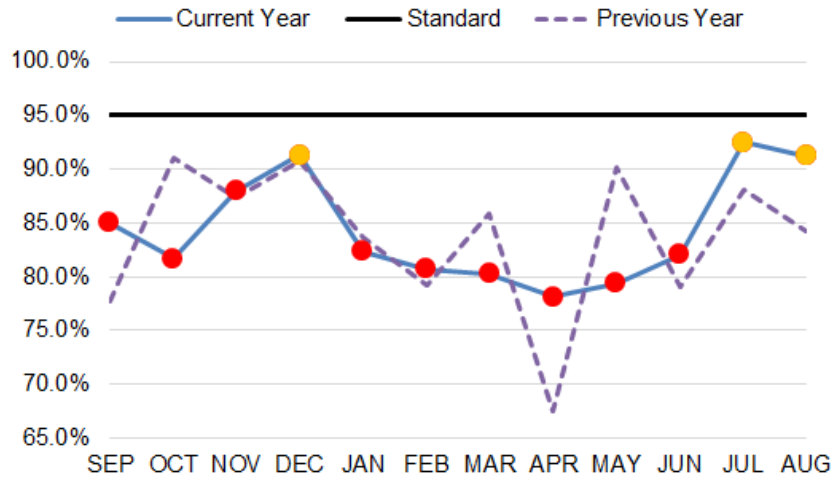
- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence and fatigue

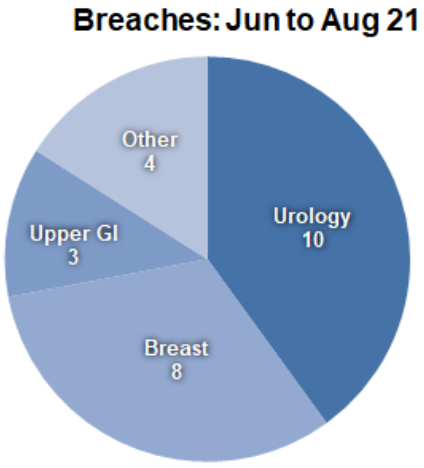
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
Monthly DCAQ monitoring in place, additional funding agreed with Scottish Government and formal review undertaken with revised plan submitted Action complete	
22.2 Explore implementation of point of care testing in endoscopy	**By Mar-22**
Testing platform chosen, governance processes to support implementation underway	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**By Mar-22**
Directorates promoting and supporting initiatives	

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	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	85.0%	81.7%	88.0%	91.3%	82.4%	80.7%	80.3%	78.1%	79.4%	82.1%	92.5%	91.3%
Scotland	86.5%	84.9%	84.8%	85.3%	81.6%	81.9%	83.0%	84.5%	83.0%	83.6%	82.8%	83.5%

KEY CHALLENGE(S) IN 2021/22

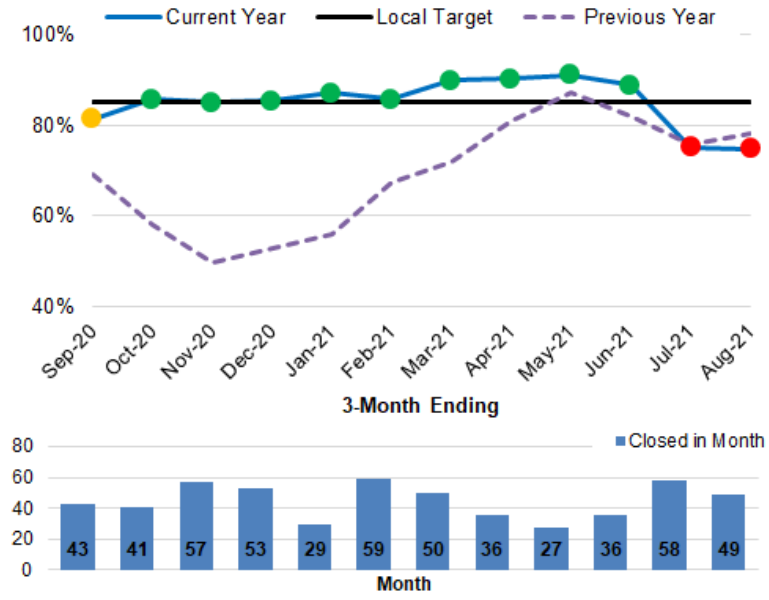
- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Social distancing will (impact on the number of patients that can be seen and treated within hospitals)
- Introduction of the robot may impact on waits to surgical treatment due to training requirements

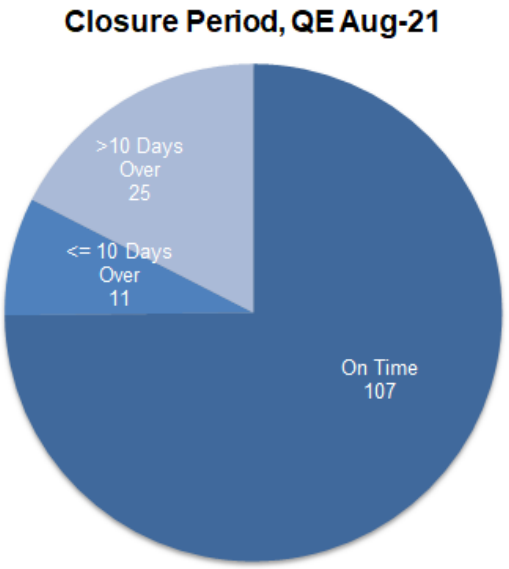
IMPROVEMENT ACTIONS	
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-22**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-22**
This is ongoing work related to Action 20.3, with the specific aim being to improve the delays within the whole pathway. A national review of the prostate pathway will be undertaken as part of the Recovery Plan.	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan	**By Oct-21**
The National Cancer Recovery Plan was published in December 2020. A Strategic & Governance Cancer Group has been established with a Cancer Framework Core Group to develop and take forward the NHS Fife Cancer Framework and annual delivery plan for cancer services in Fife.	
22.1 Effective Cancer Management Review	**By Mar-22**
The Scottish Government Effective Cancer Management Framework review to improve cancer waiting times performance is underway. The recommendations from the review will be addressed as part of the improvement process.	

Freedom of Information Requests

We will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance





Performance by Service Area

Monthly	2020/21							2021/22				
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Health Board	82.1%	96.8%	87.5%	93.5%	92.3%	83.6%	93.5%	93.5%	79.2%	88.6%	58.0%	83.3%
IJB	75.0%	50.0%	88.9%	14.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	42.9%

KEY CHALLENGE(S) IN 2021/22

Establishment of a permanent resource level for all Information Governance and Security activities. Within the area of Freedom of Information, the temporary appointment has left the organisation and an Information Governance and Security Advisor is overseeing FOI administration. The route to a permanent post is still going through Human Resources and it is hoped that this will be ready for advertisement soon.

IMPROVEMENT ACTIONS	
21.1 Organisation-wide Publication Scheme to be introduced	**Complete Jun 2021**
21.2 Improve communications relating to FOISA work	**By Dec-21**

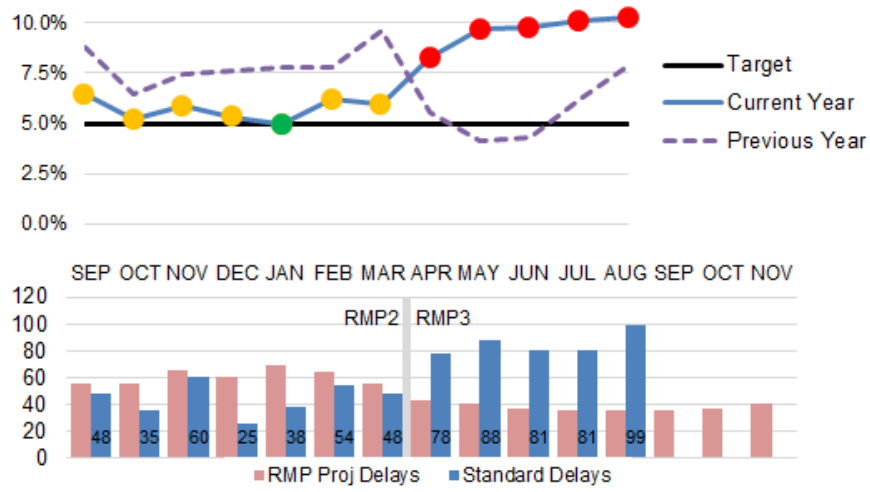
The first EDG Paper (1.0 - Process) passed through EDG in February. The Scottish Information Commissioner's Office has commended the work NHS Fife has undertaken so far to remedy the Board's previous low level of FOISA compliance.

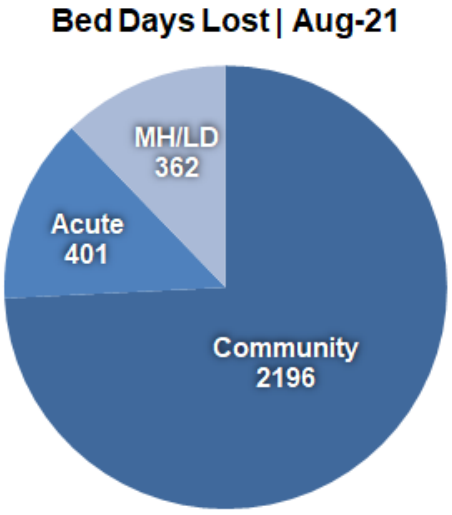
This action will be left open for the rest of 2021, while resourcing issues remain to be resolved.

Delayed Discharges (Bed Days Lost)

We will limit 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			
		Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
% Bed Days Lost	NHS Fife	8.9%	7.6%	8.0%	7.2%	8.3%	4.6%	6.8%	5.5%	5.6%
% Bed Days Lost	Scotland	6.5%	6.8%	7.2%	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%

KEY CHALLENGE(S) IN 2021/22

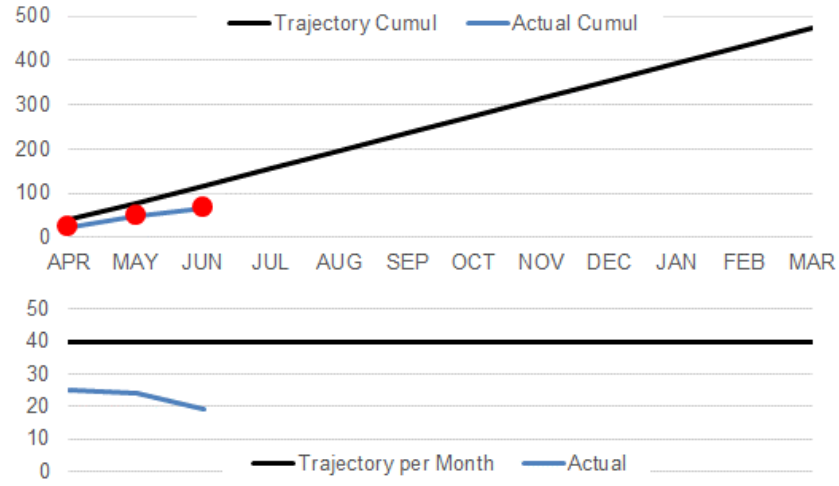
- Capacity in the community – demand for complex packages of care has increased significantly
- Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
- Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge from the acute setting to the community hospitals and social care provision

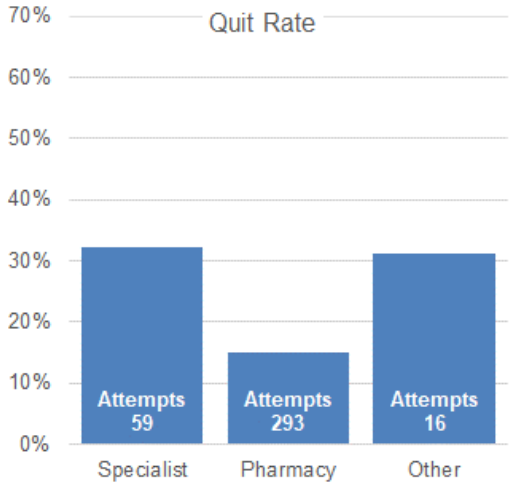
IMPROVEMENT ACTIONS	
21.1 Progress HomeFirst model / Develop a 'Home First' Strategy	**By Dec-21**
The Oversight "Home First" group meeting with H&SC, NHS Fife, Fife Council and Scottish Care took place in April. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Regular monthly meetings take place, action plans/driver diagrams are now in place for the oversight and subgroups.	
22.1 Fully implement the "Moving On" Policy in Acute and Community Hospitals	**Complete Jul 2021**
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**By Jan-22**
An SBAR was submitted to the Senior leadership Team and a test of change will start on 4th October, running for 3 months	

Smoking Cessation

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

Local Performance





National Benchmarking

		2021/22											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	25	24	19									
	Actual Cumul	25	49	68									
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	62.5%	62.0%	57.6%									
Scotland	Achieved												

KEY CHALLENGE(S) IN 2021/22

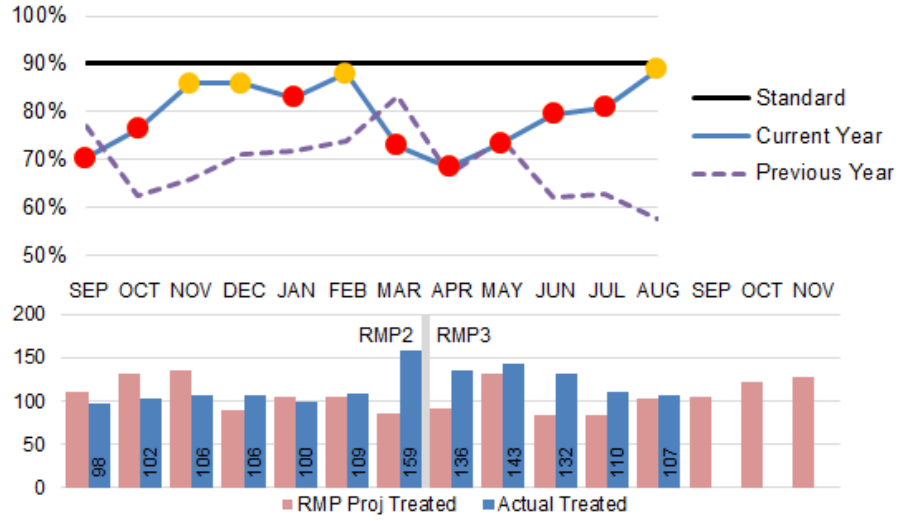
- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust in the brand
- Re-establishment of outreach work

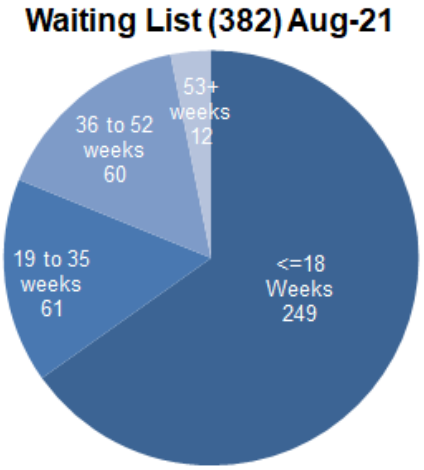
IMPROVEMENT ACTIONS	
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	**By TBD**
Action paused due to COVID-19	
20.3 'Better Beginnings' class for pregnant women	**By TBD**
Action paused due to COVID-19	
20.4 Enable staff access to medication whilst at work	**By TBD**
Action paused due to COVID-19	
21.1 Assess use of Near Me to train staff	**Complete Jul 2021**
21.2 Support Colorectal Urology Prehabilitation Test of Change Initiative	**Complete Sep 2021**
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 has been made available from April; to date, five rehabilitation patients have engaged with the service. Action complete	
22.1 Test face to face provision in two GP practices and one community venue	**By Mar-22**
Assess and engage with two GP practices and one community venue to re-establish face to face provision in the most deprived communities. Risk assessments, PPE, equipment and patient flow to be considered and included in plans.	

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	2020/21							2020/21				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	70.4%	76.5%	85.8%	85.8%	83.0%	88.1%	73.0%	68.4%	73.4%	79.5%	80.9%	88.8%
Scotland	65.9%	73.4%	72.9%	72.9%	67.5%	63.8%	67.5%	71.3%	71.8%	74.8%		

KEY CHALLENGE(S) IN 2021/22

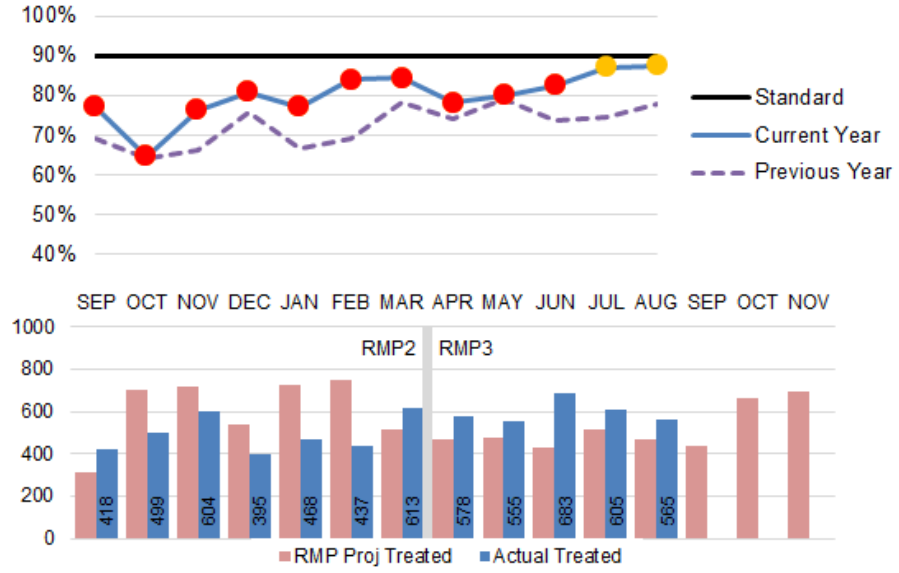
- Implementation of additional resources to meet demand
- Development of workforce to meet National CAMHS Service Specification
- Impact of COVID-19 relaxation on referrals
- Change to delivery 'models' to reflect social distancing

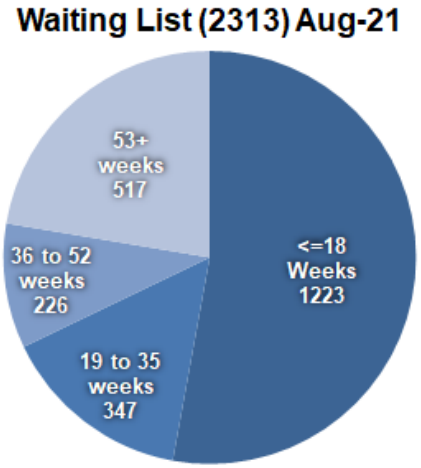
IMPROVEMENT ACTIONS	
21.1 Re-design of Group Therapy Programme	**Complete Jul 2021**
21.3 Build CAMHS Urgent Response Team	**By Dec-21**
The plan to develop a CURT in 2020 was postponed due to the COVID-19 position. Redesign has been incrementally introduced since March 2021 and a model has been implemented that prioritises responsiveness, increases the clinical remit and extends the age range of the previous Self Harm Service. An increase in staffing compliment seeks to allow the consolidation of the CURT model through ensuring adequate staffing capacity to meet increasing demand.	
22.1 Recruitment of Additional Workforce	**By Dec-21**
Investment from Fife HSCP has resulted in resources being made available to recruit additional permanent (8) and temporary (3) staff. To date, 6 permanent staff and 2 temporary staff have been appointed, with the permanent staff starting incrementally from 23/08/21. Vacant posts continue to be advertised and review of banding is underway. SG funds have been allocated in order to achieve the CAMHS National Service specification. Phase 1 recruitment is underway and Phase 2 recruitment will follow the completion of a Gap analysis against the national specification. Additional workspace and re-design of East and West CAMHS geographical boundaries has started, to accommodate staff and balance the population of referrals to best meet the ongoing demand.	
22.2 Workforce Development	**By Dec-21**
Programme of development has been instigated to ensure new and existing staff are functioning at optimal level and hold competencies to deliver evidence-based practice against the priorities established by the SG CAMHS National Service Specification. A Training programme for new and existing staff is being developed, and a training needs analysis will be re-run to ensure the right skills and competencies exist in the range of teams across CAMHS.	

Psychological Therapies 18 weeks RTT

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

Local Performance





National Benchmarking

Month	2020/21							2021/22				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	77.0%	64.7%	76.3%	80.8%	77.1%	84.0%	84.3%	78.2%	80.0%	82.6%	86.9%	87.4%
Scotland	75.8%	79.4%	78.1%	83.2%	79.3%	80.9%	80.9%	81.3%	82.5%	84.3%		

KEY CHALLENGE(S) IN 2021/22

- Meeting waiting times and waiting list trajectories in line with timescales set out for allocation of new resource
- Recruitment of staff required to achieve the above at a time of national workforce pressures
- Progressing vision for PTs within the timeframe required to sustain improved performance

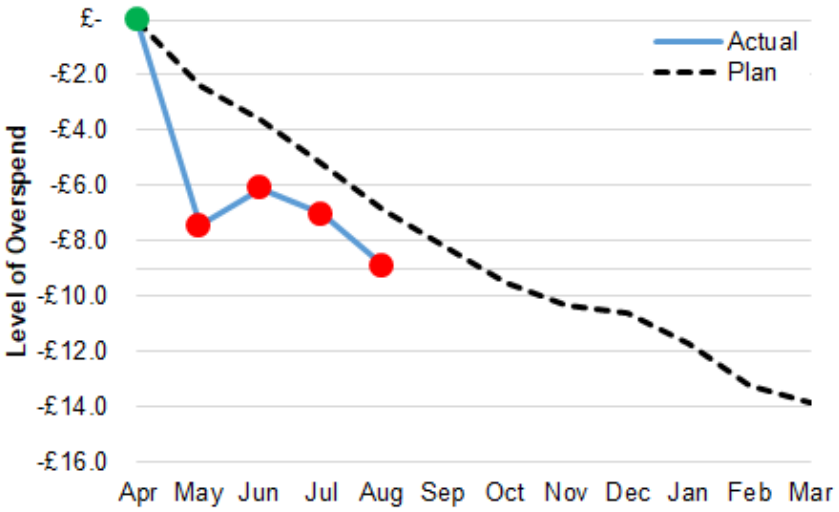
IMPROVEMENT ACTIONS

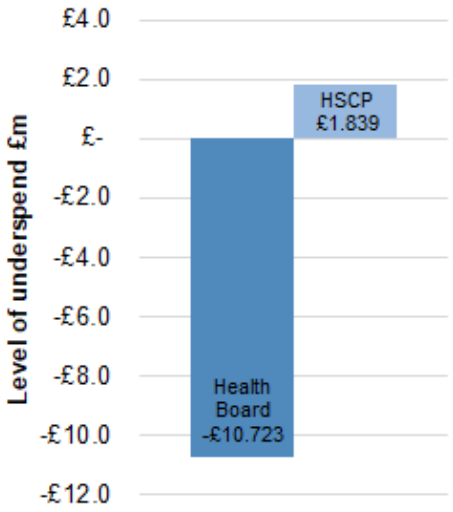
20.5 Trial of new group-based PT options	**Complete Sep-21**
Develop and pilot two new group programmes for people with complex needs who require highly specialist PT provision from Psychology service. Pilot of Schema therapy group complete, now mainstreamed as offer to people with complex needs impacting their personality. Pilot of Compassion Focused therapy group underway. Action complete	
22.1 Increase access via Guided self-help service	**Complete Sep-21**
Service now launched Action complete	
22.2 Expansion of skill mix model to increase delivery of low intensity interventions in Clinical Health Psychology service	**By Nov-21**
A change in establishment in the two Clinical Health specialities (General Medical and Pain Management) that are not meeting the RTT has allowed an expansion in capacity for low intensity psychological interventions and the introduction of a tiered service model of 1:1 psychological therapy. The impact of these changes is being evaluated.	
22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Dec-21**
Recruitment is underway for staff trained to provide specialist and highly specialist PTs (as per Scottish Government definitions). Increased capacity in this tier of service is required to meet the needs of the longest waiting patients (those with the most complex difficulties) and to support services to meet the RTT in a sustainable fashion.	

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	Savings £'000
Health Board	441,502	467,607	190,345	201,068	-10,723	-5.63%	-3,747	-6,976
Integration Joint Board (Health)	361,006	367,578	153,638	151,799	1,839	1.20%	1,839	0
Risk Share	0	0	0	0	0	0.00%	0	0
Total	**802,508**	**835,185**	**343,983**	**352,867**	**-8,884**	**-2.58%**	**-1,908**	**-6,976**

Assessment	NHS Fife's Quarter 1 review meeting with Scottish Government colleagues was held on 6 September. The outcome of this process is awaited (Scottish Government continue their series of meetings with all Boards) which will inform future funding and an approach to funding long Covid savings. Notwithstanding, this report reviews the position to 31 August (month 5).
Key challenges in 2021/22	The 2021/22 financial plan reflects an overall savings target of £21.7m and assumes £8m is achievable in-year: £4m on a recurring basis; and a further £4m on a non-recurring basis. Discussions continue with Scottish Government in relation to supporting the remaining £13.7m this financial year; with work continuing to identify potential recurring cost saving reduction schemes and programmes for both this year and the next 2 financial years.
	Continuing uncertainty in relation to the financial impact of Covid in both the short and longer-term, and its impact on both service delivery and financial plans
	Managing the underlying Acute Services core cost overspend; and emerging pressures including cross boundary flow uplift proposed arrangements
	Recruiting to the Corporate PMO the required capacity and capability to support the development of plans to deliver the pre-Covid efficiency savings on a recurring basis

Improvement Actions	Progress
22.1 RMP4	Partnering with the services to: • Identify additional spend relating to Covid-19 • Identify offsets against core positions • Understand and quantify the financial implications of recovery and 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.
22.2 Savings	Working closely with the services to ensure delivery of the £8m target as detailed above; and ensuring this focus extends to develop the agreed plans required to deliver the legacy £13.7m target over the next 2 financial years.

1. RMP Joint Fife Mobilisation Plan

1.1 The Remobilisation Plan (RMP) process commenced last financial year. The RMP3 submitted in February 2021 sets out a proposal which requests support from Scottish Government in 2021/22 in respect of the underlying unachieved savings funded as part of Covid-19 in 2020/21, with a commitment to deliver the recurring saving requirement across the medium-term financial planning period. This will be reviewed through the formal Quarter 1 review process. In parallel, Scottish Government aim to return to three year financial planning over the coming months. The RMP4 guidance has been issued with returns due by 30 September 2021.

2. Financial Allocations

2.1 Revenue Resource Limit (RRL)

NHS Fife received confirmation of the August core revenue amount on 1 September. The updated core revenue resource limit (RRL) per the formal funding letter was confirmed at £764.901m; and anticipated allocations total £59.758m. Funding this month included £1.16m for Family Nurse Partnership and Unscheduled Care Additional Summer Funding £0.180m.The anticipated allocations include Primary Medical Services and New Medicines funding.

2.2 Non-Core Revenue Resource Limit

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 anticipated funding totals £10.526m.

2.3 Total RRL

The total current year budget at 31 August is therefore £835.185m detailed in Appendix 1a.

2.4 Anticipated Funding from Health Delegated earmarked reserve

The earmarked health delegated reserve created last year and carried forward by the Local Authority Partner on behalf of the Integration Joint Board was clearly itemised and earmarked for specific purposes in this financial year. Whilst discussions continue with the IJB Chief Finance Officer, the earmarked reserve and agreed anticipated funding at month 5 is detailed per Appendix 1b.

3. Summary Position

3.1 The revenue position for the 5 months to 31 August reflects an overspend of £8.884m; which comprises a core overspend of £3.194m (£1.908m run rate overspend, and £1.286m unmet savings); and 'long Covid' savings of £5.690m.

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 the Covid-19 financial positions. An overspend of £10.723m is attributable to Health Board retained budgets; and an underspend of £1.839m is attributable to the health budgets delegated to the IJB.

Table 1: Summary Combined Financial Position for the period ended August 2021

Memorandum	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Health Board	441,502	467,607	190,345	201,068	-10,723	-5.63%	-3,747	-6,976
Integration Joint Board (Health)	361,006	367,578	153,638	151,799	1,839	1.20%	1,839	0
Risk Share	0	0	0	0	0	0.00%	0	0
Total	**802,508**	**835,185**	**343,983**	**352,867**	**-8,884**	**-2.58%**	**-1,908**	**-6,976**

Combined Position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Acute Services Division	208,954	219,729	95,497	105,003	-9,506	-9.95%	-3,652	-5,854
IJB Non-Delegated	9,170	9,173	3,818	3,792	26	0.68%	41	-15
Estates & Facilities	76,559	77,020	31,765	31,557	208	0.65%	450	-242
Board Admin & Other Services	66,950	83,826	39,746	38,987	759	1.91%	999	-240
Non-Fife & Other Healthcare Providers	90,837	90,611	37,728	40,746	-3,018	-8.00%	-2,393	-625
Financial Flexibility & Allocations	15,013	23,872	798	0	798	100.00%	798	0
HB retained offsets		60			0	#DIV/0!		
Health Board	**467,483**	**504,291**	**209,352**	**220,085**	**-10,733**	**-5.13%**	**-3,757**	**-6,976**
Integration Joint Board - Core	381,164	418,781	179,030	177,185	1,845	1.03%	1,845	0
HSCP offsets	0	270	0	0			0	0
Integration Fund & Other Allocations	18,559	7,440	0	0	0	0.00%	0	0
Sub-total Integration Joint Board Core	**399,723**	**426,491**	**179,030**	**177,185**	**1,845**	**1.03%**	**1,845**	**0**
IJB Risk Share Arrangement	0	0	0	0	0		0	0
Total Integration Joint Board - Health	**399,723**	**426,491**	**179,030**	**177,185**	**1,845**	**1.03%**	**1,845**	**0**
Total Expenditure	**867,206**	**930,782**	**388,382**	**397,270**	**-8,888**	**-2.29%**	**-1,912**	**-6,976**
IJB - Health	-38,717	-58,913	-25,392	-25,386	-6	**0.02%**	-6	0
Health Board	-25,981	-36,684	-19,007	-19,017	10	**-0.05%**	10	0
Miscellaneous Income	**-64,698**	**-95,597**	**-44,399**	**-44,403**	**4**	**-0.01%**	**4**	**0**
Net Position Including Income	**802,508**	**835,185**	**343,983**	**352,867**	**-8,884**	**-2.58%**	**-1,908**	**-6,976**

3.3 The combined position is further analysed by core; and Covid-19 as per tables 2 and 3 below. This approach allows transparency of the core position as distinct from additional Covid costs for which funding will be confirmed as part of the formal Q1 review process.

Table 2: Summary Core Financial Position for the period ended August 2021

Core Position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Acute Services Division	208,954	216,318	92,086	96,275	-4,189	-4.55%	-3,652	-537
IJB Non-Delegated	9,170	9,173	3,818	3,778	40	1.05%	41	-1
Estates & Facilities	76,559	76,586	31,331	30,907	424	1.35%	450	-26
Board Admin & Other Services	66,950	81,412	37,332	36,430	902	2.42%	999	-97
Non-Fife & Other Healthcare Providers	90,837	90,611	37,728	40,746	-3,018	-8.00%	-2,393	-625
Financial Flexibility & Allocations	15,013	23,872	798	0	798	100.00%	798	0
HB retained offsets	0	0	0	0	0	#DIV/0!	0	0
Health Board	**467,483**	**497,972**	**203,093**	**208,136**	**-5,043**	**-2.48%**	**-3,757**	**-1,286**
Integration Joint Board - Core	381,164	412,716	172,965	171,120	1,845	1.07%	1,845	0
HSCP offsets	0	0	0	0				
Integration Fund & Other Allocations	18,559	7,440	0	0	0	0.00%	0	0
Sub-total Integration Joint Board Core	**399,723**	**420,156**	**172,965**	**171,120**	**1,845**	**1.07%**	**1,845**	**0**
IJB Risk Share Arrangement	0	0	0	0	0		0	0
Total Integration Joint Board - Health	**399,723**	**420,156**	**172,965**	**171,120**	**1,845**	**1.07%**	**1,845**	**0**
Total Expenditure	**867,206**	**918,128**	**376,058**	**379,256**	**-3,198**	**-0.85%**	**-1,912**	**-1,286**
IJB - Health	-38,717	-58,913	-25,392	-25,386	-6	**0.02%**	-6	0
Health Board	-25,981	-36,684	-19,007	-19,017	10	**-0.05%**	10	0
Miscellaneous Income	**-64,698**	**-95,597**	**-44,399**	**-44,403**	**4**	**-0.01%**	**4**	**0**
Net Position Including Income	**802,508**	**822,531**	**331,659**	**334,853**	**-3,194**	**-0.96%**	**-1,908**	**-1,286**

Table 3: Summary Covid-19 Financial Position for the period ended August 2021

COVID position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Acute Services Division	0	3,411	3,411	8,728	-5,317		0	-5,317
IJB Non-Delegated	0	0	0	14	-14		0	-14
Estates & Facilities	0	434	434	650	-216		0	-216
Board Admin & Other Services	0	2,414	2,414	2,557	-143		0	-143
Non-Fife & Other Healthcare Providers	0	0	0	0	0		0	0
Financial Flexibility & Allocations	0	0	0	0	0		0	0
HB retained offsets	0	60	0	0	0		0	0
Health Board	**0**	**6,319**	**6,259**	**11,949**	**-5,690**		**0**	**-5,690**
Integration Joint Board - Core	0	6,065	6,065	6,065	0		0	0
HSCP offsets	0	270	0	0				
Integration Fund & Other Allocations	0	0	0	0	0		0	0
Sub-total Integration Joint Board Core	**0**	**6,335**	**6,065**	**6,065**	**0**		**0**	**0**
IJB Risk Share Arrangement	0	0	0	0	0		0	0
Total Integration Joint Board - Health	**0**	**6,335**	**6,065**	**6,065**	**0**		**0**	**0**
IJB - Health	0	0	0	0	0		0	0
Health Board	0	0	0	0	0		0	0
Miscellaneous Income	**0**	**0**	**0**	**0**	**0**		**0**	**0**
Total Expenditure	**0**	**12,654**	**12,324**	**18,014**	**-5,690**		**0**	**-5,690**

4. Operational Financial Performance for the year (section 4 narrative is based on core position – Table 2 above)

4.1 Acute Services

The Acute Services Division reports a **net overspend of £4.189m.** Whilst the 20/21 financial planning process approved the following uplifts for ASD: £1.5m safe staffing; £0.620m drugs; and £0.769m paediatric staffing; there remains an overspend in core run rate performance of £3.652m, and unachieved savings of £0.537m per Table 2. The core run rate position is mainly driven by pay across three staffing groups; Nursing £1.399m, Junior Medical and Dental £0.746m and Senior Medical £0.286m. Nursing overspend continues to be prominent across Care of the Elderly, Obstetrics and Gynaecology, and Colorectal due to unfunded cost pressures, incremental progression, and safer staffing requirements. Junior medical and dental continue to receive banding supplements in Emergency Care, with unfunded clinical fellows also contributing to the cost pressure. Junior medical and dental staff in WCCS will also require banding supplements dating back to February 2021, with the value yet to be confirmed. Elderly medicine and A&E consultant costs are partially offset by GI vacancies in Emergency Care, and WCCS have cost pressures against Paediatric consultants. Recruitment is in progress to recruit to some consultant posts currently being covered by locums, however they are not expected to be in post before March 2022.

Non pay cost pressures total £1.130m, with medicines overspend of £1.697m. The expenditure on drugs in 2021/22 has increased by 18% compared to the same period last year. Haematology / oncology drugs make up a significant proportion of this increase, with SMC approvals for further indications having an impact. The medicines overspend is partially offset by underspend on surgical sundries £0.417m and diagnostic supplies £0.257m. There is an expectation that these underspends will be utilised later in the year to accommodate increased levels of activity relating to waiting times initiatives. Opportunities on underspending areas need to be explored to determine if these are being driven by a change in service requirement which could be a savings initiative.

Robotic assisted surgery became operational this month. The core position currently carries the cost of unfunded instruments at £0.054m year to date, offset by opportunistic underspend. Redesign of Urgent Care (RUC) will be fully funded this year through a combination of government funding £0.681m and earmarked IJB reserves of £0.935m carried forward from 20/21. The expenditure against the Navigation Flow Hub will be monitored on a fortnightly basis alongside the other workstreams that are focusing on RUC.

Government funding is expected to cover the cost of both elective and unscheduled care waiting list initiatives and there should be no associated costs in the core position.

Table 4: Acute Division Financial Position for the year ended August 2021

Core Position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Acute Services Division								
Planned Care & Surgery	72,591	76,251	32,116	32,271	-155	**-0.48%**	-481	326
Emergency Care & Medicine	77,108	79,460	34,626	38,042	-3,416	**-9.87%**	-3,132	-284
Women, Children & Cinical Services	56,658	57,988	24,429	25,089	-660	**-2.70%**	-75	-585
Acute Nursing	874	894	380	318	62	**16.32%**	62	0
Other	1,723	1,725	535	555	-20	**-3.74%**	-26	6
Total	**208,954**	**216,318**	**92,086**	**96,275**	**-4,189**	**-4.55%**	**-3,652**	**-537**

4.2 IJB Non-Delegated

The IJB Non-Delegated budget reports an **underspend of £0.040m.** This is being driven by a pay underspend in the Daleview Regional Unit, resulting from occupational therapy and learning disabilities nursing vacancies.

4.3 Estates & Facilities

The Estates and Facilities budgets report an **underspend of £0.424m.** This comprises an underspend in pay of £0.245m across several departments including support services, catering, laundry and transport; and non pay underspend of £0.147m on PPP and £0.361m on rates, which has improved due to receipt of disabled rate relief for Lynebank. Heating fuel and power have a year to date underspend of £0.104m which is in keeping with the continued favourable weather. This underspend is partially offset by an overspend on property maintenance of £0.172m, equipment £0.099m and postage £0.081m with the balance being due to the shortfall in delivery of savings.

4.4 Corporate Services

Within the Board's corporate services there is **an underspend of £0.902m**. Further analysis of the Corporate Directorates core position is detailed per Appendix 2. The main driver for this underspend is the level of vacancies across Finance (£0.197m) and Nursing (£0.156m) directorates. Digital and Information's underspend is largely attributable to a VAT rebate of £0.228m in July offset against various overspends. Areas of overspend include interpreting services and E- job plan. As highlighted through the SPRA process, and in turn our financial planning process, investment has been made in additional governance posts and Project Management Office (PMO) capability. The development of the PMO capacity and capability will further support and drive service transformation.

Public Health are continuing with permanent recruitment based on the 'Covid-19: Test and Protect Programme and Public Health Teams' Funding letter on 13 November 2020. This commits recurring spend, however 2022/23 and future funding is not yet known.

4.5 Non-Fife and Other Healthcare Providers

The budget for healthcare services provided out with NHS Fife is **overspent by £3.018m** per Appendix 3. As reported last month, the main driver is the increase in the expected annual value of the service agreement with NHS Lothian. Discussions are ongoing. Savings yet to be delivered in this area amount to £0.625m.

4.6 Financial Plan Reserves & Allocations

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 £0.798m** has been released at month 5, with further detail shown in Appendix 4.

4.7 Integration Services

The health budgets delegated to the Integration Joint Board shows an **underspend of £1.845m**. The underlying drivers for the run rate underspend are predominantly driven by ongoing vacancies across several services including: ICASS; administrative teams; district nursing; sexual health and rheumatology; all AHP services; child health; learning disabilities; mental health; psychology; health promotion; and general dental services. Mental health continues to see an increase in addictions costs due to activity and laboratory costs for toxicology reports. Work is still ongoing to determine whether additional ADP funding can be sourced to support activity growth over recent years. The mental health services position continues to improve as medical locum costs reduce on the lead up to appointment of 8 consultants which will commence in September. Where surge bed activity has resulted from the impact of Covid-19 this has been captured and reflected as Covid-19 expenditure.

The underspend on non pay of £0.396m is mainly attributable to medicines within sexual health where the anticipated number of Hep C patients in 21/22 is less than previously expected.

Following the IJB financial planning process, supported by detailed analysis, the IJB CFO has indicated the underspend will be used to inform a non-recurring budget realignment this financial year.

Following a review of the Integration Scheme by the respective partners, plans are in place to propose a final position on this matter to both NHS Fife Board and Fife Council in September 2021.

4.8 Income
A small over recovery in income of £0.004m is shown for the period to August.

5 Pan Fife Analysis

5.1 Analysis of the pan NHS Fife financial position by subjective heading is summarised in Table 5 below.

Table 5: Subjective Analysis for the year ended August 2021

Combined Position	Annual Budget	Budget	Actual	Net (Over)/Under
Pan-Fife Analysis	**£'000**	**£'000**	**£'000**	**£'000**
Pay	424,018	181,812	182,315	-504
GP Prescribing	74,587	31,278	31,266	12
Drugs	32,762	14,831	16,091	-1,259
Other Non Pay	385,706	166,639	167,598	-958
Efficiency Savings	-17,603	-6,976	0	-6,976
Commitments	31,312	798	0	798
Income	-95,597	-44,399	-44,403	4
Net overspend	**835,185**	**343,983**	**352,868**	**-8,884**

5.2 Pay
The overall pay budget reflects an overspend of £0.504m. This comprises an Acute Services pay overspend of £2.523m. Nurse staffing accounts for 60% of this, with unfunded incremental progression, supervision policies and safer staffing being the main factors. Senior medical agency costs account for the remaining 40%, and whilst appointments are underway, the lead time on senior posts means they will not be in post until nearer the end of the financial year. This is offset against underspend across multiple directorates including community care services £0.380m, primary and preventative services £0.443m, complex and critical services £0.438m, corporate £0.363m and facilities £0.183m where vacancies are having an impact.

Against a total funded establishment of 8,222 wte across all staff groups, there was an average 8,721 wte staff in post in August (based on permanent staff plus additional hours worked and bank staff). The increase in staff in post reflects the additional staffing complement beyond recurring funded establishment and is funded from non-recurring sources - in the main, Covid funding. Work continues in that regard to capture our Covid staffing increase by staff group; the financial implications of temporary, fixed term and permanent staff cohorts; and a risk assessed exit plan/strategy.

5.3 Drugs & Prescribing
Across the system there is a net overspend of £1.247m on medicines. Full quarter 1 2021/22 (April – June) GP prescribing data is now available. Using that data, other available indicators and 2 years previous breakeven outturns, the GP prescribing position to August 21 is estimated to be breakeven. To date no significant costs have been identified as being rechargeable to Covid-19 expenditure, however an analysis of quarter 1 data can now be carried out. The forecast financial year end position is also estimated to be breakeven. Whilst the pandemic and economic situation leave supply, demand and prices of medicines at risk to increases, several positive factors influencing prescribing are also on the horizon; a move to single East Region Formulary, stabilised tariff prices and new Primary Care Rebate schemes.

Acute medicines reflect an overspend of £1.697m. The main overspend is in Haematology which is over budget by £1.126m partly due to unconfirmed spend on drugs requiring funding from the new medicines reserve. Neurology is overspent at £0.325m, where a high-cost drug is being used by a small number of patients and is an ongoing cost pressure from prior years. As a continuation from 20/21, Dermatology, GI, Neurology and Respiratory all present increased costs due to the volume of patients being treated and new drugs that are being made available via homecare. Whilst costs have been identified and recharged relating to the impact of Covid-19 on the cancer medicines spend, further work is being done to explore whether the scope can be increased.

5.4 Other Non-Pay
Other non-pay budgets across NHS Fife are collectively overspent by £0.958m. A significant element of overspend is attributable to Non Fife and Other Healthcare Providers across both SLAs and UNPACS is

£2.394m as discussed above. Further overspends derive from purchase of equipment £0.489m, property maintenance £0.187m and postage £0.111. These overspends are offset by underspends within travel and subsistence £0.445m, surgical sundries and supplies £0.344m and CSSD/diagnostic supplies £0.107m.

5.5 Efficiency Savings
The unmet efficiency savings of £6.976m comprise unmet core savings of £1.286m and unachieved legacy savings for which we seek funding support of £5.690m.

6 Other Funding Allocations

6.1 Covid-19 funding allocation
We received initial Covid-19 funding of £11.580m in our June allocation to encompass; Test and protect; vaccination funding (Covid-19 and extended flu vaccination programmes); and a general Covid funding allocation. This initial allocation is based on c50% of the retained Health Board's forecast costs per the financial planning process. There was no funding received in this tranche for Health delegated/Integration Authority given the requirement to use the carry forward of reserves from the 2020/21 financial year in the first instance. Additional funded Covid-19 spend to month 5 per Table 3 above is £12.324m; with the long Covid unmet savings to month 5 of £5.690m remaining as a gap until the outcome on funding approach is known following conclusion of the formal quarter one process.

6.2 Waiting List Funding
Waiting list funding of £9.750m based our RMP3 submission has been received to date and work is ongoing to ensure delivery of activity as laid out in our submission and correspondence with SG.

6.3 Redesign of Urgent Care Funding
Funding has been received from SG in June of £0.681m which we are treating as an interim (and on which we seek further clarity). In addition, there is £0.935m in the IJB earmarked reserve for RUC. To that end funding appears sufficient for the 21/22 financial year however there is risk exposure for future financial years where funding is uncertain. Work continues on the Redesign of Urgent Care agenda.

7 Financial Sustainability

7.1 The overall financial planning process and corporate position was approved by the NHS Fife Board at its meeting on 31 March 2021. The Financial Plan highlighted the requirement for £21.7m cash efficiency savings to support financial balance in 2021/22. Our planning assumptions reflected an achievable £8m of the target (£4m on a recurring basis), with an underlying unachieved 'long Covid' savings of £13.7m for which we have requested funding support.

7.2 As part of the financial planning process, agreement was reached to reduce budgets to allocate shares of the vacancy factor of £3.1m to devolved budgets. As such budget holders require to operate within this reduced pay budget.

7.3 Tables 6a and 6b summarise the savings position for the 2021/22 financial year. Work continues in earnest to identify potential recurring cost saving reduction schemes and programmes for both this year and the next 2 financial years.

Table 6a: Savings 21/22

Total Savings	Total Savings Target £'000	Forecast Achievement (Core) £'000	Forecast unmet savings (Covid-19) £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Identified & Achieved to August £'000	Unachieved to March £'000
Health Board	21,837	8,181	13,656	3,538	696	4,234	3,947
					0		0
Total Savings	**21,837**	**8,181**	**13,656**	**3,538**	**696**	**4,234**	**3,947**

Table 6b: Savings RAG status

NHS Fife Potential Savings Summary	£000's	Risk level	Identified CY	Outstanding Balance	Identified FY	Outstanding Balance
Workforce Capacity and Utilisation Review	1,000	High	-407	593	-41	959
Pay Vacancy Factor (1%)	3,015	Medium	-3,015	0	-3,015	0
Repatriation of Services	500	Low	0	500	0	500
External Commissioning Cost Review	1,000	Medium	0	1,000	0	1,000
Medicine Utilisation	500	Medium	-59	441	0	500
Contracts	1,500	Low	-129	1,371	0	1,500
Procurement - Non pay	500	Medium	0	500	0	500
Other	166	Low	-624	-458	-482	-316
	8,181		**-4,234**	**3,947**	**-3,538**	**4,643**

8 Forecast Q1

8.1 Our assessment (at month 5) of our forecast outturn to the year end remains as reported to Scottish Government at Q1 - a potential overspend of £19.656m. This includes the in-year deficit in our opening financial plan of £13.656m unachieved savings (for which we have requested Scottish Government support) and a core potential additional overspend of £6m. The pressures contributing to the £6m overspend are: £3m cost pressure in respect of our Service Level Agreement with NHS Lothian; £2m Acute drugs cost pressures; Microsoft 365 licence cost pressures of £0.6m (an emerging increase to the cost model adopted at the financial planning stage); and £0.4m other cost pressures.

8.2 The projected forecast does not include any risk share with the Health and Social Care Partnership - any emerging potential risk share identified by the HSCP will require robust review and discussion with the Chief Finance Officer.

8.3 In arriving at this forecast outturn, we have signposted to Scottish Government our request for non-core ADEL (Additional Departmental Expenditure Limit) funding of £2m. Existing and planned qualifying expenditure to include replacement of obsolete equipment and software that would normally be charged to revenue has been identified. Approval of this funding would assist in managing the core run rate overspend particularly in our Acute Services Division.

8.4 In addition, whilst some progress is being made, in that limited funding has been received, we remain c£5m-£8m away from NRAC funding parity across Scotland. This has a significant bearing on our financial planning arrangements and our qualitative and quantitative performance.

9 Recommendation

Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

- **Note** the reported core overspend of £3.194m for the 5 months to date
- **Note** the £5.690m underlying unachieved 'long Covid' savings, to month 5;
- **Note** the combined position of the core and Covid-19 position inform an overall overspend of £8.884m
- **Note** the potential total overspend outturn position of £19.656m; of which we seek SG funding support for unachieved full year 'long Covid' savings of £13.656m; and, the potential core overspend of £6m which we have highlighted in our Quarter 1 financial return last month to Scottish Government.

Appendix 1a: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
	Initial Baseline Allocation	712,534			712,534	
	June Letter	9,264	12,244	21,030	42,538	
Jul-21	July Letter			7,936	7,936	
Aug-21	National Cancer Strategy Fund Posts	141			141	Annual Allocation now made recurring
	Support for cervical screening incident			1	1	
	V1P			116	116	Annual Allocation
	School Nurse Commitment Tranche 1		230		230	As Programme for Government
	Unscheduled Care Summer Funding			180	180	As per submission
	Vitamins for Pregnant Women & Children			45	45	As per submission
	Training fo Cardiac Physiologists			24	24	As per allocation letter issued
	Family Nurse Partnership Tranche 1			1,156	1,156	Annual Allocation
					0	
					0	
					0	
					0	
					0	
					0	
					0	
					0	
					0	
					0	
	Total Core RRL Allocations	**721,939**	**12,474**	**30,488**	**764,901**	
Anticipated	Primary Medical Services		56,909		56,909	
Anticipated	Mental Health Bundle		1,363		1,363	
Anticipated	Salaried Dental		2,091		2,091	
Anticipated	Distinction Awards		193		193	
Anticipated	Research & development		822		822	
Anticipated	Community Pharmacy Champions		20		20	
Anticipated	NSS Discovery		-39		-39	
Anticipated	Pharmacy Global Sum Calculation		-204		-204	
Anticipated	NDC Contribution		-842		-842	
Anticipated	Community Pharmacy Pre-Reg Training		-159		-159	
Anticipated	FNP		120		120	
Anticipated	New Medicine Fund		3,415		3,415	
Anticipated	Golden Jubilee SLA		-24		-24	
Anticipated	PCIF		682		682	
Anticipated	ADP:seek & treat		1,159		1,159	
Anticipated	£20m 18-19 tariff reduction to global sum		-4,245		-4,245	
Anticipated	Waiting List		1,367		1,367	
Anticipated	Winter		661		661	
Anticipated	Covid Vaccination		1,491		1,491	
Anticipated	NSD Adjustments		-5,022		-5,022	
		0	**59,758**	**0**	**59,758**	
Anticipated	IFRS			9,352	**9,352**	
Anticipated	Donated Asset Depreciation			174	**174**	
Anticipated	Impairment			500	**500**	
Anticipated	AME Provisions			500	**500**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**10,526**	**10,526**	
	Grand Total	**721,939**	**72,232**	**41,014**	**835,185**	

Appendix 1b: Anticipated Funding from Health Delegated Earmarked Reserve

Health Delegated Earmarked Reserve		Included within Health Delegated Budgets		
	Total	To M5	Anticipated	Balance
	£000's	£000's	£000's	£000's
Vaccine	740	740		0
Care homes	526			526
Urgent Care Redesign	935	704		231
Flu	203	203	0	0
Primary Care Improvement Fund	2,524	1,011		1,513
Action 15	1,315			1,315
RT Funding	1,500			1,500
FSL	500	500		0
District Nurses	30			30
Fluenz	18			18
Core run rate	1,767			1,767
Core (covid offsets)	1,250	527	224	499
Total	**11,308**	**3,685**	**224**	**7,399**

Appendix 2: Corporate Directories – Core Position

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Digital and Information	13,085	5,490	5,291	199
Nhs Fife Chief Executive	215	80	96	-16
Nhs Fife Finance Director	6,696	2,723	2,526	197
Nhs Fife Medical Director	8,219	3,011	2,911	100
Nhs Fife Nurse Director	4,245	1,802	1,647	156
Legal Liabilities	11,128	8,707	8,665	42
Early Retirements & Injury Benefits	491	12	-63	75
Regional Funding	222	117	104	13
Depreciation	19,040	7,665	7,665	0
Nhs Fife Public Health	2,651	1,425	1,382	43
Nhs Fife Workforce Directorate	3,219	1,358	1,350	8
Pharmacy Services	12,200	4,942	4,855	86
Total	**81,412**	**37,332**	**36,430**	**902**

Appendix 3: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	99	41	40	1
Borders	45	19	24	-5
Dumfries & Galloway	25	11	24	-13
Forth Valley	3,227	1,344	1,598	-254
Grampian	365	152	118	34
Greater Glasgow & Clyde	1,680	700	698	2
Highland	137	57	55	2
Lanarkshire	117	49	106	-57
Lothian	31,991	13,330	14,161	-831
Scottish Ambulance Service	103	43	42	1
Tayside	41,584	17,326	17,619	-293
Savings	-1,500	-625		-625
	77,873	**32,447**	**34,485**	**-2,038**
UNPACS				
Health Boards	10,801	4,500	5,577	-1,077
Private Sector	1,151	480	624	-144
	11,952	**4,980**	**6,201**	**-1,221**
OATS	721	301	61	240
Grants	65			0
Total	**90,611**	**37,728**	**40,746**	**-3,018**

Appendix 4 - Financial Flexibility & Allocations

	£'000	Flexibility Released to August-21 £'000
Financial Plan		
Drugs	3,786	0
CHAS	408	0
Junior Doctor Travel	33	4
Discretionary Points	209	0
Consultant Increments	216	73
Cost Pressures	3,883	656
Developments	2,164	65
Sub Total Financial Plan	**10,699**	**798**
Allocations		
Waiting List	5,306	0
AME: Impairment	743	0
AME: Provisions	866	0
Insulin Pumps	0	0
Community Pharmacy Champion	19	0
Pay Award:AfC	1,695	0
6 Essential Action	456	0
ICU	485	0
Test & Protect	1,261	0
Covid 19	709	0
Winter	661	0
Cervical Incident	3	0
Cancer Waiting Time	622	0
Scottish Health Survey	18	0
Implementation Health & Care Act	68	0
Distinction Award	57	0
Unscheduled Care Summer	180	0
Cardiac Physiologists	24	0
Sub Total Allocations	**13,173**	**0**
Total	**23,872**	**798**

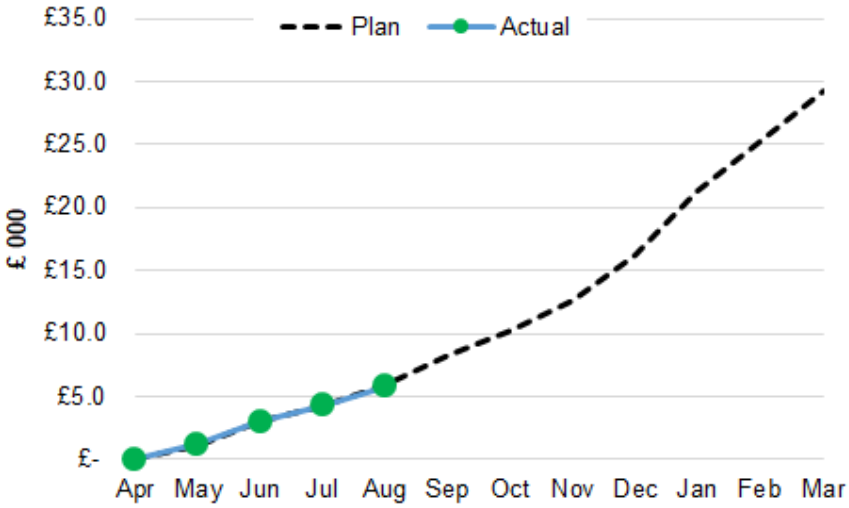
Appendix 5 – Initial Covid-19 funding

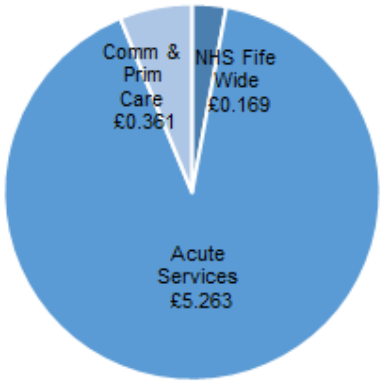
COVID funding	Health Board	Health delegated	Social Care delegated	Total	Capital
	£000's	£000's	£000's	£000's	£000's
Allocations Q1	8,702	2,878		11,580	
HSCP ear marked reserve		1,694		1,694	
Anticipated allocation		1,494		1,494	
Total funding	**8,702**	**6,066**	**0**	**14,768**	**0**
Allocations made for Apr to August					
Planned Care & Surgery	411			411	
Emergency Care & Medicine	2,200			2,200	
Women, Children & Clinical Services	800			800	
Acute Nursing	0			0	
Estates & Facilities	434			434	
Board Admin & Other Services	854			854	
Public Health Scale Up	473			473	
Test and Protect	1,560			1,560	
Primary Care & Prevention Serv		70		70	
Community Care Services		428		428	
Complex & Critical Care Serv		159		159	
Professional/Business Enabling		93		93	
Covid Vaccine/Flu		5,316		5,316	
Social Care					
Total allocations made to M5	**6,732**	**6,066**	**0**	**12,798**	**0**
Balance In Reserves	**1,970**	**0**	**0**	**1,970**	**0**

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





1. Annual Operational Plan

The capital plan for 2021/22 was approved by the FP&R Committee in July and will be tabled at the NHS Fife Board thereafter. NHS Fife has assumed a programme of £29.257m. For the year to date, NHS Fife has received £7.394m as a capital allocation. NHS Fife is also anticipating capital allocations for the Elective Orthopaedic Centre of £18.125m: A reduction of (£0.200m) due to a previous years over-allocation: HEPMA £1.1m: Mental Health Review £0.076m: Lochgelly Health Centre £0.517m and Kincardine Health Centre £0.323m: Energy Scheme Funding of £1.8m: Scheme Development Funding £0.05m. NHS Fife is also requesting to convert £0.072m Cancer Waiting Times Funding from revenue to capital.

NHS Fife is linking with the national infrastructure board on equipment requests to ascertain new and replacement equipment priorities across Scotland. Nationally there maybe slippage in capital and NHS Fife has made submissions to this process. This may inform, as a minimum, potential additional capital funding for our required radiology replacement scanner this year.

Due to the current climate there are significant potential risks associated with the capital programme this year and NHS Fife feels it is prudent to highlight them at this time. There are risks regarding the availability of materials, price increases on materials, lead times and deliverability within the financial year end. NHS Fife it striving to mitigate these risks wherever possible.

2. Capital Receipts

2.1 Work continues into the new financial year on asset sales re disposals:

- Lynebank Hospital Land (Plot 1) (North) – discussions are ongoing as to whether to remarket, there are also discussions ongoing around the potential possibility of HFS constructing a new sterilising unit for East Scotland on the site
- Skeith Land – an offer has been accepted subject to conditions for planning and access - however the GP's have now put in an objection to the planning department

3. Expenditure / Major Scheme Progress

3.1 The summary expenditure position across all projects is set out in the dashboard summary above. The expenditure to date amounts to £5.79m this equates to 19.8% of the total capital allocation, as illustrated in the spend profile graph above.

3.2 The main areas of spend to date include:

Statutory Compliance	£1.716m
Equipment	£0.470m
Digital	£0.160m
Elective Orthopaedic Centre	£3.211m
Health Centres	£0.170m

4. Recommendation

4.1 Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

note the capital expenditure position to 31 August 2021 of £5.79m and the year end spend of the total anticipated capital resource allocation of £29.257m.

Appendix 1: Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2021/22 £'000
COMMUNITY & PRIMARY CARE			
Clinical Prioritisation	123	60	123
Statutory Compliance	349	69	349
Capital Equipment	129	59	129
Condemned Equipment	24	0	24
Lochgelly Health Centre	0	0	0
Kincardine Health Centre	0	0	0
Total Community & Primary Care	625	188	625
ACUTE SERVICES DIVISION			
Statutory Compliance	2,942	1,638	2,942
Capital Equipment	1,625	331	1,625
Clinical Prioritisation	111	1	111
Condemned Equipment	63	9	63
Total Acute Services Division	4,741	1,979	4,741
NHS FIFE WIDE SCHEMES			
SG Payback Balance	200	0	200
Equipment Balance	51	0	51
Information Technology	1,000	160	1,000
Clinical Prioritisation	267	0	267
Statutory Compliance	89	0	89
General Reserve - Equipment	99	0	99
Pharmacy Equipment	200	0	200
Condemned Equipment	3	0	3
Fire Safety	60	9	60
Vehicles	60	0	60
Wash Hand Basin Replacement	0	0	0
Total NHS Fife Wide Schemes	2,028	169	2,028
TOTAL CAPITAL ALLOCATION FOR 2021/22	**7,394**	**2,336**	**7,394**

ANTICIPATED ALLOCATIONS 2021/22			
Elective Orthopaedic Centre	18,125	3,212	18,125
HEPMA	1,100	0	1,100
Kincardine Health Centre	323	73	323
Lochgelly Health Centre	517	100	517
Mental Health Review	76	0	76
Energy Funding Grant	1,800	0	1,800
Cancer Waiting Times Funding	72	72	72
Scheme Development Grant	50	0	50
SG Payback	-200	0	-200
Anticipated Allocations for 2021/22	**21,863**	**3,457**	**21,863**

Total Anticipated Allocation for 2021/22	**29,257**	**5,792**	**29,257**

Appendix 2: Capital Plan - Changes to Planned Expenditure

Capital Expenditure Proposals 2021/22 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to July £'000	August Adjustment £'000	Total August £'000
Community & Primary Care				
Capital Equipment	0	78	51	129
Condemned Equipment	0	24	0	24
Clinical Prioritisation	0	123	0	123
Covid Equipment	0	0	0	0
Statutory Compliance	0	343	6	349
Lochgelly Health Centre	0	0	0	0
Kincardine Health Centre	0	0	0	0
Total Community & Primary Care	**0**	**568**	**56**	**625**
Acute Services Division				
Capital Equipment	0	1,323	302	1,625
Condemned Equipment	0	16	47	63
Cancer Waiting Times Equipment	0	0	0	0
Clinical Prioritisation	0	85	26	111
Statutory Compliance	0	2,958	-16	2,942
	0	**4,382**	**359**	**4,741**
Fife Wide				
SG Payback Balance	200	0	0	200
Backlog Maintenance / Statutory Compliance	3,500	-3,421	10	89
Fife Wide Equipment	1,805	-1,402	-353	51
Digital & Information	1,000	0	0	1,000
Clinical Prioritisation	500	-207	-26	267
Condemned Equipment	90	-40	-47	3
Scheme Development	0	0	0	0
Fife Wide Asbestos Management	0	0	0	0
Fife Wide Fire Safety	0	60	0	60
General Reserve Equipment	94	5	0	99
Pharmacy Equipment	205	-5	0	200
Fife Wide Vehicles	0	60	0	60
Wash Hand Basin Replacement	0	0	0	0
Total Fife Wide	**7,394**	**-4,950**	**-415**	**2,028**
Total Capital Resource 2021/22	**7,394**	**0**	**0**	**7,394**

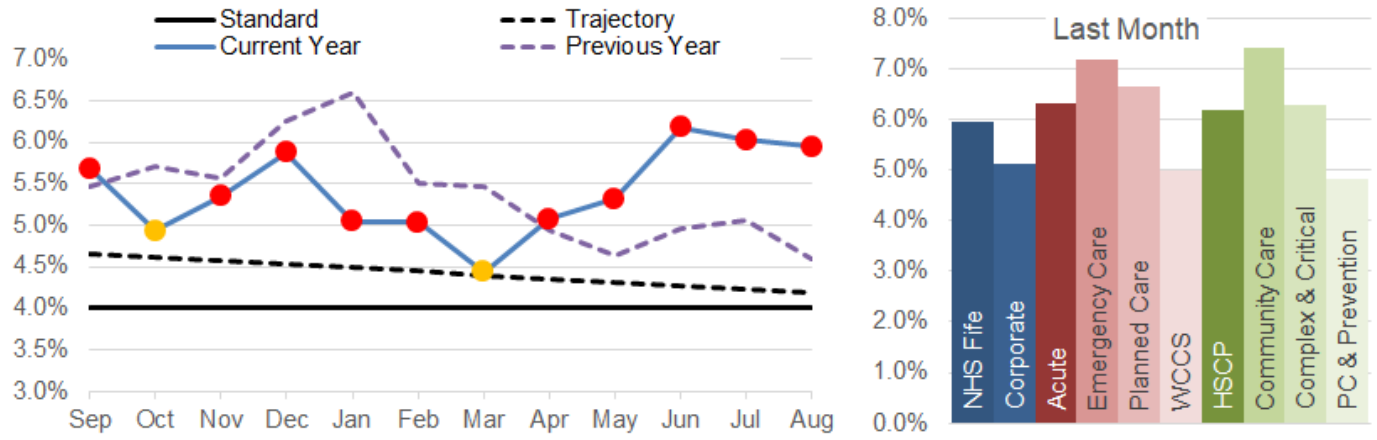
ANTICIPATED ALLOCATIONS 2021/22				
Elective Orthopaedic Centre	18,125	0	0	18,125
HEPMA	1,100	0	0	1,100
Kincardine Health Centre	323	0	0	323
Lochgelly Health Centre	517	0	0	517
Mental Health Review	76	0	0	76
Energy Funding Grant	1,800	0	0	1,800
Cancer Waiting Times Fundings	72	0	0	72
Scheme Development Grant	50	0	0	50
SG Payback	-200	0	0	-200
Anticipated Allocations for 2021/22	**21,863**	**0**	**0**	**21,863**

Total Planned Expenditure for 2021/22	**29,257**	**0**	**0**	**29,257**

Sickness Absence

*To achieve a sickness absence rate of 4% or less (Improvement Target for 2021/22 = **3.89%**)*

Local Performance



National Benchmarking

Month	2020/21							2021/22				
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
NHS Fife	5.69%	4.93%	5.35%	5.87%	5.04%	5.03%	4.43%	5.07%	5.31%	6.17%	6.03%	5.95%
Scotland	4.96%	4.93%	4.96%	5.18%	4.82%	4.30%	4.56%	4.59%	5.04%	5.52%	5.62%	5.76%

KEY CHALLENGE(S) IN 2021/22

To secure an ongoing reduction in the current levels of sickness absence performance, as services remobilise, working towards the third-year trajectory for the Board of 3.89% in with NHS Circular PCS (AfC) 2019/2

IMPROVEMENT ACTIONS	
22.1 Work towards improvement in long term sickness absence relating to mental health, using Occupational Health and other support services and interventions	**By Mar-22**
The additional Occupational Health Physician is taking forward specific support for staff affected by Mental Health and mental health training for managers. This is in addition to the ongoing case work with Occupational Health, local managers and HR Officers and Advisors, with input from the specialist Occupational Health Mental Health Nurse.	
22.2 Continue existing managerial actions in support of achieving the trajectory for the Board and the national standard of 4% for sickness absence. The means of achieving this include continuation of Promoting Attendance Review and Improvement Panels, Promoting Attendance Groups, training for managers and continued application of the Once for Scotland Attendance Management Policy and scrutiny of "hot spots" / priority areas through analysis of management information and effective reporting systems.	**By Mar-22**
Promoting Attendance Review and Improvement Panels continue to meet regularly. This is alongside monthly and bespoke training sessions and use of Tableau and Attendance Management system to identify and analyse “hot spots” / priority areas and trajectory setting / reporting. Communication was issued via StaffLink in May and July to reinforce attendance management processes, and discussions have been held, in partnership, to assess focus of improvement work in light of the changing context. Further scoping work is to be carried out.	
22.3 Consider refinements to COVID-19 absence reporting, including short term manual data capture from SSTS and eESS in preparation for any change to self-isolation guidance and to support ongoing workforce resourcing actions, acknowledging that systems development is required to develop MI reporting	**By Nov-21**
Work has been undertaken with Digital & Information colleagues to provide initial COVID-19 specific absence reports and this will be refined to take account of systems developments. Weekly reports are now being provided to EDG.	

MARGO MCGURK
Director of Finance and Performance
19th October 2021

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**HAIRT Report**
Responsible Executive:	**Janette Owens**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for October 2021 committee to provide assurance that all IP&C priorities are being and will be delivered.

This is presented to the Committee for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update for Infection Prevention and Control for October 2021 committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT presented to the Infection Control Committee October 2021

2.2 Background

Infection Prevention and Control provide a service to NHS Fife including a planned programme of visits, audit, education and support is provided to staff on an ongoing as well as a National programme of Surveillance for Surgical Site Infections, *Clostridiodies difficile* infection (CDI), *Staphylococcus aureus* bacteraemia (SAB) and *E. coli* bacteraemia (ECB).

Standards on Reduction of Healthcare Associated Infections:

October 2019: The New standards have been announced by the Scottish Government's Chief Nursing Officer for the reduction of Healthcare Associated Infections for CDI, SAB and ECB. Please see below for new LDP Standards.

***Clostridioides difficile* Infection (CDI)**

- New LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2022 in healthcare associated infection rate - rate of 6.5 per 100,000 total bed days.

***Staphylococcus aureus* Bacteraemia SAB**

- New LDP standards are to reduce incidence of healthcare associated SAB by 10% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of SAB from 20.9 per 100,000 total bed days in 2018/19, 10% reduction target rate for 2021/22 is 18.8 per 100,000 total bed days.

***Escherichia coli* Bacteraemias (ECB)**

- New LDP standards are to reduce incidence of healthcare associated ECB by 25% from 2019 to 2022, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of ECB by 25% from 44.0 per 100,000 total bed days in 2018/19, target rate for 2021/22 is 33.0 per 100,000 total bed days.

2.3 Assessment

SAB

For Quarter 1 2021 (January – March 2021)
NHS Fife was below the national rate for healthcare associated infection (HCAI).

For Quarter 2 2021 (April-June) 2021, has seen a reduction in cases;12 down from 25 (awaiting national comparator).

During August 2021 there was an increase in the number of SABs (8 cases). However, the cumulative monthly total for Jan-Aug 2021 was equally comparable to 2020 (50 cases in total).

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 the data to inform clinical practice improvements thereby improving the quality of patient care.
- Ongoing work Addiction Services to continue to reduce the number of SABs within the people who inject drugs (PWID) community.

CDI

- For Quarter 1 2021 (January – March 2021) NHS Fife was below the national rate for HCAI.
- Q2 2021 (April-June) 2021, has seen a reduction in total cases 12 down from 16 in Quarter 1. NHS Fife rates for HCAI and CAI are below the national comparator
- NHS Fife has seen an increase in CDI numbers during 2021 (January-August), when compared with the same time period in the previous 2 years. Whilst Fife's CDI Year ending Q1 2021 rates are below the national rates, the HCAI incidence must still reduce further to meet the HCAI reduction target.

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.

ECB

- For Quarter 1 2021 (January – March 2021) NHS Fife was below the national rate for HCAI & CAI
- For Quarter 2 2021 (April- June) this success continued with NHS Fife below the national comparator for HCAI & CAI

Current ECB Initiatives

- Urinary catheter Group work following raised ECB CAUTI incidence
- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- This group aims to minimize urinary catheters to prevent catheter associated healthcare infections and trauma associated with UC insertion/maintenance/ removal and self-removal to establish Catheter Improvement work in Fife.
- 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 and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now 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 2021).
- Team Lead- Continence Advisory Service
- 'Tip top' video has been published
- CAUTI Quality Improvement (QI) projects: Kelty Medical Practice- CAUTI QI project ongoing

COVID-19 pandemic

The IPCT has continued proactive work in preventing healthcare outbreaks, supporting clinical areas with outbreak management and support the safe remobilisation of services.

- The IPCT undertake patient contact tracing in the hospital environment for patients and support Occupational Health where necessary with HCWs
- Providing a programme of IPC 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 ARHAI Scotland

Surgical Site Infection (SSI) Surveillance Programme

The CNO suspended the national SSI Surveillance programme in March 2020 in response to the COVID-19 pandemic

Caesarean Section SSI

Local SSI surveillance is being undertaken by the midwifery team to provide local assurance. The surveillance team are in communication with the team & supporting this work.

Large Bowel Surgery SSI and Orthopaedic Surgery SSI

Surveillance has been temporarily paused due to the COVID-19 pandemic as per CNO letter.

Outbreaks (July - end of August 2021)

- **Norovirus**

There has been NO new ward closures due to a Norovirus outbreak

- **Seasonal Influenza**

There has been NO new closures due to confirmed Influenza

- **COVID-19**

Four outbreaks/incidents of COVID-19 are detailed in the HIIAT

Hospital Inspection Team

NHS Fife have not received any further unannounced Hospital Inspections since last report

Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- 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’

- NHS Fife overall results remain consistently ABOVE 98%, this is ABOVE the Overall target set of 95%

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 Quarter 1 (April - June 2021) was **95.4%**.

National Cleaning Services Specification

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (April – June 2021) shows NHS Fife achieving **Green** status.

Estates Monitoring

- The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 1 (April – June 2021) NHS Fife achieving **Green** status.

2.3.1 Quality/ Patient Care

Effective infection prevention and control are essential to the delivery of high quality patient care and to the provision of a clean and safe environment for patients, visitors and other service users.

2.3.2 Workforce

Effective infection prevention and control are essential to the provision of a clean and safe working environment, and to overall staff health and wellbeing.

2.3.3 Financial

No financial costs identified in this report.

2.3.4 Risk Assessment/Management

Challenges and management of any risks to national infection prevention and control guidance discussed throughout report

2.3.5 Equality and Diversity, including health inequalities

Effective infection prevention and control include assessments of equality and diversity impact as appropriate

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

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.

This is a summary of the HAIRT submitted to the Infection Control Committee October 2021

2.4 Recommendation

- **Assurance** – For Committee's information only

3 List of appendices

The following appendices are included with this report:

N/A

Report Contact
Julia Cook
Infection Control Manager
Email Julia.Cook@nhs.scot

Final Report for ICC on 6th October 2021
(Validated Data up to August 2021)

Section 1– Board Wide Issues
Key Healthcare Associated Infection Headlines up to 1st of September 2021

- **Achievements:**

The IPCT supported the "Stop SEPSIS save lives" campaign for World Sepsis day on the 13th of September 2021, which was an opportunity for people worldwide to unite in the fight against sepsis which accounts for at least 11 million deaths worldwide annually. The national campaign material promoted on Blink and NHS Fife social media platforms to raise awareness for both staff, visitors, patients and the public.

The IPCT in collaboration with Excellence in Care and Digital Information, ran a successful pilot of an electronic version of the CRA MDRO tool on Patientrack in AU2, which is now being further rolled out across the Board.

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q1 2021 (Jan-March), NHS Fife was below the national rate for healthcare associated infection (HCAI).

Q2 2021 (April-June) 2021, has seen a reduction in cases from Q1- 12 down from 25 (awaiting national comparator).

***Clostridioides difficile* Infection (CDI)**

During Q1 2021(Jan-March), NHS Fife was below the national rate for HCAI.

Q2 2021 (April-June) 2021, has seen a reduction in cases from Q1- 12 down from 16 (awaiting national comparator)

***Escherichia coli* Bacteraemias (ECB)**

During Q1 2021 (Jan-March), NHS Fife was below the national rate for HCAI & CAI.

1.1 Challenges:

For the committees awareness the IPCT Business Continuity plans were enacted for a 3 week period due to pressures on the service due to sickness/absenteeism and requirements for multiple team members to self-isolate as per national guidance.

SABs

- Vascular access devices (VAD) remain the greatest challenge for Hospital acquired SABs, ongoing improvement works.
- For Q1 2021, Fife was above the Scottish rate for CAI SABs.
- During August 2021 there was an increase in the number of SABs (8 cases). However, the cumulative monthly total for Jan-Aug 2021 was equally comparable to 2020 (50 cases in total).

ECBs

- Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate.
- During June there were 7 CAUTI (no traumas noted) related ECBs, resulting in a 32% CAUTI rate. The rate was slightly lower in July (25%), despite having the same number (7) of CAUTI related ECBs recorded.

CDI

- So far, NHS Fife has seen an increase in CDI numbers during 2021 (January-August), when compared with the same time period in the previous 2 years. This trend is also reflected in the accumulative total of CDIs in the CAI category of infection for Jan-Aug 2021.
- Whilst Fife's CDI Year ending Q1 2021 rates are 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 2021 has been paused due to the COVID-19 pandemic.

COVID-19 pandemic

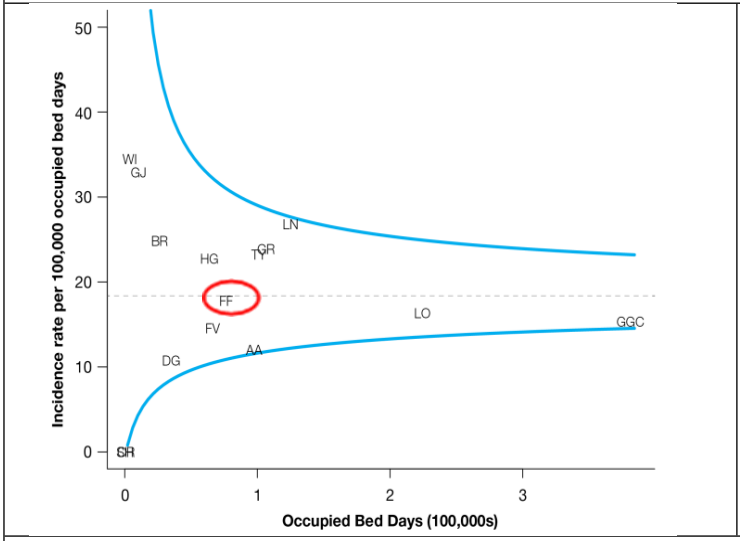
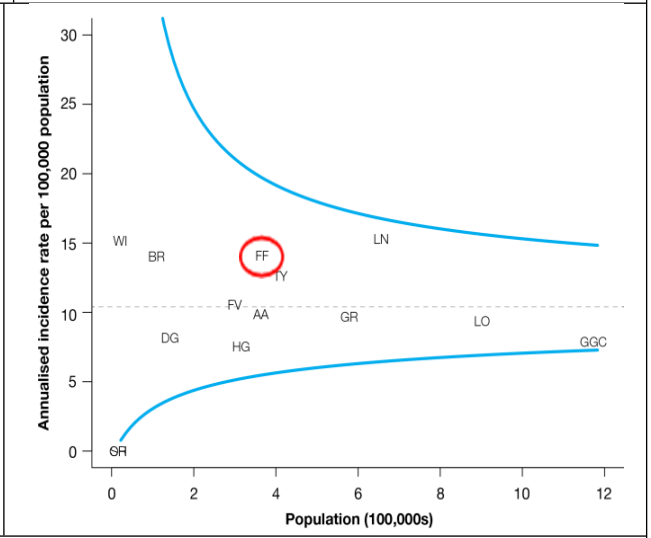
The IPCT has continued proactive work in preventing healthcare outbreaks, supporting clinical areas with outbreak management and support the safe remobilisation of services.

- The IPCT shall undertake patient contact tracing in the hospital environment for patients and support Occupational Health where necessary with HCWs
- Providing a programme of IPC 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 ARHAI Scotland

2. *Staphylococcus aureus* incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

***Staphylococcus aureus* Bacteraemias (SABs)**				
Local Data: Q2 2021 (Apr-Jun) **(Q2 2021 National comparison awaited)**				
In Q2 2021 NHS Fife had:	12 SABs	5 HCAI/HAI 7 CAI	This is **DOWN** from	25 Cases in Q1 2021

Q1 2021 (Jan-Mar) - HPS Validated data with commentary			
Healthcare associated SABs		Community associated SABs infection	
HCAI SAB rate: **17.8**	**Per 100,000 bed days**	CAI SABs rate: **14.4**	Per 100,000 Pop
No of HCAI SABs: 14		No of CAI SABs: 13	
This is **BELOW** National rate of 18.4		This is **ABOVE** National rate of 10.4	
			
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 March 2021 (HPS)		
SAB by rate 100,000 Total bed days	**16.3** per 100,000 TBDs	
SAB by Number of HCAI cases	**48**	

Local Device related SAB 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.
- There have been no further dialysis line related SABs since the most recent case in January. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

As of **13/09/2021** the number of days since the last confirmed SAB is as follows:	
CVC SABs	171 Days
PWID (IVDU)	42 Days
Renal Services Dialysis Line SABs	231 Days
Acute services PVC (Peripheral venous cannula) SABs	31 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. PGD for antibiotic prescribing now in process by Addictions team. IPCT refresher presentation prepared, awaiting input from Addictions Manager.

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 **98%** compliance with the **MRSA** CRA in Q2 (Apr-Jun) 2021

This was **UP** on Q1 2021 (95%) & **ABOVE** the compliance target of 90%.

This National Scottish average for Q2 2021 is still to be published.

MRSA Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	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	Q2 2021 Apr-Jun
Fife	93%	93%	93%	83%	98%	88%	98%	95%	98%
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 **90%** compliance with the **CPE** CRA for Q2 2021 (Apr-Jun)

This is **UP** from 88% in Q1 2021

The National Scottish average for Q2 2021 is still to be published.

Quarter	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	Q2 2021 Apr-Jun
Fife	75%	83%	80%*	93%	95%	85%	98%	88%	90%
Scotland	86%	86%	85%	85%	80%	85%	79%	82%	n/k

CPE CRA screening KPI compliance Summary- Commenced from April

MDRO CRA Patientrack Update

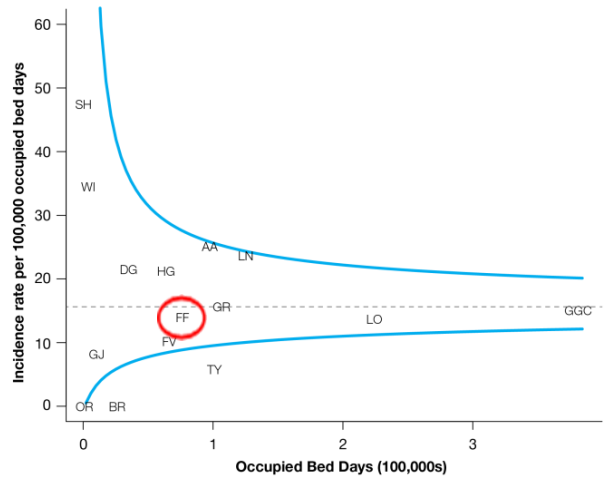
- Following a successful pilot of the electronic MDRO CRA in AU2, Patientrack has now added the CPE and MRSA assessments which were rolled out across the Board in September 2021
- The IPCT available for support to clinical teams
- Ongoing quality assurance will continue through 2021

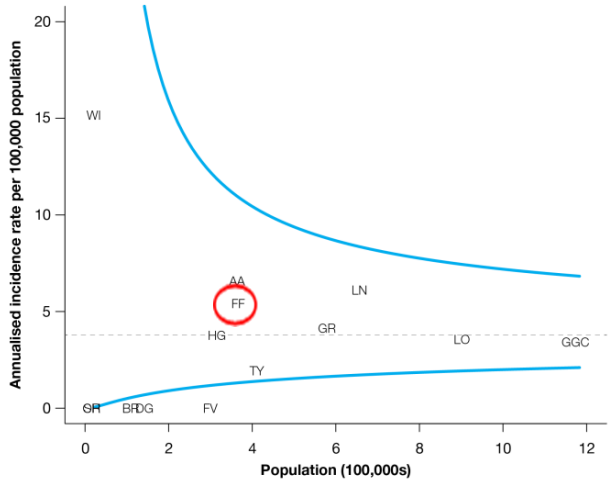
- *3* *Clostridioides difficile* Infection (CDI)

3.1 Trends

***Clostridioides difficile* Infection (CDI)**				
Local Data: Q2 Apr-Jun 2021 (Q2 2021 HPS National comparison awaited)				
In Q2 2021 NHS Fife had:	12 CDIs	8 HCAI/HAI/Unknown 4 CAI	This was **DOWN** from	16 Cases in Q1 2021

Q1 2021			
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.			
Healthcare associated CDIs		Community associated CDIs infection	
HCAI CDI rate: **14.0**	**Per 100,000 bed days**	CAI CDIs rate: **5.4**	Per 100,000 Pop
No of HCAI CDIs: 11		No of CAI CDIs: 5	
This is **BELOW** National rate of 15.6		This is **ABOVE** National rate of 3.8	





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 March 2021 (HPS)		
CDI by rate 100,000 Total bed days	**9.8** per 100,000 TBDs	
CDI by Number of HCAI cases	**29**	

3.2 Current CDI initiatives

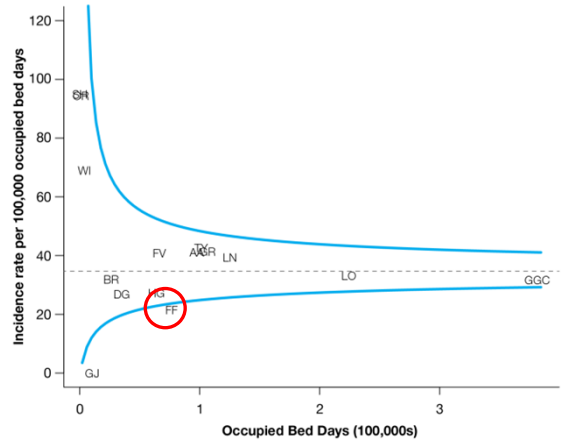
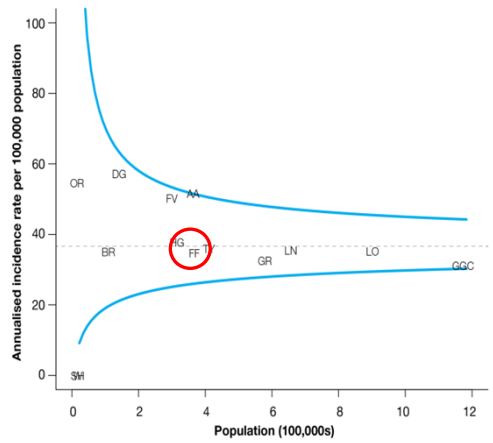
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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: Q2 Apr-Jun 2021 (Q2 2021 HPS National comparison awaited)				
In Q2 2021 NHS Fife had:	56 ECBs	30 HAI/HCAIs 26 CAIs	This is **UP** from	48 Cases in Q1 2021
Q2 2021 There were 11 Urinary catheter associated ECBs (2 x HAI & 9 x HCAI) There were no trauma related CAUTIs in Q2 2021				

Q1 (Jan-Mar) 2021			
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: **21.6**	**Per 100,000 bed days**	CAI ECBs rate: **34.7**	Per 100,000 Pop
No of HCAI ECBs: 17		No of CAI ECBs: 32	
This is **BELOW** National rate of 34.7		This is **BELOW** National rate of 36.6	
Figure 3: Funnel plot of ECB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q1 2021.[1]		Figure 4: Funnel plot of ECB incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q1 2021.[1,2]	
			
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 March 2021 (HPS)		
ECB by rate 100,000 Total bed days	**38.4** per 100,000 TBDs	
ECB by Number of HCAI cases	**113**	

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**

2021-2017 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
2021 Q2	TBC	***25%**	* Locally calculated data- TBC by HPS when Q2 data published on Discovery
2021 Q1	12.9%	**8.3%**	
2020 TOTAL	16.4 %	**27.5 %**	
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
2021 Q2	TBC	***40.9%**	* Locally calculated data- TBC by HPS when Q2 data published on Discovery
2021 Q1	27.2%	**40%**	
2020 TOTAL	24.1 %	**23.0 %**	
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 team continue to work with the Urinary Catheter Improvement group meeting- the last meeting was cancelled due to extreme hospital pressures on **17th Septemeber 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.

Proposal made through ECB strategy plan for all catheter related ECB to be reportable on Datix & to then undergo a LAER to provide further learning from all ECB CAUTIs. However, all LAERs currently on hold during to extreme hospital pressures

Monthly ECB reports & graphs are distributed within HSCP & Acute services

Up to 01.10.2021: There has been **ONE** trauma associated CAUTI 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 2021.

Pathway for management of difficult catheter insertions & associated problems- included in training pack & 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. -'Tip top' video have been published
CAUTI QI projects: Kelty MP- CAUTI QI project ongoing

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 Quarter 1 (Apr-June 2021) was **95.4%**.
- 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	Q1 Apr-Jun 21	Q4 Jan-Mar 21
Fife	95.4% ↓	95.9
Scotland	TBC	95.7

- The National Cleaning Services Specification – quarterly compliance report result for Q1 (Apr-Jun) 2021 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q1 Apr-Jun 21	Q4 Jan-Mar 21
Fife	96.2	96.2
Scotland	TBC	96.9

- The National Cleaning Services Specification – quarterly compliance report result for

Quarter 1 (Jan-Mar) 2021 shows NHS Fife achieving **GREEN** status.

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

July – end of August 2021

Norovirus

There has been NO new ward closures due to a Norovirus outbreak since last ICC report

Weekly national Laboratory reports of Norovirus in Scotland week 38 (week ending 19 September 2021):
The provisional total of laboratory reports for norovirus in Scotland up to the end of week 38 of 2021 is 99.

In comparison, to the end of week 38 in 2020 PHS received 213 laboratory reports of norovirus. The five-year average for the same time period between years 2015 and 2019 was 956.

Seasonal Influenza

There has been NO new closures due to confirmed Influenza since the last reporting period.

Weekly national seasonal respiratory report- week 37 (week ending 12 September 2021):

Overall assessment:

- Influenza activity was at **Baseline** level. There were 11 influenza cases detected in week 37: three influenza A, four influenza B, three coinfections with influenza A and influenza B, and one coinfection with influenza A, influenza B and RSV.
- The proportion of NHS24 calls that were for respiratory symptoms in week 37 remained at **Moderate** activity level for all ages. The <1-year age group increased to **Extraordinary** activity level, the 1-4 age group was at **High** activity level, the 15-44 and 45-64 age groups were at **Moderate** activity level, the 65-74 age group was at **Low** activity level, and the 5-14 and over 74 age groups were at **Baseline** activity level.
- Respiratory syncytial virus (RSV) was at **Moderate** activity level with a slight decline in the number of laboratory confirmed cases for the first time in recent weeks. The large majority of RSV detections thus far have been in those aged under 5 years. The typical RSV season

usually peaks between week 49 and week 52. However, in 2020/21, week on week increases in laboratory-confirmed diagnoses for RSV have been reported since week 23 2021.

- Rhinovirus was at **Low** activity level.

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 July – August 2021, there has been 3 new ward closures due to a COVID-19 outbreak during this reporting period.

- Radernie, Stratheden Hospital
- Letham Ward, Cameron Hospital
- Ward 4, Queen Margaret Hospital

Please note HPS/ARHAI Scotland no longer request the reporting of single cases of COVID-19 out with the RED pathway

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

There have been no inspections during this reporting period

10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has risen during 2021 (compared with the previous 2 years). Monitoring will assess if this trend continues. The number of 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
  - 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.

NHS Fife TOTAL

	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
Apr-21	4	2	6	4	0	4	5	5	10
May-21	0	3	3	3	2	5	12	12	24
Jun-21	1	2	3	1	2	3	13	9	22
Jul-21	3	2	5	3	2	5	13	15	28
Aug-21	5	3	8	3	0	3	13	15	28

Hand Hygiene Monitoring Compliance (%) TOTAL FIFE											
	Aug-20	Sept-20	Oct -20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21
Overall	99	98	99	99	98	99	99	99	TBC	TBC	TBC
AHP	99	99	98	99	98	98	100	97	TBC	TBC	TBC
Medical	99	99	99	99	97	100	97	99	TBC	TBC	TBC
Nurse	99	99	100	100	100	100	100	99	TBC	TBC	TBC
Other	96	96	99	100	95	100	100	100	TBC	TBC	TBC

Please note: there is no hand hygiene information since December 2020, available on `Ward Dashboard`.

Cleaning Compliance (%) TOTAL FIFE											
	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21	May 21	June 21	July 21	Aug 21
Overall	95.8	95.7	96.0	95.8	95.9	95.9	95.6	94.9	95.6	95.6	96.0

Estates Monitoring Compliance (%) TOTAL FIFE											
	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21	May21	June 21	July 21	Aug 21
Overall	96.0	95.7	96.2	95.7	96.3	96.5	96.3	95.7	96.4	95.7	96.3

Final Report for ICC on 6th October 2021
(Validated Data up to August 2021)

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-21	2	0	0
May-21	0	2	3
Jun-21	1	1	4
Jul-21	0	1	3
Aug-21	2	0	5

Cleaning Compliance (%) Victoria Hospital												
	Sept-20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21	May 21	Jun 21	Jul 21	August 21
Overall	95.6	95.1	95.4	95.8	95.8	95.9	96.1	95.9	95.3	95.8	95.5	96.0

Estates Monitoring Compliance (%) Victoria Hospital												
	Sept-20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21	May 21	Jun 21	Jul 21	Aug 21
Overall	95.6	95.8	96	96.4	95.2	96.9	95.2	96.5	96.4	97.2	96.5	96.8

Queen Margaret's Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-21	0	0	0
May-21	0	1	0
Jun-21	0	0	0
Jul-21	1	1	2
Aug-21	0	0	2

Cleaning Compliance (%) Queen Margaret's hospital												
	Sept -20	Oct - 20	Nov 20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21	May 21	Jun-21	Jul 21	Aug 21
Overall	96.3	96.9	96.2	96.9	96.1	96.5	96.5	96.0	96.7	96.7	96.3	97.0

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Sept -20	Oct - 20	Nov 20	Dec 20	Jan - 21	Feb - 21	Mar-21	Apr-21	May 21	Jun-21	July 21	Aug 21
Overall	96.3	96.9	96.1	97.1	96.2	95.6	97.1	95.5	94.3	95.3	94.6	95.3

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-21	0	1	0
May-21	0	0	1
Jun-21	0	0	0
Jul-21	1	0	0
Aug-21	0	0	1

Outs of Hospital Infections

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-21	2	2	3	0	5	5
May-21	0	3	0	2	8	12
Jun-21	0	2	0	2	9	9
Jul-21	1	2	1	2	8	15
Aug-21	3	3	3	0	5	15

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/

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**National Hub for Reviewing and Learning from the Deaths of Children and Young People**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gemma Couser, Interim Head of Quality and Clinical Governance & Heather Bett, Senior Manager Children's Services**

1 Purpose

The purpose of this paper is to provide an overview on the implementation of systems and processes within NHS Fife in response to the establishment of the National Hub for Reviewing and Learning from the Deaths of Children and Young People. Additionally this paper sets out the resource required in order to deliver requirements of the National Hub.

This is presented to the Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Local policy
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Scottish Government has requested that a national system for the reviewing and learning of deaths of young people is established (guidance contained within appendix 1). Healthcare Improvement Scotland (HIS) is responsible for overseeing death review activity through the National Hub. The National Hub will ensure that the death of every child and young person is reviewed to a minimum standard; defined within a national data core data

set. Within scope are all deaths of born children up to their 18th birthday or 26th birthday for those who continue to receive aftercare or continuing care at the time of their death. From year two it is anticipated that the criteria will be extended in to include reviews for those who have been looked after at some point in their lives.

Within NHS Fife there is a requirement to ensure that appropriate structures and processes are implemented to ensure delivery of the national guidance. A multi-disciplinary and multi- agency approach is central to achieving the requirements of the national guidance in delivering a high quality review which supports learning and improvement (both locally and nationally).

The National Hub went live on 1st October 2021. HIS have acknowledged that year one of implementation will be an opportunity to embed the new processes with a view to achieving business as usual from year two. For this first year there will be a requirement for Health Boards to provide quarterly reports to the National Hub.

2.3 Assessment

Deaths of Children and Young People in Fife

The sobering number of deaths of children and young people in Fife between 2015 and 2019 are shown in table below:

	2015	2016	2017	2018	2019	5 year Average
Neonatal	11	18	17	11	15	14
Paediatric	15	14	11	16	12	13
Young people aged 19-26 (note that only those who were in continuing care at the time of their death will be included within the review)	21	11	17	15	15	16
Total	47	43	45	42	42	44

*Data source: National Registers Scotland (NRS)

Social Work colleagues have undertaken a review of the young people who died aged 18-26 for the years 2018 and 2019. The review demonstrated that over this two year period 5 young people would have met the criteria for a review as they had been, at some point in their lives, looked after and accommodated. Of this 5, only 2 would have met the year one criteria as being actively in receipt of an aftercare service.

Based on the data it is estimated that there will be the requirement to conduct around 30-35 reviews annually. This is comprised of 28 cases, with approximately 50:50 split between neonates and paediatrics, under the age of 18 and between 2-5 cases of young people who meet the criteria.

Review Processes

The approach to developing local processes has worked on the principle of retaining existing mechanisms to review the deaths of children and young people whilst ensuring that the processes used capture the learning and information required and meet the needs of the families.

The existing review processes which are in place to facilitate a clinical review and identify learning from the death of a child or young person include:

- Sudden unexpected death in infancy (SUDI)
- Perinatal Mortality and Morbidity Reviews, including use of the Perinatal Mortality Review Tool (PMRT)
- Paediatric Mortality and Morbidity Reviews (Paediatric M and M)
- Drug related deaths
- Suicide
- Adverse events

The National Hub stipulates that there should be multi-agency consideration of deaths to determine which death review is the most appropriate and to identify the appropriate review route where deaths do not fit existing processes. Additionally the guidance requires reviews of deaths which currently do not typically currently receive a review in our health setting such as:

- expected deaths e.g. child or young person with a palliative cancer diagnosis
- deaths as a result of trauma e.g. drowning or road traffic accident

Key Requirements of the Guidance

The guidance places the responsibility with Health to work in partnership with local authorities and ensure that a high quality review has been conducted for each death. This requires the following to be implemented by Health Boards:

Requirement	Description
Appropriate Infrastructure	To conduct reviews in line with the guidance and to allow for the key data set to be completed
Single Point of Contact	A named single point(s) of contact for family members and carers after the death of their child or young person. They will coordinate meetings, communicate on the review process, assist in the gathering of sensitive data from the families and carers and ensure that they have the opportunity to ask questions and are responded to during the review as well as sign post to bereavement support where required.

Lead for Reviews	Appointment of a lead for reviewing and learning from deaths- with job planned time allocated for this leadership role
Governance	A governance group with representation from health and the local authority to ensure that: • Deaths of children and young people are recorded accurately with an oversight over the number of deaths • Quality reviews are undertaken working in collaboration with relevant partner organisations • There is liaison with local authority leads to identify involvement of local authority in the background of all child deaths and more particularly to ensure that there is a review conducted for care leavers up their 26th birthday who are in receipt of aftercare or continuing care at the time of their death • There is oversight in the monitoring of reviews being carried out • Learning is shared and improvement plans are progressed across departments and agencies
Family Involvement	Contact with families should be considered on a case by case basis and in a sensitive manner so as not to cause further emotional distress. The guidance states that families and carers should be included in the review process in order to ask additional questions and to provide feedback throughout the review process.
Multi-agency and multi-professional input	The membership of the review team should take into consideration the specialties involved in the child or young person's health and social care. This will determine the review panel and ensure that appropriate expertise is present in order to undertake a quality review.
National Hub core review data	There is a requirement for Boards to complete and submit a national data set. This will be submitted through the HIS Customer Relationship Management (CRM) System. Further confirmation of this system going live along with guidance for data submission is expected.

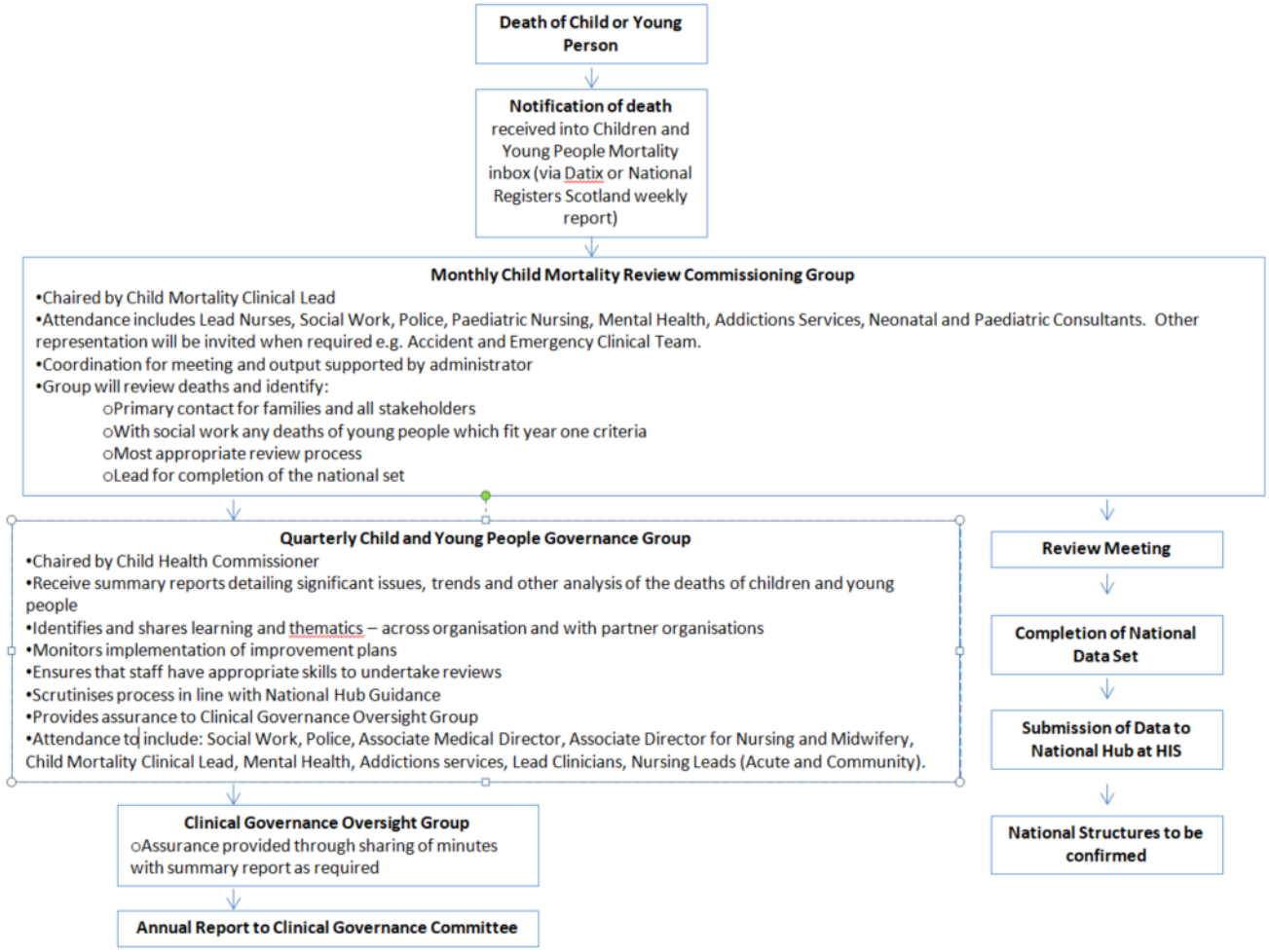
Implementation

A Short Life Working Group (SWLG) has been established in order to ensure that NHS Fife's systems and process are aligned to the National Guidance. The terms of reference for this group are set out in Appendix 2. It has been agreed that this group will continue to convene in order to support the embedding of new processes in this first year of implementation.

Commissioning of Reviews and Governance

A summary of the process for commissioning reviews of deaths and the associated governance is summarised in the flow diagram below:

Process for Commissioning Reviews and Governance Oversight



SLWG Workplan

With year one of the National Hub being viewed as the year for learning and setting up of processes there are a number of ongoing workstreams which are detailed in the table below:

	Summary of Workstream	Timeline/Status
1	Identify gaps where there is no clear process for reviews e.g. expected deaths or deaths following a road traffic accident	Complete but further learning required through commissioning process
2	Completion of Standard Operating Procedure for the commissioning of reviews for deaths of children and young people. For submission to the first Governance Group	December 2021
3	Develop and confirm Terms of Reference for the Governance Group. This multi-agency group will review decisions made	November 2021

	from the commissioning of reviews, progress with commissioned reviews, completion of data sets, family involvement, learns learnt and how it is being shared, identification of common themes, review of improvement work identified further to reviews.	
4	Complete data sharing agreement (DSA) and Data Protection Impact Assessment (DPIA)	October– November 2021
5	Further work is required to develop the bereavement support available to families. This work will continue to develop between October and December 2021. Review of existing support networks will be considered as well as the potential requirement to commission service from third sector organisations.	October- December 2021
6	Further discussion is required in relation to identifying the funding for the additional posts required to support this new workload	November 21

2.3.1 Quality/ Patient Care

National Hub will strengthen local arrangements for the review and learning of deaths.

Most deaths of under 18s are due to health conditions. Governance arrangements should usually be led by the NHS board in partnership with local authorities to ensure there is a multi-agency approach. However, in reviewing deaths it is important to consider both health and social care aspects and in some cases it may be most appropriate for the review to be led by the local authority.

The learning from the local reviews will be used to improve the quality of care and oversight groups will be formed to coordinate the learning and ensure that it is shared across the partner organisations.

There is the potential for cross over to adult protection in the extended age range (18 to 26) and therefore links with adult services will be established and the Individual Case Review process included in the review process. The Adult Support and Protection (ASP) lead will be a stakeholder in the Child Mortality Review Governance Group.

2.3.2 Workforce

This new review process is adding additional (and welcome) complexity and robustness to the current reviews being undertaken and will include cases that are not currently having any reviews. Feedback from the pilot sites for the Death Reviews elsewhere is that they have generated more work than had been anticipated. It will not be possible to deliver

these reviews without additional resource. The following workforce requirements have been identified (and would be similar to the resource available in other boards):

- The requirement to ensure that there are effective mechanisms for staff support in undertaking reviews – this is being considered by the SLWG and will be incorporated in the local standard operating procedure
- Investment to deliver the guidance as set out below

Post	Rationale	Band/ Grade	WTE/ PA
Child Mortality Clinical Lead	Provide clinical leadership in the overseeing and learning from reviews and compliance with the national guidance. Participate in review commissioning meetings and governance group	Consultant	1.5PAs
Child Mortality Liaison Nurse	To provide a single point of contact for families, coordination of reviews, participation in reviews, collation and submission of national data set, support in delivery of improvement actions.	Band 7	1.0 WTE
Child Mortality Administrator	Arrange review meetings, support Liaison Nurse and Clinician in the submission of national data set, act as a link between other Health Boards	Band 4	0.5 WTE

2.3.3 Financial

As described in section 2 the guidance places additional responsibility for Health Boards to oversee, coordinate and conduct reviews across the health and local authority system. HIS have allocated £11K non-recurring funding to support set up. Feedback has been provided to HIS that this allocation does not cover the infrastructure costs required to comply with the national guidance. It has not been confirmed if recurring funding will be allocated to Health Boards in the future.

Identification of the funding is being considered further to support for the investment at Executive Directors Group.

2.3.4 Risk Assessment/Management

The following risks to delivery of the guidance have been identified:

Risk	Mitigation
The national Data Sharing Agreement (DSA) and Data Protection Impact Assessment (DPIA) have been delayed and as such there	Local DSA and DPIA drafted has been drafted and is being prepared for sign off

is a requirement for local arrangements to be implemented. There is a risk that the reviews of deaths requiring multi-agency input could be delayed.	Reviews which align to existing NHS Fife processes will proceed as normal
There is a risk that if the investment required to support is not identified that there might not be capacity to effectively manage this new workload.	Temporary administrative support identified to coordinate review process Temporary Lead Clinician identified to lead commissioning group

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Other impact

No other impact to note.

2.3.7 Communication, involvement, engagement and consultation

Development of the local process has been through the SLWG which is multi-agency and multi-professional.

2.3.8 Route to the Meeting

This paper has been developed through collaboration with Heather Bett (Chair of SLWG), Gemma Couser (interim Head of Quality and Clinical Governance), Dr John Morrice (Associate Medical Director Women and Children's Service), Dr Lorna Watson (Consultant in Public Health Medicine & Child Health Commissioner NHS Fife) Lynette MacKenzie (Clinical Nurse Manager Paediatrics), Dr Anthony Tasker (Clinical Lead, Paediatrics) and Lynne Holloway (Service Manager, Women and Children's Service).

Earlier versions of this paper were presented to the following groups:

- Clinical Governance Oversight Group on 23rd June 2021 and 26th August 2021
- The August Senior Leadership Team meetings within the Acute Services Division and the Health and Social Care Partnership
- The August Child Protection Committee
- Executive Directors Group, 9th September 2021

2.4 Recommendation

The Clinical Governance Committee are recommended to:

- Note progress made to ensure NHS Fife align to the national guidance;
- Endorse the new governance requirements to deliver the guidance; and
- Note the risks

3 List of appendices

The following appendices are included with this report:

- Appendix1, Guidance National Hub for Reviewing and Learning from the Deaths of Children and Young People
- Appendix 2, Terms of Reference Short Life Working Group

Report Contact

Heather Bett
Senior Manager, Children's Servicers
Heather.bett@nhs.scot

Gemma Couser
Interim Head of Quality and Clinical Governance
Gemma.couser2@nhs.scot

National Hub for Reviewing and Learning from the Deaths of Children and Young People

National guidance when a child or young person dies

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Contents

Introduction

Background

Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying every year[1]. Around a quarter of those deaths could be prevented[2].

There is currently no national system to support reviewing and learning or to share national learning across all deaths and not all deaths are reviewed. We also know that the quality of reviews varies across services, and across Scotland.

The Scottish Government requested a system be established for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland, based on a National Hub, with an aim to co-ordinate all current review activity. Healthcare Improvement Scotland and the Care Inspectorate are working together to deliver the aims outlined in the next section.

The programme will use a multidisciplinary and multi-agency approach, focused on using evidence to deliver change, and ultimately aim to reduce deaths and harm to children and young people.

The National Hub wants to ensure the death of every child and young person is reviewed to an agreed minimum standard. Reviews should be conducted on the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death.

Whilst organisations are able to establish their own structure and process for reviewing the deaths of children and young people, they should ensure the local processes align to this guidance in order to enable good practice and lessons to be reflected and shared at a national level.

Organisations must ensure an infrastructure is in place that outlines all stages of the review process; from notification of the death, to carrying out the review, to sharing the learning locally and nationally.

1 National Records of Scotland. Vital Events Reference Tables: www.nrscotland.gov.uk/statistics-and-datastatistics-by-theme/vital-events

2 National Records of Scotland. Avoidable Mortality. 2018. Viewed 16 June 2020. www.nrscotland.gov.uk/statistics-and-data/vital-events/deaths/avoidable-mortality

National Hub

It is understood that the quality of reviews varies across services and across Scotland. While the National Hub aims to identify trends that could alert professionals of possible areas of risk, it will also look to establish a minimum standard for carrying out reviews into the deaths of children and young people and ensure consistency is applied to all reviews. The National Hub will operate in the context of existing review arrangements.

The aims of the National Hub are to:

- Ensure that the death of every child in Scotland is subject to a quality review:
  - develop methodology/documentation to ensure all deaths of children and young people that are not subject to any other review, are reviewed through a high quality and consistent review process, and
  - improve the quality and consistency of existing reviews.
- Improve the experience and engagement with families and carers.
- Channel learning from current review processes across Scotland that could direct action to help reduce preventable deaths.

The National Hub will:

- work with NHS boards and local authorities and request updates on the progress of reviews
- establish a national learning system to facilitate learning and disseminate best practice across health and social care including a community of practice
- securely manage data submitted to the National Hub
- use the information submitted to the National Hub to inform thematic reviews, and
- publish an annual report.

The National Hub will not:

- carry out individual child death reviews, or
- collate or publish identifiable information.

National Hub criteria

The National Hub has been tasked with ensuring reviews are conducted on all deaths of live born children up to the date of their 18th birthday, or 26th birthday[3] for care leavers who are in receipt of aftercare or continuing care at the time of their death.

This includes Scottish children and young people who die outside Scotland, and children and young people who die in Scotland that do not reside in Scotland. It also includes live-born babies where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, organisations may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive, the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law[4].

- Stillbirth: baby born without signs of life after 24 weeks gestation
- Late foetal loss: where a pregnancy ends without signs of life before 24 weeks gestation
- Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Reporting to National Hub

The National Hub is working with National Records Scotland to implement a process to ensure all deaths of children and young people are notified to NHS boards, local authorities and the National Hub. This will enable reporting organisations and the National Hub to check that all eligible deaths are being reviewed. NHS boards will also be required to report quarterly to the National Hub on the progress of reviews. This guidance will be updated to reflect the new process when available.

Once the lead organisation has carried out a review into the child or young person, it should also complete all relevant sections of the National Hub core review data set using Healthcare Improvement Scotland's Customer Relationship Management (CRM) system. Separate guidance will be available for this system.

The CRM system will be able to accept documents to be attached such as action plans.

[3] The Children (Scotland) Act 2014 introduced a new duty on local authorities to provide continuing care and extended eligibility for the receipt of aftercare to all categories of young people who cease to be looked after on or after their 16th birthday up until their 26th birthday.

[4] The Abortion Act 1967.

Purpose of this guidance

'Systematic review of all child deaths is grounded in respect for the rights of children and their families, and aimed towards the prevention of future child deaths[5].'

This guidance sets out the processes when responding to, and reviewing, the death of a child or young person. It sets out the review process and infrastructure required to support local systems from notification to reporting on the death of a child or young person, including governance and key elements that make a quality review. It takes account of the need to consider how to keep family and carers at the centre of the process and provided with opportunities to be involved in and informed about all aspects of the review process.

It provides key steps to ensure consistency when reviewing the circumstances surrounding the death of a child or young person and identify key learning that will positively contribute to ways to prevent or reduce future, preventable deaths.

This guidance has been developed with input from the National Hub expert advisory group that includes representation from service-based stakeholders, professional organisations, third sector organisations representing children and families and policy makers. We have also collaborated with colleagues from the rest of the UK and we took into account NHS England's child death review forms when developing the National Hub core review data set, mirroring key information such as categorisation of death to allow for comparable data collection across the nations.

We understand a range of review processes already exists and this guidance does not intend to duplicate. More information on the other types of reviews that NHS boards and local authorities currently undertake to support learning improvement can be found in Appendix 1: Types of review, along with the criteria that apply for these review processes.

Who is this guidance for?

This guidance is aimed at any health and care professionals from NHS boards, local authorities and health and social care partnerships who will have a role in reviewing the circumstances around the death of a child or young person. This includes chief executives and chief officers, chief officer groups and senior management teams. Other organisations who review such circumstances may also find this guidance helpful.

5 Fraser et al. 2014. Learning from child death review in the USA, England, Australia, and New Zealand.

Engaging with family and carers

Every family is entitled to have their child's death sensitively reviewed and professionals have a duty to support and engage with families at all stages in the review process. In some cases this will be to identify the cause of death and to ensure that lessons are learnt that may prevent further deaths of children and young people. In circumstances when the death was anticipated and not preventable, it is important to ensure that the experiences of the child or young person were positively managed and that anticipatory wishes of the child, young person and family were met. Engaging in this process must not make things worse for the family at this already extremely difficult time.

All staff have a duty to support family members and carers after the death of their child or young person with kindness and compassion. If questions have been raised about the quality of care provided, organisations have a responsibility to explain what has happened, to apologise as appropriate, and to identify what lessons may be learnt to reduce the likelihood of the same, or similar, incidents happening again.

When a child or young person dies it is important that family members and carers are offered bereavement support. While the support available and how this is accessed varies across Scotland, the National Hub would expect every family be offered bereavement support. Further information about national organisations offering bereavement support can be found at Appendix 2: National Bereavement links.

All bereaved families should be given a single, named point of contact. The main responsibilities for this key contact are to:

- be a reliable and accessible point of contact for family members and carers after the death
- help co-ordinate meetings between the family members, carers and professionals as required
- provide information on the review process and any investigations that relate to the child or young person, including liaising with the Crown Office and Procurator Fiscal Service (COPFS) or Police Scotland family liaison officer
- ensure that their questions are effectively addressed, and provide feedback to the family afterwards, and
- signpost to expert bereavement support if required.

In circumstances where a child or young person has died, and abuse or neglect is known or suspected, it is acknowledged that such events will be challenging for agencies and staff involved, however bereavement support should be in place throughout the entirety of the review process.

We are working with third party organisations to discuss ways of engaging with family members and carers throughout the review process. We will continue to develop this section and update links to other guidance when it is available.

Governance

Good governance systems will have clear lines of accountability and clearly defined roles and responsibilities to support the reviewing and learning from the deaths of children and young people. This includes providing opportunities for staff at all levels to take part in appropriate learning and development and recognising the time required for people to participate in reviews. They should also ensure robust and integrated systems are in place to learn from reviews and identify themes, trends or patterns in order to make improvements to reduce risks and improve quality of care.

Most deaths of under 18s are due to health conditions. Governance arrangements should usually be led by the NHS board in partnership with local authorities to ensure there is a multi-agency approach. However, in reviewing deaths it is important to consider both health and social care aspects and in some cases it may be most appropriate for the review to be led by the local authority.

NHS boards, working in partnership with local authorities, should have the following in place to support governance systems for the review of deaths of children and young people:

- a lead for reviewing and learning from the deaths of children and young people, and
- a governance group (or designate an existing group), working in partnership with local authorities, with responsibility for ensuring that every child and young person in each NHS board area receives a quality review in the event of their death and that learning is captured and shared from reviews.

NHS boards should ensure, through their clinical lead and governance group, that:

- they know the number of children and young people from their NHS board area who die
- an appropriate and quality review is carried out for live born children up to the date of their 18th birthday who die; working in collaboration with other agencies, third-sector organisations and NHS boards as relevant
- they liaise with local authority child death leads to identify and ensure that an appropriate and quality review is carried out for care leavers up to their 26th birthday who are in receipt of aftercare or continuing care at the time of their death
- timescales for carrying out reviews are monitored
- improvement plans from reviews are progressed, and
- learning from reviews is shared for the purpose of improvement.

It will be important that the nominated clinical leads have time protected in their job plan to ensure this process is properly implemented and embedded.

Governance principles

All organisations are accountable for effective governance and learning following the death of a child or young person. The following principles build on the clinical and care governance framework[6].

Organisations should:

- work in an open and transparent manner to support a just culture.
- have relevant mechanisms and governance in place to consider and monitor reviews of the deaths of children and young people. This includes identifying the most appropriate review process for each death and ensuring reviews are carried out to a high quality.
- have systems for their senior leadership team to receive regular briefings on the detail of significant issues, trends and other analysis of the deaths of children and young people. This includes consideration of such information during an organisation's Board meetings.
- ensure their senior leadership team receives summary information, including the number of reviews taking place beyond recommended timescales, to gain assurance that appropriate action and learning has been, or is being, taken to reduce risks and to understand the impact on individual families/carers and staff.
- offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- ensure that the contribution of family members, carers and frontline staff remains central to improving standards of care. This includes taking account of the views and questions raised by family members and carers and staff in all reviews and findings being shared with those involved.
- ensure sufficient numbers of staff have appropriate skills through specialist training and protected time as part of their contracted hours to review deaths.
- monitor the implementation of improvement plans including the effectiveness of any changes made following a review and that these are embedded across all relevant areas locally and at national level as appropriate.
- share relevant learning across the organisation and with other organisations and agencies where this could be useful. This includes proactively sharing emerging risks and learning with peers in an open, transparent and timely way.

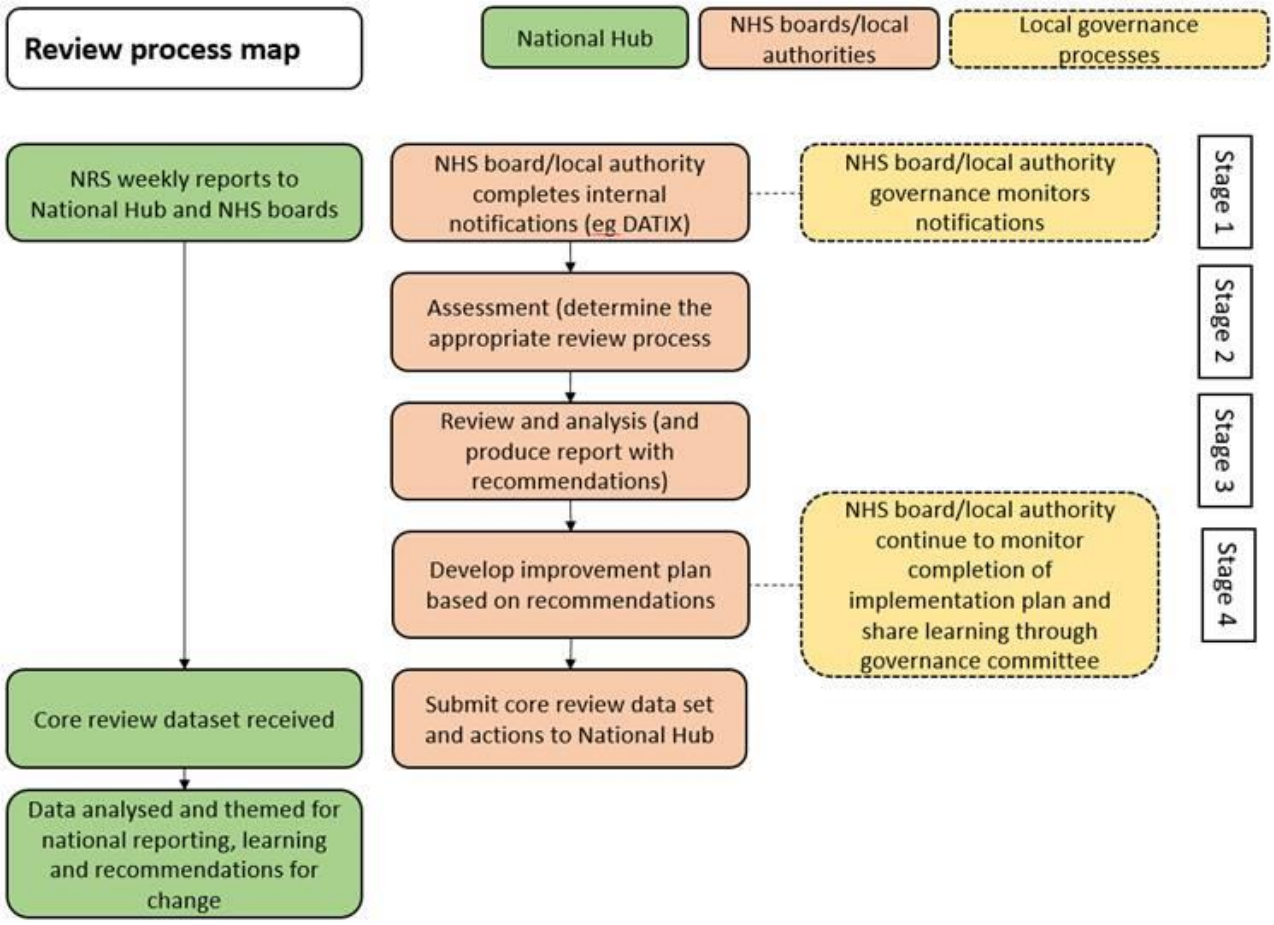
6 Scottish Government. Clinical and Care Governance Framework. October 2015. Viewed at 6 July 2020. https://www.gov.scot/publications/clinical-care-governance-framework/

Carrying out a quality review

The organisation undertaking the review must be clear and transparent from the outset that the purpose of the review is to learn and make improvements. Organisations should have a just culture that is open, supportive and focused on continuous learning and improvement. Reviews should be proportionate to the likely learning. They should obtain sufficient information to understand 'what happened and why' and determine the quality of the care provided. The review process should be carried out in a way that is flexible and relevant to the individual circumstance of the death, without incurring excessive workload. The review process can identify good practice that should be shared or learning points that are not directly related to the death that could have an impact on improving the system.

As set out in the governance section, each organisation is required to nominate a lead to liaise with the National Hub on all deaths that meet the criteria and ensure that an appropriate review is carried out. We will work with your organisation's nominated lead to ensure these processes are in place.

A single point of contact for the family members and carers should be clearly defined at the outset, as set out in the Engaging with family and carers on page 6.



Stage 1: Initial reporting and notification

Notification

Organisations are responsible for ensuring a robust system is in place for the notification and recording of the death of every child and young person in their area. This notification should prompt a discussion around the type of review required to be carried out and follow a structured review process through to completion.

Consideration of any parallel processes

Depending on the circumstances, reviews into the deaths of children and young people may run parallel to other investigatory processes or proceedings. Such as, a review by the COPFS or criminal investigation carried out by Police Scotland. Efforts should be made to minimise duplication of effort and ensure, as far as is practicable, that the various processes are complementary, even if their purpose is somewhat different. In both these circumstance, early communication is key. If the decision had been made to carry on with your review of the death of a child or young person, both processes must remain separate, and not be compromised during any parallel review.

Effective co-ordination and communication is essential to avoid unnecessary delay and additional distress or confusion for staff and families. More information about national organisations and their review processes can be found in Appendix 3.

At the outset of the review process consideration should be given to whether a collaborative approach is needed. The lead organisation, such as the NHS board of residence of the child, should contact the other organisation(s) and agree the scale of their involvement. This could be providing information or documentation or being part of the review team.

When a death occurs out with your NHS board area

Children or young people who reside in one NHS board area, may die in another NHS board area. A child or young person could be supported in one local authority area and may die in other local authority area, or even a child or young person from outside Scotland could die in Scotland.

A structured system must be put in place to ensure the lead of the child or young person's area of residence is notified of the death. These deaths will be registered under the NHS board area where death took place. Once the new process of notification between NRS, the appropriate NHS board and the National Hub is established, that NHS board will be notified of the death. It will then be their responsibility to ensure a decision is made between all relevant organisations as to which organisation will lead the review. While it is strongly encouraged that all organisations that were involved in the child or young person's care contribute to the review, one will have overall ownership of responsibility for the process and outputs. However, all involved organisations will be responsible for implementation of actions and outcomes where relevant and applicable.

When a death occurs overseas

When a child or young person, who is a resident of Scotland, dies overseas, we would expect it to be the responsibility of the residing NHS board to conduct a review to the best of their ability.

You may learn about the death from a variety of sources, such as the Foreign and Commonwealth Office, media, family members or GP. The review into the death of a child or young person that occurs overseas can be challenging. We would encourage any NHS board to contact the National Hub for further guidance.

These deaths would be registered where the death took place and therefore would not be in the data supplied by the new NRS process. We will work with colleagues from the Death Certification Review Service, to ensure deaths abroad that are reported to the service of children and young people who usually reside in Scotland are notified to the appropriate NHS board.

Expected deaths

An expected death is the death of a child or young person that was anticipated following on from a period of illness that has been identified as terminal, including where no active intervention to prolong life is ongoing. It is expected that a person with a life limiting or life threatening condition will die prematurely although, it is not possible to anticipate when, or in what manner they will die.

Effective end of life care does not stop when a child or young person dies but involves wide-ranging and sensitive care after death. The review process provides an opportunity to examine the circumstances of the child or young person's palliative care needs and support prior to their death. Reviewing the circumstances of a child or young person's death and the period leading up to this can provide significant learning. The review could include:

- looking at the end of life and anticipatory care planning
- reviewing if the child, young person or family's wishes were fully taken into account
- aspects of the end of life care which went well
- aspects of the end of life care which could be improved
- support provided to the family prior to and after the death.

Stage 2: Assessment – determining the appropriate review process

When an organisation is notified about the death of a child or young person there should be clear governance arrangements and processes in place to determine the appropriate review mechanism. Engagement must take place early in the process with any other organisations involved in the child or young person's care to reach a decision about the most suitable review process. All organisations and agencies involved should work together to undertake one single review wherever this is possible and appropriate. The rationale for deciding which review process should be carried out should be clear, take into consideration any statutory, legal or national requirements, and be

reached in a timely manner. More information on the other types of reviews that NHS boards and local authorities currently undertake to support learning improvement can be found in Appendix 1: Types of review, along with the criteria that apply for these review processes.

Stage 3: Review and analysis

A robust review should use best practice review techniques and methodologies. Methodologies should be briefly, but clearly set out in the review report. Those leading reviews should have up-to-date training and be competent in review methodologies and techniques including systems analysis and report writing.

Family involvement

All contact should consider the impact of the death of a child or young person and work sensitively with the family to ensure no additional distress is caused to them.

In the majority of cases, organisations should inform the family members and carers of any review of the death of a child or young person and invite them to contribute to the review process in accordance with their wishes. The review provides an opportunity to meaningfully consider their views and any concerns or queries they may have about the care they and their child received. A personalised supportive approach should be taken. If family members and carers are not involved, the reasons should be recorded. Processes should be in place that enables family and carers to receive feedback following the review process, including feedback on the review findings and any learning to improve future practice or systems.

Staff involvement

Staff who were involved in the child or young person's care provide an important source of information. The review process provides an opportunity to consider their perspective and experiences in identifying the factors that contributed to any interventions or the delivery of care. Staff should be made aware that a review is taking place and be clear about their role in the review process. They should also be given appropriate support throughout the review by their organisation.

Review team

The membership of the review team should take into the account the specialties and disciplines involved in the child or young person's health and social care. The organisation should ensure that individuals with all the relevant expertise according to the circumstances of the death are involved in the review. The review team should be multidisciplinary and include members who were not involved in the care provided to the child or young person. Members of the review team should have sufficient time allocated for preparing for, and attending review meetings.

Scope of the review

The scale, scope and timescale for the review must be agreed at the outset of the review process and documented in the terms of reference to help you consider:

- how best to support and engage with the family members and carers following the death and throughout the review process
- ensuring all relevant agencies are represented and have input into the review
- ensure timescales for reviews are met
- other parallel processes being conducted at the same time
- how improvement plans from reviews are to be monitored and completed, and
- how key learning from reviews are to be shared and acted upon for the purpose of organisational learning and improvement.

Decisions on the scale and scope of the review may need to be revisited as new information comes to light. Adopting a proportionate approach enables the aims of the review process to be met in a way that is flexible and relevant to the situation under review, without incurring excessive workload and is concluded in a timely manner.

Gathering and analysing information

Information sources gathered for a review to support informed judgements can include:

- a clinical and/or care history derived from relevant case records
- a timeline or narrative of the events relevant to, and preceding the death (chronology)
- statements and observations from key people involved
- perspectives of family members and carers and any questions they have
- relevant local policies and procedures
- any relevant national policies
- physical evidence, including photographs and environment layout where appropriate
- background information such as staff rotas and availability of staff, and
- relevant clinical and professional guidance documents.

Reviews should aim to be proportionate, which means that different reviews will require different amounts of information assembled to achieve their aims. Information needs may also change as the analysis progresses.

Reviews should use a structured and consistent approach. A systems approach using defined tools and techniques will identify the contributory and modifiable factors, details of the care provided and any lessons that could inform service improvement or reduce the risk of further deaths. A variety of tools, such as cause and effect charts, process mapping, fishbone diagrams and contributory factor frameworks, can be used.

At least one member of the review team should be trained in review methodologies and their application. Where this is not possible, support from central clinical governance, risk management or quality improvement teams should be sought.

The report

The report should present the key findings, learning and recommendations of the review and be shared with everyone involved in the care and death of the child or young person. The report should clearly identify the findings of the review that are key to making local improvements and national recommendations where necessary. This should include identifying practice that contributed positively to the care of the child or young person, or that may assist in the prevention or reduction of deaths of children and young people.

The roles and responsibilities of each member of the review team must be clear, including identifying a lead reviewer, and should be documented.

It is good practice to write a review report that can be used for many purposes, such as sharing with those involved in the review process and family members and carers. Writing anonymised reports from the start would help, rather than redacting identifiable information about individual staff or family members at a later point.

Organisations will have local processes for the review and approval of reports and recommendations either through clinical governance structures or management team structures.

Recommendations and findings

The review team should consider how the recommendations and findings will support changes in practice and quality improvements. Recommendations and findings must make clear what they aim to improve or how they will minimise risk. The recommendations should indicate the timescale for completion.

Recommendations made should follow the SMARTER approach and be:

- **S**pecific (what is to be done and how it can be carried out)
- **M**easurable (must be defined in a way that can be measured to ensure it had an impact)
- **A**ccountable (all actions must be assigned to someone who will be accountable for completion)
- **R**easonable (realistic and achievable)
- **T**imely (consider competing priorities and available resources)
- **E**ffective (will it make a difference?), and
- **R**eviewable (should enable effective monitoring through governance processes).

Stage 4: Improvement planning and monitoring

A review into the death of a child or young person, no matter how well it is carried out, serves little purpose if the lessons learnt are not used to improve services, enhance practice and reduce risk at

a local and national level. Organisations should ensure arrangements are in place to share learning, improvements and best practice from reviews of the deaths of children and young people across services, the wider organisation and nationally as appropriate. The use of short learning summaries or 7-minute briefings can be helpful ways to share key learning points.

Reports relating to thematic learning should be collated over specific timeframes to assist and inform wider service and organisation improvement programmes aimed at preventing deaths of children and young people.

If the findings and recommendations from the review have highlighted a need for improvements, an improvement plan should be developed. This may require other organisations and agencies to act collaboratively to achieve them.

It is not necessarily the responsibility of the review team to produce the improvement plan as they may not be best placed to produce detailed action plans and management responses. Improvement plans should be developed by those with the responsibility for making the agreed changes and who, therefore have control and responsibility for implementation. This may be the team, department or service area where the death took place. It could also be a corporate management team or partnership level if a consistent corporate and strategic response is required.

The improvement plan should set out how each recommendation from the review will be implemented, monitored and measured, and identify how learning is shared. The plan should include responsible owners, timescales for delivery and review dates. Final plans should be shared with those previously involved in the care of the child through identified local processes.

Appendix 1: Types of review

Adverse Event Reviews

An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people. All organisations should have a management system for reporting, reviewing and learning from all types of adverse events.

Adverse event reviews are not about apportioning blame. The aim is to be open and honest with people when things do go wrong and offering an apology as soon as an event has been identified. A review of the care provided determines whether there are learning points for the organisation or organisations to improve the service. Organisations then need to implement the improvements identified to support a greater level of safety for all people involved in its care systems.

Significant adverse event reviews (SAERs) are carried out following events that have resulted in unexpected death or harm. These are focused on analysing factors that have contributed to the circumstances of the event. We understand this type of review is usually applied to suicide reviews and drug related deaths.

Death of a Looked After Child

Under regulation 6 of the Looked After Children (Scotland) Regulations 2009, local authorities have a duty to notify Scottish Ministers and the Care Inspectorate of the death of a looked after child and make arrangements to carry out a review. Local authorities are required to submit written notification within 24 hours of any death of a looked after child to Care Inspectorate. Within 28 days, the local authority require to send the Care Inspectorate a detailed report and supporting information. A copy of the death certificate should be forwarded to the Care Inspectorate as soon as it is available.

The Scottish Ministers will, through Care Inspectorate or any other relevant agency or body, advise the local authority about their conclusions and indicate what, if any, further action they will take or require the local authority to take. The Scottish Ministers may take steps to:

- examine the arrangements made for the child's welfare during the time he or she was looked after
- assess whether action taken or not taken by the local authority may have contributed to the child's death
- identify lessons which need to be drawn to the attention of the local authority immediately concerned and/or other authorities or other statutory agencies
- review legislation, policy, guidance, advice or practice in the light of a particular case or any trends emerging from deaths of children being looked after.

Local authorities should also be aware of their duties to notify the Care Inspectorate without delay of the death of any service user who has died while the care service was being provided, and of the circumstances of the death, including a looked after child. This is in regulation 21 of the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, S.S.I. 2002/114.

Deaths of young people in receipt of after care

Under Section 29 (10) (b) of The Children (Scotland) Act 1995 (amended by the Children and Young People (Scotland) Act 2014), if a local authority becomes aware that a person who is being provided with advice, guidance or assistance by them under this section has died, the local authority must as soon as reasonably practicable notify Social Care and Social Work Scotland (known as the Care Inspectorate). Reviews should be conducted on the deaths of all care leavers who are in receipt of aftercare at the time of their death.

Deaths of young people in continuing care up to their 26th birthday

Under Section 26 A (10) (b) of The Children (Scotland) Act 1995 (as amended by the Children and Young People (Scotland) Act 2014), if a local authority becomes aware that a person being provided with continuing care has died, the local authority must as soon as reasonably practicable notify Social Care and Social Work Improvement Scotland (known as the Care Inspectorate). Reviews should be conducted on the deaths of all care leavers who are in receipt of continuing care at the time of their death.

Death in Prison Learning, Audit & Review (DIPLAR)

DIPLAR[7] is the joint Scottish Prison Service and NHSScotland process for reviewing deaths in custody. It provides a system for recording any learning and identified actions and is held within 2 weeks of a death. DIPLAR enables the Scottish Prison Service to contribute to the national suicide prevention policies and develop the evidence base through a reporting and learning system that analyses all suicide reviews to promote learning and improve strategies throughout Scotland.

Drug Related Deaths (DRD)

Drug-related deaths in Scotland are recorded and examined by local critical incident monitoring groups who often collaborate with the police and Procurator Fiscal to identify such cases in their local area. Each area has a data collection co-ordinator who works closely with the local critical incident monitoring group and other key partners to collate the information on each drug-related death. Data collected from all drug related deaths from NHS boards is recorded on the national DRD dataset which is managed by Public Health Scotland.

[7] Scottish Prison Service. 2018. Death in Prison Learning, Audit & Review (DIPLAR) Process Guidance. Viewed at 28 July 2020. www.sps.gov.uk/Corporate/Publications.aspx

Duty of Candour

The organisational Duty of Candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

Fatal Accident Inquiries

A Fatal Accident Inquiry (FAI) is a type of court hearing which publically inquires into the circumstances of a death. It will be presided over by a Sheriff and will normally be held in the Sheriff Court. If the death has happened as a result of an accident while at work or if the death happened while in legal custody, for example in prison or police custody, a Fatal Accident Inquiry will normally be held. FAIs can be held in other circumstances if it is thought by COPFS to be in the public interest to do so.

When considering how an FAI may impact your review into the death of a child or young person, communication must be made with your local COPFS office. In most circumstances a robust, timely review will help COPFS when deciding whether to progress to an FAI. Circumstance may be different in every case.

Learning reviews

The overall purpose of a learning review, previously known as initial case reviews or significant case reviews, is to bring together agencies, individuals and families in a collective to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children and young people. A Child Protection Committee will undertake a Learning Review in the following circumstances.

When a child has died or has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland and one or more of the following apply.

- Abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or the child was looked after by, or was receiving aftercare or continuing care from the local authority. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death or sustaining of significant harm, unless it is absolutely clear to

the Child Protection Committee that the child having been on the CPR or looked after has no bearing on the case

- The child's death is by suicide, alleged murder, culpable homicide, reckless conduct, or act of violence **and** one or more from the above apply

The key guidance for carrying out this type of review is the ***National guidance for child protection committees for conducting a significant case review[8] (Scottish Government, 2015) - To be replaced by new National Guidance For Child Protection Committees – Undertaking Learning Reviews when available.***

The recently published Protecting children and young people: Child Protection Committee and Chief Officer responsibilities[9] states that chief officers groups should be advised by the chair of the Child Protection Committee of any cases that should be considered in respect of meeting the criteria for warranting a review. Once agreed that there is a need to undertake a review, the Child Protection Committee should consider and agree how the review will be undertaken, who should lead the review and ensure that appropriate communication of the case has taken place in respect of key contacts.

Mortality and Morbidity reviews

The Mortality and Morbidity process describes the review of incidents from the initial event to the mortality and morbidity meeting and implementation of identified actions or outcomes.

A mortality and morbidity meeting is a unique opportunity for caregivers to improve the quality of care offered through case studies. They provide clinicians and members of the healthcare team with a routine forum for the open examination of adverse events, complications, and errors that may have led to illness or death in patients.

Mortality and morbidity meetings are also known as mortality and morbidity reviews or conferences, case conferences or clinical teaching conferences. The term 'patient safety' or 'quality improvement' or 'quality assurance' (or a similar variant) is occasionally appended as a prefix.

Mortality and morbidity meetings support a systematic approach to the review of patient deaths or care complications to improve patient care and provide professional learning. The meetings give ownership to clinical teams and offer a direct opportunity to improve care delivery in a timely manner.

[8] Scottish Government. 2015. National Guidance for Child Protection Committees for Conducting a Significant Case Review. Viewed at 23 June 2020. https://www.gov.scot/publications/national-guidance-child-protection-committees-conducting-significant-case-review/

[9] Scottish Government. 2019. Protecting children and young people: Child Protection Committee and Chief Officer Responsibilities. Viewed at 23 June 2020. https://www.gov.scot/publications/protecting-children-young-people-child-protection-committee-chief-officer-responsibilities/

Effectively run audit and peer review processes, incorporating analysis of mortality and morbidity cases, contribute to improved patient safety and professional development.

Perinatal Mortality Reviews

The Perinatal Mortality Review Tool (PMRT) supports standardised perinatal mortality reviews across NHS maternity and neonatal units on the deaths of babies from 22+ week's gestation to 28 days after delivery. These are reviewed using the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and PMRT.

The PMRT has been designed following these principles.

- There should be comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth; excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known.
- Such reviews should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes.
- A multidisciplinary group should review each case at a meeting where time is set aside for doing the work.
- There should be scope for parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored.
- The review should result in a written report which should be shared with families in a sensitive and timely manner.
- Reporting to the NHS board executive should happen regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

Police Investigations & Review Commissioner (PIRC)

The Police Investigations & Review Commissioner can investigate the following.

- Incidents involving the police, directed by the COPFS. These include deaths in custody and allegations of criminality made about police officers.
- Serious incidents involving the police, at the request of the Chief Constable or the Scottish Police Authority. These include the serious injury of a person in police custody, the death or serious injury of a person following contact with the police or the use of firearms by police officers.
- Allegations of misconduct by senior police officers of the rank of assistant chief constable and above, if requested by the Scottish Police Authority.
- Relevant police matters which the commissioner considers would be in the public interest.
- At the end of an investigation, the commissioner can recommend improvements to the way the police operate and deliver services to the public in Scotland.

Sudden Unexpected Death in Infancy (SUDI)

SUDI is the term used to describe sudden and unexpected death in infancy. A SUDI is deemed to have occurred where there is no known pre-existing condition which would make the death predictable.

Since the cause of death is not known, a death certificate cannot be issued and the death is not able to be registered. It is therefore routine practice that all SUDIs are reported to the Procurator Fiscal, on whose behalf the police will act. This practise is well established and the police will automatically be informed of the death by the Scottish Ambulance Service or Emergency Department. Investigations, which include a post-mortem examination may take several months. In some cases a cause of death may be found during post-mortem examination, but for many the post-mortem examination will not explain the death. The term SUDI may therefore be given as a classification of death on the death certificate, as the death is still unexplained. Healthcare Improvement Scotland will then notify the designated SUDI paediatrician in each NHS board when the Procurator Fiscal has authorised a review to proceed. Reviews are undertaken as per CEL21 (2013) using the SUDI toolkit process on all unexpected deaths up to 24 months. You will also find bereavement support links to support families on the SUDI toolkit.

A SUDI review is a multidisciplinary meeting held shortly after the final post-mortem examination report is available, which may be several months after the infant has died. The main participants may include a paediatrician, pathologist, GP, health visitor, community midwife, social worker and any other professional relevant to that particular SUDI. The purpose is to discuss all aspects of the death, including possible causes or contributing factors to see what lessons can be learned and to plan support for the family, particularly in identifying support needs for any future pregnancies.

Appendix 2: National bereavement programmes of work

Bereavement charter for Scotland

In April 2020 the first Bereavement charter for Scotland was launched. It contains 15 statements which describe what the best bereavement care and support should look like. Additional guidance is provided for the following groups and individuals:

- children and young people
- learning disabilities and degenerative neurological conditions
- pregnancy loss, stillbirth and neonatal death, and
- bereavement following suicide.

The charter and accompanying guidance attempts to describe what good bereavement support can look like and the difference it can make.

National bereavement care pathway (NBCP)

The vision of the National Bereavement Care Pathway (NBCP) is to increase the quality of bereavement care and reduce local and national inconsistencies so all bereaved women, partners and families in Scotland receive compassionate, person centred care.

The evidence-based pathways are designed to be used by all healthcare professionals and staff involved in the care of bereaved families.

Appendix 3: National organisations that may link or input to your review

Other organisations and agencies have a duty to investigate certain types of deaths. In many cases, the death will also be reported to the Crown Office and Procurator Fiscal Service (COPFS). Some organisations, such as the Care Inspectorate, are required to provide quality assurance on reviews carried out by organisations.

Adult Protection Committees

Adult Protection Committees (APCs) have a central role to play in taking an overview of adult protection activity in each council area and making recommendations to ensure that adult protection activity is effective. APCs have a range of duties, which include:

- reviewing adult protection practices
- improving co-operation
- improving skills and knowledge
- providing information and advice
- promoting good communication

Local Adult Protection Committees will carry out Significant Case Reviews (SCR) in circumstances where an adult has been abused or neglected resulting in serious harm or death.

Care Inspectorate

The Care Inspectorate is the independent scrutiny, assurance and improvement support body for social care and social work in Scotland. It regulates and inspects social care and social work services. It is a legal requirement that the death of a person using a care service is reported to the Care Inspectorate. Local authorities are also required to notify the Care Inspectorate of the death of a looked after child, the deaths of young people receiving aftercare provision and deaths of young people in continuing care.

The Care Inspectorate has a quality assurance role for reviewing the effectiveness of the processes for conducting a review of a death of looked after child carried out by local authorities. They provide feedback to Child Protection Committees on individual learning reviews to support continuous improvement. The Care Inspectorate also undertakes thematic reviews of deaths of looked after children and learning reviews completed in Scotland, reporting nationally on key learning for the benefit of national learning, policy and practice change.

Children's Hospices Across Scotland (CHAS)

CHAS offer a full family support service for babies, children and young people with life-shortening conditions. This includes palliative care, family respite and support – through hospices, homecare services and hospital presence. A child or young person may die while receiving care from CHAS or in their hospice premises. We would expect the child's usual resident, local NHS board or local authority to lead in the review of the death however CHAS should be fully involved in the process.

CHAS also has a research, advocacy and education role in informing improvements in children's palliative care to offer the highest levels of care and support.

Child Protection Committees Scotland

Child Protection Committees Scotland has a pivotal role to play, in conjunction with the Scottish Government and other partners in the protection of children across the country, by supporting the development and delivery of efficient and effective processes, common standards, and continuous improvement.

Local Child Protection Committees will carry out learning reviews into the death of a child or young person who have died or been significantly harmed within a child protection context. A learning review is a multi-agency process to support professional and organisational learning and to promote improvement in future inter-agency child protection practice. More information about undertaking learning reviews can be found on page 18.

COSLA

COSLA is a councillor-led, cross-party organisation who champions councils' vital work to secure the resources and powers they need. COSLA works on councils' behalf to focus on the challenges and opportunities they face, and to engage positively with governments and others on policy, funding and legislation.

Scotland's National Suicide Prevention Action Plan, *Every Life Matters*, contains 10 actions which together aim to reduce the suicide rate in Scotland by 20% by 2022 from the baseline level in 2017. Action 10 of the plan commits to the development of appropriate reviews into all suicide deaths and ensure the learning is shared with the National Suicide Prevention Leadership Group and partners and acted upon. COSLA has now begun to develop a model that will enable a multi-agency approach to reviewing deaths by suicide. This will gather information from health (including mental health, primary care and emergency departments), local authority (including social care, housing and criminal justice), Police Scotland, Scottish Ambulance Service, third sector and families and carers. This work will help provide a better, more timely understanding of the factors which may have contributed to an individual's suicide.

Crown Office and Procurator Fiscal Service

All sudden and unexpected deaths, including suicides must be reported to the Crown Office and Procurator Fiscal Service (COPFS) for investigation.

The Lord Advocate has the responsibility for investigating deaths that require further explanation. The Procurator Fiscal, acting on behalf of the Lord Advocate, receives reports of deaths in certain circumstances. Within COPFS, the Scottish Fatalities Investigation Unit is a specialist unit responsible for carrying out fatal accident inquiries (FAIs).

COPFS works closely with Police Scotland and the roles are complementary, and regular dialogue and co-operation enables problems and issues to be dealt with efficiently and effectively.

All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal. The Procurator Fiscal will instruct Police Scotland to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution.

The Procurator Fiscal in Scotland has an investigative role and can provide instructions and directions to the police in connection with their investigations. This happens particularly in serious cases, where the police work very closely with the Procurator Fiscal. In cases of sudden, suspicious and unexplained deaths, the Procurator Fiscal has responsibility during the early stages of the investigation to arrange a post mortem examination by forensic pathologists.

Healthcare Improvement Scotland

All NHS boards are required to notify Healthcare Improvement Scotland when a category 1[10] significant adverse event review (SAER) is commissioned. The national notification system will allow data to be collated and analysed centrally which will facilitate the recognition of trends and themes at a national level and to inform the planning of national improvement programmes and to support greater consistency in the management and review of the most serious adverse events that occur in healthcare services.

Healthcare Improvement Scotland's Learning from adverse events through reporting and review: A national framework for Scotland[11] focuses on sharing any learning that could inform service improvement and any learning that could inform organisations' adverse event management processes to improve the quality of care delivered.

Healthcare Improvement Scotland is also notified of suicides of people who have been in touch with mental health services 12 months prior to their death. Once the review has been carried out, a

[10] Category I – events that may have contributed to or resulted in permanent harm, for example unexpected death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity.

[11] Learning from adverse events through reporting and review: A national framework for Scotland. 2019. Healthcare Improvement Scotland. Viewed on 20 July 2020: www.healthcareimprovementscotland.org/learning_from_adverse_events/national_framework.aspx

learning summary should be submitted, which is published on the Suicide Review Community of Practice website.

Adverse Events Community of Practice

Healthcare Improvement Scotland hosts a community of practice website to support care providers to share learning for improvement following adverse events reviews.

Mental Welfare Commission

The Mental Welfare Commission for Scotland has statutory powers to carry out investigations when concerns are raised about the care or treatment of somebody with a mental illness, learning disability or related conditions.

From 1 January 2020, all deaths of people subject to mental health detention or a community based order under the 2003 Act of the Criminal Procedure (Scotland) Act and all homicides committed by people with recent contact with mental health services should be notified to the Mental Welfare Commission. This is to ensure complete and proportionate system of review for all deaths in detention, irrespective of the cause, in collaboration with other agencies.

Police Scotland

It is the responsibility of Police Scotland to investigate and report all deaths to COPFS that fall into the following categories:

- suspicious death - any death where the circumstances are unknown and give cause for concern (such as age of deceased, location, circumstances, intelligence, lifestyle)
- accidental deaths - including deaths resulting from falls and industrial accidents
- drug misuse
- incidents of suicide
- deaths occurring as a result of neglect or fault
- deaths in legal custody
- any death where the identity of the deceased is unknown and cannot be readily ascertained
- any death of a child or young person under 18 years, which is unexplained (or fits any of the other criteria mentioned), or
- any death as directed by COPFS.

A small proportion of deaths of children or young people are ‘expected or anticipated’ due to medical explanation or illness and are considered non-suspicious. However, even in circumstances where a child or young person has a life-limiting condition and their death is expected, the timing of that death cannot be clearly determined. Police Scotland may need to obtain more information on such deaths to inform the PF (if reportable), or make an assessment whether the death requires further investigation.

Deaths of children or young people that are 'unexplained or unascertained' cannot be categorised as non-suspicious. These deaths are likely to require a police investigation to establish a cause of death.

When a child or young person dies, Police Scotland will appoint a suitable trained child death senior investigating officer (SIO) who will:

- conduct a thorough and proper investigation
- provide an appropriate and proportionate response to the circumstances presented, ensuring the preservation and recovery of relevant evidence
- facilitate effective inter-agency information sharing and collaborative working, and
- ensure the safety and wellbeing of any other children or young people.

As part of any child death enquiry, the investigation team will make contact with the relevant local authority and NHS board, as part of normal information gathering. If the child or young person who has died had surviving siblings, then an Interagency Referral Discussion (IRD) will be held, as soon as reasonably practicable, to facilitate sharing of information, risk assessment and decision making around the needs of the surviving siblings.

Appendix 4: Other available guidance

Resource	Source viewed at 28 July 2020
Adult Protection Committee guidance	https://www.gov.scot/publications/interim-national-framework-adult-protection-committees-conducting-significant-case-review/pages/16/
Adverse Events Community of Practice: NHS boards tools, templates and guidance including learning summaries	http://www.knowledge.scot.nhs.uk/adverse-events/nhs-board-tools-templates-and-guidance.aspx
Healthcare Improvement Scotland Being Open Guidance 2015	http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/being_open_guidance.aspx
NHS Lothian's Being Open pack	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4067101/Being%20Open%20Test%20Pack.docx
SPSO How to Make a Good Apology	https://www.spso.org.uk/sites/spso/files/communications_material/2018%20SPSO%20Apology%20Guidance.pdf
Effective Communication about Adverse Events in Maternity Units	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084759/c70766d7-2524-4fb3-8e98-4fb9642e3220.pdf
Significant adverse event reviews: Information for staff	http://www.knowledge.scot.nhs.uk/adverse-events/adverse-events-toolkit.aspx
Who should participate in a suicide review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084792/2c40793d-031f-4693-84f0-7ae1e6b86eee.pdf
Areas to consider in your review reports (SRLS)	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084840/9d0dcb73-7eca-427a-a19f-4fa0d96fe954.pdf
Expectations of a suicide review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084838/50bfdbec-e377-4791-9edb-682c44f43f2b.pdf
Gathering and analysing information from a review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084795/5408f9ce-55bf-4f6c-b790-82f40858d5d3.pdf
How to chair an effective review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084796/5e689e60-9199-46af-a46f-3cfa034f433b.pdf

Participating in a review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084797/bfa98c14-7030-4265-922a-249f1cfe838c.pdf
Recommendations for action	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084798/8f919ca1-9b76-4ab6-af9a-e67c6f083490.pdf
SMARTER Recommendations	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084839/13371ca7-c84c-43e1-adb9-eee9b83687aa.pdf
From plan, to change, to improvement	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084803/6f279e4e-4ac8-4108-962b-d45e45cf3eb3.pdf
Turning recommendations into improvements	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084799/b8023561-402c-4cf8-b893-1d7e88224ab0.pdf
Making it safe to learn	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084802/98416921-8566-4ade-a411-47e24fa5eb0c.pdf
Making sure family members and carers are involved in the suicide review	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4084801/3123d32b-f2b3-461e-9535-506165e71a8c.pdf
Guiding principles for sharing information from adverse event reviews	http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058634/20150113%20Guiding%20Principles%20for%20Sharing%20Information%20from%20Adverse%20Event%20Reviews.pdf
Safety Checklist - Questions everyone should ask about safety	https://www.gov.scot/publications/safety-checklist-questions-everyone-ask-safety/pages/3/
NHS England – engaging with bereaved families	https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/
NHS England – learning from death template policy	https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-data-collection-and-reporting
Scottish Government's Thematic Review of Fatal Accident Inquiries	https://www.gov.scot/publications/thematic-review-fatal-accident-inquiries/
Learning reviews guidance	When available

APPENDIX 2

Review of Deaths of Children and Young People
Short Life Working Group
Terms of Reference

1. Background

1.1 The Scottish Government have requested that a national system is established for the reviewing and learning from the deaths of children and young people. The aim is to create a National Hub to review and coordinate national activity.

1.2 The National Hub which will sit within Health Improvement Scotland stipulates that every death of a child or young person should be reviewed to an agreed standard using a national data set.

1.3 Reviews should be conducted on the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death.

1.4 Boards across Scotland are requested to develop local infrastructures which align to the National Hub standards in order to allow for effective learning at a national level.

2. Purpose

2.1 The group will:

- Define a process and infrastructure to deliver the national standards; which will build on existing processes for death review
- Develop an implementation plan to establish local processes
- Ensure that all clinical and information governance aspects of the implementation plan are considered and addressed
- Oversee the delivery of the implementation plan to ensure that necessary processes are in place by 1st October 2021

2.2 The in developing the delivery plan the group will ensure that:

- appropriate resource and infrastructure is implemented to align to the national standards, the local process must outline all stages of the review process from notification of death to sharing the learning locally and nationally
- an inter-agency approach is implemented
- effective local systems are identified for the sharing of learning

3. Membership

3.1 The group will be chaired by the Heather Bett (Senior Manager for Children's Services). Members include:

Name	Designation
Dr John Morrice	Associate Medical Director for Women and Children
Pauline Cumming	Risk Manager
Gemma Couser	Head of Quality and Clinical Governance
Christine Moir	Senior Manager for Education, Fife Council
Lynette MacKenzie	Clinical Nurse Manager, Paediatrics
Anne MacKinnon	Quality Improvement Midwife
Scott Davidson	(title) Police Scotland
Tanya Lonergan	Head of Nursing, Fife Wide
Lee Cowie	Service Manager, CAMHS
Dr Anthony Tasker	Clinical Lead, Paediatrics
Elizabeth Muir	Clinical Effectiveness Manager
Stephen McNamee	Programme Manager
Andrew Henry-Gray	Project Support Officer
Cathy Gilvear	HSCP Quality and Clinical Governance Lead
Nicola Harkins	GIRFEC Lead/Service Manager Community Child Health
Gary Ogilvie	Superintendent, Police Scotland
Lynne Holloway	Service manager, W&C

3.1.1 Members of the group are:

- permitted to send a deputy
- responsible for ensuring that discussions and progress of the group are shared and considered within their respective areas
    -

3.1.2 Members of the group also commit to conduct business in accordance with NHS Fife's organisational values.

4. Meetings

4.1 Meetings will be held fortnightly via MS Teams.

4.2 The frequency of the meeting will be reviewed as implementation of the new process is established.

4.3 There will be a requirement for the group to continue to meet for a period of time after implementation to evaluate and monitor the changes.

5. Reporting

5.1 The group will report into NHS Fife Clinical Governance Oversight Group and if required to the Executive Directors Group.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**21 October 2021**
Title:	**Volunteering Annual Report 2020/21**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report author	**Nicola Robertson, Associate Director of Nursing**

1 Purpose

The purpose of this paper is to introduce the first NHS Fife Annual Volunteering Report to the Committee.

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to a:

- Government policy/directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

This report covers the period from April 2020 to March 2021 and provides a flavour of work undertaken during this time and describes plans as the service moves forward.

2.2 Background

NHS Fife recognises the invaluable work of our volunteers. The huge commitment and dedication to our NHS, patients and public alike, are experienced every day by the work that our volunteers do in their various roles across all our sites and in each service.

NHS Fife volunteers come from various backgrounds and from across the whole of Fife.

Volunteering also offers the volunteer a new challenge, a new focus for those retired or who have an experience to share and offer others in similar situations.

2.3 Assessment

Over the last 18 months it has been a challenging time for our volunteering services; balancing the benefit to our hospitals with the risk and considering the expectations of our volunteers.

Volunteering services and our volunteer managers have worked hard to keep volunteers engaged, informed and supported throughout. As we gradually are able to remobilise our volunteers, our Volunteer Managers are redefining roles, opportunities and managing risks so our volunteers are able to return. Many of our volunteers are ready and willing to return. We wait with eagerness for a time when our volunteers can come back to working with us.

2.3.1 Quality/ Patient Care

Our volunteers want to make a difference to the recovery and care of everyone using health services and, as such, volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day.

2.3.2 Workforce

A new line management structure for our Volunteer Managers / Leads being agreed has been established, which resulted in alignment under the management of the Head of Person Centred Care and co-hosting this new service within Patient Relations.

The team consists of three Volunteer Managers / Leads (2.8 WTE) supported by an administrative assistant (0.48 WTE). The managers report directly to the Head of Person-Centred Care.

Pre-Pandemic, NHS Fife had an over approximately 250 volunteers engaged in a range of volunteering activity across NHS Fife.

Our volunteers are supportive and find a shared purpose in their new relationships with each other as well as being able to learn new skills. Volunteers bring as much to our services as it can do to the volunteers' lives. NHS Fife is keen to explore and build on these positive achievements by working with local communities to support their return to work, personal development and community development. These new areas of focus will develop over the next 12 months.

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

Unfortunately, Covid -19 resulted in all our volunteers being stepped down from their roles. This was due to the risks associated for our volunteers, mainly for age and health reasons. NHS Fife did not utilise any volunteer capacity to assist, in person, during the pandemic as a result of the possible risks.

2.3.5 Equality and Diversity, including health inequalities

Volunteers are welcomed from all walks of life and plans have been put in place to encourage young people to volunteer with NHS Fife through the Duke of Edinburgh Award Scheme. NHS Fife Volunteering Services are now a registered approved activity provider for volunteering with the Duke of Edinburgh Award. This allows young people working towards their award to undertake the volunteering element of this with NHS Fife and for our volunteering opportunities to be displayed and promoted via their website.

Unfortunately, Covid 19 has delayed our plans for implementing the Duke of Edinburgh Award within NHS Fife but we are hopeful that we can deliver this programme in the near future. We look forward to engaging with many young volunteers, assisting them achieve their DofE award.

2.3.6 Other impact

Positive community engagement

2.3.7 Communication, involvement, engagement and consultation

NHS Fife Volunteer Managers / Leads have kept in touch with the volunteers, provided support and continued to keep them engaged with us, in the anticipation that things would be able to return in the near future and they would once again be able to volunteer with NHS Fife.

2.3.8 Route to the Meeting

Update from Patient Relations Team
EDG 21.10.2021

2.4 Recommendation

The Committee is asked to endorse the Annual report.

NHS Fife

Volunteering Annual Report

2020-2021

Foreword

NHS Fife recognises the invaluable work of our volunteers. The huge commitment and dedication to our NHS, patients and public alike are experienced every day by the work that our volunteers do in their various roles across all our sites and in each service.

NHS Fife volunteers come from various backgrounds and from across the whole of Fife. Our volunteers want to make a difference to the recovery and care of everyone using health services and, as such, volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day.

Volunteering also offers the volunteer a new challenge, a new focus for those retired or who have an experience to share and offer others in similar situations. Our volunteers are supportive and find a shared purpose in their new relationships with each other as well as being able to learn new skills. Volunteers brings as much to our services as it can do to the volunteers' lives. NHS Fife is keen to explore and build on these positive achievements by working with local communities to support their return to work, personal development and community development. This new areas of focus will develop over the next 12 months.

However, over the last 18 months it has been a challenging time for our volunteering services; balancing the benefit to our hospitals with the risk, and also the expectations of our volunteers. Volunteering services and our volunteer managers have worked hard to keep volunteers engaged, informed and supported throughout. As we gradually are able to remobilise our volunteers, our Volunteer Managers are redefining roles, opportunities and managing risks so our volunteers are able to return. Many of our volunteers are ready and willing to return. We wait with eagerness for a time when our volunteers are able to come back to working with us.

We cannot emphasise enough the value of their commitment and contribution to NHS Fife.

Nicola Robertson
Associate Director of Nursing

Introduction and Summary

This is an Annual Report for volunteering which covers the financial period 1 April 2020 to 31 March 2021 and details the volunteering activity during this period.

During the months between April 2020 and March 2021, NHS Fife made much progress in our Volunteering Service and management of this service. This included a new line management structure for our Volunteer Managers / Leads being agreed, which resulted in alignment under the management of the Head of Person Centred Care and co-hosting this new service within Patient Relations.

NHS Fife, our volunteers and Volunteer Managers / Leads have seen many benefits from this new arrangement including:

- Increased team working and support for Volunteer Managers / Leads
- Improved governance and reporting
- Central management of volunteering including recruitment, risk management and development
- Volunteer Policy
- Volunteer Procedures
- Central budget and
- Opportunities to celebrate and advance partnerships with our volunteers and our local voluntary organisations.

Forming this new Volunteer Service and co locating our Volunteer Managers / Leads has been of great advantage to the organisation during this time.

Unfortunately, Covid -19 resulted in all our volunteers being stepped down from their roles. This was due to the risks associated for our volunteers, mainly for age and health reasons. NHS Fife did not utilise any volunteer capacity to assist during the pandemic as a result of the possible risks.

Volunteers were however, involved in a number of ad hoc projects, which did not require direct contact with patients. The projects which were supported by our volunteers included those which provided support to patients and staff. These included the preparation of patient care packages and staff wellbeing packs. These projects provided essential toiletry and personal care items delivered to over 60 wards across all hospitals and over 7000 staff wellbeing bags distributed to all NHS Fife staff. Some volunteering activity moved to an online format, with those previously involved in face to face support groups as patient experts, taking part via MS Teams.

Pre-Pandemic, NHS Fife had an over approximately 250 volunteers engaged in a range of volunteering activity across NHS Fife.

NHS Fife Volunteer Managers / Leads have ensured we kept in touch with them, provided support and continued to keep them engaged with us, in the anticipation that things would be able to return in the near future and they would once again be able to volunteer with NHS Fife.

This report details NHS Fife’s volunteering activity during the Pandemic.

Assurance and Governance

NHS Fife Volunteering Service have worked closely throughout the Pandemic with a range of local, national organisations and partners.

Healthcare Improvement Scotland – Volunteering Programme supports our local developments and supports us with a range of policy and service developments including the national Volunteer Information System (VIS). The Volunteering Programme has produced regular publications and tools for health boards to reflect the changing landscape and engage with volunteers in a safe way, including extensive remobilisation guidance.

Recent publications which have supported the management of volunteers returning post Pandemic to our departments include; *Remobilisation of volunteering in NHSScotland COVID-19 Shared practice and guidance for volunteer management in NHSScotland Published: 04 May 2021 and Updated: 12 August 2021*

NHS Fife hosts a Volunteer Management Team meeting and a Volunteer Development Group, which includes partners from local organisations and representatives from local voluntary services.

Volunteering is reported via Clinical Governance

An Annual Report will be produced each year, this report being the first publication for NHS Fife covering all volunteering developments.

Staff that Support Volunteering Services

As a result of bringing together our Volunteer Managers / Leads, which were previously managed within different settings, we now have a ‘team’. Prior to the pandemic each volunteer manager/lead was managed separately via clinical divisions; all manager/leads are now managed centrally for the first time as a team within the Person Centred Care portfolio. This structural change has provided greater strategic focus and support for the Volunteer Service.

The team, consists of three Volunteer Managers/Leads in post (2.8 WTE) supported by an administrative assistant (0.48 WTE). The managers report directly to the Head of Person-Centred Care.

Voluntary organisations

There are many voluntary organisations either commissioned or involved in NHS Fife delivery, which recruit and manage volunteers within their own internal voluntary agency processes, such as RVS. These organisations are supported by a document called the ‘Clear Pathway Evaluation’. This document was released in 2020 and was precluded by a letter from the Chief Medical Officer in 2018. The report recommended that we have clear agreements with voluntary organisations and encourage strategic

development, joint learning and collaboration. The agreements can take the form of a memo of understanding or a more formal contract.

The guidance supports us to work with and provide governance and assurance to NHS Fife and our patients that our voluntary organisations provide the same patient safety, person centred care and effective care in line with our core principles as set out in our national quality ambitions.

Investing in Volunteers Awards

As with many NHS Health Boards, NHS Fife have not sought to renew our Investing in Volunteers Standard which expired July 2021, and are exploring the refreshed Volunteer Friendly Award. This was redeveloped in 2021 by Volunteer Scotland and the Third Sector Interface (TSI) Scotland Network.

Training and Development of Volunteers

All volunteers must complete a comprehensive range of training, which had previously been provided in a face-to-face method however; as a result of the Pandemic we now offer all training online for our volunteers.

NHS Scotland also provides a bespoke volunteering module and extensive additional modules in relation to infection control and prevention materials. Healthcare Improvement Scotland – Volunteering Programme is scoping more opportunities for “once for all” training specifically for volunteers.

Our volunteers also receive a comprehensive induction pack and welcome to NHS Fife.

Celebrating Volunteering; stories from our volunteers

In December 2020, we successfully, although sadly, posthumously, nominated Helen Hagan for the Volunteers Award category at the 2020 Scottish Health Awards in association with the Scottish Government and Daily Record. The nomination reached the finalist stage and Helen's family were able to join a virtual ceremony and see their mother's years of dedicated volunteering within the Children's Ward at Victoria Hospital recognised and celebrated at a national level.

Thank you to Helen's family who were able to join us in honouring her commitment to volunteering and at the same time taking receipt of a specially engraved heart shaped plaque.

Young People and Volunteering

NHS Fife Volunteering Services are now a registered approved activity provider for volunteering with the Duke of Edinburgh Award. This allows young people working towards their award to undertake the volunteering element of this with us and for our volunteering opportunities to be displayed and promoted via their website.

Unfortunately Covid 19 has delayed our plans for implementing the Duke of Edinburgh Award within NHS Fife but we are hopeful that we can deliver this programme in the near future. We look forward to engaging with many young volunteers, assisting them achieve their DofE award.

These children's murals were created by Meg Reid and Michelle Innes.

Therapets

Prior to the pandemic therapets were visiting in a number of ward areas, including the children's ward and orthopaedic trauma ward. At present their return is uncertain; however the benefit this brought to patients was widely recognised and welcomed by ward staff and patients, especially children. Staff reported children being very excited anticipating the pets visit to the ward.

Meet and Greet Volunteers

Our Meet and Greet volunteers were the first volunteer group to return throughout the pandemic in summer 2020, with a number of existing and new volunteers supporting staff at both Phase 3, Victoria Hospital, Kirkcaldy and Phase 2, Queen Margaret Hospital, Dunfermline. Their presence has been subject to changes with local and national prevalence and lockdowns and resulted in another step down from the role by our volunteers however, the volunteers are keen to return and pick up where they left off, welcoming our patients and visitors to our health settings and sign posting them to their destination.

Volunteers and NHS Fife Community Listening Service

The 21-strong team of community listening volunteers provide spiritual and emotional support to patients in 20 GP surgeries across Fife, as well as patients referred by Macmillan Cancer Support. However, during the pandemic, when they could no longer carry out face-to-face work in surgeries, they offered a telephone listening service to vulnerable patients who needed someone to talk to as they dealt with health issues and isolation. The move to a telephone based service was made possible by a donation from Fife Health Charity.

It has also been a lonely time for cancer patients as some support services in the community have not been available. The telephone support has been a great help to them. Each volunteer offers two or three hours per week. During this year, they have made around 2500 phone calls of up to 45 minutes each, listening to stories of suffering while working from home and struggling with their own isolation during the pandemic. Despite the demands on their own emotional health and wellbeing, the volunteers continued to offer the service with empathy and skill, encouraging those in need.

Lynda Wright who established the service both nationally and within NHS Fife recently retired and the Department of Spiritual Care is reviewing how this service can be developed.

Public Partners as Volunteers

There has been an effort to align public partners with the volunteering agenda. We anticipate this will provide access to a wider representation of the public, improve our accountability and ability to monitor public involvement and also to allow us to increase support to the public member and value their contribution.

Volunteering services have been working alongside, and as part of, the Participation and Engagement Advisory Group, to recruit and support public partner volunteers and provide support to the individual and services engaging together.

A Public Partner Volunteer (PPV) is usually recruited for a specific purpose such as being involved as part of a new service or a redesign of an existing service or for example being part of our new capital project, to create a regional elective orthopaedic centre. The public volunteer will usually give a public perspective on topics discussed at meetings held, given the opportunity to take part in discussions and their opinions and input should be considered just as important as any other member of the group.

However, the PPV role and support given by the volunteering service does not aim to replace or reduce the limit of public involvement work going on out with our volunteering service. Therefore, simply having a PPV on your group does not replace meaningful engagement, participation or involvement.

April 2020- March 2021

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Complaints Report**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report author	**Elizabeth Gray, Complaints Manager**

1 Purpose

The purpose of this paper is to provide an update on complaints management.

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to a:

- Emerging issue
- Government policy/directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Complaints performance is reported on a monthly basis through the Fife Integrated Performance and Quality Report. The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 65%)

Concern has been raised about the level of performance and a review is underway to improve the complaint handling performance in line with national standards, and to provide more meaningful data to the Committee. The review will consider the current process, and the quality measures that are currently reported.

2.2 Background

Complaints response activity was paused during 2020 because of the focused response required by the COVID-19 pandemic. This led to a backlog of complaints which has taken some time to work through.
A further decision was taken to pause some complaints activity in September 2021 as activity and staffing pressures were escalating.

The table below provides information on stage 1 and stage 2 complaints.

STAGE 1	2020 Jun	2020 Jul	2020 Aug	2020 Sep	2020 Oct	2020 Nov	2020 Dec	2021 Jan	2021 Feb	2021 Mar	2021 Apr	2021 May	2021 Jun	2021 Jul
Closed Complaint	24	41	44	52	95	45	28	27	31	44	47	54	42	
% closed within timescale	**70.8**	**65.9**	**86.4**	**69.2**	**87.4**	**71.1**	**82.1**	**88.9**	**93.5**	**79.5**	**70.2**	**79.6**	**73.8**	**72.8**

STAGE 2	2020 Jun	2020 Jul	2020 Aug	2020 Sep	2020 Oct	2020 Nov	2020 Dec	2021 Jan	2021 Feb	2021 Mar	2021 Apr	2021 May	2021 Jun	2021 Jul
Closed Complaint	39	34	24	22	29	31	37	15	21	40	35	46	44	32
% closed within timescales	**20.5**	**41.2**	**54.2**	**40.9**	**20.7**	**32.3**	**24.3**	**46.7**	**28.6**	**15.0**	**22.9**	**32.6**	**27.3**	**32.09**

However, it is recognised that reporting on the 'percentage of complaints closed within timescales' does not provide a full picture of patient experience and feedback.

2.3 Assessment

A dashboard, which captures the Model Complaints Handling Process indicators, is being developed. The complaints module in DATIX is being adapted to provide data on communication points with complainants.

A weekly Stage 2 Complaints update is submitted to Directors, General Managers, Service Managers, Associated directors of Nursing and Heads of Nursing. This report provides detail for each Division / Directorate on number of outstanding complaint responses.

A summary of the number of complaints and response times are provided in the tables below:

WEEKLY REPORT 27.09.21	<15 days	15 – 20 days	>20 days
Emergency Care	6	0	13
Planned Care	9	1	14
W&C	3	1	6
East Division	2	0	1
West Division	4	0	5
Fife Wide	5	0	12

WEEKLY REPORT 16.08.21	<15 days	15 – 20 days	>20 days
Emergency Care	8	2	6
Planned Care	5	4	9
W&C	3	1	5
East Division	0	0	3
West Division	2	0	5
Fife Wide	3	1	11

TOTAL	**29**	**2**	**51**		**TOTAL**	**21**	**8**	**39**

2.3.1 Quality/ Patient Care

QUALITY IMPROVEMENT

A further decision was taken to pause some complaints activity in September 2021 as activity and staffing pressures were escalating.

The Patient Relations team will continue to accept and acknowledge feedback and complaints and share these with the relevant clinical services, however, it may take longer than the national timescales to review and investigate matters.

The clinical services, despite the immense pressure they are under just now, have expressed their commitment to address and respond to complaints. However, it is recognised that the review and investigation of complaints by the clinical teams will be delayed. The patient relations team will continue to manage the communication with complainants around these delays. There are, of course, also complaints that by nature / complexity will be investigated in a timely manner.

The communications received from the SPSO and SG in March and May last year were helpful in recognising the difficulties and pressures, and acknowledgment letters have been tailored to manage complainants' expectations.

Extensions to timelines are being captured on Datix and in line with the National Complaint Handling guidelines, keeping complainants informed of this as per the SPSO advice.

Following correspondence with the SPSO, a meeting has been arranged with NHS Fife Chief Executive, Director of Nursing, and Patient Relations Manager on 7 October 2021.

Work continues with the Organisational Learning Group to report on themes, lessons learned and outcomes.

The Complaints Annual Report, which provides information based on the Model Complaints Handling Process and is submitted to SG is appended to this report.

PATIENT FEEDBACK

Compliments

'Compliments', another vital component of patient feedback, is not routinely reported on. There is a 'compliments' section in the Datix Complaints module which is not widely used and the following table only provides a small glimpse of positive patient feedback.

Summary of Compliments recorded on Datix

Compliments recorded in Datix by Organisation level - 2021	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Total
Emergency Care & Medicine	1	0	0	1	9	2	1	1	0	15
Planned Care & Surgery	2	9	20	15	17	8	20	17	25	133
W&C&CS	2	0	1	1	1	0	1	1	4	11
Community Services (West)	2	6	4	6	22	4	10	7	6	67
Community Services (Fife-Wide)	1	5	10	9	5	3	5	14	7	59
Community Services (East)	0	1	5	2	9	5	6	2	4	34
Corporate Directorates	1	1	4	1	2	6	2	0	3	20
No value	5	10	5	4	12	2	6	0	0	44
Total	14	32	49	39	77	30	51	42	49	383

Comments

To all the wonderful staff in ward 10, so attentive, professional, patient and empathetic.
Thank you all very much for looking after me so well. God bless you all with health, wealth and happiness and hopefully an early retirement. Your quality of care is second to none and the dedication is much appreciated. You are all gems
To all the staff at the Hospice: a month ago my mum was in your care very briefly. The beauty of her surroundings and the love and care of your staff made her passing as beautiful and as peaceful as it could be. Your tenderness and love down to the details of brushing her hair. And that love extended to myself, my brother and his partner. Finding us all recliner chairs, toothbrushes and numerous cops of tea and toast. Your gardens are beautiful. My mum loved her garden and to be in yours made leaving her own easier. Once she arrived with you she was ready to go. Thank you. Enclosed

is a cheque which cannot quantify what you do but hopefully it will help you to be able to continue offering this love at end of life to many more people. Thank you from my mum, my sons and myself.

2.3.2 Workforce

Workforce planning
The Patient Relations Team establishment is under review, examining workload and workforce planning. The team consists of a Band 7 team leader; 3.4WTE Band 6 Patient Relations Officers; 1.8 WTE Band 4 Patient Relations Support Officers; 2WTE Band 3 Administrators.

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk.

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

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Relations Team

2.4 Recommendation

The Committee is asked to support the direction of travel indicated in the report:

- To continue with quality improvement work, streamlining and enhancing processes
- To provide more meaningful data that considers patient feedback and experience
- To provide analysis and learning from themes and trends; progressing with the Organisational Learning Group

Report Contact

Author Name Lizzie Gray
Author's Complaints Manager
Email: lizzie.gray@nhs.scot

APPENDIX 1

NHS FIFE

Annual Report on Feedback and Complaints 2020/21

NHS Fife understands and values the importance of gathering patient, families and carer feedback to support a culture of listening and learning. We are committed to enhancing patient and staff experience by using feedback to identify change and make improvement to the delivery of our services.

We continue to use a range of methods to obtain feedback and are encouraged by the high level of positive feedback we continue to receive. A new Care Experience Improvement Model was developed to ensure a continual cycle of feedback and improvement across services. Unfortunately, due to the impact of the Covid-19 pandemic, this piece of work has not progressed as we would have liked and will be revisited in 2022.

The use of Care Opinion continues to grow and NHS Fife is proud to have one of the highest response rates in Scotland. A large number of frontline staff respond to stories and there is evidence that the many positive stories have boosted moral and confidence among our teams.

Our revised model for community engagement enhances our commitment to involving the public in the co design and production of our services and we continue to focus on engaging with the right people at the right time.

We continue to face challenges in responding to complaints in a timely manner. With the Covid-19 pandemic, the last 12 months have been exceptionally challenging for all and have taken their toll on the wider workforce. Clinical services have had to focus their efforts on responding to the pandemic and delivering safe, effective and person centred care, which has resulted in delays in responding to complaints within the national timeframes. We have seen an increase in the complexity of complaints and have managed several complaints and enquiries in relation to delay in treatment as a result of the pandemic. We have also been inundated with calls, complaints and enquiries in relation to the Flu and Covid-19 vaccination programmes.

This being said, we are committed to delivering a quality feedback and complaints service to the public. We will continue to work collectively with the public, our health and social care services, the SPSO, Scottish Government and all Third Party Sectors to ensure this happens as we work towards recovery.

In presenting the 2020/21 Annual Report I would like to extend my grateful thanks to every person who has taken the time to provide us with feedback and to every staff member who has responded to it. I would also like to extend my thanks to those who have supported this work, including; Patients, Carers, Volunteers, Public Partners, Staff, Patient Relations, Care Opinion and Third Sector Partners, which includes

Advocacy providers, Health Improvement Scotland Community Engagement Team, Scottish Government, Patient Advice and Support Service and the wider community.

Janette Owens
Director of Nursing

INDICATOR 1: LEARNING FROM COMPLAINTS

INDICATOR 2: COMPLAINT PROCESS EXPERIENCE

SECTION 3: COMPLAINTS PERFORMANCE

SECTION 4: ACCOUNTABILITY AND GOVERNANCE

Indicator 1: Learning from Complaints

NHS Fife values complaints alongside all other forms of feedback. Our staff actively welcome and encourage patients, carers, service users and members of the public to let us know what we do well and what we can do better, in order that we can share good practice and make improvements to maintain the quality and safety of the care we deliver.

A range of promotional materials are on display in wards, departments, units to promote the Board's desire to receive feedback. We have used every opportunity as part of our wider Participation and Engagement activities to encourage people to tell us what they think about our services. When attending community groups about other aspects of business we have taken the opportunity to deliver the message that NHS Fife welcomes all forms of feedback and are committed to improving and learning as a result.

NHS Fife provides British Sign Language (BSL) interpreting for all BSL speaking patients. We achieve this by providing a face to face BSL interpreter or an online video relay interpreting service, provided via ipads and Interpreter on Wheels devices.

NHS Fife works closely with BSL speakers and is a leading organisation facilitating and supporting the local Deaf Action Plan, Deaf Forum which guides our health-related activity and our delivery of the local BSL action plan.

In 2020/21 NHS Fife received 481 Stage 1 complaints and 334 Stage 2 complaints. Below is an example of feedback received and the learning and change that has occurred as a result.

Acute Services Division (ASD)

A patient receiving a cancer diagnosis was prescribed a new medication to treat this while awaiting further investigations. The patient felt overwhelmed with their diagnosis and that the medication had not been fully explained to them. No information had been shared with them about the medication.

Following the complaint, apologies were given to the patient that they had not received any information to explain the new medication, and for any upset or worry this had caused. The service developed a new patient information pack which will be given to all newly diagnosed patients, which provides all relevant patient leaflets and information to support them with their diagnosis and new medication. This was a successful outcome and an example where a complaint has lead to positive change for future patients and service users.

Shared learning from complaints continues across the Boards. We explore every opportunity to discuss the learning and share stories via our internal mechanisms to improve services and patient care. Discussions are taking place about how we review, improve and capture learning from complaints and adverse events.

Care Opinion

We continue to promote care opinion across the Board. There has been a significant increase in the number of responders at local level with department managers and senior charge nurses embracing the opportunity to responding to stories about their service.

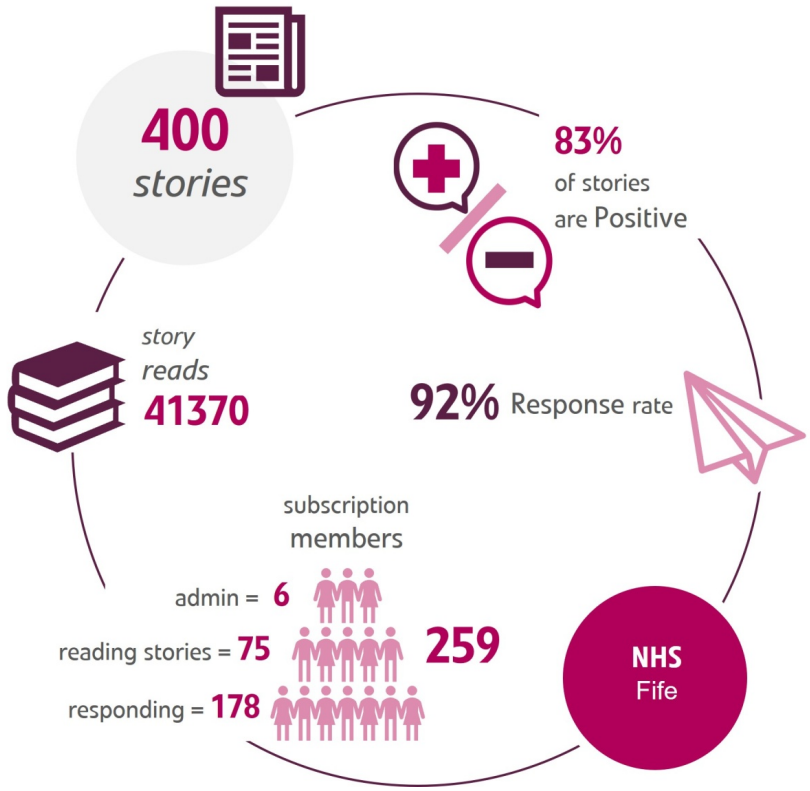
A large percentage of our stories are positive in relation to staff and care, however, we are aware of the stories where improvement is required. While we continue to address the concerns raised, we continue to monitor the information closely and compare with our complaints data.

During the pandemic, we have seen an increase in Care Opinion posts in relation to patient visiting as a result of the restrictions. This was to be expected, however, it is encouraging to note that any concerns raised have been dealt with quickly at service level to ensure patient centred visiting has been accommodated in accordance with the Scottish Government guidance.

The following demonstrates that we have achieved what we set out to do and more:

- 17% decrease in stories posted; 386 stories compared to 455 stories posted in the previous year. The decrease in stories posted is due to Covid-19
- 371 of stories responded to; 246 (66%) within 5 days compared to 431 (73%) in previous year
- 87% of stories posted were non-critical (79% in previous year)
- 2 stories led to a change being made
- 73% increase in the number of responders

The below graphic shows the Care Opinion activity across NHS Fife during 2020/21:

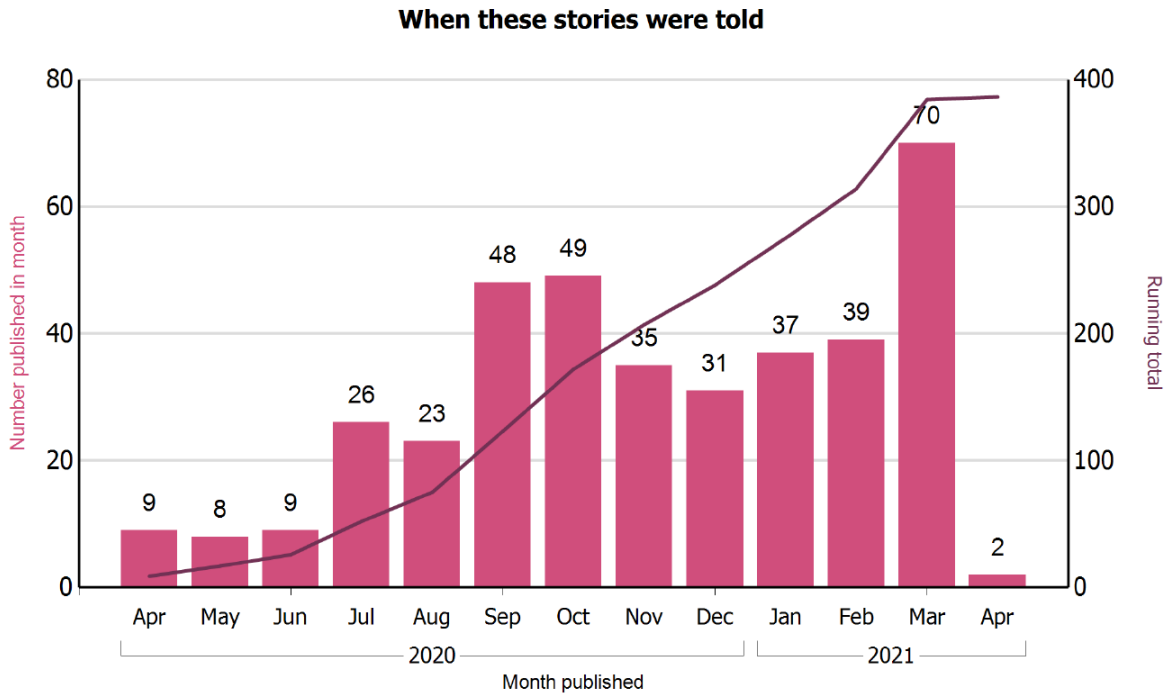


As previously advised, a large number of frontline staff respond to stories. Care Opinion provides the opportunity for staff reflection and learning in the moment. Below

is a quote from a member of NHS Fife staff which evidences their experience of Care Opinion:

"It's a real honour when a patient, or their carer, takes their own time to provide us with feedback about our service. We all get a real 'buzz' if we are mentioned personally. Whether the feedback is positive or constructive, it can help us shape our service delivery in a way that is patient centred. We are thrilled if we can make a change, however small, that enhances our patient experience when using our service. "

The graph below shows the distribution of stories received. There was a decrease in the number of stories received in April, May and June 2020 however; this will be directly linked to a reduction in the delivery of services as a result of Covid-19.



The graphic "Tag Bubbles", accessed via https://www.careopinion.org.uk/vis/6w56z, highlights themes extracted from individual stories posted on Care Opinion. Green indicates positive opinions with pink identifying areas for improvement. Specific examples are:

- Staff: 170 positive opinions
- Care: 114 positive opinions / 6 negative opinions
- Communication: 26 positive opinions / 14 negative opinions
- Staff Attitude: 10 positive opinions / 3 negative opinions
- Friendly: 67 positive opinions

Indicator 2 - Complaint Process Experience

NHS Fife is committed to ensuring all complainants have a positive experience when making a complaint. Last year we undertook a public engagement exercise to seek public opinion on how easy it is to find information on making a complaint or to make a complaint using our website. This included individuals from hard to reach groups. This feedback was used to further develop the website and the new website went live in September 2020.

When processing complaints we believe it is important to find out what matters to the person raising the complaint and to determine from the outset what it is they would like to achieve as a result of the complaints process. To do this we speak to people to ensure that no assumptions are made and to make sure that people understand and feel able and have access to support to be involved in the complaints process. The Patient Relations Team in NHS Fife supports this by establishing contact on receipt of a complaint.

To enhance people's experience and to ensure the Patient Relations Team has all the relevant information necessary to process a complaint, a new electronic feedback and complaint form was developed with the support from other services to ensure the form is fit for purpose, accessible to users and complies with relevant guidance and regulations. The feedback and complaints form is now available to the public through a link on our new website and can also be provided to members of the public contacting the Patient Relations Team directly.

In order to reflect and make improvements in the complaint process it is important we gather feedback from complainants however, this has been challenging. We have tested a number of methods to obtain feedback with poor results. Our feedback forms were often returned only when the complainant was dissatisfied with the complaint outcome and so we ceased to use these. The feedback and complaint form contains an 'opt in' feedback section, and the plan was to obtain feedback each month by contacting a random selection of complainants who have opted in. However, as a result of the Covid-19 pandemic, the collation of feedback has ceased and not progressed as we had planned. This has been as a result of the pressures on all services in our response to the pandemic.

We understand the importance of collating feedback on the complaint process and that not all complaints are submitted electronically. We need to consider additional ways of capturing feedback and as services remobilise, this is something we will revisit when there is capacity to do so, to ensure we are capturing this valuable feedback.

As part the overall quality assurance checks, the Patient Relations Team undertake a monthly review of closed complaints. This focuses on compliance with the national complaints procedure. Any learning or areas for improvement are shared with the team and individual officers.

The Patient Relations Team also carries out in house quality assurance checks, which involves the review of complaint responses in the moment. This ensures the response adheres to the Scottish Public Services Ombudsman Framework guidelines on what a quality response should look like. It also identifies any areas of learning or themes within the clinical service area, which allows feedback to be provided in the moment.

Indicator 3 – Staff Awareness and Training

To support the ongoing development of a person centred culture the Board supported more staff to undertake training in relation to adopting a personal outcomes approach. Good conversations training is available for all staff across the organisations to support staff in their conversations with patients/carers and families at local level.

The Patient Relations Team continually develops their own skills in relation to listening and communicating to ensure an efficient and effective service is delivered. The Patient Relation Officers also participate in supervision and reflective based learning.

The Patient Relations and Clinical Governance Teams had previously aligned common elements of work and were delivering joint induction training for staff which covers safe, effective and person centred care. However, this was reviewed following feedback from both Teams. The outcome was that each Team would deliver separate presentations specific to their role. Staff have felt more confident in delivering the presentation and Patient Relations have been focussing more on the role of the department and the Power of Apology. Induction is on hold currently due to the Covid-19 pandemic.

We continue to encourage staff to complete the elearning feedback and complaints training developed nationally. The Patient Relations Team also supports the delivery of bespoke training sessions with individual services.

Due to the Covid-19 pandemic, face to face training has not taken place. There has also been a reduction in the ability to deliver virtual training, and a reduction in the overall uptake of virtual training due to the pressures on services caused by the pandemic.

The Patient Relations Team are exploring the opportunity of expanding the elearning and training programme for feedback and complaints with the aim of making this training mandatory for all staff. This piece of work is on hold, but we will revisit this as services recover post pandemic.

The following information relates to additional training delivered.

Medical Staff Core Training

Course – FY2 Term 3 Programme	Attendance
Power of Apology	7

Corporate Induction	Attendance
Delivery of induction training in relation to Patient Relations and Clinical Governance roles. Corporate Induction has been delivered virtually as an online programme during the pandemic.	417

SAER / Duty of Candour

NHS Fife is committed to delivering training on Adverse Event and the following table demonstrates number of staff trained in 2020/21.

Course	Attendance
NES Duty of Candour module	545
NHS Fife Datix Reporting learn pro	360
NHS Fife Datix Reviewer learn pro	98

Performance Indicator Four:

4. Summary of total number of complaints received in the reporting year

4a. Number of complaints received by the NHS Territorial Board or NHS Special Board Complaints and Feedback Team	**853**
4b. Number of complaints received by NHS Primary Care Service Contractors (*Territorial Boards only)*	**683**
4c. Total number of complaints received in the NHS Board area	**1536**

NHS Board - sub-groups of complaints received

NHS Board Managed Primary Care services;	
4d. General Practitioner	**9**
4e. Dental	**5**
4f. Ophthalmic	**0**
4g. Pharmacy	**0**
Independent Contractors - Primary Care services;	
4h. General Practitioner	**556**
4i. Dental	**7**
4j. Ophthalmic	**5**
4k. Pharmacy	**115**
4l. Total of Primary Care Services complaints	**697**
4m. Total of prisoner complaints received *(Boards with prisons in their area only)* **Note: Do not count complaints which are unable to be concluded due to liberation of prisoner / loss of contact.**	**N/A**

Performance Indicator Five

5. The total number of complaints closed by NHS Boards in the reporting year *(do not include contractor data, withdrawn cases or cases where consent not received).*

Number of complaints closed by the NHS Board	Number	As a % of all NHS Board complaints closed (not contractors)
5a. Stage One	**481**	**59%**
5b. Stage two – non escalated	**272**	**33%**
5c. Stage two - escalated	**62**	**8%**
5d. Total complaints closed by NHS Board	**815**	**100%**

Performance Indicator Six

6. Complaints upheld, partially upheld and not upheld

Stage one complaints

	Number	As a % of all complaints closed by NHS Board at stage one
6a. Number of complaints upheld at stage one	**193**	**40%**
6b. Number of complaints not upheld at stage one	**180**	**38%**
6c. Number of complaints partially upheld at stage one	**104**	**22%**
6d. Total stage one complaints outcomes	**477**	**100%**

Stage two complaints

Non-escalated complaints	Number	As a % of all complaints closed by NHS Boards at stage two
6e. Number of non-escalated complaints upheld at stage two	**53**	**20%**
6f. Number of non-escalated complaints not upheld at stage two	**103**	**38%**
6g. Number of non-escalated complaints partially upheld at stage two	**114**	**42%**
6h. Total stage two, non-escalated complaints outcomes	**270**	**100%**

Stage two escalated complaints

Escalated complaints	Number	As a % of all escalated complaints closed by NHS Boards at stage two
6i. Number of escalated complaints upheld at stage two	**12**	**19%**
6j. Number of escalated complaints not upheld at stage two	**29**	**47%**
6k. Number of escalated complaints partially upheld at stage two	**21**	**34%**
6l. Total stage two escalated complaints outcomes	**62**	**100%**

Performance Indicator Eight

8. Complaints closed in full within the timescales

This indicator measures complaints closed within 5 working days at stage one and 20 working days at stage two.

	Number	As a % of complaints closed by NHS Boards at each stage
8a. Number of complaints closed at stage one within 5 working days.	**142**	**63%**
8b. Number of non-escalated complaints closed at stage two within 20 working days	**85**	**37%**
8c. Number of escalated complaints closed at stage two within 20 working days	**0**	**0%**
8d. Total number of complaints closed within timescales	**227**	**100%**

Performance Indicator Nine

9. Number of cases where an extension is authorised
This indicator measures the number of complaints not closed within the CHP timescale, where an extension was authorised* .

	Number	As a % of complaints closed by NHS Boards at each stage
9a. Number of complaints closed at stage one where extension was authorised	**43**	**19%**
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	**180**	**81%**
9c. Total number of extensions authorised	**223**	**100%**

***Note:** The SPSO confirm that there is no prescriptive approach about who exactly should authorise an extension – only that the organisation takes a proportionate approach to determining an appropriate senior person – and this is something that NHS Boards should develop a process for internally. This indicator aims to manage the risk of cases being extended beyond the CHP timescale without any senior officer approval.

Completed by:

Name: **Elizabeth Gray**	**Position:** **Patient Relations Team Lead**
Tel: **01592 648153**	**E-mail:** **Lizzie.Gray@nhs.scot**
Date: **16 September 2021**	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 November 2021**
Title:	**Medical Appraisal and Revalidation Annual Report 2020/2021**
Responsible Executive:	**Dr Chris McKenna, Medical Director, NHS Fife**
Report Author:	**Alison Gracey, Medical Appraisal and Revalidation Coordinator**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Medical Staff Revalidation and Appraisal report for 2020-2021 is being brought to the Staff Governance Committee for their awareness. The reports provides the committee with an assurance that doctors in NHS Fife are up-to-date and are practising to the appropriate professional standards.

2.2 Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3 Assessment

NHS Fife responds well to the challenges of Medical Revalidation and Appraisal with few problems, is managing to meet the requirements of the GMC. However, appraisal was put on hold this year due to Covid 19, causing significant delays. Secondary Care have struggled to recruit and retain sufficient NES Trained Appraisers, particularly with Covid impacting the NES training. Secondary Care are relying on bank appraisers to fill the gap and continue to advertise the role now that training is reinstated.

2.3.1 Quality/ Patient Care

Medical appraisal ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.2 Workforce

2020/2021 was challenging for all those working in the health and care services. As a result of this pandemic, appraisal and revalidation activities were temporarily put on hold so that colleagues could focus on helping with the pandemic.

The national data collection for 2020/2021was cancelled by National Education Scotland (NES) due to the Covid 19 pandemic. Appraisal figures for the year are noted within the report.

2.3.3 Financial

- Not applicable

2.3.4 Risk Assessment/Management

There may be a risk of being unable to meet the GMC requirements for Medical Revalidation and Appraisal if unable to recruit and retain sufficient numbers of NES Trained Appraisers.

2.3.5 Equality and Diversity, including health inequalities

- Not applicable

2.3.6 Other impact

- Not applicable

2.3.7 Communication, involvement, engagement and consultation

NHS Fife has a Medical and Appraisal Revalidation Group, who assess and implements any changes which need to be made to current system to keep in line with the national enhanced appraisal process.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases,

closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

2.3.8 Route to the Meeting

- Not applicable.

2.4 Recommendation

- Assurance – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Not applicable

Report Contact

Alison Gracey
Medical Appraisal and Revalidation Coordinator, NHS Fife
Email alison.gracey@nhs.scot

NHS Fife

Medical Appraisal and Revalidation Annual Report

Consultants, Career Grade Doctors and General Practitioners

2020/2021

Contents

Medical Appraisal and Revalidation 2019/2020

Consultants, Career Grade Doctors and General Practitioners

Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

Revalidation requires annual appraisal, including feedback from colleagues and patients at least once during the five year period. Evidence of the doctor's range and volume of practice, such as the number of operations carried out or prescribing patterns is also reviewed.

Governance Structure

Every doctor wishing to practise medicine in the UK must be linked to a Designated Body and its' Responsible Officer (RO) referred to as a "prescribed connection". Recommendations for the revalidation of all doctors is achieved through each Health Board's RO.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

In line with national policy Dr Chris McKenna is NHS Fife's Responsible Officer, Dr Robert Cargill and Dr Helen Hellewell are NHS Fife's Deputy Responsible Officers. This responsibility covers all Consultants, Career Grade Doctors and General Practitioners employed by NHS Fife.

Medical Revalidation in NHS Fife is overseen by the Medical Appraisal and Revalidation Group chaired by Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife. This group reports to NHS Fife's Clinical and Staff Governance Committees.

Annual Appraisal

The Scottish Government agreed that for doctors in Scotland, revalidation is achieved by using a standardised bespoke "Enhanced Appraisal" system designed by the National Appraisal Leads Group for Scotland (NALG).

All doctors in both Primary Care and Secondary Care are required to participate in an annual appraisal.

Appraisals are documented using the NHS Education Scotland (NES) provided web based system SOAR (Scottish Online Appraisal Resource). A signed Form 4 (appraisal summary) is proof that an individual has successfully engaged in the Appraisal process for that year.

Appraisers

All appraisers in Scotland must be NES trained. In Primary Care there are **13** NHS Fife appointed NES trained Appraisers. This allows every General Practitioner (GP) to have an annual appraisal. GP Appraiser recruitment is undertaken locally.

In Secondary Care there are 36 NES trained appraisers as at 31 March 2021, having lost some in the last year to retirement/resignation.

NHS Fife has faced difficulties with recruitment and retention of appraisers in Secondary Care and has enlisted the help of a small bank of retired appraisers to help undertake appraisals. The total includes 10 retired appraisers on the bank and 3 Educational Supervisors within Emergency Medicine who undertook the training to carry out appraisals for the Clinical Fellows in their department as the needs of the Clinical Fellow is slightly different to that of a consultant or career grade doctor.

Impact of Covid 19 Pandemic on Appraisal/Revalidation 2020/2021

On 16 March 2020 all appraisal activity was put on hold to support the health service in prioritising frontline clinical care for patients during the pandemic response.

The GMC automatically deferred anyone due to revalidate from 16 March to 30 September 2020 for a year, to allow time to reschedule, complete appraisals and avoid the need for RO's to make revalidation recommendations during that time. This was later extended to include those due for revalidation up to 16 March 2021. This affected a total of 273 due for revalidation during this time.

The RO however, was still able to make a recommendation for these doctors if they had all their evidence ready. He was able to revalidate 90 of those originally due for revalidation during 2020/2021.

Appraisals were reinstated nationally on 1 October 2020 with the focus being on wellbeing and an understanding that there would be areas that doctors would find it difficult to collect evidence for this year.

NHS Fife put appraisal on hold for a second time at the beginning of January 2021 for a period of 6 weeks to allow clinicians to respond to rapidly increasing cases of COVID at that time. This put additional pressure on appraisers, particularly in secondary care where there is already a shortage of trained appraisers.

The Covid 19 pandemic also meant that the NES appraiser training course was cancelled from March 2020 and was only reinstated as a virtual course in February 2021. The course previously a 2 day course held at venues across Scotland is now 2 half days delivered virtually with e-learning modules to be completed prior to the course by all candidates.

NHS Fife continues to advertise, on an ongoing basis, for additional trained members of medical staff to undertake the training in an effort to ensure there are sufficient trained Appraisers to share the appraisal workload.

The postponement of appraisal resulted in long delays which would continue into the next appraisal period. It was agreed following a meeting of the Medical Appraisal and Revalidation Group in January 2021, that it would be too much for the appraisers to attempt to catch up in such a short time with the new appraisal period starting in just a few months.

Therefore, following the example of other Boards, it was decided to offer those affected by the delays, who had not managed to complete an appraisal and whose revalidation would not be affected, the option of a Form 5A (exemption) for 2020/21. However with the focus being on wellbeing they could still opt for an appraisal if they preferred. This should aid NHS Fife's recovery and allow us to get the appraisal process back on track to support our doctors through their revalidation.

Patient feedback, which must be included as supporting evidence within an appraisal at least once during the 5 year revalidation cycle for all those with patient contact, has proved difficult to obtain for those requiring it during the pandemic. Many services have reduced face to face appointments and doctors are having to look at different ways to obtain this feedback. This is particularly evident within General Practice.

Appraisal within NHS Fife for Period 1 April 2020 – 31 March 2021

As at 31 March 2021 there were 692 doctors with a prescribed connection to NHS Fife. This includes Primary Care (GP's), Secondary Care (Consultants, SAS Doctors, Clinical Fellows and Honorary Consultants), University staff without an honorary contract and one external doctor who has requested connection to NHS Fife. Numbers and appraisal status for 2020/2021 can be seen in Chart 1.

A much larger number than is usual were given a Form 5A (exemption) due to the Covid 19 pandemic, however, despite the prolonged delays NHS Fife managed to complete just over 66% of all appraisals due during 2020/2021. The reasons for issuing Form 5A during 2020/21 can be seen in Chart 2.

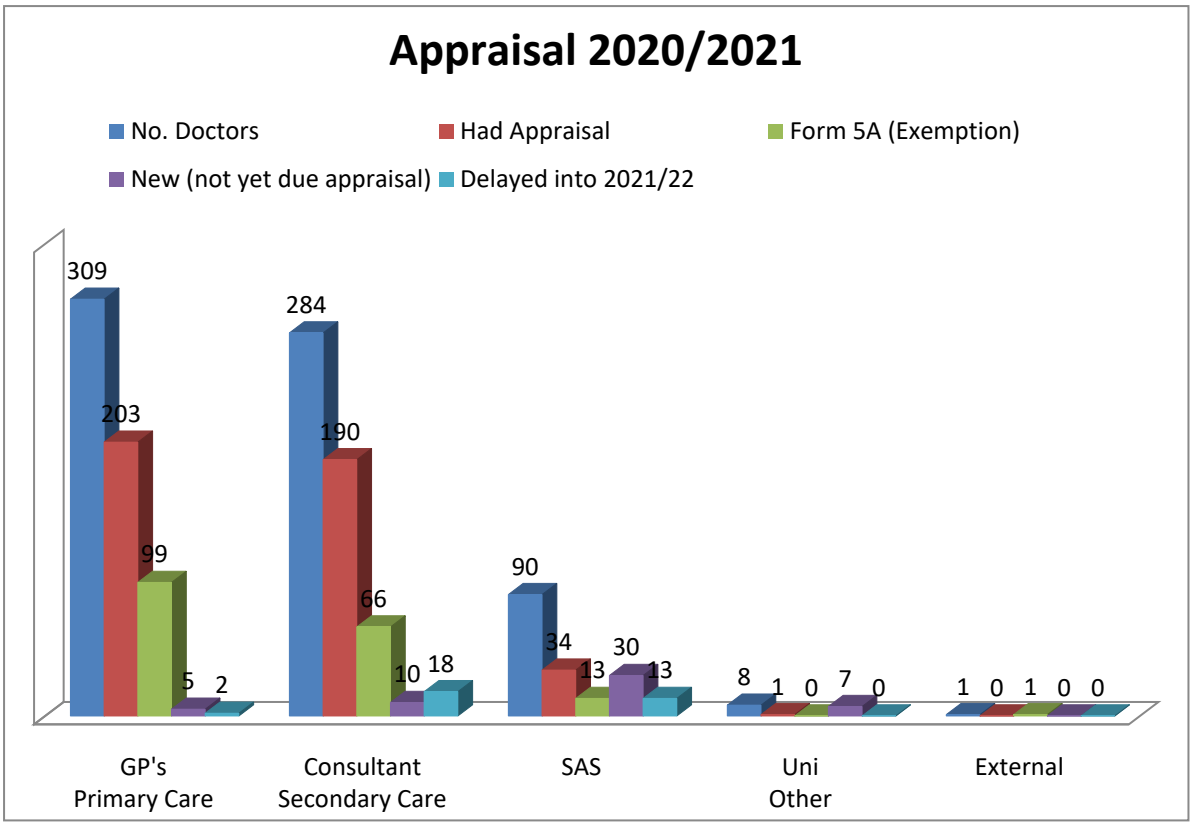
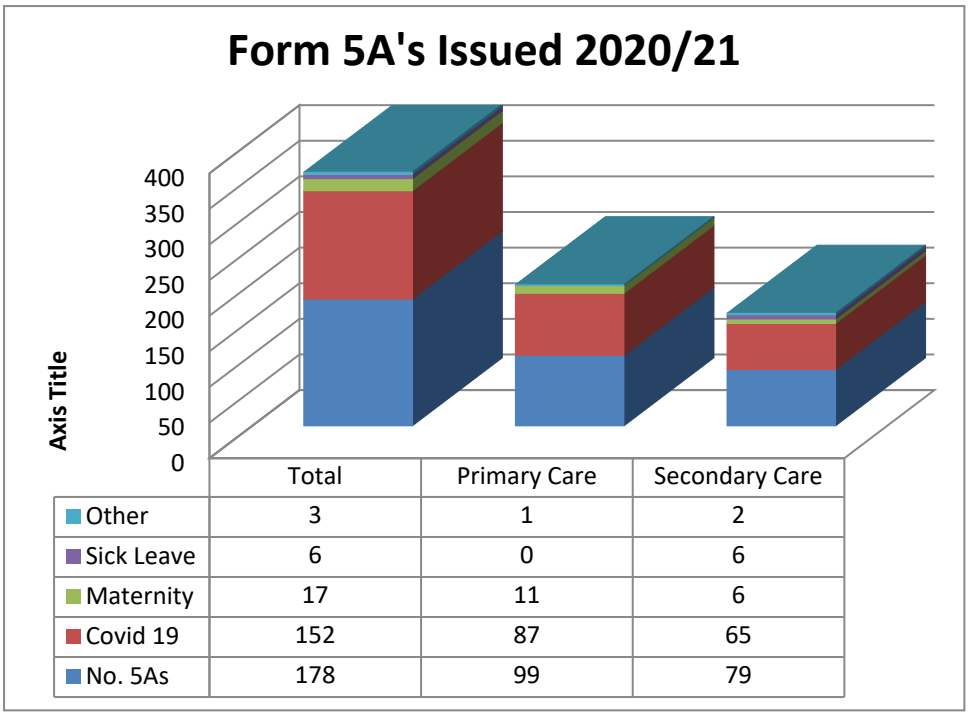


Chart 1: Appraisal 2020/21



	Total	Primary Care	Secondary Care
Other	3	1	2
Sick Leave	6	0	6
Maternity	17	11	6
Covid 19	152	87	65
No. 5As	178	99	79

Chart 2: Form 5A's Issued 2020/21

Summary

The key issues for 2020/2021

1. NHS Fife continues to respond well to the challenges of Medical Appraisal and Revalidation despite the Covid 19 pandemic delays and issues around patient feedback.
2. The GP Appraisal scheme in Fife continues to run well with little or no problems identified therefore no further action is required at this time.
3. The Appraisal process in Secondary Care continues to run well with few problems identified other than recruitment and retention of Appraisers.
4. There is no dedicated budget to fund Bank Appraisers.
5. MARG continues to be instrumental in overseeing the appraisal and revalidation processes and ensuring any issues/challenges that arise are resolved.

The key actions for 2021/2022

1. Continue to maintain an up-to-date record of all Consultants, Career Grade Doctors and General Practitioners with whom NHS Fife has a "prescribed connection".
2. Continue to advertise for doctors to become NES trained Appraisers to ensure that NHS Fife continues to have sufficient NES trained Appraisers to meet the number of Appraisees within NHS Fife.
3. Continue to support doctors with the appraisal/revalidation process following the Covid 19 pandemic who are having difficulties obtaining patient feedback or getting back on track after significant delays.
4. Continue to provide appraisal and revalidation support to those doctors not employed or contracted to NHS Fife but who still have a prescribed connection.
5. Continue to provide training sessions for both Appraisers and Appraisees.
6. Action feedback as appropriate.

Alison Gracey
Medical Appraisal and Revalidation Coordinator
NHS Fife
30 September 2021

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

NHS Fife

IPCTeam
Infection Prevention & Control

NHS Fife Prevention and Control of Infection Annual Report 2020-2021

Julia Cook Infection Control Manager

Approval Record	Date of Approval
NHS Fife Infection Control Committee	October 2021
NHS Fife Clinical Governance Committee	November 2021
Chief Executive for NHS Fife Board	October 2021

CONTENTS

1.0 INTRODUCTION

Infection Prevention and Control Team (IPCT)

Julia Cook, Infection Control Manager
Margaret Selbie, Acting Lead Infection Prevention and Control Nurse (Bank)
Elizabeth Dunstan, Senior Infection Prevention and Control Nurse
Nykoma Hamilton, Infection Prevention and Control Nurse
Jacqueline Donachie, Infection Prevention and Control Nurse
Janice Barnes, Infection Prevention and Control Nurse
Catherine McCullough, Infection Prevention and Control Nurse
Mirka Barclay, Infection Prevention and Control Nurse
Rosemary Shannon, Infection Prevention and Control Audit Nurse (Bank)
Suzanne Watson, Infection Prevention and Control Surveillance Nurse/Trainee IPCN
Lynsey Delaney, Infection Prevention and Control Surveillance Midwife
Lori Clark, Personal Assistant/Office Manager
Kathleen Diamond, Clerical Officer
Ken Marshall, Data Analyst (Bank)
Dr Keith Morris, Dr Priya Venkatesh, Dr Craig Ferguson, Dr David Griffith, Dr Stephen Wilson, Infection Control Doctors (ICDs)

Celebrating Success

During 2020, the Infection Prevention and Control Service have:

- Recruited to the substantive posts of IPC Team members;
  Infection Control Manager
  Senior Infection Prevention and Control Nurse

- Continued to support two of our IPCNs with post graduate study for the MSc specialist practitioner qualifications in Infection Prevention and Control.

- One of IPCNs sponsored to undertake the 12 month NHS Fife Clinical Leadership programme commenced November 2019.

- NHS Fife IPC team have been supporting capital projects such as the Elective Orthopaedic Centre at the Victoria Hospital in Kirkcaldy, Lochgelly and Kincardine Health Centre Project Team

- IPCT presented at the Grand Round on COVID-19 along with the Health Protection Team, Consultant Microbiologist and Infectious Disease Doctor.

- Lead IPCN nominated for “Unsung Hero” award with Kingdom FM, reaching the final 3.

Nationally recognised work

The IPCT supported and continue to support work across a broad range of national stages. The team supported/are supporting:

- **National Services Scotland** with the Excellence in Care (EiC) programme. The IPCT are involved with the EiC lead to develop reliable systems for Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment and Screening using Quality Improvement Science. The developed tool had been trialled in AU2 and AU1 and has now been rolled out both in NHS Fife and nationally. An electronic version for Patientrack is in development with plan for roll out in 2021.

- **NHS Tayside and the University of Dundee** with a four-year research study; *ARCH: Antibiotic Research in Care Homes*. The aim of the study is to carry out a programme of in-depth multidisciplinary research around how we might safely improve/reduce antibiotic use and ultimately Antimicrobial Resistance (AMR) in care homes. Although there was a temporary pause to this research due to COVID-19 meetings recommenced July 2020.

- Centre for Excellence- NHS Fife participated in national workshops regarding HAI-SCRIBE and the new Centre for Excellence

- NHS Fife supported the development and piloted the new ARHAI Scotland outbreak reporting tool

- Participate in the Scottish Antimicrobial Nurses' Group meetings virtually and deputise (as required) representing IPS at the Scottish Antimicrobial Prescribing Group meetings

The team continued to develop the Infection Prevention and Control Service to

- ✓ focus more on prevention than control
- ✓ sustain and build on achievements and strengths to date
- ✓ ensure that what works is implemented across the healthcare system
- ✓ support greater integration and partnership across the healthcare system
- ✓ ensure we prepare for the future and respond to emerging threats
- ✓ demonstrate our commitment to sustainable improvement
- ✓ promote a culture of zero tolerance of avoidable infections

The Board recognises our collective responsibility towards Healthcare Associated Infection (HCAI) risk and continuously supports our implementation of new initiatives to control these risks. Development, implementation and review of policies alongside surveillance and education are key components of the Infection Prevention and Control Team's proactive approach to addressing the HCAI agenda.

Prevention and control of infection is everyone's responsibility and, as a multidisciplinary team, every member of staff is dedicated to maintaining consistently high standards to ensure patients receive clean, safe care.

2.0 EXECUTIVE SUMMARY

- In response to the World Health Organisation declaration of a COVID-19 pandemic on 11th of March 2020, NHS Fife and the Infection Prevention & Control Team (IPCT) focused on supporting the COVID-19 pandemic response through Gold, Silver and Bronze Command structure.

- IPCT continues to work towards improving surveillance, prevention and control of HCAI across Fife through collaborative joint working.

- During 2020, the IPCT was almost fully established, however the substantive post of Lead Infection Prevention and Control Nurse was unsuccessful in recruitment and the post filled by acting Lead IPCN.

- National Hand Hygiene auditing in Fife continues and has shown sustained high levels of compliance.

- Fife continues to comply with national mandatory surveillance requirements.

- Surgical Site Infection (SSI) pause to national programme

- The Scottish Government's Chief Nursing Officer in October 2019 announced the new standards for the reduction of Healthcare Associated Infections (Hospital acquired (HAI) & Healthcare associated (HCAI)) for the following: ECB, CDI and SAB.

- *Escherichia coli* bacteraemia (ECB) surveillance continued during 2020. NHS Fife witnessed a decrease in the number of cases from 2019.

- *Clostridioides difficile* infection (CDI) rates continue at a level below the national average. For 2020 NHS Fife had the best year for total number of infections in NHS Fife

- The SAB rate for NHS Fife in 2020 was the lowest year and on target to meet the new reduction standard.

- 2020 saw no outbreaks of norovirus of influenza.

- NHS Fife did experience incidents and clusters of COVID-19, with 22 incidents involving 2 or more patients and/or healthcare workers reported to ARHAI Scotland. Staff demonstrated great commitment and effort working with the IPCT during outbreaks.

- Due to COVID-19 national restrictions around unnecessary travel, social distancing affected how IPC education and training was delivered, facilitated by an increased investment in IT services and software.

- Fife remains GREEN in the National Cleaning Specification monitoring reports.

- The Healthcare Environment Inspectorate inspected Fife twice during 2020. An unannounced inspection took place at Glenrothes Hospital, NHS Fife, from 7-9th of July 2020 This inspection resulted in 1 IPC requirement. An unannounced inspection took place at Adamson Hospital, NHS Fife, on 27th of October 2020. This inspection resulted in 2 IPC requirements.

- IPCT continue to work collaboratively with the Women and Children's Directorate to support improvements in the care of patients undergoing Caesarean Section procedures.

- IPCT continued to support quality improvements projects across the organisation through collaborative joint working across all of health and social care to improve clinical outcomes for patients with vascular access devices.

NHS Fife has responded to the COVID-19 pandemic, by adopting the best evidence available, responded quickly and effectively to developments and changes in national guidance from the emerging evidence base on COVID-19 which was rapidly evolving. Fife has made significant progress in the prevention and control of infection and the management of SAB, ECB and CDI HCAI during 2020, and responded quickly and effectively to developments and changes in national strategy. This will form a strong base from which to move forward on the challenges of the next twelve months.

Julia Cook, Infection Control Manager on behalf of the Infection Prevention and Control Team

3.0 PURPOSE OF REPORT

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2020-21),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) Standards (2015)* are included.

4.0 INFECTION CONTROL STRUCTURE AND ORGANISATION

4.1 Structures

Infection Control structure is defined within the *Prevention & Control of Infection Implementation Framework 2019-21* which lays down individual responsibilities and committee accountability for delivery of Infection Prevention & Control in NHS Fife and the Health and Social Care Partnership.

In 2020-21, the IPCT reported through the NHS Fife Infection Control Committee (ICC), to the NHS Fife Clinical Governance Committee (NHSFCGC), the HSCP Clinical and Care Governance Committee and the Executive Directors Group (EDG). These groups then reported to the NHS Fife Board and Integrated Joint Board. The ICC meets bimonthly with minutes of the meeting being widely distributed.

NHS Fife has systems in place to ensure that national requirements for infection control, decontamination and cleaning as laid down in Chief Executive Letters (CEL), Chief Medical Officer for Scotland (CMO) letters, Chief Nursing Officer for Scotland (CNO) letters and other mandatory guidance are identified and addressed. These are disseminated direct to the Infection Control Manager (ICM) from the Scottish Government Health & Social Care Directorate (SGHSCD) Healthcare Associated Infection (HCAI) Policy unit or via the Chief Executive and the Executive Lead for Infection Prevention & Control.

4.2 Staffing and Resources

- The IPCT was successful in recruiting to the substantive posts of IPC Team members; Infection Control Manager and Senior Infection Prevention and Control Nurse. However the IPCT were unsuccessful in recruiting to the substantive post of Lead Infection Prevention and Control Nurse.

- Absence was a challenge 2020, with absence rates of 17.7%.

- COVID-19 related absences and the requirement for shielding and working from home also impacted the service.

The challenges of COVID-19 have compelled the NHS to make the best use of our people's skills and experience, to provide safe and effective person-centred care. The IPCT has risen to the challenge and has been flexible and adaptable – with new ways of working such as MS Teams meetings training, and safety huddles. Infrastructure to enable

staff to work from home has been facilitated by an increased investment in IT services and software.

With increases in demand for IPCT support across NHS Fife due to the COVID-19 response, 2020 also saw a requirement for IPC and Care Home Support, with additional funding granted in December. This has allowed a recruitment drive to commence, with trainee IPCNs joining the NHS Fife IPCT in February 2021 and further new trainee IPCNs due to join the team late May 2021.

IPCT resource challenges have been highlighted in the HAIRT report and to the ICC and HAI Executive, with assurance there have been interim measures introduced to ensure the safety of the service. This includes seeking supplementary staffing and offering additional hours to existing team members.

5.0 GOVERNANCE

5.1 Internal Audit

The IPCT did not receive any requests for review of IPC services, from the Internal Audit team for this reporting period.

6.0 NATIONAL STRATEGY

6.1 COVID-19 PANDEMIC RESPONSE

A coordinated hospital-wide approach was taken to infection prevention and control including close collaboration with Health protection Scotland (HPS) now known as ARHAI Scotland. The IPCT have provided NHS Fife and the HSCP with support and advice for health care workers involved in receiving, assessing and caring for patients who are a possible or confirmed case of COVID-19 in line with national guidance.

The infection prevention and control advice in response to the COVID-19 pandemic, is based on the best evidence available from previous pandemic and inter-pandemic periods and the emerging evidence base on COVID-19 which is rapidly evolving. From January 2020 the IPCT have attended national meetings with HPS to be fully informed of the most up to date situation with COVID-19 and current national guidance.

The IPCT annual work plan was reviewed and COVID-19 response prioritised:

· An increase in frequency of IPCT ward/department visits

· Focus on education and training

· Focus on preventing infection in healthcare

· Support to clinical teams to investigate and implement control measures during outbreaks

· Participated in local and national COVID-19 meetings

During the height of the pandemic the IPCT increased working hours to meet the demands of the services, this included on site weekend cover to fully support the NHS Fife and the HSCP to ensure safe cover for all areas.

To aid communications a new IPCT COVID-19 contact number and a generic IPCT email address was created and rolled out as a single point of contact, available to all NHS Fife staff for guidance and support.

During the pandemic the IPCT have been working collaboratively with the Health Protection Team, Microbiology, Health and Safety, Occupational Health and Infectious Disease Doctors to support the senior management teams. Local meetings include Hospital Control Teams, Silver Command Procurement, Scientific Technical & Advisory Cell (STAC), Mental Health Services meetings, Local Resilience Partnership (LRP) and Remobilisation Oversight Group.

As part of these MDT meetings, IPCT has provided input into the development of patient pathways, such as creating Red pathways for suspected/confirmed COVID-19 patients only and Green pathways for patients assessed as not at risk of having COVID-19 during the first wave of COVID-19 and then the 3 patient care pathways introduced in September 2020. Early recognition or reporting of cases, early assessment or triaging of cases and implementing control measures is vital to reducing risk of transmission in NHS Fife and the HSCP.

IPCT supported the Health Protection Team and HSCP with the development of local guidance for the new Community Testing Team (CTT) in February, one of the first community testing teams in Scotland. Training provided to all CTT on how to don Personal Protective Equipment (PPE) for high consequence infectious disease (HCID) and how to competently obtain the correct microbiological samples for testing.

Education and training has been provided to all levels of NHS Fife staff from presenting at Grand Rounds, tailored training sessions on standard infection control precautions (SICPs) and transmission based precautions (TBPs) and outbreak management. Updates on national guidance were shared with the hospital control teams for dissemination and advised at IPCT ward visits. National resources were also shared and prompted such as the donning and doffing of PPE in primary care and how to obtain a COVID-19 swab. Prior to the development of national resources NHS Fife IPCT developed a poster illustrating how to safely don/doff PPE for HCID which was shared with other health Boards in Scotland.

The IPCT have recently joined the Care Home Oversight Group in May 2020 and delivered IPC training and education to a number of care home staff across Fife. Funding was agreed for IPC care home support December 2020 and recruitment drive took place.

IPCT have also worked closely with Procurement and Health and Safety with weekly meetings to ensure provision of PPE. The vast majority of PPE used by healthcare staff is single-use and disposable, the result of this is that significant quantities of these materials can be used up relatively quickly. NHS Fifes Laundry Manager and Lead IPCN took pragmatic steps to ensure that they could procure crucial PPE necessary to protect healthcare staff and patients in NHS Fife. They were able to source reusable gowns, after collaborating with HPS and vigorous testing; NHS Scotland purchased these gowns for distribution to Boards across Scotland. This ensured adequate access to PPE and safeguard patients and staff.

Winter planning, outbreak management and supporting the, seasonal influenza vaccination programme and the COVID-19 vaccination programme were a key focus for the IPCT to prepare for the winter season.

The below Figure 1 Epidemic curve of COVID-19 cases with first positive specimen taken during an inpatient stay by onset status. Illustrating the 2 waves of COVID-19 During 2020.

Figure 1: Epidemic curve of COVID-19 cases with first positive specimen taken during an inpatient stay, by onset status: week-ending 1 March to week-ending 27 December 2020 (n=10,154). [1,2]

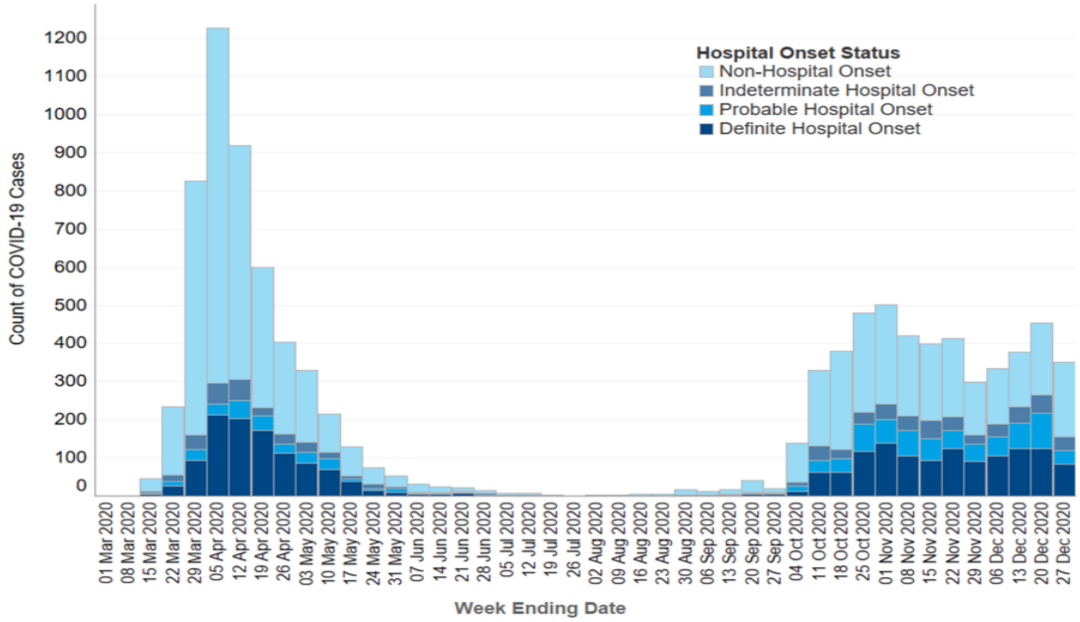


Table 1 presents the number of COVID-19 cases, by onset status and NHS Board up to the 27th of December 2020. The data used has not been adjusted for different patient groups and size of NHS Board.

Table 1: Number of COVID-19 cases, by onset status and NHS board: specimen dates up to 27 December 2020. [1,2,3]

NHS board	Total COVID-19 cases (n)	Non-hospital onset (n)	Indeterminate hospital onset cases (n)	Probable hospital onset cases (n)	Definite hospital onset cases (n)	Non-hospital onset (%)	Indeterminate hospital onset cases (%)	Probable hospital onset cases (%)	Definite hospital onset cases (%)
Ayrshire & Arran	8,949	500	60	113	205	5.6%	0.7%	1.3%	2.3%
Borders	1,436	88	9	16	50	6.1%	0.6%	1.1%	3.5%
Dumfries & Galloway	1,464	96	9	2	2	6.6%	0.6%	0.1%	0.1%
Fife	6,013	322	18	14	145	5.4%	0.3%	0.2%	2.4%
Forth Valley	5,408	264	15	12	43	4.9%	0.3%	0.2%	0.8%
Golden Jubilee	15	7	4	2	2	-	-	-	-
Grampian	7,405	263	35	41	127	3.6%	0.5%	0.6%	1.7%
Greater Glasgow & Clyde	40,293	2,161	329	382	906	5.4%	0.8%	0.9%	2.2%
Highland	1,954	83	10	7	23	4.2%	0.5%	0.4%	1.2%
Lanarkshire	23,340	1,031	119	147	325	4.4%	0.5%	0.6%	1.4%
Lothian	17,894	850	98	163	342	4.7%	0.5%	0.9%	1.9%
Orkney	36	4	0	0	0	11.1%	0.0%	0.0%	0.0%
Shetland	94	9	0	0	0	9.6%	0.0%	0.0%	0.0%
Tayside	7,935	428	59	64	142	5.4%	0.7%	0.8%	1.8%
Western Isles	94	8	0	0	0	8.5%	0.0%	0.0%	0.0%
Scotland	122,330	6,114	765	963	2,312	5.0%	0.6%	0.8%	1.9%

1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) data and Rapid Admission Preliminary Inpatient Data (RAPID) data or local admission data.
2. NHS Golden Jubilee has been excluded from the proportions data since data for this board will not be comparable with others due to no "community onset" cases assigned to that board.
3. The data used has not been adjusted for different patient groups and size of NHS board.

6.2 NHS HIS HAI Standards (2015)

The 2015 standards provide the core structure for inspection tools used by the Healthcare Environment Inspectorate (HEI) for hospital inspections.

NHS Fife received two unannounced inspections in 2020

Glenrothes Hospital Inspection

Unannounced Hospital Inspection to: Glenrothes Community Hospital, NHS Fife on 7-9 July 2020

The inspection methodology had been adapted to combine safety and cleanliness and care of older people. NHS Boards are measured against a range of standards, best practice statements and other national documents, including the Care of Older People in Hospital Standards (2015) and Healthcare Associated Infection (HAI) standards (2015).

The report and improvement action plan was published on Tuesday 15 September 2020.
(For purposes of the IPCT Annual Report only IPC related information will be reported)

NHS Fife was thanked and in particular all staff at Glenrothes Hospital for their assistance during the inspection.

- patients were treated with dignity and respect
- good compliance with standard infection control precautions
- cleanliness of environment was very good
- wards felt well supported by IPCT and line management

The inspection resulted in 1 IPC related requirement

- NHS Fife must ensure that the condition of all patient equipment allows it to be effectively decontaminated

This is to comply with healthcare Associated Infection (HAI) standards (2015) Criteria 8.1.

Action plan has been agreed and submitted including a review of the system to which near patient equipment and furniture is inspected and reviewed, and a timeous replacement is in place.
Up to date training available for MICAD system on requests for all staff.

Adamson Hospital Inspection

Unannounced Hospital Inspection of: Adamson Hospital, NHS Fife on 27th October 2020

The inspection team thanked the staff for their contribution and assistance with the organisation and planning around the hospital inspection to Adamson Hospital on Tuesday 27 October 2020.

- The report and improvement action plan was published on Tuesday 19 January 2021

Areas of good practice noted in the report include:

- The inspection highlighted a very good standard of hospital environmental cleaning
- Wards appeared calm and organised with evidence of good team working
- Compliance with standard infection control precautions such as linen, waste and sharps management was good. The inspectors saw the staff using PPE appropriately and staff in clinical areas wore surgical face masks at all times.
- Training records for ward staff were available which showed good compliance with mandatory training for infection prevention and control.
- Ward level infection prevention and control audits were being carried out, including environment and hand hygiene audits. The inspectors were told that the infection prevention and control team also carry out audits. Audit activity was fed back to the staff by posters, email and at meetings.

However, the inspection resulted in 2 IPC requirements:

- 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.

- NHS Fife must ensure that the condition of all patient equipment allows it to be effectively decontaminated.

Key Learning:

All wards and departments must ensure they can demonstrate:

- Compliance with Standard Infection Control Precautions (SICPs), specifically Management the Care Environment and Care Equipment and Hand Hygiene.

6.3 HAIRT reporting to Board

As part of the National HCAI Action Plan, all NHS Boards are required to provide a report on HAI during the public session of their bimonthly Board meetings, and to publish this on their website. A national HAI Reporting Template (HAIRT) produced by SGHSCD and revised in June 2010 has been used to update the NHS Fife Board. The report provides a spreadsheet of monthly case numbers and comparative data for ECB, CDI and SABs for individual acute hospitals, for community hospitals and for the community. It also highlights key actions and improvement work aimed at reducing these infections.

7.0 PROGRESS AGAINST INFECTION CONTROL PRIORITIES 2020-21

The Prevention and Control of Infection Work Programme 2020-21 is the NHS Fife delivery plan to comply with the national strategic objectives. The programme of work support the National Quality Strategy ambitions as below.

National Quality Strategy ambitions

Patient centred

Control and prevention of HCAI measures will be proportionate and appropriate for the person receiving healthcare and the environment that healthcare is delivered.

Safe

A clean safe environment and the control and prevention of HCAI and antimicrobial resistance will reduce the risk of the population being exposed to or acquiring an HCAI (including resistant organisms) within any setting, that healthcare is delivered.

Effective

Control and prevention of HCAI measures and programmes, including prudent use of antimicrobial agents, surveillance, new technologies, education, training and research will support effective, equitable and consistent delivery of healthcare.

The *Prevention and Control of Infection Communications Plan 2018- 2020* separately details how the Infection Prevention and Control Team communicate on a formal and informal basis with other colleagues, departments and the public.

Achievements within the seven main delivery areas of the *HAITF Delivery Plan* were reported to the ICC at its bimonthly meetings and to CGC through the ICC minutes and papers. Progress against the seven delivery areas is summarised below.

7.1 Antimicrobial Prescribing and Resistance

7.1.1 Antimicrobial Prescribing Guidelines

NHS Fife has an established antimicrobial management team (AMT) which reports to the NHS Fife Managed Services Drug and Therapeutic Committee. Minutes are provided to the ICC.

The AMT has produced antimicrobial prescribing guidance since 2009 covering adult and paediatric prescribing in both primary and secondary care. Since 2014, the guidance is available as a Smartphone app and via a web viewer. Guidance is reviewed at least every 2 years but with the introduction of the app, it can now be updated instantly and this is done as required.

The aim of guidance is to restrict use of agents particularly associated with *Clostridioides difficile*, to limit the use of very broad-spectrum antimicrobial that may promote emergence of resistant strains, and to ensure that Scottish Antimicrobial Prescribing Group (SAPG) policy on hospital antimicrobial prescribing was met. Guidance takes into account local resistance data collected by the labs.

A protected antimicrobial list covering all wards has been in place since March 2009 and is updated annually or when required.

The antimicrobial pharmacist maintains a database of all AMT guidelines with review dates to ensure they are reviewed every two years (or sooner if necessary), as per the most recent recommendation from SAPG. This activity has been necessarily displaced over the last 18 months by activity related to the COVID-19 pandemic.

7.1.3 Antimicrobial Prescribing Education and Training

Education on antimicrobial prescribing is given at junior doctors' induction to raise awareness and promote use of the guidelines. Training on antimicrobial prescribing is also given at NHS Fife Mandatory Training for Consultants days. The AMT has provided training to community prescribers at protected learning time sessions and clinical forum meetings.

In addition to the education given to medical prescribers, IPCT nurses promote the NES AMS workbook for nurses during induction/core update training. Information on the importance of appropriate antimicrobial use is communicated to all staff at NHS Fife Corporate Induction and Statutory Training. The topic is also included in a presentation given to nursing staff at their induction.

A planned focus on promoting timely switch from intravenous to oral antibiotics is currently on hold, pending return a return to more normal NHS and AMT functioning as the COVID-19 pandemic recedes.

7.1.4 Outpatient Parenteral Antimicrobial Therapy (OPAT)

The OPAT service contributes to prevention of healthcare-associated infections (such as MRSA and *Clostridioides difficile*) by allowing earlier discharge or admission avoidance for patients who would otherwise be confined to hospital solely for the delivery of intravenous antibiotic treatment.

The service also promotes the rational use of antimicrobials, and effective antimicrobial stewardship, through close clinical supervision by infection specialist doctors.

7.2 Cleaning, Decontamination and Estates

7.2.1 Cleaning and Estates Monitoring

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).

The *National Cleaning Services Specification* – quarterly compliance report results for 2020-21 consistently showed NHS Fife achieving GREEN status for both cleaning and for estates monitoring. Results are reported bimonthly to the ICC via the HAIRT report.

7.2.2 Decontamination

The Decontamination Group meets quarterly and receives reports on primary care decontamination in dental Local Decontamination Units (LDU), endoscope decontamination in Endoscope Decontamination Units (EDU), and central decontamination delivered through a Service Level Agreement with Tayside CSSD.

7.2.2.1 Primary Care Decontamination

In NHS Fife, general practice instruments are either single-use or are decontaminated centrally and podiatry services moved to single –use instruments in 2010, so only dental services operate LDUs.

7.2.3 Estates - Equipment Procurement

Nominated IPCNs sit on National Procurement Commodity Advisory Panels (CAPs) and on Board procurement groups as part of NHS Fife's strategy for effective and safe procurement of a wide range of patient related equipment, soft furnishings, furnishings and medical devices.

7.3 IPC Policy Guidance and Practice

7.3.1 Infection Control Manual

The NHS Scotland National Infection Prevention and Control Manual (NIPCM) was first published on 13 January 2012, by the Chief Nursing Officer (CNO (2012)1), and updated on 17 May 2012 (CNO (2012)1 Update).

The NIPCM was endorsed on 3 April 2017 by the Chief Medical Officer (CMO), Chief Pharmaceutical Officer (CPO), Chief Dental Officer (CDO) and Chief Executive Officer of Scottish Care.

The NIPCM provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS Scotland. In all other care settings to support with health and social care integration the content of this manual is considered best practice.

The manual aims to:

- make it easy for care staff to apply effective infection prevention and control precautions
- reduce variation and optimise infection prevention and control practices throughout Scotland
- improve the application of knowledge and skills in infection prevention and control
- help reduce the risk of Healthcare Associated Infection (HAI)
- help alignment of practice, education, monitoring, quality improvement and scrutiny

The NIPCM currently contains guidance on; Standard Infection Control Precautions (SICPs) (Chapter 1), Transmission Based Precautions (TBPs) (Chapter 2) and Healthcare Infection incidents, outbreaks and data exceedance (Chapter 3).

Chapter 3 of the NIPCM was further developed throughout 2020:

The purpose of this chapter is to support the early recognition of potential infection incidents and to guide IPCT/HPTs in the incident management process within care settings.

This guidance is aligned to the Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led Incident Management Teams (2017)

Built environment incidents/outbreaks

HPS are currently working towards delivery of comprehensive evidence-based guidance which will form Chapter 4 of the NIPCM on the built environment and decontamination.

October 2020 saw the addition of:

- Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings

This addendum has been developed in collaboration with NHS boards to provide Scottish context to the UK COVID-19 IPC remobilisation guidance, some deviations exist for Scotland and these have been agreed through consultation with NHS Boards and approved by the CNO Nosocomial Review Group. These processes deviate from the National Infection Prevention and Control Manual normal process for sign off due the timescales for COVID-19 guidance approval.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

The *NHS Fife Infection Control Manual* is available exclusively in electronic format on the NHS Fife StaffLink powered by Blink and NHS Fife external website.

As per **CNO (2012) 01**, Chapter 1 to 3 of the *National Infection Control Manual* are incorporated into the online NHS Fife manual with direct links. Further sections of the *National Infection Control Manual* will replace NHS Fife chapters as they are published.

Implementation of policy elements is monitored through the Infection Prevention and Control Team audit programme and Senior Charge Nurses fulfil the requirements for SICPs auditing laid down in **CNO (2012) 01** and later modified by the CNO letter of 17 May 12.

Manual sections sit under the overarching Infection Control Policy with the status of Standard Operating procedures (SOPs) which are updated on a rolling programme (every two years in line with HAI Standards 2015).

7.3.2 HCAI Education, Training and Development Strategy: Mandatory and Continuing Education

The *HCAI Education, Training and Development Strategy* was developed to ensure that all staff had access to appropriate HCAI education and training. (Line managers are required to ensure all staff have HCAI objectives in their annual personal development plans).

The IPCT in previous years delivered face to face education sessions throughout the year on various Infection Prevention and Control (IPC) topics open to all staff; doctors, nurses, midwives, AHPs, estates and facilities staff, outside contractors and students within NHS Fife. From full day IPC study days in lecture theatres, interactive session at the University

of Dundee School of Nursing to small-scale on-site training delivered at ward level ward and having stands at entrances to hospitals and health centres etc. to reach as many staff and members of the public as possible.

COVID-19 pandemic has necessitated restrictions upon numbers of staff gathering and on non-essential travel. Therefore restricting ability to provide previous models of education and training. The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach and exploring alternatives to face-to-face training.

IPCT 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 StaffLink 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 have been released weekly via StaffLink app, with links for each session providing staff flexibility.

Throughout 2020 and into 2021, the IPCT have delivered education sessions via Microsoft Teams and small numbers of face to face sessions when risk assessed and deemed essential. These are restricted due to requirement for physical distancing at this time, sessions have include Grand Rounds, donning doffing of PPE at ward/department level, Support Services Staff, FPMA Fie Practice managers, FY1 Shadowing week, SCOTGEM medical students, Obstetrics/Gynecology Induction Programme etc there have been 482 staff trained by IPCT.

The IPCT have actively promoted the National IPC education and training resources on COVID-19 available on Health Protection Scotland website and the NES modules, which include eLearning- Respiratory protective equipment (RPE), presentations and webinars on COVID-19 and IPC.

Learning and Development team have provided the following numbers for SIPCEP from Learnpro for 2020. There have been 21,655 individual modules completed for the foundation layer, however this is likely to capture staff who may have completed several modules.

HCAI education is a core component of corporate induction, nurse induction, junior doctors' induction, Consultant Mandatory Programme, and Core Update training programmes and is available as an e-learning module(s) on NHS Fife LearnPro. All NES developed e-learning programmes are available to staff on NHS Fife LearnPro and TURAS Learn.

The IPCT also scrutinises audit and surveillance results and other local data sources i.e. the Dashboard, LanQip, Serious Adverse Event Reviews (SAER) learning identified during incidents and outbreaks as well as intelligence gathered during clinical visits. All of this information is used on an ongoing basis to drive education and training interventions. In addition, intelligence shared nationally through the infection prevention and control community e.g. SICN, from Health Protection Scotland (HPS) etc. is utilised to inform local education and training interventions.

7.3.3 Hand Hygiene

7.3.3.1 Trends

Publication of National Hand Hygiene Audit data ceased in Sept 2013 with Boards moving to reporting of data in their bimonthly HAIRT reports.

Since then, NHS Fife has maintained a consistently high average compliance. The IPCT carry out Hand Hygiene quality assurance audits as part of the *HCAI Prevention and Control of Infection Assurance Framework*.

7.4 Organisational Structures

7.4.1 Public Involvement

A member of the public is invited to sit on the NHS Fife ICC and contribute to the outcomes of the committee.

7.4.2 Communications

The IPCT has a *Prevention and Control of Infections Communications Plan*, which has been in place since June 2011 (updated accordingly). NHS Fife recognises the importance of having a comprehensive set of accurate, relevant and accessible information available for patients and the public. During the year, NHS Fife Communications Team have played a vital role in providing essential communications to the patients, visitors and population of Fife during the COVID-19 pandemic. Patient and public information leaflets on MRSA, *Clostridioides difficile,* Norovirus, Laundering of Patient Clothing, and Infection Control advice for Patients & Visitors have continued to be provided to wards and clinical areas. Leaflets on peripheral vascular devices, Vancomycin Resistant *Enterococcus* (VRE), Carbapenemase Producing *Enterobacteriaceae* (CPE) and MRSA screening are provided on a targeted basis to patients affected by these issues.

In addition to hard copy leaflets distributed to wards and clinics, these have been made available online to ensure that they are available for staff to use when briefing patients and visitors. Translation services are available on request.

In response to HEI requirements, and to ensure that all patients are provided with relevant HCAI information on admission, the general Infection Prevention and Control advice for Patients & Visitors leaflet is available to all clinical areas for distribution. Banner-stand posters aimed at both staff and visitors reinforce key HCAI messages.

7.5 Staff and Leadership

7.5.1 Structures and accountabilities

In October 2015, the IPCT was reorganised to comply with the *Vale of Leven Public Enquiry Report (2014)* recommendations. The IPC team returned to single system working managed by an Infection Control Manager with responsibility for a Fife wide service.

7.6 Quality Improvement

7.6.1 *Quality Improvement Programmes and partnership working with the Scottish Patient Safety Partnership (SPSP)*

During 2019, the IPCT worked collaboratively to support improvement work in preventing SAB, in supporting improvements in Urinary Catheter Care via the Urinary Catheter Improvement Group (UCIG) and in standardising the Standard Infection Control Precautions (SICPs) audit tool, methodology and reporting via the new Safe and Clean Care Audit Framework.

UCIG update for 2020

To support a reduction in Catheter Associated Urinary Tract Infections & complications and to assist achieving the HCAI *e.coli* bacteraemia (ECB) reduction targets by 2022 & 2024, Fife established a Urinary Catheter Improvement Group (UCIG).

This multi-disciplinary and multi-agency programme works across all of Fife, both in the Acute Services Division (ASD) and the health and social care partnership (HSCP) with some initial Care homes involvement.

The UCIG will lead the delivery of an improvement plan linked to the nationally agreed targets with locally agreed milestones to drive improvement.
The four priority areas are the four 'P's:

Promote: Hydration and continence as the first line treatment to enable good bladder health and prevent risk of bladder and bowel dysfunction.

Prevent: Prevent the insertion of unnecessary, long term urinary catheters to reduce the risk of harm and to support effective and person centred care

Protect: Persons with urinary catheters are protected from harm through the application of best evidence and practice.

Prioritise: This will be a clinical and care governance priority with leadership to enable deliver of pathways of care promoting self management, mutual partnerships with carers and care providers across health and social care

The aim of this work is:
To minimise the incidence of urinary catheters
To reduce avoidable harm from urosepsis and associated catheter trauma
To optimise communication of care between all care disciplines & locations
To optimise education around urinary catheter insertion & maintenance for health care workers, patients & carers
To optimise documentation of urinary catheter care across Fife
To improve quality & standardise pathways of urinary catheter care across the system
To optimise the procurement of catheters & associated devices

To ensure governance for all urinary catheters to ensure there is robust, accessible, consistently applied and measures (process and outcome) are reported reliably and consistently to provide assurance and data for improvement.

Initiatives up to 2020 include:

- Implementation of the MORSE electronic Urinary Catheter Insertion and Maintenance bundles for District Nursing documentation.
- Urinary catheter insertion and maintenance bundles to be developed and incorporated into Patientrack for Acute services electronic documentation.
- Trial without catheters (TWOC) in the community supported by the use of bladder scanners
- Quality Improvement CAUTI projects within West Fife District Nurse Teams Pathway for complex catheterisation incorporating use of prophylactic antibiotic cover both in an acute and community setting
- Catheter maintenance solutions reviewed to inform standardised guidance for staff
- Implementation of the national catheter passport
- Roll out plan of urinary catheter valves & Tiemann tip catheters
- Promotion of hydration and optimisation of continence care, by continence services, to all care homes/residential homes in Fife
- All CAUTI ECBs associated with trauma during insertion or removal/self removal, submitted for DATIX to maximise learnings
- Monthly reporting and graphs to support data for governance provided.

Safe and Clean Care Audit Framework

This programme of work was established to standardise the current SICPs audit tool and provide a consistent and reliable method for IPC auditing in NHS Fife. The tool is built on the *National Monitoring Framework to Support Safe and Clean Care Audit Programmes: An Organisational Approach to Prevention of Infection Auditing (2018).*

The *National Monitoring Framework for Safe and Clean Care Audits* has been produced as an agreed recommended minimum approach to auditing for all NHS boards. The framework applies to all audits of prevention of infection practice across primary and secondary care settings. The framework supports a strategic approach to *Safe and Clean Care Audis* in line with the *HIS HAI Standards (2015).*

NHS Fife was the first board in Scotland to develop a tool based on the national framework, which went live September 2019. To help achieve a consistent approach to auditing, there is currently over 400 trained auditors, who have electronic access to the tool. An extensive programme of auditor training was undertaken in 2019, with ongoing refresher training, new user training and senior manager support throughout 2020.

Bespoke Dashboard reporting for each of the divisions was developed in 2020. For 2021 a focus on increasing uptake across NHS Fife with the IPCT supporting clinical teams with their role out of the tool.

People Who Inject Drugs (PWID) SAB Project update for 2020

A reduction in total number of SAB infections were identified in people who inject drugs (PWID) was noted in 2020 with 5 cases, this is down from 13 cases identified in 2019. Ongoing support for this project continued through 2020, however the COVID-19 pandemic

restrictions have impacted Addictions Services, with a greatly reduced footfall through clinics. Patient information leaflets and pocket sized information cards were developed and are available to all Addictions service users on recognising injection site soft skin tissue infections and advice on seeking early treatment. Additionally a Harms Reduction Training refresher was provided December 2020 from the Scottish Drugs Forum, focusing on wound care management, which is in line with national guidance.

For 2021 focus on training Nurse Prescribers within Addiction Services to support timely treatment of skin and soft tissue infections with an aim to continue to reduce SABs and improve Addictions service users safety.

SAB Project "Are you #EPIC?" Ensure every PVC Interaction Complies

A targeted quality improvement (QI), involving ward 44, Victoria Hospital Kirkcaldy, aimed to achieve 300 days without a peripheral vascular cannula (PVC) associated *S. aureus* bacteraemia (SAB). By ensuring each PVC insertion site received 3 observed and recorded checks in a 24 hour period, an increased focus on hand hygiene, with the introduction of a hand hygiene contract the ward devised to reinforce hand hygiene opportunities are taken each and every time, to feel safe and able to challenge others practice and be challenged themselves. The clinical teams QI programme was successful in reducing their SAB incidence, reaching an impressive 278 days without a PVC associated SAB.

7.7 Surveillance

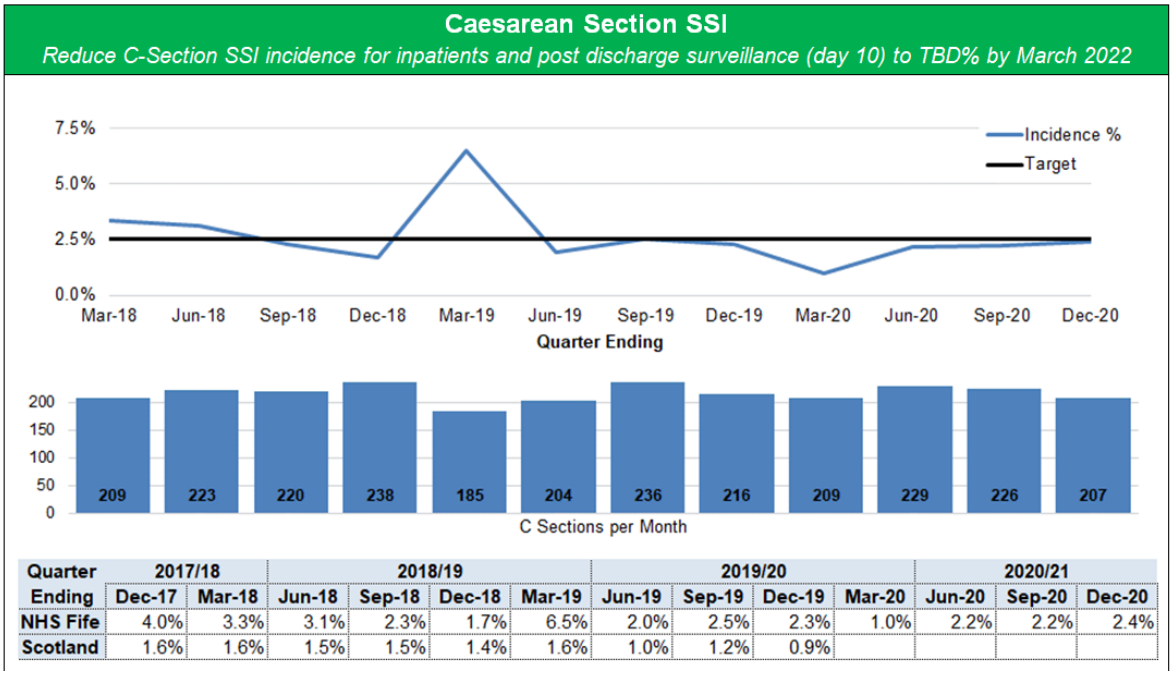
7.7.1 Surgical Site Infection (SSI)

A CNO letter on 25 March 2020 advised of changes to HAI surveillance requirements with temporary changes to routine surveillance:

- All mandatory and voluntary Surgical Site Infection (SSI) surveillance should be paused until further notice.

7.7.1.1 Caesarean section

Due to the 2020 COVID-19 pandemic, there has been a temporary pause on SSI surveillance, until further notice from Scottish Government. Maternity Services have continued to monitor their Caesarean Section SSI cases liaising with the IPCT and incidence of infections reported via Fife Integrated Performance and Quality Report. Note that the performance data provided is non-validated and does not follow the agreed NHS Fife Methodology, and that no national comparison data has been published since Quarter 4 2019.



Quarter	2017/18		2018/19				2019/20				2020/21		
Ending	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20
NHS Fife	4.0%	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%	1.0%	2.2%	2.2%	2.4%
Scotland	1.6%	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%				

Table 2 - from the local surveillance of Caesarean section SSI, throughout all of 2020, NHS Fife consistently achieved infection incidence rates below the reduction target. Aim for 2021 to continue to sustain this improvement.

The SSI Implementation Group continued to meet, until the group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there is a robust system in place for reviewing any Deep or Organ Space SSI cases via a local adverse events review (LAER). The group will re-establish should any future concerns develop.

7.7.1.2. Hip Arthroplasty

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.3. Large Bowel

All Large Bowel surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.4.a Standards on Reduction of Healthcare Associated Infections:

The New standards have been announced by the Scottish Government's Chief Nursing Officer in October 2019 for the reduction of Healthcare Associated Infections (Hospital acquired (HAI) & Healthcare associated (HCAI)) for the following:

For *E. coli* bacteraemia (ECB)

- New LDP standards are to reduce incidence of healthcare associated ECB by **25%** from 2019 to 2022, utilising 2018/19 as baseline data
- And a 2nd reduction standard of **50%** by 2023/24 (from 2018/19 baseline):

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 TBDs	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**

1) 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 TBDs	**44.0** per 100,000 TBDs	**22.0** 100,000 TBDs
ECB by Number of HCAI cases	**160**	**80**

For *Clostridioides difficile* infection (CDI)

- New LDP standards are to reduce incidence of healthcare associated CDI by **10%** from 2019 to 2022, utilising 2018/19 as baseline data:

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**

For *Staphylococcus aureus* bacteraemia (SABs)

- New LDP standards are to reduce incidence of healthcare associated SAB by **10%** from 2019 to 2022, utilising 2018/19 as baseline data:

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 BDs	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**

7.7.1.2 Escherichia coli Bacteraemia (ECB)

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli,* and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals, care homes, under social care and the wider community.

Nationally during 2020, there were 4,206 cases of ECB in Scotland with a rate of 77.0 per 100,000 population. Rates have decreased since 2016, however, the rate of healthcare associated ECB has increased 4.3% over the last 4 years; the reasons for which are being

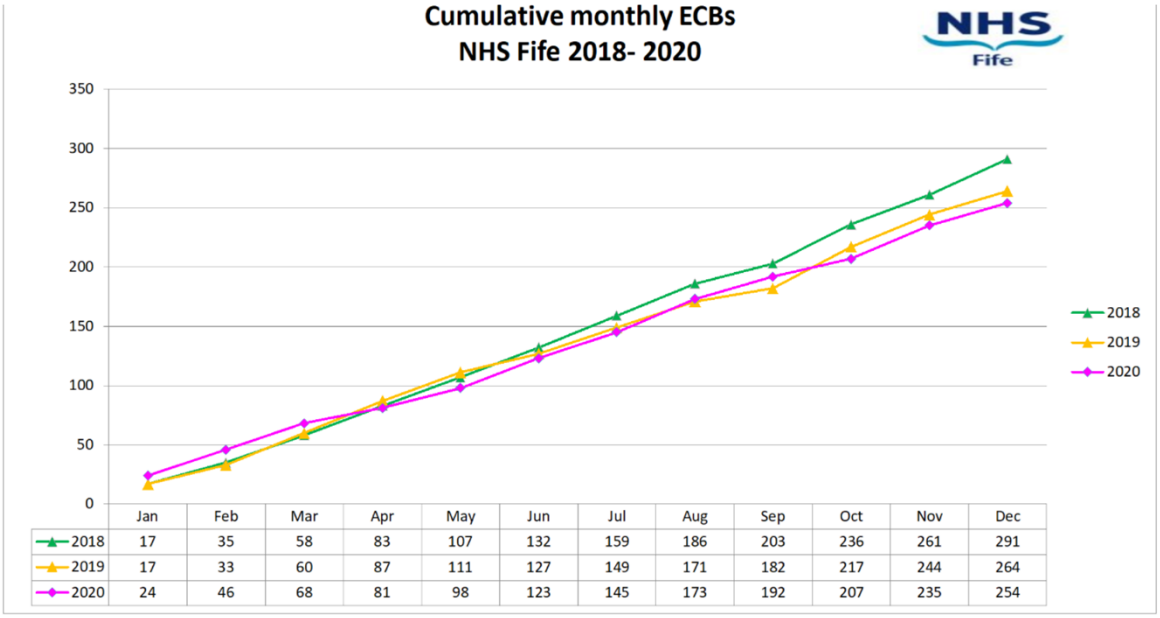
investigated as part of the Gram-negative bacteraemia programme. In 2020, the incidence rate of healthcare associated ECB was 39.7 per 100,000 bed days and remains stable compared with 2019. The incidence rate of community associated ECB in 2020 was 39.1 per 100,000 population, this is a decrease from the 2019 community associated ECB rate.

The ECB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the first lockdown starting on 23rd March 2020 all elective surgery and medical admissions were paused. This may have influenced the number of hospital acquired ECB.

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). The letter set out a reduction of 50% in healthcare associated E. coli bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22 (2018/19 should be used as the baseline)

Between 1st January and 31st December 2020 there were 254 episodes of ECB. A reduction from year end 2019 (see Figure 2).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	17	35	58	83	107	132	159	186	203	236	261	291
2019	17	33	60	87	111	127	149	171	182	217	244	264
2020	24	46	68	81	98	123	145	173	192	207	235	254

Figure 2- Cumulative monthly ECBs NHS Fife 2018-2020

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 December 2020 (HPS)		
ECB by rate 100,000 Total bed days	45.5 per 100,000 TBDs	
ECB by Number of HCAI cases	138	

144 occurred in females and 110 in males, Figure 3 demonstrates the trend in the number of ECB over the last five years split by gender.

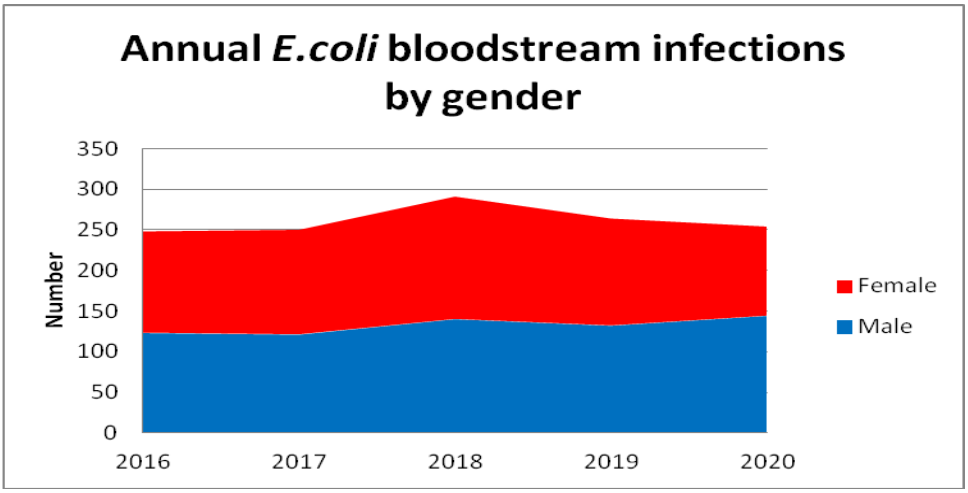


Figure 3: Trend in ECB by gender

Surveillance has shown gender does have a role to play in the entry points for ECB. Males are more likely to have a urethral catheter as the cause of an ECB, while lower UTI as an entry point is more common in women.

Of the 254 ECB cases identified in Fife; 50 (19.7%) episodes were hospital acquired and 204 (80.3%) were non hospital acquired. Non hospital ECB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections. Table 3 Demonstrates the age and gender of patients with a hospital or non hospital acquired ECB

	Hospital acquired infection* (*n*=50)	Healthcare associated infection* (*n*=87)	Community Acquired infection* (*n*=117)	Total ECB (*n*=254)
	n (%)	n (%)	n (%)	n (%)
Male	34 (68.0)	49 (56.3)	61 (52.1)	144 (43.3)
Female	16 (32.0)	38 (43.7)	56 (47.9)	110 (56.7)
Age: mean (Range) years	64.9 (22 – 92)	61 (0-83)	57.1 (10 – 91)	61.0 (0 – 92)

Table 3 Age and gender split by origin of infection
*The origin of a ECB is defined in the Enhanced *E. coli* Bacteraemia Surveillance Protocol

Figure 4 demonstrates the trend between hospital acquired and non-hospital ECB over the last five years.

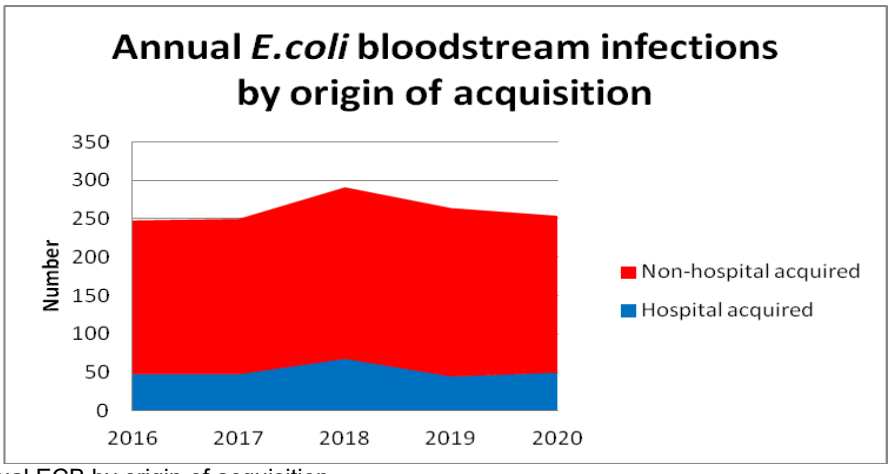


Figure 4: Annual ECB by origin of acquisition

Figure 5 presents data on the entry point of each hospital acquired ECB by system during 2020.

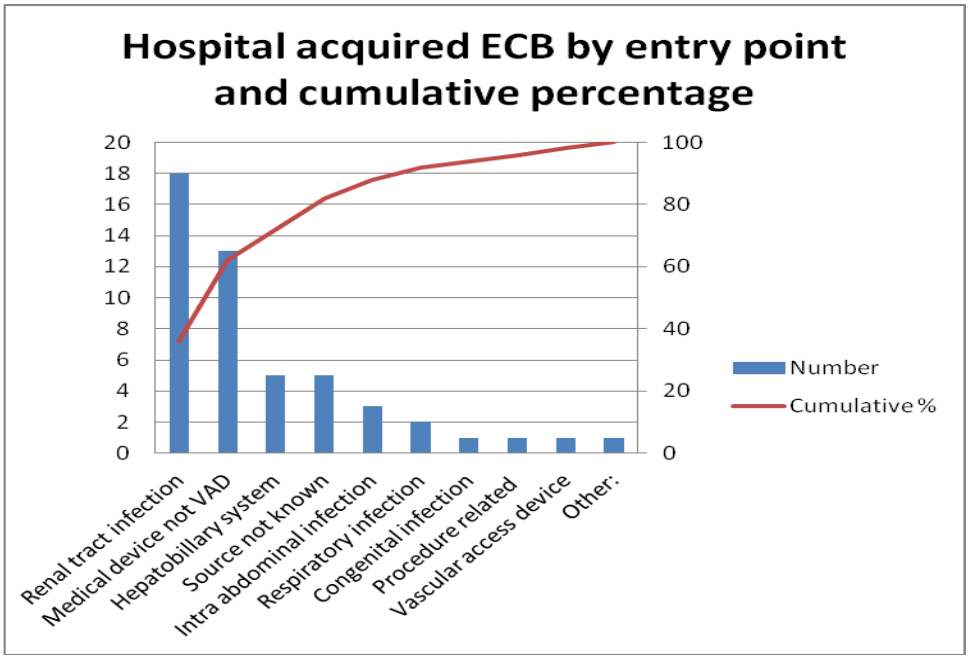


Figure 5: Pareto chart demonstrating the entry point by system of each hospital acquired ECB.

All thirteen “Medical device not VAD” were due to catheter associated UTI (CAUTI).
15 of the “Renal tract infections” were due to lower UTI, two were due to pyelonephritis and one was the result of infected urostomy urine

Figure 6 presents data on the entry point of each non hospital acquired ECB episode during 2020.

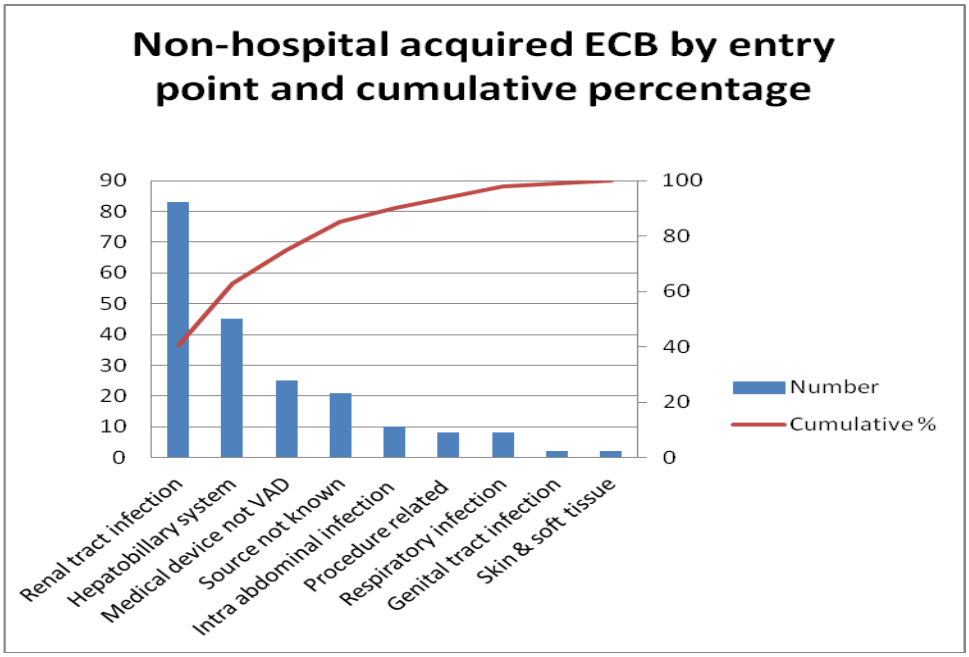


Figure 6: Pareto chart demonstrating the entry point by system of each non hospital acquired SAB.

Figure 7 demonstrates the entry point for non-hospital acquired ECB that are related to the renal tract.

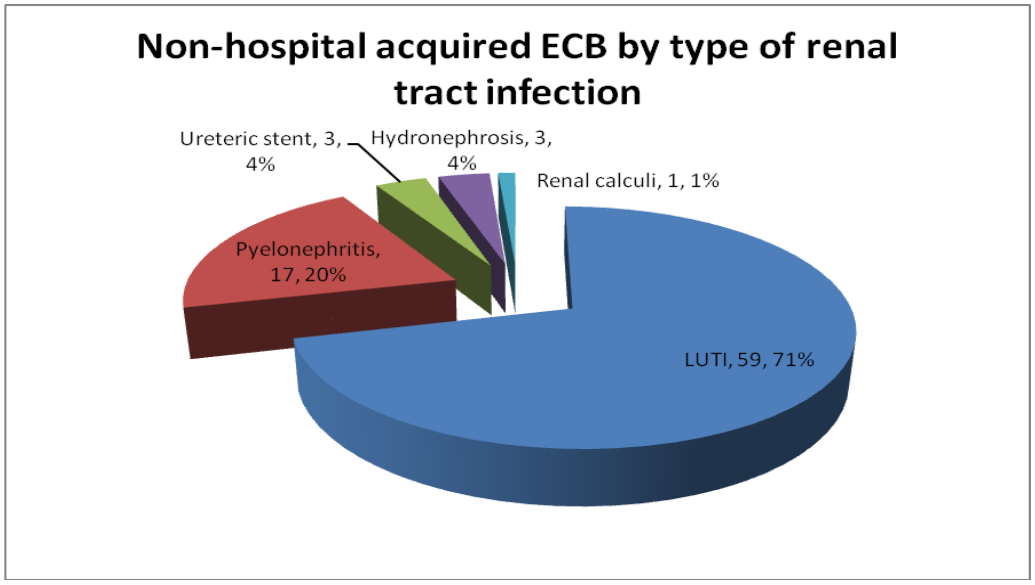


Figure 7: Non-hospital acquired ECB by renal tract entry point

Figure 8 demonstrates the entry point for all non-hospital acquired ECB due to a non-VAD medical device.

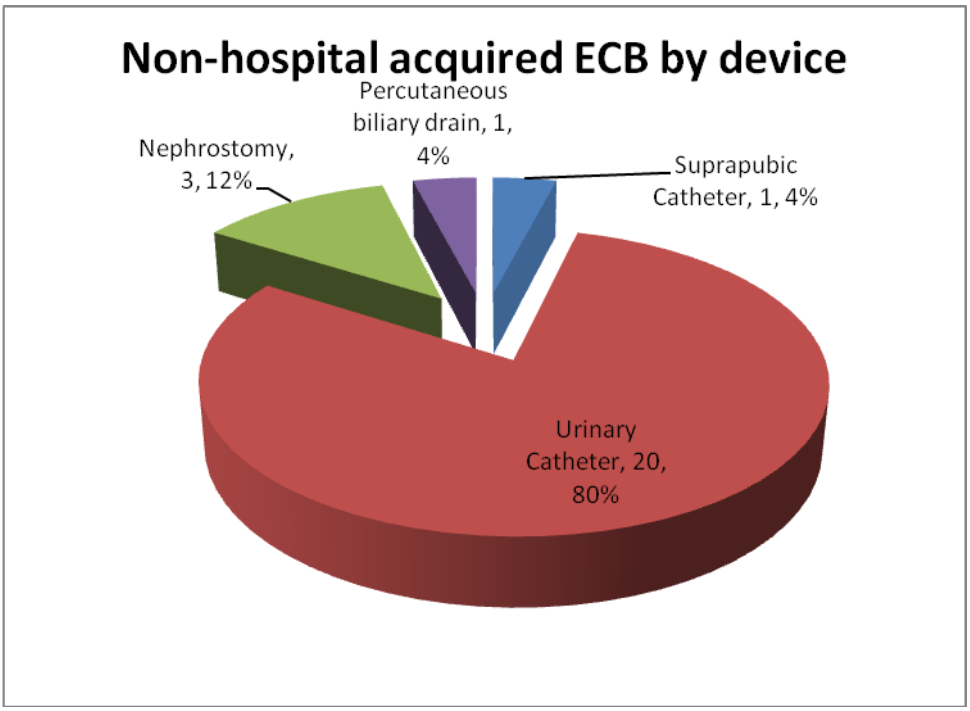


Figure 8: Non-hospital acquired ECB by device

Local reduction targets:

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 December 2020 (HPS)	
ECB by rate 100,000 Total bed days	**45.5** per 100,000 TBDs
ECB by Number of HCAI cases	**138**

SUMMARY

- The total number of ECB remains static over the last five years
- ECB are evenly split by gender. The age range for an *E.coli* bloodstream infections is skewed towards the over 50s in non-hospital acquired infections and over 60years of age if acquired in hospital. This possibly reflects the age of patients admitted to hospital and co-morbidities.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by urethral catheters. However in hospital acquired ECB, urethral catheters are the second most common source of infection.
- Hospital patients only account for ~20% of the total ECB therefore reducing ECB to achieve the LDP will require infection prevention measures in both the hospital sector and in the Health and Social Care Partnerships.

Quality improvement programs need to focus on greater awareness and improved management of UTI and CAUTIs in patients; to prevent these infections developing into bloodstream infections.

Current challenge	Improvement Actions	Timescale review
Achieve HPS reduction of Healthcare associated ECBs by 25% by April 2022 & 50% by April 2024	Optimise communication with key clinical teams Monthly reporting & graphs of ECB data across Acute services & HSCP to increase learning around CAUTIs, UTIS & other sources	Annually
Address the high incidence of ECBs due related to urinary catheter (CAUTIs) as source	Ongoing support and communication within the Urinary Catheter Improvement Group (UCIG) Monthly reports & graphs to UCIG Monthly graphs of Days between ECB CAUTIs Monthly graphs of Days between ECB CAUTIs with associated trauma DATIX all trauma associated ECB CAUTIs to increase learning- for learning's to be fed back to UCIG	Annually

7.7.3. *Clostridioides difficile Infection* (CDI)

Clostridioides difficile is a bacterium found in people's intestines. Healthy people may have in gut flora, where it causes no symptoms. However, it may cause disease when the normal bacteria in the gut are disadvantaged, usually by antibiotics. When *C. difficile* is

able to multiply this allows its toxins to reach levels where it attacks the intestines and causes mild to severe diarrhoea. *C. difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel.

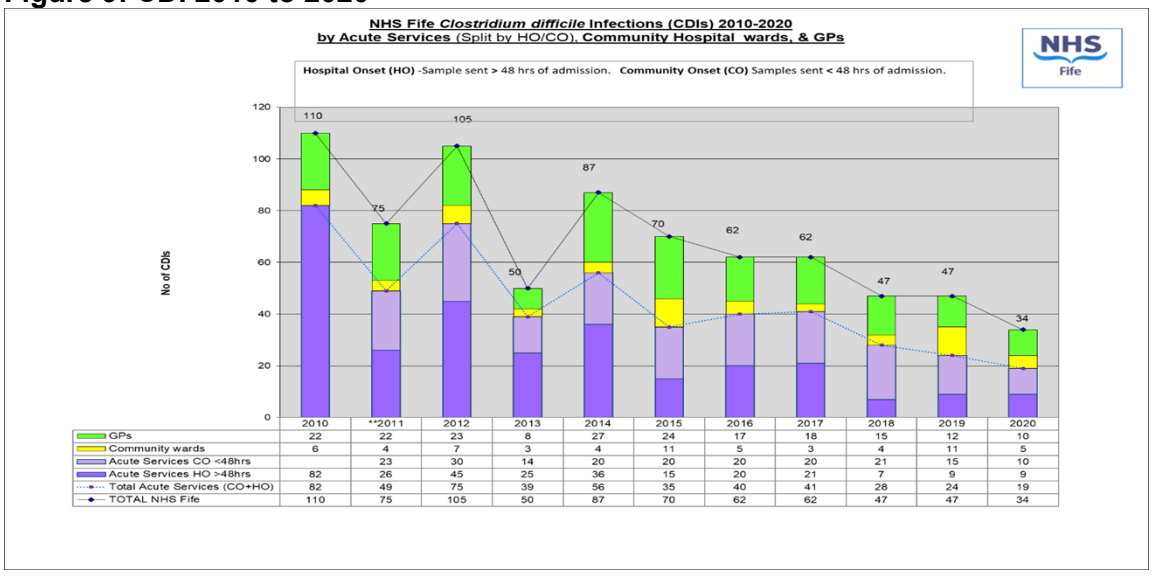
Nationally during 2020, 1,088 cases of CDI in patients aged 15 years and older were reported in Scotland. There was a decreasing year on year trend in the incidence rates between 2016 and 2020. Much of the decline in CDI can be attributed to a decrease in community associated CDI. In 2020, the incidence rate of healthcare associated CDI was 15.6 per 100,000 bed days, this is an increase from 2019. The incidence rate of community associated CDI in 2020 was 5.0 per 100,000 population and remains stable compared with the 2019.

NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 10 years (see Figure 9). Much improvement work has taken place to address this issue and to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback /information is provided to those responsible for the patient care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control meausures.

Each improvement strategy has contributed to the reduction since 2010 :-

- 69% overall reduction in cases
- 77% reduction in the Acute Services Division (ASD)
- 46% reduction in community wards and GP surgeries

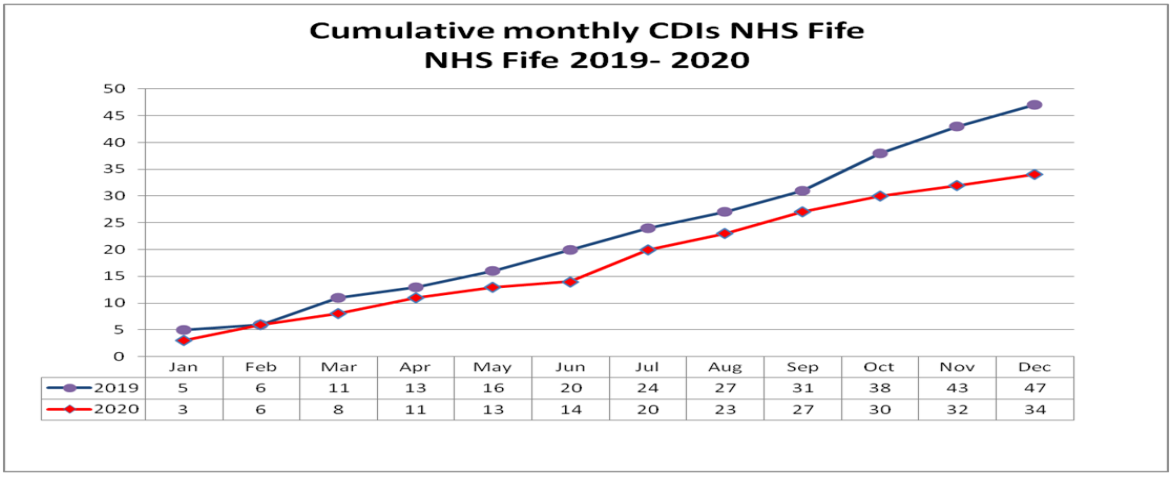
Figure 9: CDI 2010 to 2020



CDIs for 2020

During 2020, there were 34 cases of CDI in patients aged ≥15 years in Fife, which is a 28% decrease from 2019 (47 CDI cases). This includes all healthcare (HCAI) & community (CAI) acquired infections. Reducing HCAI CDIs remains an ongoing challenge however to achieve our 10% reduction target.

Figure 10: CDI cumulative graph for 2019-2020 for all HCAI & CAIs



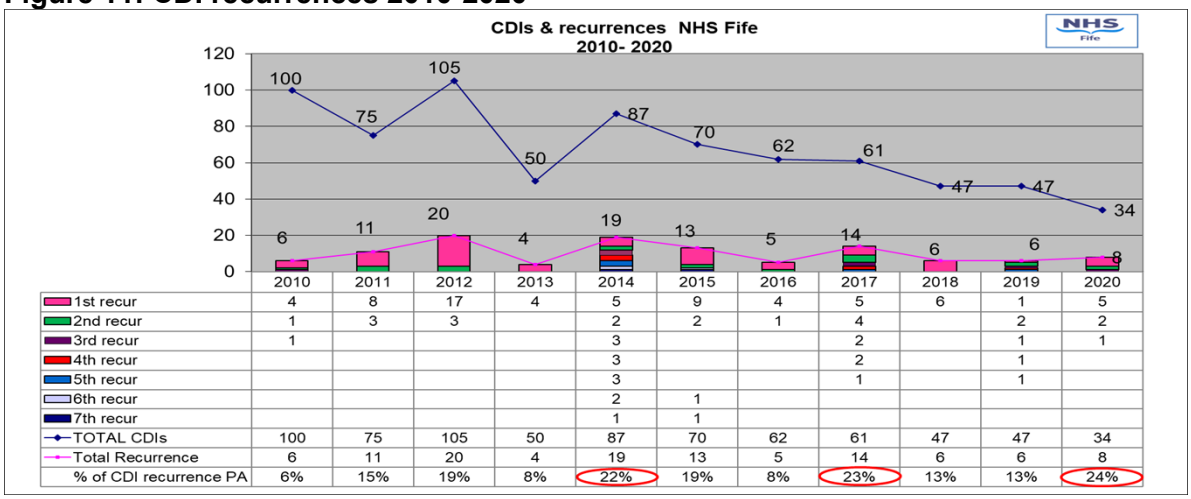
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	5	6	11	13	16	20	24	27	31	38	43	47
2020	3	6	8	11	13	14	20	23	27	30	32	34

Recurrence of CDI

The pioneering work focused on reducing the number of recurrent infections and improving patient outcome has continued throughout 2020. Recurrence remains an ongoing challenge for NHS Fife, contributing to 24% (see Figure 11) of the total number of Fife CDI cases in 2020.

2019 saw the launch of pioneering treaments; Extended Pulsed Fidaxomicin (EPFX) regime and the use of commercial FMT (Faecal microbiota transplantation). Unfortunately, the commercial FMT is currently unavailable in Scotland due to COVID-19. However, Bezlotoxumab is also presently being used in Fife for recurrent infection.

Figure 11: CDI recurrences 2010-2020

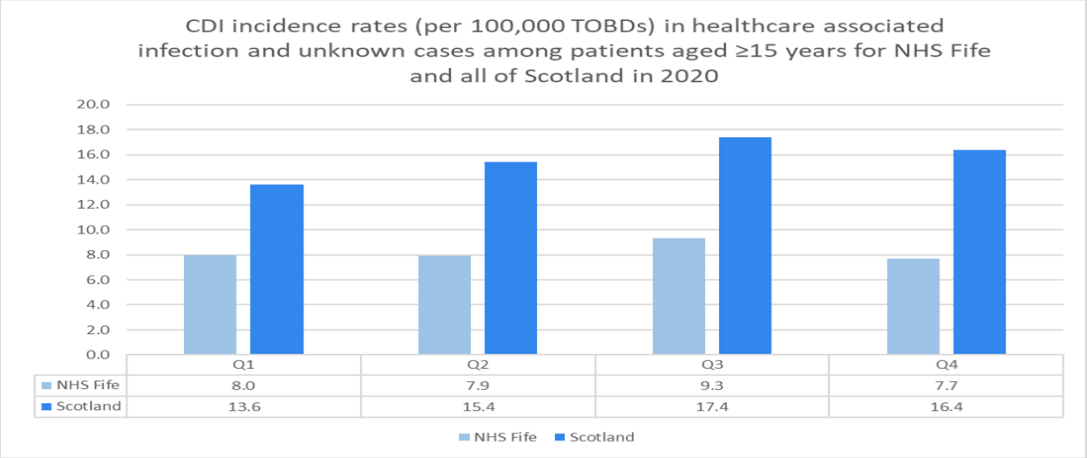


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1st recur	4	8	17	4	5	9	4	5	6	1	5
2nd recur	1	3	3		2	2	1	4		2	2
3rd recur	1				3			2		1	1
4th recur					3			2		1	
5th recur					3			1		1	
6th recur					2	1					
7th recur					1	1					
TOTAL CDIs	100	75	105	50	87	70	62	61	47	47	34
Total Recurrence	6	11	20	4	19	13	5	14	6	6	8
% of CDI recurrence PA	6%	15%	19%	8%	22%	19%	8%	23%	13%	13%	24%

National context

Fife has remained below the national comparator for each quarter in 2020.

Figure 12: National comparison of Fife CDI quarterly incidence rates in healthcare associated infection and unknown cases amongst patients ≥ 15 years



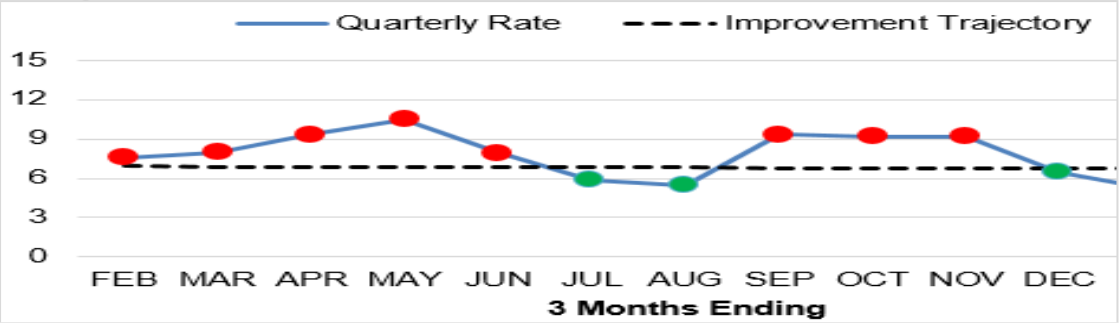
Target reduction of HCAI CDIs

NHS Fife remains committed to achieving the standard for reducing all Healthcare Associated CDIs by 10% by 2022 (from 2018/2019 baseline), see below:-

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**

Figure 5 demonstrates the challenge for NHS Fife to achieve the 10% reduction target by April 2022 although by Dec 2020, the trajectory line was met. It will remain an ongoing challenge for 2021, to further reduce Healthcare Associated CDIs, to meet the target reduction by 2022.

Figure 13: NHS Fife CDI Quarterly rate against the Improvement Trajectory (3 months ending)



Challenges identified in 2020

Recurrent CDI remains an ongoing challenge in NHS Fife.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2022
Continue stewardship advice where any inappropriate prescribing is identified.
General advice against using of quinolones wherever possible is given to both GPs and hospital doctors as part of routine antibiotic advice.

Management of recurrence of CDI for 2020 & for 2021

Patients with recurrent CDI are advised pulsed Fidaxomicin and are followed up until day 30.

Bezlotoxumab has been used in cases where other modalities have failed.

Key actions for 2021

Continued surveillance and follow up of CDI cases.

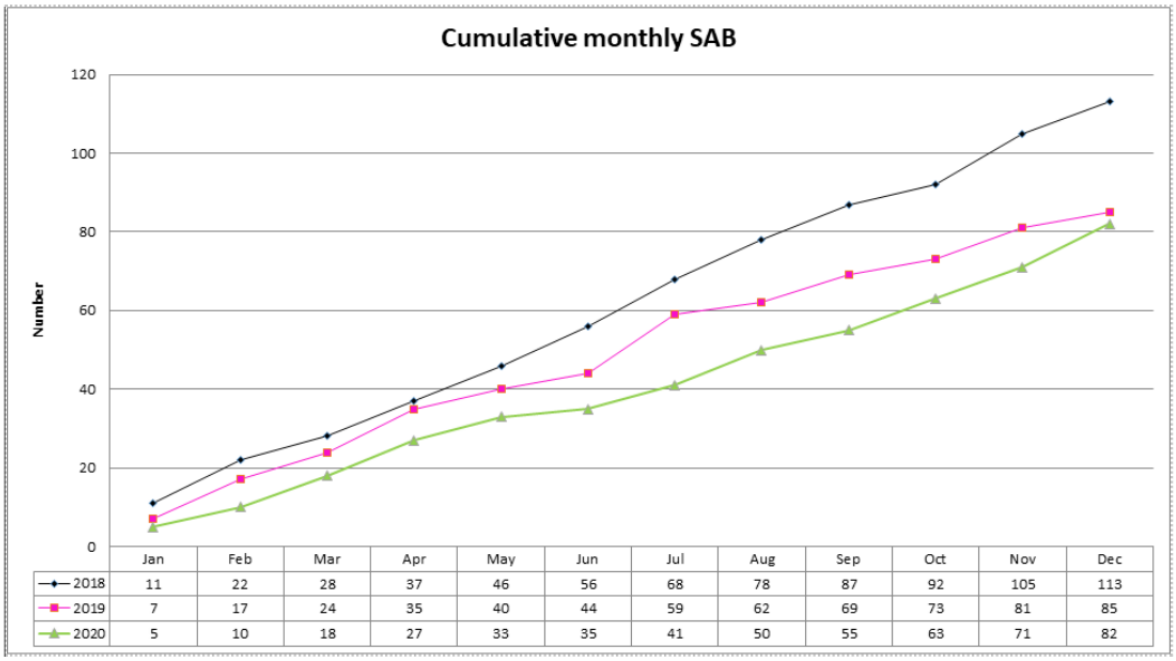
7.7.4 *Staphylococcus aureus Bacteraemia (SAB)*

Staphylococcus aureus is a bacterium that commonly exists on human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. If the bacteria enter the body, illnesses, which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves, pneumonia and blood stream infection (bacteraemia).

Nationally during 2020, 1,501 cases of SAB were reported in Scotland, with 2.6% reported as meticillin resistant S. aureus (MRSA) bacteraemias and 97.4% as meticillin sensitive S. aureus (MSSA) bacteraemias. There was a decreasing year on year trend in both overall SAB and in MRSA between 2016-2020, however the incidence rate of MSSA has not changed over this time period.

In 2020, the incidence rate of healthcare associated SAB was 18.0 per 100,000 bed days, this is an increase from the 2019. The incidence rate of community associated SAB in 2020 was 10.3 per 100,000 population and remains stable compared with the 2019. The main entry point for healthcare associated cases was relating to a device whereas skin and soft tissue infection were the main entry point for community associated cases

NHS Fife during the surveillance period there was a total of 82 SAB. 79 SAB were identified in the Victoria Hospital and three were acquired in Queen Margaret Hospital. None of the other hospitals in NHS Fife or patients under the care of Hospital at Home acquired a *S. aureus* bacteraemia.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	11	22	28	37	46	56	68	78	87	92	105	113
2019	7	17	24	35	40	44	59	62	69	73	81	85
2020	5	10	18	27	33	35	41	50	55	63	71	82

Figure 14

The SAB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the first lockdown starting on 23rd March 2020 elective admissions to hospitals were stopped and all elective surgery and medical admissions were paused. This may have influenced the number of hospital acquired SAB. There were certainly less peripheral vascular catheters inserted. However COVID-19 infections also resulted in four *S.aureus* blood stream infections as a result of post COVID *S. aureus* pneumonia associated with mechanical ventilation (ventilator associated pneumonia).

Between 1st January and 31st December 2020 there were 82 episodes of SAB. 82 (100%) were due to MSSA and none were due to MRSA. Figure 15 demonstrates the trend of SAB over the previous 15 years.

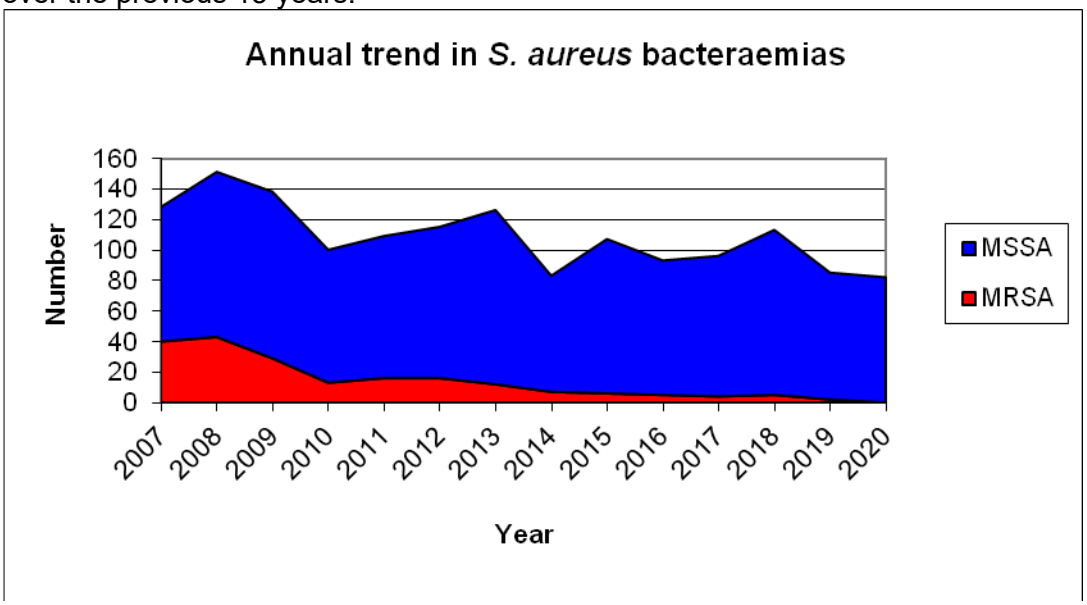


Figure 15: Trend in SAB

37 (45.1%) of SAB episodes were hospital acquired and 45 (54.9%) were non hospital acquired. Non hospital SAB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections. Table 4 demonstrates the age and gender of patients with a hospital or non hospital acquired SAB

	Hospital acquired infection* (*n*=37)	Healthcare associated infection* (*n*=8)	Community Acquired infection* (*n*=37)	Total SAB (*n*=82)
	n (%)	n (%)	n (%)	n (%)
Male	26 (70.3)	7 (87.5)	24 (64.9)	57 (69.5)
Female	11 (29.7)	1 (12.5)	13 (35.1)	25 (30.5)
Age years: mean (Range)	64.9 (22 – 92)	61 (0-83)	57.1 (10 – 91)	61.0 (0 – 92)
MRSA	0	0	0	0 (0.0)
MSSA	37	8	37	82 (100)

Table 4 Age, sex and susceptibility to meticillin of each SAB by origin

*The origin of a SAB is defined in the Enhanced *S. aureus* Bacteraemia Surveillance Protocol April 2016, Version 1.0

Figure 16 presents data on the entry point of each hospital acquired SAB during 2020.

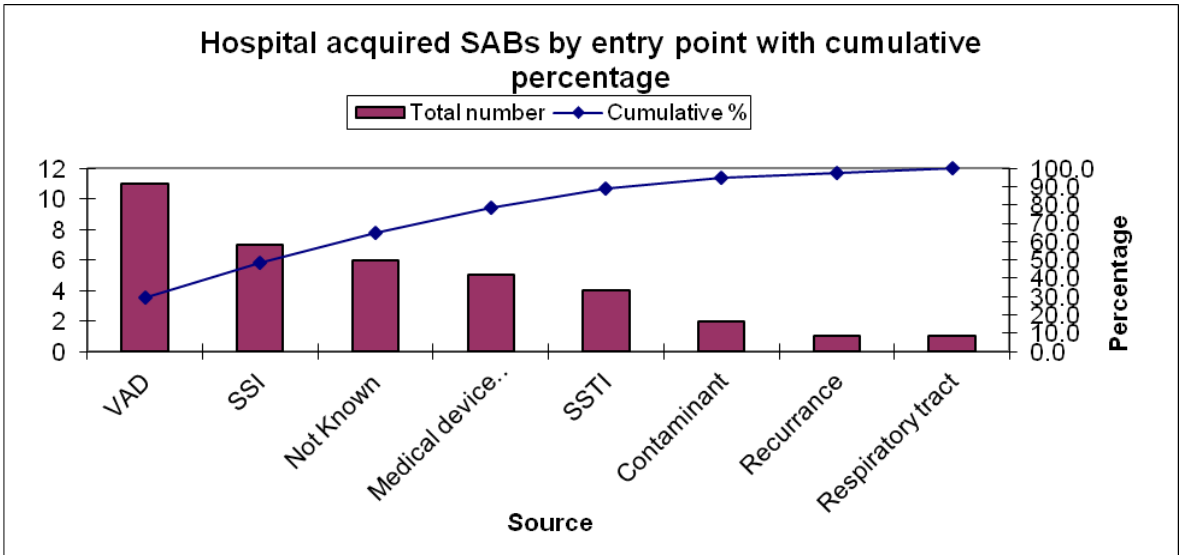


Figure 16: Pareto chart demonstrating the entry point of each hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection.

Figure 17 provides a breakdown of the different types of vascular access device for every hospital acquired SAB episode where a VAD was identified as the entry point for the bacteraemia.

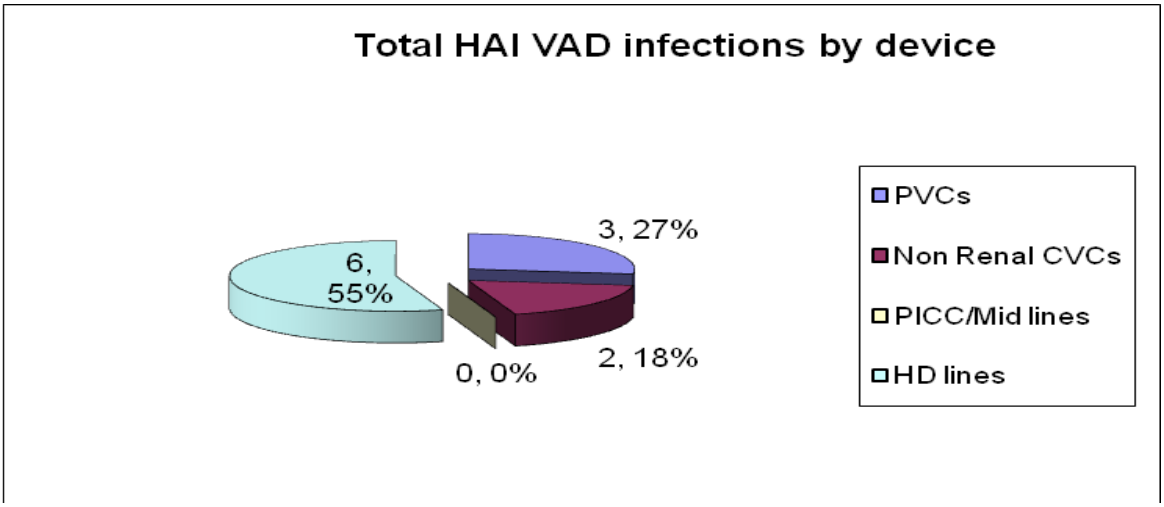


Figure 17: Types of VAD infection in 2019. PVC=peripheral vascular catheter, HD=haemodialysis, CVC-central venous catheter. PICC=peripherally inserted central catheter

Figure 18 demonstrates the trend in hospital acquired SAB over the last six years in relation to the entry point for the bacteraemia.

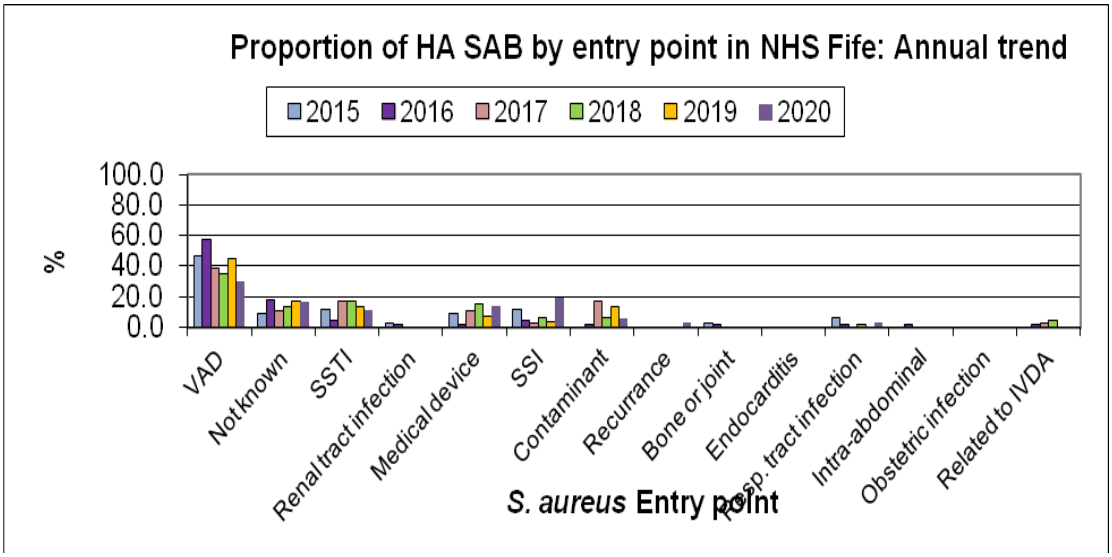


Figure 18: Trend in the entry point of hospital acquired SAB over six years. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection, SSI=surgical site infection

Figure 19 presents data on the entry point of each non hospital acquired SAB episode during 2020.

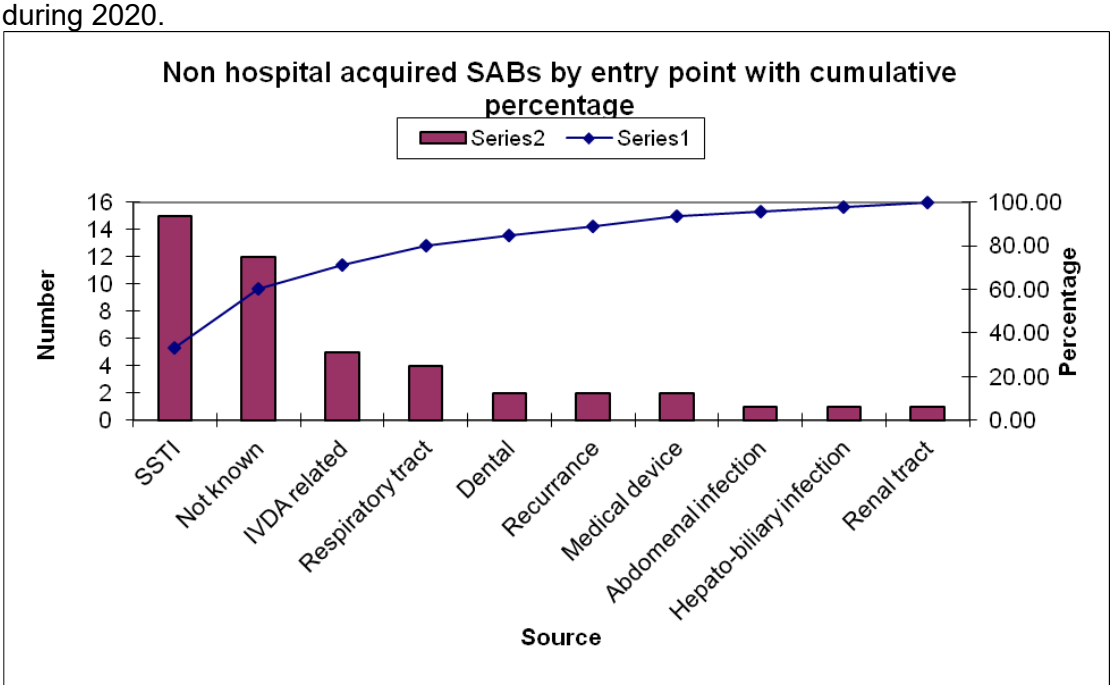


Figure 19: Pareto chart demonstrating the entry point of each non hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified,.

SUMMARY

1. Compared to 2019 there has been a 3.5% decrease in the number of SAB. This is the lowest annual total on record.
2. In 2020 there were no MRSA bacteraemia. This is the first year NHS Fife has recorded no MRSA bloodstream infections using blood culture records in the Laboratory Information management System (LIMS). The LIMs was introduced in 1997. **NHS Fife has achieved the local improvement target** set by the ICC for MRSA bacteraemia to be less than 5% of total *S. aureus* bacteraemias.
3. The proportion of hospital acquired SAB in 2020 increased to 45.1% from 31.7% in 2019.

4. The proportion of VADs resulting in a hospital acquired SAB in 2020 has reduced to 29.7% from 44.8% in 2019. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. Three SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The proportion of non-hospital SAB due to Illicit IV drug decreased from 14 episodes in 2019 to 5 episodes in 2020, 64.3% reduction.
7. Figures 2 and 5 indicate the areas where effort needs to be focused to reduce SAB further; vascular access devices, skin and soft tissue infections plus people who inject drugs.
8. In 2020 there has been an increase in SABs related to surgical site infections

LOCAL TARGETS TO BE ACHIEVED BY END 2020

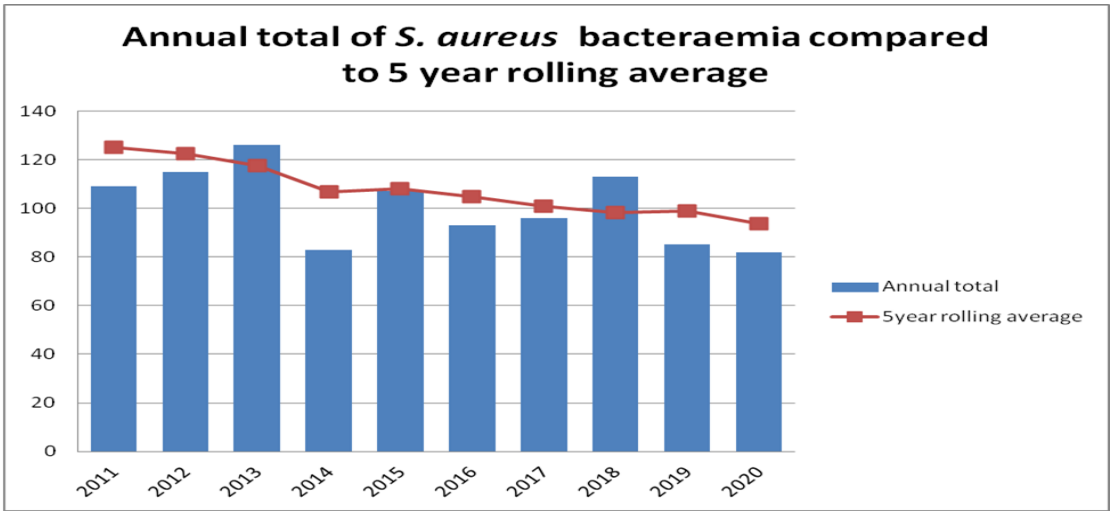
	Local targets first set in 2014	Review end 2019	Review end 2020
1	Meticillin resistant *S. aurues* to be ≤5% of total *S. aureus* bacteraemia.	Proportion = 2.4% **Target achieved**	No MRSA bacteraemia **Target achieved**
2	Vascular access device SAB to be ≤35% of hospital acquired SAB.	44.8% of HAI SAB due to VAD **Failed to achieve target**	29.7% of HAI SAB due to VAD **Target achieved**
3	Total number of PVC related SABs to be halved compared with 2013. (Total in 2013 was 12)	Six PVC related SAB. **Target achieved**	Three PVC SAB **Target achieved**

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). All Health Boards have to achieve a 10% reduction in Healthcare associated SAB by 2021/22 using 2018/19 as the base year. This requires NHS Fife to have no more than 66 Healthcare associated SABs by 2021/22. NHS Fife is on track to achieve the target by 31st March 2021 and will need to maintain consistency.
NOTE: Healthcare associated SAB referred to in the DL (2019) 23 include hospital acquired SAB plus Healthcare associated SAB discussed defined in this report. Trend data

Chart 1 demonstrates annual number of *S. aureus* blood stream infections compared to the five year rolling average. Identifies the long term trends set against the spikes and troughs set against individual years. Using the 5 year rolling average a subjective judgement can be made on the Health Boards performance in any one year.

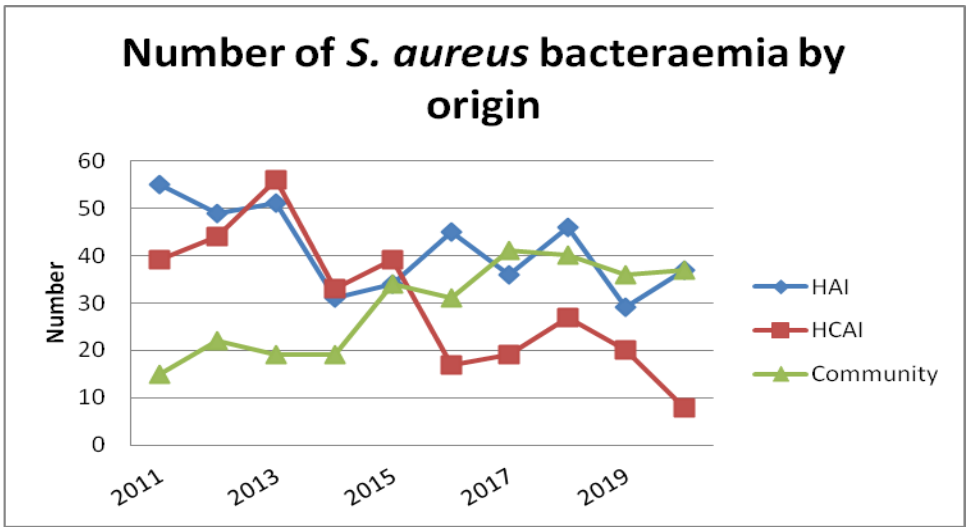
Chart 1: Fife year rolling average of SAB against annual total



Total number of SAB per annum	Performance rating
≥100	Poor
90-99	Average
80-89	Very good
70-79	Excellent

Chart 2 demonstrates the trend in *S. aureus* blood stream infection acquisition by patients and the healthcare sector which requires targeting to reduce the total annual number of *S. aureus* bacteraemia.

Chart 2: Trend in *S. aureus* bacteraemia by origin of acquisition



7.7.5 2019 Surveillance Summary:

- Surgical Site Infection (SSI) rates pause to national programme

- Rates for Caesarean Section achieved local incidence targets, however there are no National comparators due to cessation of the Mandatory National SSI programme

- *Escherichia coli* bacteraemia (ECB), NHS Fife witnessed a decrease in the total number of cases in 2020 compared to 2019. Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate

- *Clostridioides difficile* infection (CDI) rates continue at a low level, achieving rates below the national average: for HCAI Infection Rate and community associated infection rates. In 2020 NHS Fife achieved the best year for total number of infections in NHS Fife (n= 35). Pioneering work to reduce incidence of recurrent infection introduced in 2019 and continued through 2020.

- The total number of SAB rate for NHS Fife in 2020, was the lowest year with 82 cases reported. There were NO MRSA bacteraemias identified in 2020, the lowest number on record and the fourth consecutive year where the proportion of invasive MRSA has been less than 5%.

- 2020 did not see norovirus outbreaks or influenza outbreaks.

- COVID-19 incidents and clusters – 22 reported to ASRHAI Scotland, wards and staff demonstrated great commitment and effort working well with IPCT during the COVID-19 pandemic.

- ***7.7.6 National MRSA and CPE screening programme***

The number of carbapenemase-producing organisms (CPOs) overall remains low, however in Scotland a total of 59 CPO were reported in 2020. Incidence of CPO isolates decreased from 2.3 per 100,000 population in 2019 to 1.1 per 100,000 population in 2020

The MRSA Screening Key Performance Indicator (KPI) for 2020-2021 remains set as '*90% of all acute admissions must have CRA within 24 hrs of admission'.*

Table 6: MRSA CRA Compliance to end 2020

MRSA				
MRSA Critical risk assessment (CRA) screening KPI compliance summary:				
Quarter	**Q1 2020 Jan-Mar**	**Q2 2020 April- June**	**Q3 2020 Jul-Sept**	**Q4 2020 Oct-Dec**
Fife	83%	98%	88%	98%
Scotland	87%	84%	86%	82%

Table 7: CPE CRA Compliance to end 2020

CPE (*Carbapenemase Producing Enterobacteriaceae*)				
For 2020, CRA has also included screening for CPE				
Quarter	**Q1 2020 Jan-Mar**	**Q2 2020 April- June**	**Q3 2020 Jul-Sept**	**Q4 2020 Oct-Dec**
Fife	93%	95%	85%	**98%**
Scotland	85%	80%	85%	79%

Compliance with MRSA CRA completion fluctuates however is predominantly above the Scottish national average and within the 90% compliance target in 2020 (Table 6). Compliance with CPE CRA has improved since 2019 (Table 7). The IPC are working closely with Excellence in Care, who have developed a national tool for Multi-Drug Resistant Organisms surveillance, which is be used locally. This tool will support a consistent pathway for the clinical risk assessment of patients and patient placement.

7.7.7 Outbreaks and Incidents

7.7.7.1 Norovirus

The year of 2020 saw a decrease in the number of ward and bay closures due to Norovirus in comparison with the year before (2019): there were NO ward closures.

7.7.7.2 Other Outbreaks

For the year of 2020 there were NO wards/bays closed due to Influenza and/or other respiratory illnesses such as Rhinovirus and Respiratory Syncytial Virus (RSV).

7.7.7.3 COVID-19 Clusters and Incidents related to healthcare

The IPCT provided support to clinical teams to investigate and implement control measures during the COVID-19 pandemic which saw a significant increase in incidence of COVID-19 respiratory illness. There were 22 incidents/clusters that involved patients and/or healthcare workers.

7.7.8 Infection Control Audits

The IPC audit programme provides assurance to the organisation that the required HAI standards are being met board wide. The focus is on intelligence led auditing which will assist in validating the ward level audit programme and ensure a consistent approach is taken.

A two-year rolling programme was initially commenced in August 2016 and again in 2018; which encompasses all divisions and a wide range of clinical areas.

Due to the COVID-19 pandemic response there was 2 pauses to the programme of audit during 2020; March – June and December. As part of the remobilisation of services, the audit programme was recommenced in July 2020 with the appointment of a part time IPC Audit Nurse.

The IPC nurses prioritise areas where issues with compliance have been identified through either observation or other assurance processes provided by other services within the board.

Monitoring and reporting of Estates issues is conducted by the domestic teams as part of NHS Scotland National Cleaning Standards monitoring and Quality Assurance team undertake additional audits.

Auditing of Standard Infection Control Precautions is the responsibility of Senior Charge Nurses (SCNs) as part of the Leading Better Care Programme (LBC). In addition to this, the IPC launched the new *Safe and Clean Care Audit* framework in September 2019 with mixed initial uptake. A renewed focus on the programme is currently underway with support from senior leaders across NHS Fife.

8. REFERENCES

Better Health Better Care (2007)
www.sehd.scot.nhs.uk/mels/CEL2008_20.pdf

SGHD HAI Taskforce Delivery Plan 2011 and beyond (2011)
http://www.scotland.gov.uk/Resource/0039/00398323.pdf

SGHD HAI Action Plan (2008)
www.scotland.gov.uk/Resource/Doc/924/0064225.pdf

Healthcare Associated Infection (HAI) standards (2015)
www.healthcareimprovementscotland.org/his/idoc.ashx?docid=90f299a8-d500-4285-9eeb-f6f9b05457db&version=-1

HPS HAI Annual Report 2018

HFS National Cleaning Services Specification: Quarterly Compliance Reports
www.hfs.scot.nhs.uk/online-services/publications/hai/

Scottish Management of Antimicrobial Resistance Action Plan 2 (ScotMARAP) (2014)
https://www.scottishmedicines.org.uk/SAPG/News/ScotMARAP2_final.pdf

Vale of Leven Hospital Enquiry Report: November 2014

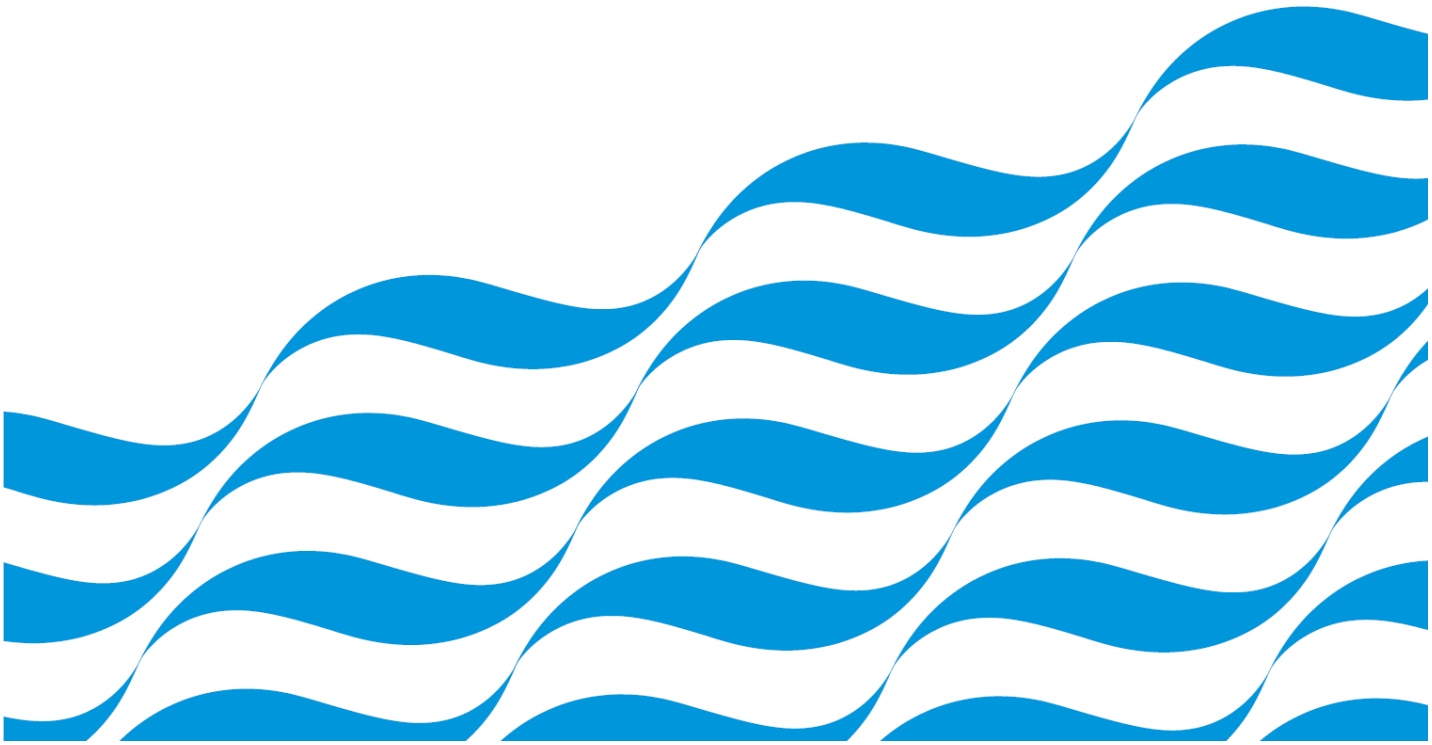
COVID-19

Date	Issued CNO Letters
09/12/2020	Guidance on expansion of twice weekly testing for patient facing staff within hospitals, the Scottish Ambulance Service and COVID-19 Assessment Centres – Latest guidance on staff testing can be accessed here
27/11/2020	Letter on the Testing Expansion Plan – Staged Roll-out – Summary table providing an overview of all hospital testing requirements here (updated on ongoing basis); Testing section of COVID Addendum here; and Chief Executive letter on Testing Expansion Plan here
27/10/2020	The Scottish COVID-19 Infection Prevention and Control (IPC) Addendum for acute healthcare settings - Accessed here
19/10/2020	Letter reiterating existing IPC policies and guidance in light of increasing transmission – Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here
16/10/2020	Letter on serial testing of patients determined by local epidemiology – Summary table providing an overview of all hospital testing requirements here (updated on ongoing basis); Testing section of COVID Addendum here; and Chief Executive letter on Testing Expansion Plan here
22/09/2020	Letter re guidance for physical distancing requirements in NHS Scotland For ease of reference: Built environment physical distancing guidance and signage is publicly available at: NHSS Social Distancing Guidance & Signage (nhsnss.org).
18/09/2020	Letter re revised guidance on the extended use of facemask guidance and face coverings in hospitals, primary care, wider community care and adult care homes. Guidance found here

14/08/2020	Letter on publication on UK IPC guidance for the remobilisation of health and care services - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
03/07/2020	Letter and guidance on asymptomatic staff testing in high-risk specialties. Latest guidance of staff testing can be accessed here
01/07/2020	Letter re assurance - COVID-19 Remobilisation plans to reduce the risk of nosocomial COVID-19 - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
29/06/2020	Letter on COVID-19 Remobilisation plans to reduce the risk of nosocomial COVID-19 - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
23/06/2020	Letter re interim guidance on the wider use of facemasks and face coverings in health and social care. Guidance found here
26/05/2020	Letter on guidance on the reuse of PPE - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
02/04/2020	Letter on publication of revised COVID-19 UK IPC guidance - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
25/03/2020	Letter to NHS Scotland Boards regarding revised HAI surveillance requirements

Interim Annual Organisational Duty of Candour Report

2020-2021



www.nhsfife.org

Contents

1. Introduction and background

NHS Fife

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

Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations -during the period 1 April 2020 to 31 March 2021 (2020/2021). NHS Fife identified these events mostly through its adverse event management processes. The organisation adopts a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and which is aligned with a national framework[3].

This report is being issued on an interim basis due to the ongoing response required by NHS Fife to the Covid-19 pandemic. This has resulted in a delay to the completion of adverse event reviews. This is reviewed regularly with processes in place to ensure reviews are progressed and completed. Consequently there are a number of events reported during this period which are currently under review and which may be reported as activating organisational DoC. It is therefore possible that the number of reported DoC events may be higher than stated in this report. Only those events with a confirmed decision have been included in this report. An updated annual report for 2020/2021 will be issued in March 2022.

A look back at year 1 (2018/2019) and year 2 (2019/2020) is also included in this report. Previous years are included for completeness as DoC applied to cases which concluded review after the submission of respective annual reports. Also contained in appendix 1-4 reports from the four health board managed general practices in NHS Fife.

Organisational Duty of Candour

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

The Organisational Duty of Candour guidance[2] outlines the procedure which must be a

followed as soon as reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:
  - **(a)** the incident appears to have resulted in or could result in any of the outcomes below (see Table 1).
  - **(b)** the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

This means if a patient suffers from an unintended or unexpected harm as a result of an adverse event then the following should happen:

- The patient or relative is notified and an apology is offered.
- An investigation is undertaken.
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation.

NHS Fife has an embedded process for the decision making for activating organisational duty of candour and ensuring all necessary actions are undertaken in accordance with national guidance. On review, any event which is considered to activate duty of candour is escalated to the Board Medical Director for ratification and confirmation of decision.

[1] NHS Fife Strategic Framework. 2015.

[2] Organisational Duty of Candour guidance. The Scottish Government. March 2018

[3] Learning from adverse events through reporting and review: A national framework for Scotland, revised July2018, NHS Fife review all adverse events.

- On completion of the investigation the findings and report are offered to be shared with the patient or relative.
- A meeting is offered.
- Throughout the review and investigation support is to be offered to the people affected which may include staff members involved.

The outcome for organisations is to learn from the investigation and make changes identified as part of the review.

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

Between 1 April 2020 and 31 March 2021, there were 15 adverse events where the duty of candour applied. The main categories of event which activated DoC during this period were:

- Other clinical events
- Patient fall
- Tissue viability

Table 1 details the outcomes which have occurred across NHS Fife after 1 April 2020 to 31 March 2021.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred
The death of the person	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
An increase in the person's treatment	6
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	<5
The person requiring treatment by a registered health professional in order to prevent: • the death of the person, or • any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5

The most common outcome which these events have resulted in is an increase in the person's treatment. This can range from additional antibiotics required to additional nightsstay in hospital.

Summary of Years 1-3

Table 2 sets out the events where DoC applied in 2018/2019, 2019/2020 and 2020/2021. This additional information is being included for completeness as DoC was applicable to events which concluded review after respective annual reports were submitted.

The number of events where DoC applied in year 1 is higher than the subsequent years. This can be attributed to the development of learning and assessment in the application of DoC Regulations. Table 3 sets out the DoC outcomes for the three year period. Across this period the most common outcome is an increase in the person's treatment.

Table 2

	Year 1 18/19	Year 2 19/20	Year 3 20/21
Number of events where DoC applied and where included in respective annual report	46	28	15
Number of events where DoC applied and where not included in annual report	10	10	To be determined
Total number of events where DoC applied	56	38	To be determined

Table 3

	Number of times this occurred		
Duty of Candour outcome arising from an unexpected orunintended incident	**Year 1 18/19**	**Year 2 19/20**	**Year 3 20/21**
The death of the person	<5	<5	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5	<5	0
An increase in the person's treatment	34	22	6
Changes to the structure of the person's body	<5	0	0
The shortening of the life expectancy of the person	<5	<5	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	<5	0	0

The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuousperiod of at least 28 days	8	<5	<5
The person requiring treatment by a registered health professionalin order to prevent: • the death of the person, or • any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5	7	<5

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

Of the 15 identified cases, each one was reviewed to assess for compliance with the procedure on the following elements:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified. These are:

- notifying the person and providing details of the incident
- provision of an apology, and
- Reviewing all cases.

Areas for improvement which are attributable to the pressures as a result of the pandemic include:

- Arranging the meeting following offer to meet
- Providing the patient with a written apology

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

4. Information about our policies and procedures

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

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

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

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

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

5. What has changed as a result?

Further to reviews of DoC events in 2020/2021 the following changes have been implemented:

- Improvement work to increase compliance with the pressure ulcer risk assessment (PURA) including training, education and introduction of a PURA sticker on admission to increase compliance
- Updates to wound care guidance supported by clear escalation plans
- Daily input from off site Plastic Consultant team inputting into multi speciality reviews
- Identification of additional ward Falls Champions to lead improvement work to reduce patient falls
- Review of the pathway for paediatric patients requiring rapid review
- Development of a standard operating procedure to support clinical teams with Warfarin prescribing, monitoring and follow up which includes communications with GPs.

Given the delays described in this report it is anticipated that more changes will be implemented following conclusion of events which are still under review. These will be captured in the March 2022 updated report.

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

Board Medical Director Office
NHS Fife
Hayfield House
Hayfield Road
Victoria Hospital
Kirkcaldy
KY2 5AH
Telephone: 01592 648077

Appendix 1: Linburn Road Health Centre

Linburn Road Health Centre
124 Nith Street
Dunfermline, KY11 4LT
Tel: 01383 733490
Fax: 01383 748758
Email: Fife-UHB.F20502LinburnRoad@nhs.net

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

Duty of Candour Report

Report period: 1 April 2020 to 31 March 2021

Completed by: Sharon Duncan, Practice Manager (Job Share)

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

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

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2020 and 31 March 2021)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

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

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

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Kinghorn Medical Practice

Kinghorn Medical Practice
Rossland Place
Kinghorn
Fife
KY3 9RT
Tel: 01592 890217

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

Duty of Candour Report

Report period: 1 October 2020 to 31 March 2021

Completed by: Fay Paterson, Practice Manager

Kinghorn Medical Practice provides general medical services to around 3360 registered patients residing within the practice boundary which encompasses Burntisland, Kinghorn and the bottom part of Kirkcaldy and some surrounding rural areas. Our mission is to provide a personal quality service making the best use of available resources.

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

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 October 2020 and 31 March 2021)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

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

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

What has changed as a result?	N/A

Other Information	N/A

Appendix 3: The Links Practice

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF

Tel: 01592 873321

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

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

This short report describes how our care service has operated the duty of candour during the time between 1st April 2020 to 31st March 2021. We hope you find this report useful.

Our Practice serves a population of 1947 patients within the Burntisland, Kinghorn, Aberdour area.

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

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

Information about our policies and procedures.

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

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

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife
KY3 9JD

Tel: 01592 873321
Email: Fife.F20184LinksPractice@nhs.scot

Appendix 4: Valleyfield Medical Practice

Valleyfield Medical Practice
Chapel Street, High Valleyfield
Fife, KY12 8SJ
Tel: 01383 880511
Email: Fife-UHB.F20729valleyfield@nhs.net

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

Duty of Candour Report

Report period: 1 April 2020 to 31 March 2021

Completed by: Michelle Parker, Practice Manager

Valleyfield Medical Practice provides Health Care to patients within the High Valleyfield, Low Valleyfield, Culross, Torryburn, Newmills, Cairneyhill and Crossford. The Health Centre's aim is to provide high quality care for every person who uses our services.

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

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2020 and 31 March 2021)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice

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

What has changed as a result?	N/A

Other Information	N/A

NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages, who require Easy Read versions, who speak BSL, read Braille or use Audio formats.

NHS Fife SMS text service number 07805800005 is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife-UHB.EqualityandHumanRights@nhs.net or phone 01592 729130

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

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NHS Fife Clinical Governance Committee

Title of Group/Sub-committee	ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE
Date of Group/Sub-committee Meeting:	WEDNESDAY 15th SEPTEMBER 2021
Release: draft/final minutes	UNCONFIRMED
Author/Accountable Person:	Dr Rob Cargill/ Ms Lynn Campbell/Professor Morwenna Wood

Summarise the items of significance from the minutes and the important points you want to raise to the attention of the committee?
Robotic Surgery is continuing with 10 cases completed between August and time of this meeting in Gynae-Oncology and Colorectal surgery. Progress continues to go well and in line with plans and to date, there have been no unplanned conversions to open the Laparoscopic surgery and no unexpected complications. The Vulnerable Pregnancy Team have been nominated for a "making a difference award" at the Scottish Champions Award which is scheduled for Saturday 18th September. Pamela Galloway and Katie Potten have been shortlisted for the Royal College of Midwives awards.
What are the concerns/issues/risks you want to bring to the attention of the committee?
Continuing to review workforce issues in the context of high demand on acute services. Note ongoing activity to address complaints, LAERs and SAERs but incurring delays to timescales in these as a result of ongoing demands.

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 15th SEPTEMBER 2021 AT 2.00PM VIA MS TEAMS

Present	**Designation**
Mrs Jane Anderson	Radiology Manager / Professional Head of Service - Radiography
Mrs Norma Beveridge	Head of Nursing – Emergency Care Directorate (for Items 7& 8 only – until 14.40)
Dr Robert Cargill (Chair)	Associate Medical Director – Acute Services Division
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator
Dr Sally McCormack	Clinical Director – Emergency Care Directorate (for Items 7 &8 only – until 14.40)
Mrs Gill Ogden	Head of Nursing – Planned Care Directorate (For Items 7 & 8 only – until 14.40)
Ms Marie Paterson	Head of Nursing – Acute Services Division
Mrs Mims Watts	General Manager – Emergency Care Directorate (for Item 7 only – until 14.25)

Apologies	**Designation**
Dr Annette Alfonzo	Clinical Director – Emergency Care Directorate
Mr Ben Hannan	Chief Pharmacist – Acute Services Division
Mrs Lynn Campbell	Associate Director of Nursing – ASD
Ms Arlene Saunderson	Head of Nursing – Planned Care
Ms Aileen Lawrie	Associate Director of Midwifery
Mrs Donna Galloway	General Manager – WCCS Directorate
Mr Ken Campbell	Laboratories Manager
Prof. Morwenna Wood	Director of Medical Education

In Attendance:

Mrs Margaret Dodds	Senior Nurse – Quality & Risk – Emergency Care Directorate
Mrs Pamela Galloway	Inpatient Midwifery Manager (rep A Lawrie)
Miss Lynn Godsell	PA to the Associate Medical Director & Associate Director of Nursing (minutes)
Ms Nicola Harkins	GIRFEC Lead/Service Manager (rep WCCS Directorate)
Ms Andrea Smith	Pharmacist (rep Ben Hannan)

ACTION

1 Welcome and Introductions

Dr Cargill welcomed everyone to the meeting and advised that due to organisational pressures he had agreed to adjust the format of the agenda allowing the Directorates teams to present then the normal business items would be covered. Dr Cargill added that the meeting was being recorded using the Echo Pen to assist with the note taking process.

2 Apologies for Absence

Apologies for absence were noted from the above named members.

3 Unconfirmed Minute of ASDCGC Meeting held on 21st July 2021

The previous minutes were approved as an accurate record.

4 Matters Arising

4.1 Action List

The action list was not discussed during the meeting. It was agreed that Miss Godsell would cross check the action list for any actions that have been covered in the meeting and update accordingly. Any live actions will be carried forward to the November meeting. **LG**

5 Hospital/Board or Population Level Reports:

Scheduled Governance Items:

- **Mortality Report**

  There was no local update.

- **Integrated Performance & Quality Report (IPQR)**

  The Integrated Performance & Quality report was included for information. There were no exceptional issues raised from the report.

- **HACP/DNACPR Report**

  There was no update available – c/f to November 2021.

- **OPAH Report – N/A**

  The OPAH report is now part of the joint inspection.

- **Deteriorating Patient Report (G Simpson) – N/A – c/f to November 2021**

  This item will be carried forward to November 2021.

- **SSR Report/Audit – c/f to Jan 2022**

  The SSR report will be submitted to the Committee in January 2022.

6 Women, Children & Clinical Services Directorate

6.1 Directorate Governance – Specialty National Reports

There were no Specialty National reports submitted.

6.2 Directorate Level Outcomes Data:

- **Clinical Audit**

There was no submission.

- **SAER LEARN Summaries**

This was covered under Agenda Item 6.3.

6.3 Departmental Report/s

- **Clinical Services Report**

Mrs Anderson provided the Clinical Services report update:

Incidents
There were 147 across the three services, a slight increase on the last reporting period and this was due to an increase in incorrectly labelled samples in Laboratories. Mrs Anderson was unsure if this was directly linked to an increase in sampling so would try and find out. **JA**

There were 24 Radiation incidents and 5 of these were reportable incidents. This is when patients receive a dose of radiation when they should not have. Mrs Anderson said one was related to a wrong referral and as Radiology do not use Trak, it makes it more difficult for the staff to understand how referrers do use Trak and seems that sometimes a bed space is used. Radiology are trying to promote that referrers must use the CHI number to eliminate this type of incident. Mrs Anderson said that a review took place but the doctor in question was informed but had moved on and had not returned the reflective template.

The other four incidents related to Nuclear medicine when the patients had had an injection in preparation for scans and the camera then developed a fault. Contingency plans have now been put in place with Lothian and Tayside should this happen again providing transport can be arranged safely.

Therapies and Rehab incidents all relate to falls and are unintended consequence by the very nature of rehabilitation.

There were nine near miss events in July, these all related to referrer error.

Falls Incidents – There were 5 falls incidents recorded in Radiology – all were no harm.

Major Incident – There was a missed radiology finding. A GP referral for an x-ray and then the Radiologist who reported the x-ray missed the finding and the patient re-presented through A&E 4 months later with sinister findings. Mrs Anderson said that an SAER will be commissioned due to the fact that this has crossed both primary and secondary care and this will also need Oncology input.

SAERs – There were 3 SAERs completed in July and the LEARN summaries have been issued for two of these. These related to a mis-diagnosis for a patient who had breast cancer and there was a delay due to double reporting the MRI images then significant delay in diagnosis. Mrs Anderson said that the department has developed a system in partnership with NHS Forth Valley that any MRIs are double reported the same week which is a huge improvement and this is reviewed on a monthly basis.

The other was a patient diagnosis which could have been an abscess or a tumour in the brain and it was due to lack of access to Specialist Neurological Radiologist input this occurred, Mrs Anderson said that and agreement has been developed with NHS Lothian to provide this service for 4 Programmed Activities (PA's) a week.

Complaints – There are no complaints in Laboratories and one complaint which involved Physiotherapy was remappedtransferred to maternity as there was no physiotherapy issues. Radiology complaints were all managed at stage 1 and some were cross Directorate.

SPSO – There is 1 SPSO enquiry for diagnostic reports which has been actioned.

Risk Register – The risk register is managed appropriately and is up to date. Mrs Anderson advised that there is a risk for the lack of Radiologists and also lack of Radiographers on the on call rota. An SBAR has been prepared to outline the Radiology management actions that are currently being taken, SLAs, use of SERRIS, Locum Radiologists to try and mitigate those risks and this was presented to Staff Governance by Claire Dobson. Mrs Anderson added that the service continues to seek new ideas to fill the 50 % vacancy.

Mrs Anderson highlighted a risk around Q-Pulse in Laboratories and an email has been circulated regarding an NHS Fife approach to Q-Pulse but the Laboratories Manager reports that the system they work with has out of date hardware and software and it is hindering a good working system. Mrs Anderson asked about a timescale for the Fife wide project and asked if this was something that should be pushed forward for Laboratories independently?

Dr Cargill said that the Blood Tubes shortage was a live issue and was a clinical risk that was being managed around the shortage of blood specimen tubes hence a number of changes have been made both in back office functions and in Laboratories to reduce the amount used and there are some early successes. Dr Cargill added that emerging intelligence is that the supply disruption may not be for as long as anticipated.

- **Women & Children**

Incidents
Mrs Galloway advised that during this reporting period that have been 4 major incidents – a neonatal death, two unexpected admissions of babies over 37 weeks to NNU/ICU and a wound dehiscence. In connection with these incidents, there is an existing LAER and one new LAER (requested to be upgraded to a SAER) and several existing SAERs.

Mrs Galloway advised that since May there have been 6 babies admitted unexpectedly to the Neonatal Unit all requiring cooling. Although these cases had all been reviewed through the SAER or LAER process, a decision was taken to undertake a further review of this cluster. The review team did not identify any common themes but there is learning from the cases to be shared. Dr Morrice is content with the representation in the review team and the way it has been carried out. The SBAR with the findings will be shared with the Medical Director.

Paediatrics - There were no major or extreme events noted.

Neonates: There were 3 major events reported – these were all linked to the cluster review.

Obstetrics: The Obstetrics Post Partum Haemorrhage (PPH) incidents remain the same although the trends in PPH over 1000mls have increased but over 1500mls have decreased. Mrs Galloway said some but not all good news as the bleeding is being managed before it reaches 1.5 litres.

Medication Incidents – There have been 3 medication incidents during the reporting period. Two of these were prescribing incidents and one was a dispensing error.

Paediatric Incidents – Falls are noted as the most common type of incident. These are mainly in active children and none are attributable to the failure of equipment or staff supervision.

Mrs Galloway advised that there is a monthly focus group looking at PPH and the department is also looking at a Therma-regulation as there are often babies admitted to the Neonatal unit who are cold so a group has been set up to support prevention of babies being admitted.

Gynae Incidents – There were 7 incidents – 6 graded as minor and 1 moderate harm.

LEARN Summaries - There was one LEARN summary where a lady died and the learning from the incident highlighted that her BMI had not been appropriately calculated and this would have impacted on the care that she received. Mrs Galloway said the consent form doesn't detail exactly the risks so work will be done in conjunction with the deteriorating patient and escalation.

SAERs & LAERs – There are no ongoing SAERs in Paediatrics and one LAER in progress.

There are two ongoing SAERs and 3 ongoing LAERs in Neonatal, with a further 4 incidents being Datixed across the service and are under consideration of LAER./SAER.

Complaints – It was noted that during July & August, there were 16 Stage 1 complaints with 12 being closed within the 5 day timeframe. The common theme for the complaints was medical treatment, communications and waiting times.

There were 11 Stage 2 complaints received during the reporting period with the themes being the same as the Stage 1 complaints.

Mrs Galloway shared a good news story with the Vulnerable Pregnancy Team have been nominated for a "making a difference award" at the Scottish Champions Award which is scheduled for Saturday 18th September.

Mrs Galloway also noted that both she ~~herself~~ and Katie Potten have been shortlisted for the Royal College of Midwives awards which are ~~is~~ in October.

Dr Cargill congratulated Mrs Galloway on her award and hoped the awards go well.

Dr Cargill asked about the cluster review and said that any outcomes or reports should be submitted to this Committee. Mrs Galloway advised that the report had not yet been written but will share it in due course. **PG/WCCS**

Dr Cargill said he noted in the LEARN summary about escalation for Gynaecology patients and noted that NHS Fife has an escalation procedure for all adult patients and asked if there was a need to create a separate for Gynae patients? Mrs Galloway advised that there was a lot of learning to come from the SAER and rather than create something new it may be about educating the staff re process already in place. Dr Cargill said that would be the preferred option. Mrs Galloway agreed to feed that back to the department. **PG**

Community Paediatrics

Ms Harkins summarised the update from Community Paediatrics.

There were no incidents and no SAERs or LAERs within Community Paediatrics.
The biggest challenge for the service is around the complaints and the number being received currently has decreased. Most of the complaints are around the Autism waiting list. Ms Harkins said that Community Paediatrics does not manage the waiting list for autism but because a Community Paediatrician is involved, then the complaints come in to the service. Ms Harkins advised that the Autism waiting list is currently sitting at around 1300 children which will take around 3 – 4 years with current capacity but are in partnership with Health & Social Care Partnership so are looking at various options working with Psychology colleagues too.

Ms Harkins said that another challenge is staffing capacity and the ability to recruit Community Paediatricians. It was hoped that the service will have two new recruits starting in February 2022 which will lessen the need for agency staff. This would take the service to four Consultants. Ms Harkins said there are ADHD nurses who are assisting with the review of children on controlled drugs which is making a significant difference to the review appointments.

Dr Cargill said that these are operational difficulties in trying to deliver a service whilst being so constrained. Dr Cargill advised that this Committee is interested in the governance and safety of the service and with the staffing problems are the clinical risks and harms being evidenced and measured? and what is the service doing about mitigating these risks and how is medication safety being maintained?
Ms Harkins advised that incidents are normally Datixed but there haven't been any recently in terms of lack of review and the mitigation is around the ADHD Nurses and this has made a huge difference with children being reviewed more frequently. Ms Harkins said that she would bear that in mind for the next time.

6.4 Specialty/departmental audit & assurance data (incl. guidance)

- **Clinical Quality Indicators**

There were no Clinical Quality Indicators.

6.5 New Interventional Procedures

- **Update re Interventional Procedures Register**

There was no update provided.

- **Update re Robotic Assisted Surgery – Gynaecology**

See update provided by Planned Care Directorate.

6.6 SPSO Recommendations

This item was included under Agenda Item 6.3.

7 Emergency Care Directorate

7.1 Directorate Governance – Specialty National Reports

7.2 Directorate Level outcomes data:

- **Clinical Audit**

- **Sweet Dreams Project**

Mrs Beveridge advised that this project focussed on the patient experience. It was noted that patients' experience sleep deprivation as well as the cognitive effect of delirium. The aim of the project was to reduce noise levels, patient delirium, staff stress and unnecessary work. A survey revealed that patients felt that the alarms disturbed their sleep, alarms were constantly beeping during their stay, there was no "quiet" time and constant alarms made them feel anxious. Electronic ears have been introduced in the department which flash green, amber or red according to the noise level in the area. Mrs Beveridge advised this will be included in the new induction for nurses.

The project was noted.

- **ECD Project List**

The ECD Project list was noted – there was no exceptional issues to raise from it.

- **SAER LEARN Summaries**

Mrs Dodds advised that the SAERs were all independent patients and personal accidents and mitigation had been very good.

The SAERs related to:

- Warfarin prescribing for a patient who had been discharged, and the IDL was incorrectly written with wrong dates and the patient did not get their INR checked resulting in a stroke and subsequently died. Mrs Dodds said there was a lot of learning to be gained from this case.
- Elderly patient who had a sudden death – there had been poor management of her having recurrent hypoglycaemia senior and although this did cause the death, areas of learning have been identified and new processes have

been introduced.

The SAERs were noted.

7.3 Directorate Report

Mrs Dodds presented the Directorate report. The following information was noted:

Incidents
There were 559 incidents reported during the reporting period which was a slight decrease on the previous period. The incidents recorded with harm have increased slightly and the top 5 categories remain unchanged. These are Tissue Viability, Patient Falls, Other clinical events, Medication Incidents and Personal Accident.

There were 16 major incidents reported. 6 of these relate to cardiac arrests and these have been reviewed at the Emergency Bleep Meeting with all cases being closed with no further actions.

LAERs
Mrs Dodds advised that there are 15 ongoing LAERs of which 7 are outstanding and there are 21 ongoing SAERs. Some of these cases are ready to be closed off. It was noted that due to current organisational pressures the SAER and LAER process has been paused.

Patient Falls
Mrs Dodds said that there had been 122 patient falls during the 2 month reporting period and of these,

- 1 is categorised as major harm
- 3 are moderate harm
- 8 are minor harm

Ward 32 continues to report a higher number of falls than all other areas but there has been a sustained reduction each month.
Wards 43, 6 and AU1 all reported an increase in falls – particularly during July. These areas are being closely monitored.

Mrs Dodds informed members that a deep dive had been carried out which highlighted that:

- Falls have increased including harm overnight as staffing levels are reduced overnight in order to maintain safe staffing across the whole organisation.
- Two periods where falls are low is during handover between day and night shift when we have double staffing numbers on ward.
- Patients requiring supervision are being maintained by existing staffing levels as no additional staff available to support. This reduces the ability to complete hourly comfort rounding. Each patient is individually risk assessed and staff manage this according to resources available to ensure patient safety.

Tissue Viability
There have been 32 incidents of hospital acquired Pressure Damage – 6 of these are grade as major harm. On ward developed accounts for 19% of all Tissue Viability incidents reported on Datix. It was noted that:

- There has been a reduction within ICU
- Ward 32 remains the highest reporter although assurance audits identify good compliance
- Ward 9 and Ward 43 have shown an increase.

Medications Incidents
Mrs Dodds advised that there has been an increase in Medications Incidents during July with 63 incidents in total. 6 of these are CD audits carried out by Pharmacy. The main themes remain to be prescribing and administration. Many prescribing errors contribute to administration errors, and both are linked to lack of knowledge and understanding of the formulary and SSUMP process. Mrs Dodds said that this is being closely monitored as there is an increase in errors being made in clinical areas.

There have been 72 reported incidents showing a significant increase in the following sub-categories:

- Delay in treatment
- Unexpected deterioration in condition of patient
- Failure to act upon a clinically significant abnormal result
- Failure of diagnosis and referral
- Conflict over case management
- Failure to follow policy/protocol etc

Mrs Dodds advised that 40% have been reported with a level of harm.
There has also been an increase in reported infrastructure incidents with the main category being staffing levels within clinical areas. It was noted that staffing levels have also been contributing factors in a large number of patient falls and on ward pressure damage incidents on Datix.

SABs
There has been good compliance with SAB's. One incident occurred recently with this being the first since January 2021.

Complaints
Mrs Dodds advised that there has been an increase in the number of stage one complaints which have not met the 5 day target. This is because there has been a dramatic increase in complaints involving the Emergency Department and the ability of the medical staff to engage to respond to the complaints.

There has also been a reduction in stage 2 complaints although the main themes remain consistently the same (delay in treatment, communication and attitude and behaviours). Mrs Dodds informed members that there has been an increase in multi-directorate complaints which causes delays in meeting the 20 day target.

Risk Register
The Directorate risk register is maintained regularly and is up to date.

SPSO
There are 10 SPSO reviews ongoing. No new outcomes from reviews received from SPSO.

Dr Cargill thanked Mrs Dodds for her update and noted that the thematic layout of the harms identified was helpful.

Dr Cargill then commented that staffing is quite a hot topic both operationally and in terms of governance. Dr Cargill noted that Mrs Dodds identified some staffing shortfalls as incidents and asked if any shortfalls were associated with identifiable patient harm? Mrs Dodds said that it is very difficult to specifically identify them to patient harms but it is evident that both the Falls and Tissue Viability incidents are increasing as the nurses cannot meet the 2 hourly comfort rounds – this is being done every 3 - 4 hours. Mrs Dodds said that it can be a cause of harm but it was very difficult to pinpoint it. Dr Cargill said it would be helpful to give the issue some thought on how best to link the two otherwise it becomes an unspoken concern about staffing levels rather than a direct consequence of the staffing levels causing actual or potential harm. Mrs Beveridge tended to agree that there is a correlation between the two and added that an incident has been reported today which directly links staffing levels in the Emergency Department with patient harm. Mrs Beveridge said this requires further investigation but will be grade as major on Datix. Mrs Beveridge added that we need to start demonstrating that there is a cause and effect relationship between the two. Dr Cargill said that this should be kept as high profile as possible.

Mrs Ogden advised that members would also hear this in the Planned Care report that in terms of some medication harms the Directorate can attribute to staffing and it not being substantive staff in the wards all the time. Mrs Ogden said it was a similar picture regarding falls with harm and the comfort rounds being done on time but this is being mitigated by increasing the number of feet on the floor.

Dr Cargill said that going forward, it would be helpful to separate the two things – harms caused by staffing numbers (not enough staff) and harms caused by staffing competencies (temporary) staff with not enough competences as this may strengthen the case.

Dr Cargill asked what three risks had been added to the register? Mrs Dodds advised that these related to:

- Staffing Levels
- Capacity in AU1
- Delay for package of Care in the community.

The report was noted.

7.4 Specialty/departmental audit & assurance data (incl. guidance)

There were four departmental reports. Dr McCormack provided verbal updates for each of these.

- **Endocrine**

Dr McCormack highlighted that:
Endocrine have now seen 400 out of their 1500 Type 1 patients which was the backlog from COVID and are hoping to get through the backlog within the next 18 months. Dr McCormack said that this has been quite relevant from past clinical governance meetings and there are still ongoing concerns about the treatment.

The morbidity and mortality meeting for Endocrine has identified a further MHDU DKA patient, this was following a SGLT 2 monitors being started and there has been 5 or 6 previous cases that have been recognised in the past and the

department are going to look at increasing medication and patient warning and information leaflets as this was concerning.

- **Dermatology**

Dr McCormack noted that:
Dermatology were nominated for a GEM (this is a generating excellent moment certificate) and these are given out by Paediatrics. Dr McCormack noted the service is very grateful.

Dermatology are holding M&M meetings and have highlighted an issue about deteriorating patients in CIU who do not have a clear pathway for medical assistance. This will be taken forward by Dr McCormack, Mrs Beveridge & Mrs Dodds as this has not been highlighted through the normal Datix pathway.

The service has introduced a Duty Nurse prescriber to support junior staff during out of hours at Queen Margaret Hospital.

The service is looking to avoid any external locum agencies for waiting lists due to previous communication and processing results issues.

- **Respiratory**

Dr McCormack advised that Respiratory report on an audit which was done into cancer specialist specimens for diagnosis of lung cancer and assessing the diagnostic yield and time to diagnosis – this showed good results and there is no need to change the current process.

- **Renal**

Dr McCormack highlighted that:
The Renal team have established a new Clinical governance Lead, Dr Kate Shiel has been appointed to this post and regular monthly meetings are being held.

The Renal team took part in a national Kidney care patient survey which showed less favourable results for Fife compared to other centres. It was noted, however, that only 22 patient responses were received which covered all dialysis patients and all CKD patients. Dr McCormack highlighted that a similar internal review took place in January 2021 and there was a 70% response rate from dialysis patients with the majority of patients responding that they were happy or very happy. Dr McCormack felt confident that the national survey results were a misrepresentation and it could well have been patients who had had their clinic appointments cancelled throughout COVID.

There was a further ongoing National Audit which showed slightly higher rate of Peritonitis in the Peritoneal dialysis patients at 1 in 16, rather than the average of 1 in 18. Dr McCormack said that these were extremely small numbers of patients and that was it was not too concerning at present.

- **SBAR – Violence & Aggression – Q1 21-22 – For Info only**

  The Violence & Aggression SBAR for quarter 1 was noted.

- **SBAR – Missing Patients – Q1 – 21-22 – For Info only**

  The Missing Patients SBAR for quarter 1 was noted.

7.5 New Interventional Procedures

- **Update re Interventional Procedures Register**

There was no update regarding the Interventional Procedures register.

7.6 SPSO Recommendations

There were no issues from SPSO.

8 Planned Care Directorate

8.1 Directorate Governance – Speciality National Reports

There were no specialty national reports.

8.2 Directorate Level Outcomes Data

- **Clinical Audit**
- **BRS Rhinology COVID Audit**

Mrs Ogden advised that NHS Fife have participated in this audit and it was included for noting. The audit is about the restart in nose and sinus surgery following COVID and the conclusions from the audit are noted as being favourable and there are no harms apart from a communication issues in Theatre with PPE and vision being impaired because of PPE.

The audit was noted.

- **SAER Learn Summaries**

Mrs Ogden said there was only 1 this month relating to a Data Protection incident whereby a whole filing cabinet of pain psychology notes went missing from Queen Margaret. Mrs Ogden said this was at the time when services were moving, around the start of pandemic. The cabinet has still not been found. The learning from this incident is that there is no checklist or Standard Operating Procedure when services are moving areas hence this was recommended.

Dr Cargill commented that paper case notes in a filing cabinet will always pose a risk and suggested that an action for the team would be to look at digital record keeping. Mrs Ogden agreed to take this on board and pass on to the relevant parties. **GO**

8.3 Directorate Report

- **PCD Clinical Governance Report**

Incidents
There were 320 incidents reported during June and July.
There were 6 major incidents within those reported. These included an unexpected complication following procedure, complications during surgery, tissue viability and cardiac arrests.

Mrs Ogden referred to a similar incident within Ophthalmology in the previous

reporting period and noted that an action was to have a review of the clean room that is used for injections at the Victoria Hospital. Mrs Ogden noted that this remains ongoing and Microbiology are convinced that the size of the room is a contributing factor to these infections, the service are now looking to extend the room. Discussion is ongoing between Infection Control and Microbiology regarding size, layout and flow in and out.

SAERs
There are 10 SAERs being progressed – 5 of these are overdue.
There are 11 LAERs being progressed – 3 of these are overdue.

Mrs Ogden said the de-commencement of the local oversight meetings is a factor in the delay of the SAERs and LAERs and in terms of the actions arising from these the Directorate do work through these but are aware that this needs further work to close the actions that arise in a timely fashion.

Patient Falls
There were 44 patient falls during the reporting period with 1 patient sustaining moderate harm.

Medications Incidents
There were 35 medication related incidents reported across the Directorate.
Mrs Ogden noted that of the 4 incidents with moderate harm, 3 of these were in Ward 52 and directly relate to lack of staff competence of a nurse who had been drafted in to support the ward. Mrs Ogden noted that there is 50% vacancy of Band 5 staff in the ward. This has been mitigated by moving staff on a longer term basis so wards have a steadier workforce. Mrs Ogden added that medication incidents have decreased during August and September.

Dr Cargill asked if any changes had been made regarding induction of temporary or deployed staff in an effort to mitigate these errors? Mrs Ogden said that the Senior Charge Nurses are looking at what is currently provided but Mrs Ogden said it may be something that need to be done Acute wide as there is so much deployment of staff at the moment. Dr Cargill suggested that the Directorates team up and do this jointly.

Tissue Viability Incidents
It was noted that there were 13 Tissue Viability related incidents reported as developing on ward or caseload. There was one patient who sustained a Grade 3 pressure Ulcer. Mrs Ogden said that Ward 31 had the most tissue damage due to the frailty of the patients, there had also been an increase in cases in Ward 52 and these wards will participating the Pressure Ulcer Improvement Programme, although regrettably due to the current pressures, the programme has been temporarily paused.

Incident Themes
The incident themes remain unchanged. The top five categories are consistently: tissue viability, patient falls, medication incidents, patient information/records and other clinical events.

Risk Register
Mrs Ogden said that no new risks have been added but on reflection she thought that Vacancy/staffing for Ward 52 should be added. Mrs Ogden asked Dr Cargill for

clarity if this should be added? Dr Cargill said that he wouldn't disagree but was not in a position to direct the content of the risk register but said that if the Directorate think that this is a risk which needs visibility and kept under review then use the risk register to do this.

SABs
There were no SABs reported

Effective
The Plastics Nurses had a poster published, this was for Smith and Nephew who are on the Procurement list.

Ward 44 took part In the Pressure Ulcer Improvement Programme and developed a sticker which has been useful as a visible tool to aid in their pressure ulcer prevention and care.

Complaints
Mrs Ogden advised that the Directorate closed 16 stage 2 complaints. There were 6 fully upheld, 3 partially upheld and 7 not upheld. There were also 16 Stage 1 complaints closed during the reporting period.

SPSO
There were two decision outcomes and they were both not upheld. There was also one legal claim made.

Care Opinion
Care Opinion continues to be promoted within the Directorate. 75% of these are mainly good news stories.

Ms Paterson asked about the medication incidents on Ward 52 and whether this was drugs that were specific to this area or more the fact the nurses were under pressure as they were new to the area? Mrs Ogden said that it was not specific drugs.

Ms Paterson noted that Ward 52 are continuing to test different change ideas in the background whilst the Pressure Ulcer programme is paused.

8.4 Specialty/departmental audit & assurance data (incl. guidance)

- **Cyclodiode Procedure**

  Mrs Ogden advised that the procedure had been updated as requested and it has now been signed off. Dr Cargill asked that it be added to the Interventional Procedures register and that an audit be submitted within the first year of implementing the procedure.

  Mrs Ogden agreed this would be actioned. **GO**

- **Update re Interventional Procedures Register**

  There was no update provided.

- **Update re Robotics Assisted Surgery (Urology/Colorectal)**

  Mrs Ogden provided a verbal update on the Robotic Assisted Surgery programme.

  Mrs Ogden advised that this commenced at the end of August and to date 10 cases have been undertaken between Gynae-Oncology and Colorectal surgery. It is going well and the Gynae-Oncology Consultant has had sign off by his Proctor and the other on remains ongoing.

  Mrs Ogden noted that the Urology Consultant who will be undertaking Robotic Surgery has completed wet lab training and he will commence operating with the robot at the end of September. To date, there have been no unplanned conversions to open the Laparoscopic surgery and no unexpected complications.

  Dr Cargill said that the Committee will require a formal report on the Robotic programme at each meeting for the first year of its implementation. Dr Cargill asked Mrs Ogden to encourage the team to ensure this was submitted in an appropriate format. **GO**

8.5 New Interventional Procedures

There were no new Interventional Procedures.

8.6 SPSO recommendations

This was noted under Item 8.3.

9 Divisional Risk Register – Active Risks

The Risk Register was included for information. There were no issues raised from the register.

10 ASD CGC Terms of Reference - FINAL

The Terms of Reference were included to reflect any updates to changes in staffing and positions.

Dr Cargill said that this document will capture the staff who will be continuing the work of this important Committee.

11 Items for information only:

11.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

11.2 SIGN Guidance

The SIGN Guidance was noted.

11.3 ASD CGC Workplan 2021/2022

The workplan for 2021/2022 was noted.

11.4 Infection Control Committee Minutes

The Infection Control Committee minutes were unavailable. c/f to November 2021.

11.5 HAIRT Report – July 2021

The HAIRT report was noted.

11.6 NHS Fife CP&PAG Minute of 21st June 2021

The NHSF CP&PAG minutes were noted.

11.7 Resuscitation Minutes of 14th July 2021

The Resuscitation minutes were noted.

12 AOCB

Ms Smith commented about the general conversations from the Directorates about the impact of staffing is having on Tissue Viability/Falls etc and this tends to have an impact on medications too as staff are unable to complete two hourly comfort rounds so to highlight that as Ms Smith noted that there are some medications that are time critical – e.g. Parkinsons medications and insulin for diabetics. Ms Smith requested that issues be highlighted to the Pharmacy team and they can do some online training for any deployed staff who may be unfamiliar with areas and systems. Dr Cargill suggested to the Heads of Nursing that any ward level inductions should include the Pharmacy team. Mrs Dodds added that Joanne Bellesini is very valuable and supports the wards.

Dr Cargill thanked members for their valued contributions to the work of this Committee and wished them well for the future.

13 Date of Next Meeting/s:

Wednesday 10th November 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 13 OCTOBER 2021 VIA MICROSOFT TEAMS

Present: Dr Chris McKenna (Chair)
Ms Claire Fernie
Dr David Griffith
Mr Ben Hannan
Mr David Pirie
Mr Euan Reid
Ms Rose Robertson
Dr Morwenna Wood

In attendance: Mr Ryan Headspeath, Senior Pharmacist - Dermatology and Shared Care
Mrs Sandra MacDonald (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were noted for Dr Annette Alfonzo, Ms Lynn Barker, Dr Marie Boilson, Mr Scott Garden, Dr Iain Gourley, Dr Helen Hellewell, Dr John Kennedy, Ms Nicola Robertson, Ms Olivia Robertson, Ms Andrea Smith.

Dr McKenna welcomed Ryan Headspeath, Senior Pharmacist - Dermatology and Shared Care to the meeting as an observer.

It was noted that the meeting was not quorate and agreed that any agenda items requiring wider discussion and decision would be deferred.

2 MINUTES OF PREVIOUS MEETING ON 11 AUGUST 2021

The minutes of the meeting held on 11 August 2021 were confirmed as a true record.

3 SUMMARY OF ACTION POINTS FROM AUGUST 2021 MEETING

The summary of action points was reviewed and updated.

There was a discussion around the content of the action list in general and agreed that several of the outstanding items should be removed and progressed as part of the Committee's workplan. Scott Garden/Ben Hannan/Euan Reid to refine the action list. **SG/BH/ER**

IT Repository for Clinical Guidance Documents
A decision on national roll-out of Microsoft SharePoint is anticipated by the end of the year. Mr Reid to update at the next ADTC meeting. **ER**

Lithium SBAR

No further update available at present. Mr Reid to follow up with David Binyon, Lead Clinical Pharmacist - Mental Health. ER

AMT Update - discussion around implications of antibiotics not recommended by SMC due to non-submission
Discussed as a separate agenda item. To be removed from the action list.

High Risk Pain Medicines
Action closed.

Safer Management of Controlled Drugs Annual Report
Action closed.

EAMS Consultation
ADTC response submitted. Action closed.

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

Dr Griffith introduced the update report from the final meeting of the Formulary Committee on 22 September and highlighted key points. It was noted that the Fife Formulary Committee has now been subsumed into the East Region Formulary Committee and Dr Griffith has been appointed to the role of co-chair.

Several submissions were approved subject to MSDTC approving the guidance/protocol: nintedinib (Ofev®) for chronic fibrosing interstitial lung diseases with a progressive phenotype other than idiopathic pulmonary fibrosis; guselkumab (Tremfya®) for active psoriatic arthritis in adult patients who have had an inadequate response or who have been intolerant to a prior disease-modifying antirheumatic drug therapy, alone or in combination with methotrexate; upadacitinib (Rinvoq®) for patients with psoriatic arthritis whose disease has not responded adequately to at least two conventional DMARDs, given either alone or in combination. A Formulary Amendment to include naloxone (Nyxoid®) 1.8mg nasal spray in the Formulary for immediate administration as emergency therapy for known or suspected opioid overdose as manifested by respiratory and/or central nervous system depression was approved as well as a Formulary Amendment request to include rituximab (Ruxience®) in the Formulary for rheumatoid arthritis (Mabthera® and Trixuma® to be removed from the Formulary for this indication).

The Formulary Committee also discussed and approved updates to Chapter 5 Infections and the Adult Primary Care Antibiotic Guidance. An SBAR outlining the actions in response to the MHRA Drug Safety Update on the risk of topical steroid withdrawal reactions was also discussed and agreed.

The ADTC noted the update report from the Fife Formulary Committee and Minutes from the meeting on 22 September.

6.2 MSDTC

Mr Hannan provided a verbal update on behalf of the MSDTC and highlighted key points from the meeting on 1 September.

It was noted that several Clinical Guideline/Pathway submissions were approved, including Clormethine Gel CTCL Pathway; Dermatology Eczema Pathway; updated Stroke/TIA Ambulatory Pathway; and Clozapine Physical Health Monitoring Guidance. A FAF3 for Melatonin for treatment of sleep-wake cycle disorder was also approved.

The importance of the MSDTC continuing to function strongly within the new East Formulary Committee (ERFC) structure was highlighted. It was noted that the MSDTC will receive regular updates from the ERFC which will allow the Committee to be kept abreast of developments and implications for the development of local protocols.

The ADTC noted the update report from the MSDTC and Minutes from the meeting on 1 September.

6.3 PGD Group

Mr Reid introduced the update on behalf of the PGD Group and highlighted key points.

There are 200 PGDs currently in use within NHS Fife which are reviewed according to the Standard Operating Procedure interval process.

The main activities since the last report include urgent updating of COVID-19 and influenza PGDs (to date there have been 30 amendments to COVID-19 vaccine PGDs as well as amendments to two influenza PGDs); the development of several PGDs for ENT and Dermatology; and audit undertaken to ensure that the correct processes and procedures are being followed.

The workplan for the next six months includes the development of nine new PGDs for ENT; review of current PGDs, including COVID-19 and other vaccine PGD updates; and a manager level PGD audit.

The ADTC noted the update report on behalf of the PGD Group and the critical role of the group in terms of NHS Fife's response to COVID-19 and other vaccines.

6.4 Fife Prescribing Forum

Mr Reid introduced the update report on behalf of the Fife Prescribing Forum.

The Fife Prescribing Forum (FPF) is a new group with the role of delivering a whole system approach to developing prescribing efficiency plans, implementation of prescribing projects and monitoring, identification and management of financial risks within prescribing. The FPF membership includes Clinical, Pharmacy, Finance and General Manager representation from the Acute Service and Health and Social Care Partnership.

It was noted that there have been four meetings of the FPF to date with Service updates presented by representatives from Respiratory, Gastroenterology, Rheumatology and Dermatology. Common themes identified include realignment of budgets across specialties, ambulatory care unit capacity, Homecare for specialist medicines to reduce expenditure, and Shared Care of medicines. There has been good engagement with the Specialties and excellent Service update submissions presented by Lead Clinicians and Specialist Clinical Pharmacists supported by Finance Business Partners and Service Managers. Further FPF meetings are scheduled for the remainder of the year with submissions from Mental Health (October), Cancer Services (November) and Cardiology (December) expected. Meeting dates for 2022 are currently being arranged.

The ADTC noted the update report from the FPF.

6.5 Safe Use of Medicine Group

Mr Hannan introduced the update report on behalf of the Safe Use of Medicine Group and highlighted key areas.

Current progress includes approval of several audits which are due to commence over the coming months: a discharge and take home medicines audit; return and destruction of medicines audit; and a security of prescription stationary audit. Audits completed and due to be reported to the forthcoming Safe Use of Medicines Group include a medical gas audit, ward CD audit and medicines requiring refrigeration audit.

The workplan for the next six months includes launch of Version 9 of the SSUMPP in January 2022; review of the Terms of Reference for the group with an increased focus on the creation of a wider learning system associated with medication incidents; and the review and approval of several audits due to be completed in 2022.

The ADTC noted the issue highlighted around the supervision of preparation of medication on the theatre sterile field. No immediate risks were identified and a full review of practice was undertaken with subsequent amendments to the SSUMPP. The framework developed will be used as a template for other supervised practice.

The ADTC noted the update report on behalf of the Safe Use of Medicine Group and acknowledged the vital role of the group in relation to medicines safety.

6.6 Medical Gas Committee

Mr Reid highlighted that historically the Medical Gas Committee has reported to the MSDTC. To give the Committee more prominence and the risk management forum as appropriate it is proposed that it report to the ADTC directly.

The ADTC agreed that the Medical Gas Committee should sit as a sub-group of the ADTC.

7 SBARs

7.1 Antibiotics Not Recommended by SMC Due to Non-Submission

Dr Griffith introduced the SBAR Antibiotics Not Recommended by SMC Due to Non-Submission and briefed the ADTC on the background to this.

In recent years several new antibiotics have been licensed in the UK but are not recommended for use in NHS Scotland due to non-submission to the SMC. The current process for accessing these within NHS Fife is on an individual patient basis through the SMC Non Submission Treatment Request application process. There are concerns that this process could potentially lead to delays in accessing these medicines in acute emergency situations. The ADTC has been asked to consider the addition of specific antimicrobial agents to the Fife Formulary to minimise any potential delays. These medicines would be restricted to microbiologist advice only and would also be added to the protected antimicrobial list. In addition they would not be routinely stocked by Hospital Pharmacy but would be available to order immediately from wholesalers or obtained from neighbouring Boards.

It was highlighted that at present the review of the East Region Formulary Chapter 5 has largely focused on Primary Care antibiotic use and pathways however clarity is being sought with regard to the inclusion of IV and hospital antibiotics. At present there is no update with regard to discussions around establishing a list of agreed antimicrobial medicines and development of a potential regional / national approach for accessing these through the existing Rarely Used Urgent Medicines (RUUM) list process.

A discussion followed around the potential implications of the proposals. It was noted that there is no precedent for the ADTC approving drugs not recommended by the SMC for Formulary inclusion. The current PACS2/SMC Non-Submission Treatment Request is a robust governance process that should continue to be adhered to. The ADTC noted the implications for antimicrobials that are required in acute emergency situations and there was support in principle for establishment of an emergency out of hours process with retrospective PACS Panel approval. Dr Griffith to produce a more **DG/ER/ BH**

detailed paper in discussion with the Medicines Management Team for consideration by the ADTC.

7.2 Procedure for SMC Not Recommended Advice ≥ 10 Years

Mr Reid presented the SBAR "Local Authorisation Procedure for SMC Not Recommended Advice ≥ 10 Years" and briefed the ADTC on the background. This paper was tabled at Lothian ADTC and the recommendations were accepted. As medicines policy resides with individual Board ADTCs it has been circulated to NHS Fife and NHS Borders ADTCs for their approval.

It has been noted at recent meetings of the ADTC Collaborative that national governance routes for authorisation of some SMC not recommended advice issued several years ago may no longer be considered suitable due to the emergence of new evidence and evolvement of clinical practice. It is proposed that a local medicines governance approval procedure be introduced for medicines not recommended by the SMC, where the advice was issued more than 10 years earlier, or generic medicines are available following patent expiry, and where the place of the medicine in a therapeutic pathway is considered to have changed, based on significant new evidence, safety, and cost effectiveness. Introduction of this process would allow submission of an application to the East Region Formulary Committee who would then determine clinical and cost effectiveness of the medicine. Appended to the SBAR is a list of medicines that would fall into this category. It was acknowledged that some of these medicines are available on other Health Board Formularies and there is potential inequity of access for some patients. At present requests to use non-SMC approved medicines follow the PACS2/SMC Non-Submission Treatment Request process.

Following discussion and in light of quorate issues Dr McKenna, Mr Garden, Mr Hannan and Mr Reid to discuss further and decide on an appropriate plan of action. **CMcK/ SG/BH/ ER**

7.3 East Region Formulary Update and Terms of Reference

Mr Reid highlighted the East Region Formulary Project Update and Terms of Reference for the East Region Formulary Committee (ERFC), East Region Working Group and Chapter Expert Working Group.

The inaugural meeting of the ERFC was held on 29 September, with the main focus of the meeting to agree Terms of Reference for the groups, documentation and formulary application forms. Three co-chairs have been appointed to chair the ERFC (David Griffith, NHS Fife, Andrew Watson, NHS Lothian and Alison Wilson, NHS Borders). The intention is for each to chair for a block of 6 months, then repeat the cycle for a three year maximum term.

The first three East Region Formulary Chapter reviews are ongoing (Skin, Infection and Gastrointestinal) and engagement has been excellent. The next three Chapter Expert Working Groups will be Diabetes, Respiratory and Cardiology and meeting dates have been scheduled for November/ December.

The ADTC noted the update and the robust governance processes for the East Region Formulary.

7.4 Steroid Emergency Card

It was agreed that this item should be carried forward to the December ADTC meeting. **ER**

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 1621 - Cost of Medicines Increased Due to National Shortages
The ADTC noted the update and agreed that no change was required to the current risk level.

Risk 522 - Prescribing Budget
The ADTC noted the update and agreed that no change was required to the current risk level.

Risk 1347 - Out of Date Shared Care Protocols
The ADTC noted the update and agreed that no change was required to the current risk level.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 SMC Advice on Buprenorphine Medicines in Opioid Substitution Treatment

It was agreed that this item should be carried forward to the December ADTC meeting. **ER**

10 EFFECTIVE PRESCRIBING

10.1 SMC Not Recommended Drugs April-June 2021

The ADTC noted the SMC Not Recommended Drugs April-June 2021 quarterly report produced by National Services Scotland.

10.2 Early Access to Medicine Scheme - Consultation Response

The NHS Fife ADTC response to the consultation on proposed statutory instrument for the Early Access to Medicines Scheme was noted.

10.3 Early Access to Medicine Scheme - Nivolumab

The ADTC noted the EAMS operational guidance for nivolumab in combination with fluoropyrimidine-and platinum-based combination chemotherapy for the first line treatment of adult patients with HER2 negative

(or undetermined) advanced or metastatic gastric, gastro-oesophageal junction or oesophageal adenocarcinoma.

10.4 Medicines Procurement Newsletter

The ADTC noted the Medicines Procurement Update September 2021.

11 HEPMA Update

Update deferred to the December ADTC meeting. **BH/DW**

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS/SMC non submissions was noted.

13 ADTC 2022 Meeting Dates

The ADTC 2022 meeting dates were agreed as follows:
9 February
27 April
22 June
24 August
12 October
7 December
(all meetings via Ms Teams at 1.00pm)

14 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items for escalation to the Clinical Governance Committee.

15 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 8 June, 14 September**. For information.

b **Minutes of Respiratory MCN Prescribing Sub-Group 9 September**. For information.

c **Date of Next Meeting**
The next meeting is to be held on **Wednesday 8 December 2021 at 1.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 24 November.

Fife Health & Social Care Integration Joint Board

Supporting the people of Fife together

CONFIRMED
MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE
WEDNESDAY 4 AUGUST 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 Wilma Brown, Employee Director
Attending:	Dr Helen Hellewell, Associate Medical Director Nicky Connor, Director of Health & Social Care Lynn Barker, Associate Director of Nursing Cathy Gilvear, Quality Clinical & Care Governance Lead Fiona McKay, Interim Divisional General Manager Rona Laskowski, Head of Complex and Critical Care Services Bryan Davies, Head of Preventative and Primary Care Services Simon Fevre, HSCP LPF Co Chair(Staff Side) Kathy Henwood, Chief Social Work Officer
In Attendance:	Jennifer Cushnie, PA to Dr Hellewell (Minutes)
Apologies for Absence:	Lynne Garvey, Head of Community Care Services Janette Owens, Director of Nursing Corporate Services Chris McKenna, Medical Director Paul Madill, Consultant in Public Health

NO	HEADING	ACTION
1.0	**CHAIRPERSON'S WELCOME & OPENING REMARKS** The Chair welcomed everyone to the meeting. Cllr Brett noted the Scottish Drug Death Report, which was published the previous week highlighted that there had been a 20% reduction in Drug Deaths in Fife. He advised that he had communicated with Elizabeth Butters within the ADP Team asking if there had been a particular reason for the reduction in deaths and is awaiting a response. Cllr Brett also wished to note that he had hoped to receive a report on Autism, particularly regarding the waiting list and waiting times for children who have been referred to the diagnostic service. He advised that he had a helpful conversation with Bryan Davies who advised that more work was required on the report before it can be tabled at the committee.	

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 HELD 2 June 2021** Cllr Brett asked if members wished for any changes to the previous minutes of 2 June 2021 or had any matters to raise. **Decision –** As no changes were requested, the Committee agreed to approve the Minute of 2 June 21.	
5.0	**ACTION LOG**	
	Cllr Brett asked for an update on the action relating to a group being set up to look at reaching people who are difficult to reach and whether the details had been forwarded to Martin Black as requested. Dr Hellewell advised that this was ongoing but confirmed that she would follow this up. Cllr Brett queried whether the EqIA Policy had been shared. Dr Hellewell agreed to get this shared.	**HH** **HH**
6.0	**GOVERNANCE**	
6.1	**Clinical and Care Governance Update**	
	Cllr Brett invited Dr Hellewell and Lynn Barker to give a verbal update around Clinical and Care Governance. Dr Hellewell advised that she was not planning to use this section to go into detail as there was a substantive item on the agenda for assurance. Dr Hellewell wished to note that Tranche 1 for the covid vaccine is nearly finished and the preparation for Tranche 2 for both covid and flu vaccination is going well with good structures in place. Cllr Brett advised that he had a weekly meeting with the Director of Public Health so had received an update on the planned autumn vaccination programme. Martin Black noted under adverse events there was a plan to visit Queen Margaret Hospital and asked if this had happened. Lynne Barker advised that a senior leadership walk round did take place with herself and Lynne Garvey.	

6.2	**Clinical Quality Report**	
	Cllr Brett noted at the last meeting that it had been agreed that there would be an in-depth review of a topic from the quality report and following discussion with Dr Hellewell and Lynn Barker it was agreed that falls would be looked at in more detail. Lynn Barker spoke to the presentation. Lynn Barker noted that although common, falls can be devastating with significant implications for elderly patients who experience a fall. She confirmed a fall is defined as someone 'coming to rest inadvertently on the ground or floor or lower level'. Lynn advised that the definition is key when defining a fall within the DATIX Safety Reporting System and noted the reason why patients fall is complex but often result in patients losing confidence while being in the healthcare setting. Lynn advised that quality improvement is continuously reviewed but noted that the pandemic has impacted the ability to do this. The clinical teams have refocused, and a multi-disciplinary team is being set up to address falls in particular within Mental Health and 3 wards within the Community Hospitals. They will be looking at the challenges that the clinical teams are facing and what actions are required. Lynn confirmed membership of the review team with Heads of Nursing, Medical Staff, Lead Nurses, Senior Charge Nurses and Service Managers to ensure that there is a multi-disciplinary team approach with the Clinical Care Governance team providing support. Lynn confirmed that there are regular meetings to review the data. Lynn advised that the weekly data is demonstrating that within the areas that are focusing on falls, 3 Mental Health Wards & 2 wards within the community setting are showing an improvement, the other ward requires to collect data for 1 more month to reach this status, but early indications are showing that there has been an improvement. Lynn noted that the next steps for the clinical teams are to continue with the programme, ensuring that the learning is embedded and spread across all the care settings within the HSCP. Jan Wincott asked what t impact on staffing levels had on patient falls. Lynn confirmed evidence shows where there are full staffing levels there is an improved experience for both staff and patient. Lynn confirmed the Partnership has a robust system and process in place to ensure that there is sufficient staffing across the services but advised this has been exceptionally challenging lately for various reasons such as staff absence and members of staff having to self-isolate. Jan Wincott asked over the last 18 months when it has been very challenging whether there had been an increase in patient falls? Lynn advised that the data has demonstrated that there have been spikes but was pleased to note that there had been recent improvement within the Mental Health Wards with the focused work that has been done. Tim Brett queried whether the report showed that there had been an increase in falls overall within the HSCP settings during the pandemic and asked why this had been happening. Cathy confirmed that here	

	has been an increased number of falls and was the reason why this element of patient safety was chosen to focus on. The data was reviewed to highlight the specific areas that needed to be focused on. Cathy confirmed that the falls work will be ongoing. Lynn noted although staffing is a key element it is not the only factor for the increased falls, the acuity of patients that have been in the care settings has also had an impact. Martin Black noted historically there had been an investigation into footwear that had drastically reduced falls and queried whether this methodology was still used. Lynn confirmed that this was the slipper socks with rubber on the soles and noted that anyone who came into hospital without slippers were provided with these slipper socks and for those who had slippers that were not well fitting were provided with the socks to wear as a second defense. Cllr Ross queried whether the patients who are visually impaired with glasses, and the importance of ensuring that glasses are clean to support reduction in falls and queried what precautions would be taken for patients who came in who were totally blind or had only light/dark perception therefore did not wear glasses and noted from his personal experience how hesitant he was going into areas that he did not know. He also noted that 'Falls Clocks' were available in some wards and queried what this was? Lynn advised that patients who were visually impaired coming into wards, if they had aids or tools to assist them, they would be encouraged to bring them into the hospital to assist the patients remaining mobile and independent. Lynn noted the clocks were for plotting the times for when a patient fell if they fell more than once to see if there was a pattern associated with the falls. Cllr Ross queried whether the nursing team have training in 'sighted guide' and asked if this was still delivered? Lynn noted that she was not aware of any training provided and advised that she will investigate and report back. Christina Cooper asked if Estates were involved in the multi-disciplinary team especially where falls are often a result of the environment and queried whether there was specific review and assessment of areas with dementia patients. Lynn noted that she was not aware of the Estates team being part of the multi-disciplinary team but confirmed there are close links with the estates team and they are actively involved when estates issues are highlighted. Cathy Gilvear advised that the Estates Team are informed of actions resulting from leadership walk rounds. Christina asked about the learning for the anticipated preventative work for falls that is happening within the community and where this aligns. Lynn Barker noted that there are overarching groups where the community and inpatient falls team engage with each other and share the learning. Dr Hellewell confirmed that there has also been work done in General Practice to prevent people falling in their own homes. Lynn noted that there had been significant work prior to covid with dementia diagnosis and tools that could be put in place such as specific coloured toilet seats, place mats and cups that has been maintained.	**LB**

	In addition, there are dementia champions within ward areas with training courses which are ongoing. Simon Fevre wished to pick up the mental health section in relation to the significant adverse events and noted that he was aware of two serious assaults on staff in the past month and would like reassurance that these have been actively dealt with. He noted that staff side and himself will be involved with the subsequent adverse event process. Lynn confirmed that both situations have been reviewed taking into consideration the seriousness of the events and wished to assure the committee that the appropriate processes have been followed. Rona Laskowski stated that a range of support has been made available to staff involved in the incidences. Martin Black queried with regards pg 41 in relation to CAMHS and noted concern that the person has to reapply to CAMHS and noted surprise that this is not monitored resulting in the parent having to reapply to the service. Cllr Brett asked Rona Laskowski to feedback to Martin Black. Christina Cooper noted concern with the process and the challenges that the family has had noting that there is no clear pathway and asked how clinical and educational psychology is integrated ensuring that children do not need to get separate assessments done. Rona Laskowski advised that there has been and continues to be a range of initiatives with CAMHS and Education relating directly to the National Service specification with expectation on CAMHS which will address points raised and will provide a significantly more combined approach. Cllr Brett asked with regards pg 38 and the patient's positive feedback regarding the palliative care received and asked whether everyone who wishes this type of palliative care in the community receives it and whether there are sufficient resources to provide everyone with this standard of care. Dr Hellewell wished to clarify that there are different needs for palliative care and confirmed that there is palliative care for everyone at home which is provided by General Practice and the District Nursing Team. There is then a more specialist requirement for those with complex needs where close working with the palliative care team is required and it is not about want it is about need. Dr Hellewell wished to confirm that all who wish to have their palliative care at home will receive this, but not everyone will require the more specialist palliative care. Cllr Brett noted that the Dashboard on Pg 17 indicates that there has been an increase in ligature incidents during the current reporting period. Cathy Gilvear agreed to investigate and feedback to Cllr Brett. Nicky Connor queried with regards to the format going forward, noting during this meeting the committee had reviewed falls in depth, but whether the overview was still required to allow discussion and provide answers for the committee shaping what areas require a deep dive at future meetings. It was agreed that both the executive summary and deep dive was beneficial and would continue but acknowledging that as the committee structure changes this may change going forward.	**RL** **CG**

6.3	**GP Cluster Update**	
	Dr Hellewell advised that the paper had been prepared by Dr John Kennedy, Clinical Director for Primary Care. Cllr Brett noted it would be good if the wider public could be advised of the continuing restrictions within health care settings as he was concerned that there would be expectations that everything is back to normal with the reducing restrictions. Dr Hellewell advised that promotional material has been provided to all GP practices. Cllr Ross asked with regards 'Near Me' whether all practices were able to use the programme. He also noted that the report outlines delays with clinics and asked how the backlog will be cleared. Dr Hellewell confirmed that all practices had access to 'Near Me' and were able to provide a blend of virtual or telephone appointments. Dr Hellewell confirmed that a risk assessment has been undertaken as to the management of the back log of chronic diseases within each general practice. Cllr Ross noted that the report advises that it is anticipated that there will be a blended model of patient consultations going forward and asked how this would work. Dr Hellewell confirmed that an increase in face-to-face appointments is the preferred option, but the current difficulty is the number of people that can be in the waiting room at the same time and flow is being reviewed. Dr Hellewell advised that some patients have fed back that they like the option of continuing with 'Near Me' and telephone consultations therefore it is anticipated that a blended service will be provided going forward. Martin Black noted that communication for how people can access services urgently needs to be reviewed and noted the time it takes for people to get through to NHS24 when they are not able to access their GP is excessive. Bryan Davies advised the paper that Dr Hellewell presented was a snap shot of the service back in May 2021 which provided insight into what is being delivered in GP Practices and he proposed that this is reviewed on an ongoing basis as part of supporting an action plan around sustainability of GP Practice delivery. The information will also be able to address the mixed messages and give a clearer dialogue of what is being delivered by General Practitioners. Bryan Davies confirmed that a strategy will be developed for Primary Care sustainability and improvement which would include an underpinning communication strategy. Cllr Brett would like to suggest that these discussions are continued at the Development Session on Friday 6 August 2021. Christina Cooper noted that she welcomed the report as it gives assurance of the work going forward, although the report is a snap shot some of the examples provided are significant and helps to promote the integration and partnership working. Cllr Brett asked if Dr Hellewell could briefly provide more information on the assessment work that has been carried out in relation to addictions, 'Let's Prevent', flow and navigation. Dr Hellewell advised that the work	

	carried out in relation to addictions was looking at how GPs can work more closely with services to ensure that people who are struggling with addictions continue to get their general medical needs met within primary care. 'Let's Prevent' is around early intervention to prevent diabetes. Flow and navigation work is around making sure that people are seen in the right place at the right time and this links across the whole spectrum with Pharmacy First, the Flow and Navigation Hub in the Hospital. Dr Hellewell confirmed that the Flow and Navigation Hub looks at the pathway into the hospital ensuring that patients are in the correct place or whether a community setting would be more appropriate to avoid hospital admission. Dr Hellewell confirmed that there has been a lot of work to ensure patients are on the correct pathway but noted a lot of work is still required to ensure the communication is available.	
6.4	**Assurance Committee Update**	
	Lynn Barker advised that the Partnership has been through a re-organisational structure and with this, there was a requirement to review the governance committees. The Senior Leadership Team have reviewed the structure to ensure that the Partnership has assurance under the principles of the Integration Scheme that it is safe, effective, person-centred in the delivery of all care provided regardless of setting across the Partnership. A 'Quality Matters Assurance Group' has been established which will replace the three previous divisional groups. The group will consist of a wide membership from across the Partnership to ensure that safe, effective and person-centred care is provided. Lynn advised that she will be the Chair of the Group on a rotational basis with the Associate Medical Director and the Social Work Lead, she indicated that the first meeting had gone well. Dr Hellewell advised that with establishing this group, we bring together all areas of the partnership allowing assurance for all pathways of care across the services. Cllr Brett noted that it would be helpful for the update to be provided in a paper and tabled at a future meeting. Nicky Connor noted that the next steps will be outlined at the Development Session on Friday 6 August 2021.	**HH/LB**
6.5	**Mental Welfare Commission Authority to Discharge Audit and Findings**	
	Fiona McKay advised that the updated report on the work that has taken place since the Mental Welfare Commission issued a directive to all Health and Social Care Partnerships around people moving from hospital to care homes throughout the pandemic and the inappropriate use of 13ZA or 51X which are the codes used for certain delayed discharges and to ensure that people had capacity or had an appropriate power of attorney in place.	

	When the report was first published, Fiona advised that she was Interim Divisional General Manager and noted that Fife took the decision to look at everyone who had moved to assure that the moves had been undertaken appropriately. A full review was undertaken to ensure that everything was in place. Fiona advised that the Mental Welfare Commission took a cross sample of cases from across NHS Scotland and we were pleased to note that their report showed that Fife had not broken any legislative rules. The Mental Welfare Commission provided some recommendations and Fife has taken the relevant actions forward. Fiona advised that this report was to provide the committee with assurance that Fife has acted within the legislation throughout the pandemic and to assure that all the information is well documented within the services. Cllr Brett noted that there are 11 recommendations with 3 that are not applicable to Fife and noted that that he was happy that everything has been covered but noted that some of the action deadlines were the end of August. Cllr Ross noted that there are a number of abbreviations used within the report that were not explained.	
7.0	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	Unconfirmed Minutes were received from Fife Area Drugs & Therapies Committee – 30 April 2021 and 9 June 2021 Scott Garden advised the 3 items for escalation were: • East Region Formulary Development – moving to 1 medicine formulary with Borders, Lothian and Fife with funding from SGHD to March 2022. • High Risk Pain Medicines Patient Safety Programme Development which is a Corporate Objective for NHS Fife which will run over 3 years. • The remobilisation of Medicine Governance Committees. Cllr Brett asked with regards to the Drug Formulary; whether the clinicians are provided with a choice of drugs and asked if this would continue. Scott Garden confirmed that it was a pre-requisite that this was retained as it was fundamental to the savings that had been achieved within Fife. Scott Garden confirmed the Business Case for HEPMA was approved last November by NHS Fife and the service was currently in the procurement phase but it was hoped that the final contract would be signed this month therefore it was anticipated that Fife would start the 3 year phased programme roll out of hospital electronic prescribing from January 2022.	

	Scott advised there has been work done around the diabetes and frailty guidelines in particular building on the work carried out in 2019 relating to hypertension and frailty.	
	Unconfirmed Minutes of the Infection Control Committee Minutes from 14 April 2021 and 2 June 2021. Lynn Barker advised that there were no issues for escalation. Cllr Brett noted that there was reference to vaccination uptake in care homes and was pleased to see that the reference was advising more staff were being vaccinated.	
	Minute of the Clinical Governance Oversight Group from 25 February 2021, 22 April 2021 and 23 June 2021. Lynn Barker advised that there were no issues for escalation.	
	Cllr Brett noted that it was helpful that there was the item on the agenda for escalation to C&CG Committee on the Fife Area Drugs & Therapies Committee and asked if this can be added as a standing item on the other agendas.	**HH/LB**
8.0	**ITEMS FOR ESCALATION**	
	Cllr Brett advised that Mental Welfare Commissioning Update will be going to the IJB. Cllr Brett would like to commend to the Board the GP Cluster Update as this was helpful in setting out what GP Practices have been able to do.	**TB**
9.0	**ANY OTHER COMPETENT BUSINESS**	
	No other competent business was raised.	
10.0	**DATE OF NEXT MEETING –** Wednesday 8 September 2021, 1000hrs MS Teams	

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED
MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE
WEDNESDAY 8 SEPTEMBER 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 Nicky Connor, Director of Health & Social Care Lynn Barker, Associate Director of Nursing Audrey Valente, Chief Finance Officer Cathy Gilvear, Quality Clinical & Care Governance Lead Bryan Davies, Head of Preventative and Primary Care Services Simon Fevre, HSCP LPF Co-Chair (Staff Side) Kathy Henwood, Chief Social Work Officer
In Attendance:	Jillian Torrens, Senior Manager Lee Cowie, Clinical Service Manager Lisa Cooper, Immunisation Programme Director Heather Bett, Senior Manager Marie Boilson, Consultant Psychiatrist (Section 6.4) Lesley Gauld, Information Compliance Manager (Section 6.5) Joy Tomlinson, Director of Public Health (Section 6.6) Carol Notman, PA to Chief Finance Officer (Minutes)
Apologies for Absence:	Wilma Brown, Employee Director Lynne Garvey, Head of Community Care Services Rona Laskowski, Head of Complex and Critical Care Services Janette Owens, Director of Nursing Corporate Services Chris McKenna, Medical Director

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** Cllr Brett welcomed everyone to the meeting noting concern that covid-19 cases have significantly increased across Scotland including Fife which is adding to the pressures for all services and confirmed that Nicky Connor will be providing a full update at the IJB Development Session on Friday 10 September 2021. Cllr Brett noted following the announcement regarding Social Care Funding in England that although the detail does not apply to Scotland, additional funding will come to Scotland through Barnett consequentials.	

	Cllr Brett noted that there is no Quality Report on the agenda at this meeting as there has been a relatively short period of time from the last meeting the next report will come to the meeting in October.	
2	**DECLARATION OF MEMBERS' INTEREST** There were no declarations noted.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 04 AUGUST 2021** The minutes of the previous meeting on 4.8.21 were accepted to be an accurate record of the meeting although it was noted that there was a small typing error.	
5	**ACTION LOG** Cllr Brett noted the Action Log of 04.08.21.	
6	**GOVERNANCE**	
	6.1 Professional Lead Update Cllr Brett invited Dr Hellewell and Lynn Barker to give a verbal update around Clinical and Care Governance. LB wished to stress that the challenges were not only associated with the nursing team, it is also currently very challenging to ensure that all clinical areas are staffed appropriately .HH advised that more detail of the plans that are being developed will be brought to the Development Session on Friday. Nicky Connor noted that the acute services are currently feeling significant pressure and the priority is how the Partnership supports the capacity and flow. Work is underway to review services to understand what could possibly be done to respond to the current situation. Cllr Ross asked that communication to the public regarding any change is front and centre of any planning process.	
	6.2 Mental Health Strategy Direction – Update on Implementation Cllr Brett invited Jillian Torrens to speak to the paper on the Mental Health Strategic Direction. Jillian Torrens provided an update on implementation of the Fife Mental Health Strategy 'Lets Really Raise the Bar 2020-2024' noting that the Board had signed off the Strategy in February 2020 with the Direction then from the IJB to NHS Fife and Fife Council to implement the strategy. Jillian noted that the recommendation in the strategic outcomes are to be reviewed following new national requirements being issued and as a consequence of the impact of the pandemic. Cllr Brett thanked Jillian for the update Timelines require to be added to recommendations for the review to be completed. Cllr Ross noted that he could see that the priorities have changed, and that the strategy needs to be reviewed but reaffirmed the requirement that there were associated timelines. Cllr Ross queried the renewal and recovery fund	

	from SGHD and asked whether the service had received any extra funding or whether all the funding has been received. Cllr Ross also queried whether the SGHD were aware of the strains between inpatient work and other mental health work and asked if there was anything that could be done nationally to help resolve this. Jillian confirmed that the service had not received further funding and the money incrementally comes in and has clear caveats on how it is to be spent. She noted that SGHD is fully aware of the tensions in the system, and it was why they were undertaking the benchmarking exercise. Jillian wished to assure the Committee that there had been progress with the strategy throughout the pandemic with a 25% reduction in inpatient beds and shorter lengths of inpatient stays. Christina Cooper advised that she welcomed the report and noted that it was realistic acknowledging that the services have just come through a pandemic which is still ongoing and that there has been innovative work across the Partnership including the third and independent sectors and agreed that it would be useful to see a workplan with clear timescales aligned to it. Cllr Brett noted that the report talks about an increase in demand for mental health services and asked if this had been linked to the pandemic and if the increase mentioned relates to people attending their GP or increased referrals to specialist services. Dr Hellewell noted the increase in demand, and advised that referrals for increased stress, can be met by primary care, but a small number of people have had to be referred to secondary care. Nicky Connor acknowledged the concerns of the committee noting that the opening statement from Jillian recognised that the current strategy required to be refreshed. Cllr Brett noted that the committee would like to add its thanks to the staff acknowledging the challenges they have faced operating through the pandemic. The committee agreed to receive an update at the next committee.	
	6.3 National Hub for Reviewing and Learning from the Deaths of Children and Young People Heather Bett noted that the paper provided an update on the implementation of systems and processes in response to the establishment of the National Hub for Reviewing and Learning from the Deaths of Children and Young People. Cllr Brett asked what the evidence was that necessitated the national review of children's deaths. Heather Bett noted that a paper published by HIS highlighted that Scotland has a higher mortality rate for under 18's (or 26 if it is a young adult who has been in care) and any research will help to identify any patterns. Heather confirmed that NHS Fife has set up a Quarterly Oversight Group to investigate all deaths and that a national group would also be set up. Cllr Brett asked that the annual review from Fife would come to this Committee.	

	Martin Black queried what the implications on the Third Sector would be such as bereavement support. Heather Bett confirmed that the service is currently scoping and investigating what support will need to be expanded or developed. Christina Cooper recommended that a representative from the Third Sector is asked to join the Oversight Group which Heather agreed would be helpful and beneficial for the group and would investigate this.	
	6.4 CAMHS Resource & Intervention Update Lee Cowie noted that the paper provided an update on CAMHS Workforce developments and the progress against achieving the Scottish Government CAMHS 18-week Referral to Treatment Target (RTT). Cllr Brett noted that his understanding was that the Partnership has invested in Mental Health Nursing Staff to work within GP Practices to deal with issues at primary care level to reduce the demand on the service and asked if this was working. Lee Cowie confirmed that the service had identified that this model had not been well received therefore the nursing staff had been changed from GP Practices to being within CAMHS. He noted that although there hadn't been a reduction in referrals, it has resulted in children who previously would not have met the criteria for referral having an assessment carried out by the mental health nursing team. Martin Black queried that it says in the report the age range for CAMHS is extending up to the age of 25 for targeted groups and asked if this should not be 26 as in other areas? Lee Cowie acknowledged this and agreed to investigate the discrepancy. Cllr Wincott noted concern with the CAMHS Backlog of over 2 years which was highlighted in the paper for the previous agenda item. It was agreed that this would be checked.	**LC** **JT/RL**
	6.5 Complaints Update Audrey Valente advised that this was the regular complaint report which is tabled at the committee twice yearly and introduced Lesley Gauld the HSCP Information Compliance Manager. Martin Black queried the 49 complaints that were upheld whether there was a common theme. Cllr Brett note that the themes were outlined within the paper but asked what actions were taken when there is a complaint relating to attitude and behaviour or the co-ordination of clinical treatment. Lesley Gauld advised that each complaint was dealt individually, and the staff members line manager would be responsible for addressing the issue. Lesley Gauld confirmed that the complaints regarding attitude and behaviour were spread throughout the whole service and not associated with one department. Helen Hellewell noted that the complaints regarding the coordination of clinical treatment often took longer to respond to as they often involved more than one service. Cllr Brett queried the compliments received whether they were written or did the statistics include verbal compliments received. Lesley Gauld confirmed the compliments received were when people had sent cards, emailed or had phoned the service to specifically thank the staff. Cllr Ross noted that only 44% of the Stage 2 complaints were responded to within the statutory timescale and asked if there is anything that the services	

	can do to improve this compliance rate? Lesley Gauld advised that she was working with the services to streamline the process. Cllr Brett noted that he was aware that some areas in England had changed their response timelines to 40 days to support clinical teams during the pandemic. Lynne Barker advised that the Director of Nursing is setting up a group to look at what support can be put in place to assist clinical teams produce quality responses to complaints while adhering to the associated deadlines.	
	6.6 Fife Immunisation Strategic Framework 2021-24 Joy Tomlinson spoke to the Fife Immunisation Strategic Framework paper advising that it was an integrated framework requiring sign off from all partners and she had presented it at a special NHS Fife Clinical & Care Governance Meeting. Joy confirmed that the Strategic Framework covers child and teenage immunisation as well as the ongoing flu and covid immunisation programmes. The Strategic Framework outlines some changes such as transferring responsibility from Primary Care Services. It also highlights 4 main priorities and has an associated action plan that outlines the key actions, the performance measures and who is responsible. Nicky Connor noted that this Strategic Framework does have a Directions Element as there is shared responsibility. The Public Health element and delivery of immunisations sits with the Health Board through the Director of Public Health The delivery of the services sits under the delegated services with the Health and Social Care Partnership under the IJB. The aim is to bring it through both governance structures before being tabled at the IJB for approval with direction. Nicky Connor confirmed that there was some fluidity around the Immunisation budget because of the national priority been placed on Immunisation and workforce plans are still being developed it is likely that a more enhanced financial envelope will be received once this had been agreed. Cllr Ross queried what challenges were anticipated going forward with the vaccination programmes. Joy Tomlinson advised getting clarity on technical elements in a timely fashion is very important noting that guidance and direction from government can come with very short turnaround times which is resulting in clinical teams having to plan for all eventualities. Nicky Connor noted that there are challenges with the workforce and getting public engagement. Martin Black confirmed that Public Health have responsibility for the Strategy, but it is the HSCP clinical teams undertake the role of implementing the strategy. Nicky Connor confirmed that it was confusing and agreed to take the roles and responsibilities paper to the Development Session on Friday 10.9.21 to help explain the complexities in more details. Cllr Brett noted that the recommendation in the paper is that the committee agree the Strategic Framework be tabled at the IJB Committee Meeting and this was agreed by all.	**NC**

6.7 Flu Vaccination Covid Vaccination Tranche 2 Plan Delivery

Bryan Davies noted that the previous agenda item had been the high level strategic framework paper while this paper was an operational paper providing an update on the vaccination programme within Fife.

Bryan advised that all adults aged 18 and over have been offered a vaccine but noted that there are still some priority areas that need to be delivered, such as 2nd doses that will be delivered within Tranche 2.

Bryan advised the service is actively planning for different scenarios as currently it is unknown whether the flu and covid booster will be provided at the same appointment or not, which product will be used for the covid booster and whether 12-15 year olds will require to be vaccinated. It is anticipated that further guidance will be provided on the 13th September 2021.

Lisa Cooper advised that there is a special promotion currently for 16-18 year olds and the team are focussing on the under 40's age group as there is a decrease in the uptake of 2nd doses within this age group.

Martin Black wished to thank the vaccination team for all their efforts over the last year but queried if it would be the national services who would be responsible for sending out the appointments again and whether the timescales would take into consideration that we are approaching winter. Lisa Cooper confirmed that it would the NVSS System that will be sending out the appointments.

Cllr Brett stated that the national scheduling system had accounted a range of difficulties, highlighted on pg 104, and asked if there is assurance that these difficulties have been addressed. Lisa Cooper advised that these issues have been thoroughly investigated and lessons learned to ensure that similar errors do not reoccur.

Martin Black wished clarification around overseas students being vaccinated and how the NHS will know what vaccine they have already had and who will be responsible for covering the costs. Lisa Cooper advised that students are required to provide evidence of their vaccination when they arrive and it was confirmed that the students would not be expected to cover the costs of their vaccination. Lisa Cooper advised that the service was working closely with both university and colleges within the region and drop in clinics had been organised.

Cllr Ross queried how well attended the drop-in clinics had been and had they helped with the vaccination uptake with the younger population. He also queried whether the self-referral option was only available for health and social care staff or whether the general public would be given appointments or asked to telephone to arrange an appointment and whether there would be an impact on the delivery of the programme if the rollout extended to 12-15 year olds. Bryan Davies advised that Fife had been commended for its use of Drop-In Clinics at a national meeting and believed that they had been effective in increasing the uptake but agreed that there was more work to be done. Bryan noted that there would be an impact on the delivery of the vaccinations depending on whether the flu and covid booster could be provided at the same appointment and whether the 12-15 year olds would require a vaccination, but until the guidance was issued it is not known the full extent of this impact. Lisa Cooper confirmed that people

	will be given appointments but will have the opportunity to telephone and change the appointment if required. Cllr Wincott queried following the success of drop in clinics for vaccinations whether this could be extended for flu vaccinations. Bryan Davies noted that there would be merit and this was being discussed in the logistic workstream currently. Christina Cooper queried what the position currently was for staff within care homes and their requirement to be vaccinated. Lynne Barker confirmed that staff who work in care homes need to be vaccinated and a specific team has been set up for vaccinating both residents and care home staff. Cllr Brett thanked Bryan and Lisa for their update and agreed that the committee would be updated at the next meeting but this would not hold up the delivery of the vaccination programme.	
7	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	7.1 Fife Area Drugs & Therapeutics Committee Unconfirmed Minute from Dr Hellewell confirmed that there were no issues requiring to be escalated.	
	7.2 Confirmed Minute of the Infection Control Committee from 2 June 2021 Cathy Gilvear advised that there is a new Infection Control Manual specifically for Care Homes In addition there is going to be a focussed review of all E.coli infections related to catheters	
	7.3 Confirmed Minute of the Clinical Governance Oversight Group from 23 June 2021 Cllr Brett queried what NEWS2 was (pg 130-131)? Lynn Barker confirmed this stood for National Early Warning Score which monitored patients statistics such as temperature and blood pressures. Lynn advised that with the introduction of NEWS2 the recording was now electronic and a subgroup was leading on the implementation.	
8	**ITEMS FOR ESCALATION** Cllr Brett noted that the Immunisation Papers will be tabled at the Board Meeting but would like the committee to commend them.	
9	**AOCB** No issues were raised under ACOB	
10	**DATE OF NEXT MEETING** Friday 1 October 2021 at 1000hrs MS Teams	

Fife NHS Board
CONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON WEDNESDAY 21ST JULY 2021, 0900 VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
John Chalmers	Clinical Lead, Digital & Information
Andy Mackay	Deputy Chief Operating Officer (on behalf of Director of Acute Services)
Margo McGurk	Director of Finance & Strategy
Euan Reid	Lead Pharmacist (on behalf of Director of Pharmacy & Medicines)
Amanda Wong	Associate Director, AHPs
Jillian Torrens	Senior Manager, Mental Health & Learning Disabilities Service
Janette Owens	Director of Nursing
Philip Duthie	General Practitioner
Miriam Watts	General Manager, Emergency Care
Nicky Connor	Director Health & Social 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
Maxine Michie	Deputy Director of Finance
Apologies:	
Eileen Duncan	Directorate Solutions Manager H&SC
Andy Brown	Principal Auditor
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Lynn Barker	Associate Director of Nursing
Helen Hellewell	Associate Medical Director
Margaret Guthrie	Information Governance and Security Manager/DPO

1	**WELCOME AND APOLOGIES**	
	Dr McKenna welcomed everyone to the Digital & Information Board and a round of introductions were made.	
2	**MINUTE & ACTIONS OF MEETING HELD – 20/04/21**	
	Minutes were reviewed and agreed. Actions updated.	
3	**MATTERS ARISING**	
	3.1 Clinical Engagement J Chalmers noted to Board that discussions regarding Clinical Engagement have been undertaken over the last few meetings and also with the Digital Leads who meet on a monthly basis. There have been helpful discussions and it is hoped a solution has been found, which is promising. This is still in progress but great work has been achieved so far. Further communications to take place with Planned Care and it is hoped to use HEPMA post to engage with Nursing. A brief discussion was undertaken with Digital Engagement and it was hoped this could become a standing item in all meetings. Communications to start with H&SCP and linking in with Fife Council. N Connor advised a Group is being established within H&SCP and this could be a route	

	to achieve this. J Chalmers advised they are happy to be included and also M Ansar. N Connor to take forward and communicate. C McKenna advised that a functioning Medical Committee would be a good opportunity, but NHS Fife doesn't currently have one. This is the responsibility of medical staff to have this committee. Will take this forward. A Graham and J Chalmers have been working on standard items to be cascaded with support from K Laing. M McGurk queried if it would be useful to have a representative from Finance as discussions develop. C McKenna noted this doesn't entirely have cost implications but will have a think about the best route. **Action** - N Connor to speak with colleague regarding Clinical Engagement within H&SCP and adding this to Group.	**NC**
4	**RISK MANAGEMENT**	
	4.1 Risk Management A Graham delivered a presentation regarding risk profiling and a core understanding of what we provide to our Board members. Within the last few meetings there have been requests to separate risks from Digital & Information and Information Governance Security. Work is continuing. • At present there are 31 Risks, 9 in the high category. Summary of these risks are in Appendixes 1 • A number of high risks have been reclassified to moderate. • 1 risk has been reviewed and this has increased to high. • A number of moderate risks require to be reviewed as these have obtained their risk level A Young provided a brief background to increased risks of Cyber-attacks. A lot of work has been undertaken regarding Cyber-attacks, with other Health Organisations being targeted. These are now human led attacks rather than computer based, this is increasingly worrying as we are seeing evidence of these attacks are now more frequent across many countries. These human based attacks would start with reviewing the company, possibly contacting an individual to work their way in. With moving from back up tapes to networks and online this provides more of an opportunity to take data. A continuing challenge for Health Boards is to recruit and retain trained members of staff. Within Cyber Security, we have lost 2 members of the team. A number of exercises have taken place within NHS Fife and actions are being updated from these. Staff from a range of levels have been invited to workshops from June to Sept. Strong support has been received from EDG and other committees so this good. Work is currently ongoing with the Resilience teams. C McKenna noted this is worrying as we have been targeted with these malware attacks a few years ago so this all likely this could happen again. A Graham noted they are currently looking into different back up systems. There is also a level of technical exposure from the companies that provide medical devices into the Healthcare market. M McGurk thanked A Graham for bringing this paper to Board, this has been the clearest and easiest document. M McGurk queried if there are any additional exposures to O365? A Graham advised they are managing to	

	mitigate. There is improvement to the O365 platform progresses to come with year 4 deal. Further discussions were undertaken about how we can provide key messages to staff i.e. checklists, where staff complete a form to tick to ensure they have been reminded re attacks, fake emails etc. A Graham noted a paper has been issued to EDG this could be used as further comms. Comments were raised if we could possibly do sample tests/emails to see if staff are aware of the dangers. A Young confirmed exercises have been carried out in the past with staff receiving NCS guidance should they fail. Repeat of these exercises could be undertaken again. A brief discussion was held regarding Business Continuity, A Mackay noted there was a real play exercise a few weeks ago where Business Continuity was introduced, they moved to paper based systems. Although a few disruptions, this worked well although. **Action** - A Graham & A Young to review and issue comms to staff highlighting awareness to potential dangers of links within emails.	**AY&AG**
5	**PERFORMANCE**	
	5.1 Scorecard A Young presented D&I Performance Summary noting the below: • **EOL servers 2003** – 15 remain, a list is being created to the advise on the costs involved to upgrade. • **EOL servers 2008** – 121 remain, work continuing, this isn't an urgent upgrade as support is still available for these. • **Password resets** is currently amber. Changes have been implemented to password policy, staff are being encouraged to use more user friendly remembered words. • **Cyber Exposure Score** – this is measured nationally and we are consistently sitting third within Scotland. This score does fluctuate depending on new patches to deploy. Work is continuing to reducing this score as this does remain our focus point.	
6	**Strategy & Programmes/Projects**	
	6.1 Strategic Delivery Plan M Richmond provided an overview to the Strategic Delivery Plan noting they have added an additional key to the plan with indicative costs to the organisation. M Richmond provided a brief summary to some of the current ongoing projects: • **Modernising Patient Delivery** – Lims will now be 2022. Business Case to be completed currently waiting on National Team. • **Near Me** – This is to be moved in BAU, progress is slower than hoped as there is no dedicated resource to progress further. This will be reviewed once capacity allows. • **Paperlite** – Progress is slower than hoped as there is no dedicated resource to progress further. M Richmond highlighted due to the speed of the systems being introduced due to Covid-19 there was no Business Case provided so no defined resource or	

	financials. M McGurk noted there is a possibility of Covid funding, linking with R Robertson regarding. Finance are putting a report for Q1 to Scottish Government if there any costs this could be included but would need to clear what is Capital and what is Revenue. **Action** M Richmond to discuss further with M Michie.	**MR**
	6.2 Programmes/Projects update (incorporating Digi Ops Portfolio) M Richmond presented paper noting demand for Digital Health requests are still high, receiving 35 requests from one member of staff. After investigation some of these requests were already in progress so this was reduced but many were not so at present they are prioritising all the requests. Biggest challenge is recruitment, they have waited over 12 weeks for the recruitment process for x3 Band 7. Technical Post for HEPMA remains vacant but this is back out to advert so hopeful for a successful candidate. • **HEPMA** – Progressing well. Contract has been drafted and currently with company, waiting on feedback. It is hoped HEPMA product will be by mid-August. • **O365** – Paper with R Robertson for consideration for Phase 1. Wished to present to finance first and will then bring to Board. Business Case will then be completed for Phase 2 to introduce next phase e.g. SharePoint. Working is continuing. • **Urgent Care Transformation** – Work is ongoing with team to understand the requirement for Phase 2. This will be led by D&I to ensure we are aware of the scope of what requires to be delivered. • **Community System Replacement (Morse)** – Great work ongoing, now in migration 8. This has been very well received within the teams. Discussions was undertaken regarding Digital Health requests, a query was raised on the vetting process, M Richmond confirmed Clinical & Technical requests are discussed within D&I and the Digital Clinical Leads. M McGurk raised a query regarding the financing of these requests to ensure that we are productive with our opportunities and for these to reduce costs. M Richmond advised our Business Analysts look at existing products and are seeking maximum utilisation rather than possible new solutions. P Duthie noted that systems may not necessarily have a financial saving but this assists with GP's time and helps them with Clinical efficiencies. A Mackay queried the process on how Digital Request are being received and a review of process on departments approach for these. M Richmond advised they looking at a comms strategy to go out to staff. **Action** – M Richmond to review how we can handle requests made and what improvements could be made in processing/providing visibility. **Action** – A Graham to review the prioritisation and how do we make these choices and present at next Board.	MR AG
7	**Business Cases / Proposals**	
	7.1 Digital Pathology – Outline Business Case M Richmond advised they were approached by Digital Pathology to seek approval but due to time constraints this have been brought straight to a Business Case. The framework is due to finish in Sept 21. M Richmond provided background to the Business Case and also the figures for implementation of new framework and confirmed after discussion with D&I,	

	these costs cannot be met within the D&I budget as this has already been committed within their Digital Delivery plan. M McGurk raised concerns if this is a service sustainability how this is only been brought to Board with only 6 weeks prior to the existing framework expiring. If this had been brought sooner other alternatives may have been sought. Concerns were also raised that a Business Case of this value has reached this stage. M McGurk confirmed there is no funding available within budget, and the Board has cost savings to be met. Further discussions were undertaken with regards to the process on how these Business Cases are brought to this Board and when they should have come through Acute SLT and then EDG. D&I is not the approval for budgets it is the approval for the concept. Concerns were raised on the demand this will have to implement, ongoing costs and maintaining. Business Case **declined** to the financial constraint and not full understanding where this sits within organisational priorities. **Not approved.**	
	7.2 SBAR FEOC and Paperlite M Richmond advised in line with the new Orthopaedic Centre one of the priorities was to operate a Paperlite system. At present there is currently no Business Case for Paperlite seeking approval for this to be taken to Business Case. Discussions were undertaken on the benefits of Paperlite, improving patient journey, cost savings and to discontinue the vast number of papers notes moving around all departments. The requirement for this, not just to be implemented in the Orthopaedic Centre but throughout the organisation. M Michie advised they have recently left a previous Health Board where they have implemented Paperlite and there are great efficiencies. **Approved** to progress with Business Case. Further information to be presented through Initial Agreement and Business Case.	
	7.3 eRostering – National Agreement A Graham noted this has been brought to Board for awareness purposes. There is an expectation this will be a framework and NHS Fife would be one of the earlier Boards to implement. M McGurk advised ongoing discussions to take place.	
8	**FINANCE**	
	8.1 Digital Strategy and Operations – Financial Assessment A Graham advised paper has been brought to Board for discussion but noting there already has been financial discussions in previous items. Look to set priorities of benefits and frameworks to extend this planning into years 5, 6 & 7 for the digital landscape. Look at priorities of projects and no funding available.	

9	**AUDIT / ACTION PLANS**	
	9.1 B23-21- ITIL Response A Young noted this paper has been brought to Board for awareness. Will produce a paper for next D&I in October for the costs benefits. **Action:** A Young - Cost Benefit Paper to be produced	**AY**
	9.2 B23-B26 – Business Case Template M Richmond advised there was an audit action to bring templates to Board for agreement. The current NHS template that is currently being used does not list all information and to use these templates. M McGurk noted this is definitely the process we should be using to go through the 4 stages of approval, but this should be used on certain financial limits. M Richmond noted these would be used for any projects 1 million and above. These would come to the Board for approval and any smaller projects are decided within our SLT meeting. Templates **agreed**	
10	**AOCB**	
	No further comments or business was raised. Dr McKenna advised a productive meeting with good conversations noting our limitations and the financial challenges we face for our organisation to become digital. C McKenna thanks all for their attendance.	
11	**DATE OF NEXT MEETING** 0900, 19th October 2021, via MS Teams	

UNCONFIRMED Minutes of the Health & Safety Sub Committee held on Friday 14th September 2021 at 13:30 within Microsoft Teams

Present:

Neil McCormick (NM) Director of Property & Asset Management
Conn Gillespie (CG) Staff Side Representative
Kevin Reith (KR) Deputy Director Of Workforce (Deputising for Linda Douglas)

In attendance

Craig Webster (CW) Health & Safety Manager
David Young (DY) Minute Taker

1. Chairperson's Welcome and Opening Remarks

NM Welcomed everyone to the meeting and reported that this will be CW's last meeting as the Health and Safety Manager. As from this week, Craig has moved across to work with the Infection Protection and Control Team.
NM thanked CW for all his endeavours over the years in Health & Safety and wished him luck in his new role.

2. Apologies for absence

Dr Chris McKenna (CM) Medical Director
Linda Douglas (LD) Director of Workforce

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 Update	
3.2.1. Theatre Locker Rooms	
NM reported that the Health & Safety Executive are now happy that NHSF were working within National Guidelines and had addressed the issues raised as a result of the HSE Inspection. The Organisation has received two invoices from HSE for the work that they undertook. Action Closed.	
3.2.2. Clinical Areas - welfare areas and communal rooms	
NM indicated that this was the updated Return to Work Guidance for Staff Returning to Work. KR stated that the Learning and Development Team have now incorporated the guidance into online resources for staff returning to work which fulfils all requirements. Action closed.	
3.2.3. Laundry	
Action Closed	
3.2.4. Face Fit Testing	
CW reported that following the HSE Inspection, there was an issue raised regarding the competency of the H&S team to conduct Face Fit Testing. CW informed the group that a company named fit2fit, who are accredited trainers, carried out some work with the H&S Team on quantitative and qualitative fit testing and the team now have certification in place. Action closed	
3.3. Changes to Terms of Reference	
NM raised some points mentioned at the last meeting relating to the Terms of Reference.	
3.3.1. Updating Names and Job Titles in ToR	
NM noted that CW had sent an up-to-date copy of the ToR to the group. CW confirmed that the tidying up of names and job titles has been completed.	
3.3.2. Links relating to resilience and resilience forums	
CW told the group that he hasn't made any changes to the resilience group diagrams, so that's	

something that the committee may wish to consider moving forward or as a review next year.	
3.4. Work Plan to be reviewed.	
CW reported that the review of the Work plan has still to be done.	
3.5. Reports to Clinical Governance.	
NM stated that CW had updated the annual report to that new format. CW said that would be covered later on in the agenda	
3.6. 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 pointed out two issues that have significantly changed since March	
• **1 and 2 meter social distancing**	
NM discussed the recent DL letter outlining the move to a policy of 1 and 2 meter social distancing. He expressed his concern about how confusing the guidance was so has asked the Communications Team to post a message on Blink that will help clarify the new guidance to staff. NM discussed the changes to the 10 day isolation period so that if you have both your vaccines and a negative PCR test, Staff can return to work as long as you're not in a very specific clinical area with clinically vulnerable patients. NM believes that both issues have been addressed across the organisation now and are better understood. NM asked if anyone has anything to add. CW said that NSS health Facility Scotland has issued an update to the social distancing guidance document. The problem is that they have issued this without any contact with RHIGH and it appears to contradict some of the guidance that's been coming out from RHIGH and Protection Scotland.These issues have been flagged and will be raised to the Hospital Control Team. NM has attached the file he received from NSS for information.	
• **Changes to the 10 day isolation period**	
NM discussed the changes to the 10 day isolation period so that if you have both your vaccines and a negative PCR test, Staff can return to work as long as you're not in a very specific clinical area with clinically vulnerable patients.	
NM believes that both issues have been addressed across the organisation now and are better understood. NM asked if anyone has anything to add. CW reported that NSS health Facility Scotland has issued an update to the social distancing guidance document. However, they appeared to have issued this without any contact with RHIGH and it seems to contradict some of the guidance that has been coming out from RHIGH and Protection Scotland. These issues have been flagged and will be raised to the Hospital Control Team. NM told the group that he has attached the file he received from NSS for information.	
5. Governance Arrangements	
5.1. Discussion around H&S arrangements for 2021-2022 (and beyond)	
NM informed the group that, in light of CW's move and having spent some time with a colleague from another board, Peter Mackie (former H&S Manager in NHS Forth Valley) have looked at the function of Health & Safety within NHSF and the different strands that need to be addressed; • An up-to-date Health and Safety Policy and Policy Statement • Arrangements around about the reporting structure of the Health and Safety Sub committee • The resources that the Health & Safety team are require terms of advising on health and safety and also Manual Handling and Violence and Aggression training An independent review was carried out which NM found to be helpful and has given him some food for thought; He said that the organisations needs a Health and Safety Manager so will be moving to put an advert in place to see if there's interest and to take up that post moving forward. He plans to	

look at how the team can prepare to get through the backlog of Staff that need Manual Handling and Violence & Aggression Training, as well as a plethora of things to discuss regarding Health and Safety, Risk Management etc. NM stated that the Health & Safety Policy was reviewed and so it's on the agenda today for approval. PM was thoughtful about the number of staff and that NHSF have working on manual handling and violence and aggression training NM stated that the Team needs to consider different ways that we can work in the Community and how we can deliver the amount of training done that we need to. He has spoken been speaking to Fife Council to see if there something that we can do jointly in terms of manual handling training NM has also had a conversation with the H&S Manager in NHS Tayside to see if we could potentially call on their expertise should any health and safety issues materialise NM hopes to submit a SBAR to EDG in the next month or so outlining the main points that need to be addressed in order to get the Health and Safety, Manual Handling and Violence & Aggression Team shaped the way that we need for the future. There was some discussion regarding the need to nominate deputies in order to maintain the quorum and how this may need to be reflected in the in the terms of reference.	
6. NHS Fife Enforcement Activity	
CW informed the group that the Enforcement Notice has been closed. The Organisation has sent the information that the HSE had requested and they emailed back indicating they were happy with the direction of travel. No other activity at present. CW reported that he is aware of HSE activity in other NHS Boards looking at Manual Handling and Violence & Aggression	
7. Policies & Procedure	
7.1. Health and Safety Policy review	
The health and policy and policy statement has been updated to reflect changes in job titles CW has made some changes to make it more readable. NM asked if the group were happy to approve the policy and statement for approval There was some discussion regarding the appropriate route to send the policy to and it was finally decided that NM should take it to EDG but with a question attached to that for a discussion about if it should be routed to clinical governance either for approval or for information. NM noted that CW had helpfully provided the group with a document showing the current status of policies and procedures relating to health and safety. CW reported that the document listed all of the policies he is responsible for making sure they get updated and reviewed at the appropriate time. There was some discussion regarding the contents of the document. CW added that he believed that GPE8.9 - Work Environment Procedure was no longer fit for purpose but was unsure how to have the procedure deleted. NM suggested that CW should contact **HAZEL** and ask her how to remove this document from the system. NM stated that the list is helpful to the group and should be kept up to date. NM has asked DY to make sure that the list is updated on a quarterly basis.	
8. Other business	
8.1. Management of Sharps	
CW informed the meeting that he has completed all actions within his remit. There are still some outstanding actions against the Sharps Strategy Group and another in relation to Sharps Investigation Incident Management which is within the scope of the adverse event review policy process. CW has communicated all relevant info to the internal audit team and all the actions have been updated.	
CW informed the group that Waste Management is back into contingency arrangements as the company who took over the contract has effectively collapsed. Information that the contract was being pulled came through very late and very suddenly so Facilities have been firefighting since the weekend but are now on top of things. NM added that he had raised this issue with EDG gold and agreed that the facilities team seem on top of things.NSS and HFS have been very helpful and are in working with trades to resolve issues, so, at	

the moment there is an issue but is being managed.	
9. FOR INFORMATION/ NOTING	
Committee Minutes CW reported that there were no other committee minutes to review at present.	
10. Next Meeting	
Next meeting will take place on Friday 10th December 2021 @ 12:30 on Teams NM asked if the meetings for next year have been set up. DY confirmed that dates have been scheduled.	CW/NM

NHS FIFE INFECTION CONTROL COMMITTEE
6TH OCTOBER 2021 AT 2PM
VIA MICROSOFT TEAMS

Present	
Janette Owens	Director of Nursing
Julia Cook	Infection Control Manager
Margaret Selbie	Lead Infection Prevention and Control Nurse
Elizabeth Dunstan	Senior Infection Prevention and Control Nurse
Keith Morris	Consultant Microbiologist
Paul Bishop	Head of Estates
Catherine Gilvear	Patient Safety Programme Manager
Lynn Campbell	Associate Director of Nursing
Fiona Bellamy	Senior Health Protection Nurse Specialist
Yvonne Chapman	Risk Management Co-Ordinator
Craig Webster	Deputy Infection Control Manager
Apologies	
Esther Curnock	
Jim Rotheram	
Midge Rotheram	
Sue Blair	
Pauline Cumming	
Lynn Burnett	
In Attendance	
Lori Clark	Notes

1	**APOLOGIES** Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – August 2021** Group approved previous minute as accurate reflection	
3	**ACTION LIST (August 2021)**	**ACTION**
	Group talked through each open action and the actions were closed or completed as appropriate. 4.1a – JO will share SBAR re action plan for HIS Inspection 4.1d – KM updated he didn't get any comments but does have the template to submit to EDG and is working on this. 4.8 – JC advised that Angela Swift chairs the PWID QI Group and is attended by Alex Baldacchino Consultant Psychiatrist in Addictions, Keith Morris Consultant Microbiologist, Mirka Barclay IPCN, Gareth Balmer from "We Are With You" voluntary service, Marion Wilson Team Leader, Ian Davidson Lead Nurse, Paul D'Mello Addictions Nurse and David Binyon Lead Clinical Pharmacist. 7. ToR update – JC thanked all for comments and is currently updating to reflect these comments and will have a draft to send to JO soon. 7. Fans – These documents were recirculated and updated to include non-clinical areas, this was then published on Blink and sent around teams 4.1e – JO will take to the next meeting a week on Friday. **Action list updated to reflect.**	
4	**STANDING ITEMS**	
4.1	4.1a HAIRT Report JC advised with regards to achievements that IPCT have supported the 'Stop SEPSIS save lives' campaign for World SEPSIS day on 13th	

	September. There were national campaign materials promoted on Blink and social media. IPCT are also in collaboration with Excellence in Care and digital information teams and have completed a successful pilot of an electronic version of the CRA MDRO tool in AU2 which is now being further rolled out since 20th September. ED updated for SAB achievements NHS Fife was below the national rate for HCAI in Q1 2021 and in Q2 there has been a reduction in cases from 25 in Q1 to 12 cases in Q2. For CDI Q1 2021 NHS Fife was below the national rate for HCAI and in Q2 there has been a reduction in cases from 16 in Q1 to 12 in Q2. We are on track for reaching the reduction targets for CDI's. In relation to ECB's NHS Fife was below the national rate for HCAI and CAI. This is also the case for Q2. ED updated for the committee's awareness the IPCT business continuity plans were enacted for a 3 week period due to the pressure on the service. JC added the team were flexible and adapted shifts and maintained the service throughout. ED updated on challenges around SABs advising that VAD remain the greatest challenge for hospital acquired SAB's, in Q1 NHS Fife was above the Scottish rate for CAI SABs. In relation to ECBs, UTI's and CAUTIs remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate. During June there were 7 CAUTIs but no traumas noted resulting in 32% CAUTI rate. The rate was lower at 25% in July despite having the same number of CAUTI's. For CDI NHS Fife has seen an increase in CDI numbers during 2021 when compared to the same time the previous 2 years. NHS Fife must reduce HCAI further to meet the reduction target. SSI national surveillance programme is still paused at this time. JC updated that in relation to the COVID 19 pandemic IPCT has continues to work in preventing healthcare outbreaks, support clinical areas with outbreak management and support the remobilisation of services. The team have been undertaking contact tracing in the hospital environment. IPCT are providing a programme of IPC education and supporting many groups such as the bronze logistics group, HCT, STAC, LRP and remobilisation. IPCT also have a representative at the weekly national meeting with ARHAI. ED talked through the data from the HAIRT report. For SABs in Q1 NHS Fife had 12 SABs this is down from 25 cases in Q2. In Q1 NHS Fife are below the national rate for HCAI and above for CAI but are on target for reaching reduction target. NHS Fife achieved 98% compliance with the MRSA CRA in Q2 which is up from 95% in Q1. NHS Fife achieved 90% compliance with the CPE CRA in Q" which is up from 88% in Q1. In Q2 NHS Fife had 12 CDIs which is down from 16 cases in Q1. NHS Fife is below the national rate for HCAI CDIs and above for CAI CDI's. We are above the reduction target rate. In Q2 NHS Fife had 56 ECBs which is up from 48 cases in Q1. In Q1 NHS Fife is below national rate for both HCAI and CAI ECBs. We are on track for reaching the first reduction target of 25% for ECBs. Ed updated that for Hand hygiene NHS Fife overall results remain	

	consistently above 98%. National cleaning services are 95.4%compliance in Q1 this shows NHS Fife are achieving a green status. Estates monitoring is 96.2& compliance in Q1 showing NHS Fife achieving a green status. JC updated that there has been no ward closures due to norovirus outbreaks since the last ICC meeting. JC added that there has been no ward closures due to influenza since the last reporting period. The team are preparing for a busy winter throughout the hospital. JC updated on COVID 19, there has been 3 outbreaks but 4 ward closures due to COVID in this reporting period. Radernie ward was closed on 30th June, 5 patients in total affected. Letham Ward was closed on 16th July, 3 patients and 2 HCWs affected then again closed August for 1 asymptomatic patient in a bay. Ward 4 QMH closed 22nd July, 3 patients and 1 HCW were affected in this outbreak. ED advised that there is no available SSI data and there has been no further HEI inspections since the last reporting period. Members **noted** the update.	
	4.1b HAI LDP Update – SABs Reports Reports on agenda for information Members **noted** the update.	
	4.1c HAI LDP Update – CDIs Reports Reports on agenda for information Members **noted** the update.	
	4.1d ECB Surveillance Report Reports on agenda for information Members **noted** the update.	
	4.1e HAI Update – C Section SSI Reports This surveillance has been paused following a CNO letter however is being monitored at a local level. Members **noted** the update.	
	4.1f HAI Update – Orthopaedic SSI Reports This surveillance has been paused following a CNO letter. Members **noted** the update.	
	4.1g Colorectal SSI Surveillance Report This surveillance has been paused following a CNO letter. Members **noted** the update.	
	4.1h CPE Surveillance Report and MRSA Surveillance	

	Members **noted** the update.	
	4.1i Outbreaks, Incidents and Triggers Covered in HAIRT agenda item Members **noted** the update.	
4.2	Care Home update JC updated that IPC care home team are continuing to support care homes with the rollout of both the NIPCM for Older People and Adult Care Homes and the National Cleaning Specifications. These were launched in May 2021 and are to be implemented by September. The care inspectorate began using the new guidance and have been inspecting against this since 1st September. There has been increased COVID activity in the care homes recently and the team have been actively supporting the homes referred, attending PAGs and providing education. The team are about to commence the winter training programme for the care homes which will go along side other training topics such as hand hygiene, donning and doffing of PPE etc. JO added that she attends the weekly care home meeting and the infection control care home team receive lots of positive feedback on the work they are doing and support they are providing. FB agreed with this and added it's great to have their input in the care homes. Members **noted** the update.	
4.3	NHS National Cleaning Services Specification Attachment on agenda for noting. Members **noted** the update.	
4.4	Risk Register YC updated that there were 3 risks overdue for review at the time of the report being written. YC updated that she has sent a reminder email this morning about risk 743 regarding flexible water hoses. Risk 1612 looked like it had been reviewed but just not had the dates changed so has emailed about this one also. For risk 2167 provision of instrument decontamination for robotic surgery is a new risk and YC advised it had been updated on 27th September. Overall there are 24 risks in report, 3 are high risk, 19 moderate risks and 2 low risks. YC looked to see if there were any risks up for review from the time of the report to this meeting there were 8; 4 have been updated and YC has emailed about the other 4. Risk register is approved. Members **noted** the update	
4.5	Learning Summaries One learning summary has been brought to this ICC regarding a SAB infection from a PVC in July, reason is failure to document insertion and	

	ongoing maintenance resulting in PVC being in situ for over 80 hours. Members **noted** the update	
4.6	National Guidance JC updated for the committees awareness that ARHAI Scotland and Public health England are developing winter guidance developing a respiratory pathway. This work has been going on for some time and has had considerable consultation. At the national meeting this week the group were informed that there will be communications out to boards on Friday this week, Boards will have until 1st November to implement the pathway. NES will be supporting the role out and have set up a task and finish group and are reviewing all the IPC materials they have on the NES TURAs websites and are archiving anything not relevant. They are going to be working on some new resources, some animations, short videos/clips etc. Some boards asked if these can go live before 1st November to support the role out/implementation. KM added that although we have 3 weeks there is annual leave coming up which doesn't leave much time. KM added this will be difficult for ward staff as this is a complete change from current pathways but eventually it will be easier. There may be challenges around unexpected day 5 positives and we haven't seen the surgical pathway in this document yet. LC added that 3 week implementation will need careful planning but could possibly do bullet point briefings for staff who do not regularly use a computer. A good communications plan will be key. KM added that he has offered to present a grand round presentation to attempt to capture more of the medical staff. Members **noted** the update	
4.7	HEI Inspections JC informed group that the HEI inspection continuing, inspectors were in the Golden Jubilee last week and Shetland 3 weeks ago and seem to still be looking at the same standards as VHK was inspected against earlier in the year. Members **noted** the update.	
4.8	Quality Improvement Programmes UCIG No update at this ICC. PWID JC updated that the meetings for PWID are ongoing the last meeting was in September and the next meeting scheduled in November. The team have been working on some education with the tissue viability nurses on identifying soft skin tissue infections and are liaising with the addictions team for a suitable opportunity to provide training. Members **noted** the update.	
4.9	Education JC updated that we have been developing and updating some of our presentations from last year, the team have a number of voiced over presentations available on Blink for staff to access at any time. Also available are teams sessions ongoing weekly on GI illness, Flu, outbreaks and terminal cleans this gives staff the opportunity to ask questions at the	

	end. We also have face to face sessions upcoming for some support services staff. Members **noted** the update.	
4.10	Infection Prevention & Control Audit Programme MS updated that Rosemary Shannon continues to audit one day per week for IPCT and the infection control nurses have also started auditing again. We have managed to keep up to date with the programme and have been supporting the wards to complete actions etc. There is a trial ongoing at the QMH where we have broken up the action plan into separate ones for estates, domestics and the ward staff for example so the actions are easily identified. LC added that they are currently trying to reconcile all of the data burden/audit reporting that senior charges nurses do as there is a bit of inconsistency. They are currently trying to pull together a list of what they might stop or reduce in frequency and will take list to JO for comment and will catch up with JC after the meeting but discussion have been started. Members **noted** the update	
4.11	Prevention and Control of Infection Work Programme 2019-2020 (for noting) Work programme is for noting Members **noted** the update.	
5.	**NEW BUSINESS**	
5.1	COVID-19 Lessons learned for noting Members **noted** the update	
5.2	Excellence in Care JC updated that the Excellence in Care project has been ongoing for 2 years. AU2 trialled the tool which is now on patientrack and the pilot was successful. The feedback was that the tool was easy to use, supported patient placement and helped determine what samples to take and ultimately helped to improve patient safety. The tool went live on 20th September and all seems to be going well. We are just about to start this quarters KPI audits and we will be focusing more on AU1 and AU2 rather than the high impact areas for this quarter. Members **noted** the update	
5.3	Safe and Clean Audit ED updated that they have been offering 2 sessions of training initially for new auditors and this is now down to 1 per week. There has been some great response and have auditors in outpatients areas, GP practices. Occupational health etc. Everyone seems to be really engaged in the process. We currently train between 3-5 new auditors each week 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 JC added that there has been a new ventilation group set up and the first meeting has occurred. These will take place quarterly, the first meeting was very positive. This meeting will feed into the ICC meeting. JO added that she has been looking at the NHS Assure document in relation to the new orthopaedic building and this can be sent to the committee for information and it will go to EDG. 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 SCRIBE works ongoing nothing major to note. 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** JC updated with regards to the ARHAI annual report that NHS Fife have performed very well and were not identified as outliers for any of the key national surveillance programmes, the report contains some great information and anaylsis. KM added that it was interesting that the number of CPE was significantly down on the previous year and suggests this might be a result of COVID as not so many people coming in so less swabs, clinical risk assessments etc. Members **noted** updates.	
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held 1st December 2021 at 2pm via Microsoft Teams	

NHS Fife

NOTE OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 10 AUGUST 2021VIA MS TEAMS

Present:

Dr Phil Duthie (Chair)	
Dr Chris McKenna	Medical Director
Dr Marie Boilson	Clinical Director H&SCP (Fife-wide)
Dr Rob Cargill	AMD ASD
Dr Fiona Henderson	General Practitioner
Dr John Kennedy	Clinical Director H&SCP (East)
Dr Sally McCormack	Clinical Director Emergency care

In Attendance:
Catriona Dziech (Notes)

1 APOLOGIES FOR ABSENCE
Dr Annette Alfonso, Dr Helen Hellewell

2 DECLARATIONS OF MEMBERS' INTERESTS
There were no declarations of interests.

3 MINUTES OF PREVIOUS MEETING HELD ON 8 JUNE 2021
The notes of the meeting held on 8 June 2021 were approved.

4 MATTERS ARISING

i) Revised Constitution Attendees

It was agreed the current attendees would remain and continue to encourage people to attend.

It was noted the lack of an effective working Medical Staff Committee is an issue and if there is no input to the AMC how would issues be escalated to the Board.

It was agreed Dr McKenna would ask Gillian MacIntosh, Board Secretary/ Fay Richmond to find out what the requirements are for an AMC in statute and if it is possible to change the function and membership?

Action: CMcK

ii) Medical Workforce – links with Commercial Partners

Dr McKenna confirmed he and Phil Duthie had met with Comms and the next phase is being developed. This item can now be closed.

It was noted for public perception to change the rules allowing General Practice / Secondary Care to see patients face to face would need to change.

5 STANDING ITEMS

i) Financial Position – Including IPQR

Dr McKenna advised there is currently an overspend in ASD. Finance is trying to align, where appropriate, overspends to Covid.

ii) Medicines

Dr McKenna advised medicines are as aspect to the overspend in ASD.

iii) Adverse Events

Dr McKenna advised the Adverse Events Policy is currently being revised and will be available later in the year.

iv) Medical Staff Committee

Considered at Item 4i.

v) Update from GP Sub Committee

Dr Duthie advised there was no major update.

Dr Cargill asked if there was anything that attracts attendance at the GP Sub Committee that could be transferred to the Medical Staff Committee. Dr Duthie advised members are paid to attend the evening meeting. As GP Practices work in small groups and are unconnected the GPSC allows them to get together and send a unified message of any issues back to secondary care. Members to the GPSC are self-selecting by individuals who wish to make general practice better.

vi) Realistic Medicine

Dr McKenna advised there has been no response from SGHD as to whether the recently submitted Value Improvement Bids had been successful. There had been bids for high-risk medicine prescriptions, support for additional backup and support for the Early Cancer Diagnostic Centre and one from an Inverkeithing GP practice for group consultation.

vii) Medical Workforce

Considered at Item 4i.

viii) Education & Training

New Doctors have started in August.

It was noted following recent Deanery visits to Medicine and Surgery both have improvement plans and action plans to follow up.

Dr McKenna advised the Committee of the death of Dr Alistair Dewar, A&E Consultant. This has impacted on everyone within the hospital at this difficult time.

It was noted from the six GP Registrars in training two have signed for Fife. Due to the Pandemic some GPs in training have not had the normal GP experience so this may be an issue going forward.

ix) LAER/SAERs – Report from Adverse Events/DoC
Noted.

6 STRATEGIC ITEMS

i) Health & Care Services Transformation

Dr McKenna advised this will start to look different once the governance structure is agreed. Margo McGurk is leading on this and further details will follow in due.

There may be a series of Programme Boards that will report to a Programme Board Oversight Group. The Programme Boards will be aligned to the four Government priorities: Mental Health, Unscheduled Care, Scheduled Care and Population Health and Well Being. This will also encompass and inform what our Health and Well Being Strategy will be for Fife.

ii) GMS Implementation

Dr Duthie advised following the issue of Memorandum of Understanding (MoU)2 it highlights some significant issues for the Board. SGHD have identified three areas they wish to focus on (Pharmacy, CTAC, Vaccinations).

There are statements within MoU2 which state; anything in place at the moment cannot be removed; and the need to implement these irrespective of the Primary Care budget is required. This means as there is not enough funding within the budget, the responsibility to fund lies with the IJB/Board to ensure they are implemented within the timeframe.

iii) COVID & Remobilisation

Dr Cargill advised the resurgence in community cases did not translate into the same rate of hospitalisation and in-patient critical care need. Community prevalence has been dropping and will waver as things open up. At present there is about ten Covid confirmed patients, plus three confirmed Covid critical. It is likely this will continue over the next few months.

As we remobilise services are reshaping and slowly building up in terms of non-emergency capacity and outpatient capacity. There will be a shift if the two-metre distancing rule is changed to one metre for healthcare settings and plans are in place to capitalise this.

The cost of the Pandemic is unknown in terms of pent up healthcare demand and we are now starting to see the wait presentations and the delayed attention to chronic disease along with the psychological and psychiatric co-morbidities of Covid and Long Covid.

With the closing of clusters managing CAC Dr Kennedy confirmed as from 1 June NHS Fife have repatriated all undifferentiated cases back to General Practice and there have been less than five queries in the last two months and no concerns raised. Most of the Covid exposure now is noting the people who are positive and arranging to see people who may have symptoms of Covid. Dr Duthie advised he has had no negative feedback.

7 ITEMS FOR INFORMATION

i) **Notes of the GP Sub Committee held on 18 May 2021**
Noted.

ii) **Notes of the Adverse Events / Duty of Candour meeting held on 20 April 2021**
Noted

8 AOCB

Dr McKenna suggested, and it was agreed, Susan Fraser be invited to attend the next meeting and present the Transformation / Strategic plans for Fife. Alistair Graham would also be invited to attend to present an update on the Digital Strategy.

Action: CMcK

9 DATE OF NEXT MEETING

Tuesday 12 October 2021at 2pm via MS Teams

Unconfirmed NHS FIFE CANCER & STRATEGY GROUP (CGSG)

Draft Note of the Meeting Held at 14:00 on Tuesday 17th August 2021 via Microsoft Teams

Present:	**Designation:**
Chris McKenna (CM) Chair	Medical Director
Bobby Alikhani (BA)	SCAN Network Manager
Paul Bishop (PB)	Head of Estates
Joanna Bowden (JB)	Consultant – Palliative Care
Gemma Couser (GC)	Head of Quality and Clinical Governance
Claire Dobson (CD)	Director of Acute Services
Susan Fraser (SF)	Associate Director of Planning & Performance
Alistair Graham (AG)	Associate Director Digital and Information
Nick Haldane (NH)	Lead Cancer GP
Ben Hannan (BH)	Deputy Director of Pharmacy & Medicines
Murdina MacDonald (MM)	Lead Cancer Nurse
Neil McCormick (NM)	Director of Property and Asset Management
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Neill Storrar (NS)	Lead Cancer Clinician, Medicine/Oncology
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Catherine Jeffery Chudleigh (CJC)	Consultant in Public Health
Nicky Connor (NC)	Director Health and Social Care
Scott Garden (SG)	Director of Pharmacy & Medicines
Donna Hughes (DH)	Head of Person Centred Care
Margo McGurk (MMcG)	Director of Finance and Strategy
Janette Owens (JO)	Director of Nursing
John Robertson (JR)	Lead Cancer Clinician - Surgery
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Support Officer (minute taker)

		Action
	Welcome	
	CM welcomed everyone to the meeting.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 04 May 2021 via Microsoft Teams**	
	The Unconfirmed Note of 04 May 2021 was **accepted** as an accurate record however it was agreed this would be the inauguration meeting of the Cancer Governance and Strategy Group.	

3.	**Matter Arising/Action list**	
	Item 3 - Action List CSGG - 170821.docx	
4.	**GOVERNANCE**	
4.1	**Terms of Reference (ToR): Governance & Strategy Group**	
	GC advised at the last session there was a significant discussion on the ToR. GC advised the purpose of this group is to for assurance and oversight, focusing on cancer QPIs, cancer waiting times, detect cancer early, and to oversee and share the development and delivery of the cancer framework. The group to review the ToR and feedback any comments. CM advised the landscape for cancer is very complex and this group will not be addressing operational matters; Review of the Cancer Operational Group will be undertaken. BH advised once supporting operational structures are re-established, it may be worthwhile reviewing with the group AG suggested a form of an annual assurance report to other groups should come from this group. CM to consider further. GC agreed with this comment and advised she will update the ToR to reflect this. CM advised the ToR will be reviewed in 6 months to determine if still fit for purpose.	**All** **CD/BH** **CM** **GC** **GC/KN**
4.2	**QPI Governance Process**	
	The revised Quality Performance Indicator (QPI) Governance Process has been reviewed to ensure prompt return of the action plan to SCAN, timely discussion at this group and appropriate visibility within the organisation. The process was **agreed** with the group. It was agreed that going forward all QPI actions plans would be signed off by CM and CD. QPI performance will be an important factor in the development of the Cancer Framework to ensure strategic versus operational areas of concern are addressed. Operational actions will be taken forward through appropriate operational teams. QPIs will be taken through the NHS Fife and Acute Clinical Governance Committees and EDG where issues require further discussion	

	CD, GC and KN to arrange a session with the leadership team to understand the current status of the strategy which would be helpful to ensure continued engagement. To be discussed offline.	**CD/GC/ KN**
4.3	**Cancer Waiting Times & Management of Breach Reports Flowchart**	
	The cancer services and governance structure for the management of wating times and breach analysis was tabled for agreement. KN advised the responsibility of the management of cancer waiting times performance should lie within operational services through the weekly Patient Tracker List (PTL) meetings and the IPQR reporting process; thereafter operational leadership support and updates to the strategy group for assurance purposes is required with subsequent submission to Clinical Governance. There is an opportunity to strengthen current processes to improve performance. Further discussion between CM and CD is required The Cancer Waiting Times SOP is currently under review and the process tabled may be subject to change. SF advised the areas of concern within cancer waiting times performance are drilled down in the IPQR and actions identified. SF to liaise with GC The Scottish Government Effective Management of Cancer Framework is due to be published and a visit from the Effective Cancer Management Framework Consultant will take place.	**CM/CD** **SF/GC**
4.4	**Cancer Risks**	
	A summary of risks relating to cancer has been created and will be reviewed with the risk owners. Risks will be added to the Cancer Risk Register or linked as appropriate to ensure they are meaningful and can be aligned to the development of the framework and strategic directions. It was agreed to use the approach taken by Digital & Information. Twenty cancer risks have been identified. The age of risks ranges from zero to 19 years. Any risks that have materialised, e.g., a risk contained within the Quality and Safety for the management of cancer waiting times performance will be closed and redefined. The risk relating to the lack of cancer strategy has been closed. An update will be brought to the next meeting.	**GC/KN**
4.5	**CEL 30 Update**	
	A CEL 30 audit is currently being undertaken supported by Clinical Effectiveness. The lead job description is in draft format and the role is expected to be advertised shortly	

	The lack of a CEL 30 lead is a risk to the organisation and discussion has taken place with NHS Lothian to determine if an oncologist could take up this role thought the SLA. MM advised a colleague within NHS Lothian has expressed an interest in this role. An update will be brought to the next meeting	**MM/GC**
4.6	**ECDC Update**	
	MM advised ECDC was launched at beginning of June. Over 116 patients have been appropriately referred with a conversion to cancer rate of 14% which exceeds current average conversion rates of 10%. There has been four deaths; these have been reviewed. Ten protective slots have been secured for CT. To date the roll out of the service has been well received by GPs and there has been excellent feedback through Care Opinion. Since the launch there has been no breaches and patients are receiving a diagnosis within 21 days. Training of the newly appointment lead nurse is underway. The patient navigator will take up post on 20 October. MM confirmed the service is sustainable and there is a vision to roll this model out to the tumour specific pathways to ensure equity. Other pilot boards have seen different degrees of success in terms of conversion to cancer. Of 76% that did not have cancer, onward referral or discharge is arranged. MM will provide an update at the next meeting. There is a group of patients who require longer term follow up and will be monitored until discharge. Patient stories are done each month with good patient engagement. Rejected referrals are reviewed. The role of dietetics is clearly emerging in evaluation of referrals. NH advised ECDC is a standing item on the Scottish Primary Care Cancer Group (SPCCG), and the SCAN Primary Care Group and he provides a NHS Fife update Concerns were raised regarding an overuse of referrals to the pathway however there is confidence that referrals are robustly vetted. FQ advised there is research collaboration between Neil Cruickshank and St Andrews staff around ECDC. St Andrews have been made aware of the opportunity to bid against national ECDC evaluation.	**MM**
5.	**STRATEGY/PLANNING**	
5.1	**Development of the Cancer Framework**	
	GC tabled an update on the cancer framework. The engagement process has been outstanding across the organisation with the return of 28 forms	

	including a SWOT analysis and key priorities from services GC advised the importance of this being reflected within the framework Next steps will be to conclude the engagement sessions and hold a workshop for stakeholders to discuss thematics that have emerged and determine key principles and priorities. GC advised of some of the keys thematics from the engagement sessions: adequate workforce and skill mix; digital innovation, trial access, and a desire to develop an identity for cancer services including an appropriate space A draft framework and delivery plan is expected towards the end of December CM stressed how important his piece of work is as cancer touches all aspects of our organisation R&D advised they are in discussions with NHS Lothian, Tayside and Forth Valley around utilising a hub and spoke model for trials access. AG advised he has been tracking the Centre for Sustainable Delivery (CfSD) where there are specific outcomes and objectives around cancer performance and early diagnosis. KN advised Fife are in touch with the team around the key priorities. KN will map priorities against the CfSD to ensure strategic objectives are satisfied. SF advised CfSD has a heat map of programmes of work and some of the cancer work will be included. SF advised she will liaise with GC regarding this.	**KN** **SF/GC**
5.2	**Regional Update**	
	BA advised Regional Cancer Advisory Group (RCAG) discussed the need for a regional forum to discuss local cancer strategies. A draft term of reference for a regional cancer strategy group was circulated at the Regional Cancer Planning Group (RCPG) to collaboratively support the SCAN in development strategy to ensure complimentary and to identify common areas where boards cancer strategies require regional alignment. The group would also act as a reference group for the Lothian cancer centre re-provision programme and in development of the Business Case. An updated Initial Agreement (IA) is required to be resubmitted to Scottish Government with clarification and assurance that the service model has undergone external review. A rapid review of that service model will be carried out by the newly appointed healthcare planner. A regional representative will be requested from all boards. The Chemocare upgrade project continues and significant strides have been made over the past year. User acceptance is completed and there are plans for training sessions. There are still a number of issues from	

	user accepter testing. The SCI-Store demographic interface testing as well as the move from SGD to Dameware is underway. Printing functionality is an ongoing issue. There is a regional board meeting on the 30th August; the aim is to to go live with the new version in November/December this year. HIS are undertaking their external review process of cancer QPIs across Scotland on a rolling tumour specific basis reviewing a different tumour group every 3 months with Melanoma being the first The regional cancer team have met with health finance within the Scottish Government and there is a potential funding for Acute Oncology and SACT; information on capacity requirements has been requested from each Board. Following the National Cancer Recovery Group meeting a formal working group will agree some national principles. BA agreed to share slides in respect of national groups and work schemes.	**BA**
5.3	**Scottish Government Cancer Funding Update**	
	KN advised the Scottish Government has allocated £114.5 million to support cancer recovery. The first round of bids was mainly unsuccessful due to the total number of bids submitted exceeding available funds. NHS Fife were successful with two bids: Early Cancer Diagnosis Centre and equipment for Head and Neck. A more focussed approach has been carried out for round two of the funding process. There is only a very limit amount of money, about £3 million, £1.5 million for recurring and £1.6 million for non-recurring and SCAN has agreed to submit a limited number of bids; there is a focus on Single Point of Contact SPOC) and a Regional Speech & Language support for head & neck cancer services. A SPOC bid to enhance the Cancer Audit and Performance is being put forward. KN to forward to CM and CD once complete KN advised that further funding has been allocated to Fife to support the improvement of cancer waiting times (CWT) performance, £10 million non-recurring revenue funding across NHS Scotland has been released, of which NHS Fife has received £681,000. KN advised they have undergone the formal bidding process and some of the bids that have been supported are Gynaecology, HPB MDT, Breast, Haematology, Dermatology, Colorectal, Radiology, Oncology, Pathology, SACT, Urology, and Pharmacy. KN advised it has gone through a formal governance process. Meetings with Haematology, CNSs, ED Service Manager, and Pharmacy are under way to understand acute oncology requirements.	**KN**

6.	**QUALITY/PERFORMANCE**	
6.1	**Quality Performance Indicators**	
6.1.1	**Colorectal 2019-2020**	
	CM advised at RCPG recently, colorectal is excellent across the region and there are not any real significant performance issues relating to the colorectal QPIs. KN advised in regard to QPI 6 which was Neo-adjuvant Radiotherapy, KN spoke to the Cancer Audit Facilitator and she has advised that that QPI will no longer be measured going forward.	
6.1.2	**Melanoma 2019-2020**	
	KN provided an update to the group. CM advised there is a degree of concern regionally with the main issue in Lothian. CM advised the narrative behind the numbers is important as it explains the decision making that resulted in us not necessarily meeting QPIs.	
6.1.3	**Breast 2019**	
	CC unable to attend. CM advised this will be carried forward to the next meeting. KN to invite CC.	**KN**
6.1.4	**Acute Leukaemia 2018-2019**	
	CM advised due to small numbers one patient missing the target can have a significant impact on performance. NS advised QPIs were missed due to SCAN routines. There were 2 major trials for acute leukaemia, but due to COVID-19 patients could not be enrolled; there were several trials available nationally but not in Fife. NS advised tissue typing to check if someone is suitable for a stem cell transplant is problematic. This is currently done is Glasgow. There is a new process that has just been trialled in the last 6 months.	
6.1.5	**Head & Neck 2019-2020**	
	CM advised QPI 7 has informed a regional bid and shows the importance of ensuring that QPIs are more visible at a local level. JB advised for people with HPB cancer discussion was had to exclude patients were there was a clear plan for supportive care as it affected performance. CM acknowledge this however felt it should be embedded within the target. Targets will never be 100% as there will be people to whom these targets don't apply.	

	BA advised there many complicated exclusions and will always an element of analysing case by case. BA advised the QPIs are trying to hit a broad range nationally but where clear exclusions apply they are built into the QPIs.	
6.2	**National Quality Performance Indicators**	
6.2.1	**HPB 2019 (National)**	
	This was noted by the group.	
6.2.2	**Brain/CNS 2019 (National)**	
	This was noted by the group.	
6.2.3	**Sarcoma 2019-2020 (National)**	
	This was noted by the group.	
6.3	**Cancer Waiting Times**	
6.3.1	**Quarter 1 2021**	
	KN tabled an update for the group. CM is still to determine if cancer waiting times comes to this group. MM raised concerns regarding patients that exceed 100 days on the pathway. KN advised there is currently one patient who is awaiting robotic surgery. All patients over 100 days are reported to the Scottish Government. CM advised this is an operational issue and good clinical escalation is required. This is challenging due to the lack of an operational group.	
7.	**PERSON-CENTRED CARE, PARTICIPATION AND ENGAGEMENT**	
7.1	**Patient Engagement Update**	
	MM advised there has been discussion with HIS employee representing the National Cancer Alliance. MM advised we should bring important issues through this group and share them with the various groups that we are linked in with as well as public engagement with a view to them feeding back into the Cancer Governance and Strategy Group CM advised patient engagement is an important part of what we are doing. CM advised it is good that MM has received positive and informed feedback. GC suggested we should ensure that there is a wide range of feedback that is reflective more on our population instead of relying on one	

	individual. GC and MM to discuss further FQ asked if these were mutually exclusive as models. FQ advised we may want to consider some sort of public patient involvement as a member of this committee and also the other broader engagement.	**GC/MM**
7.2	**EQIA Update**	
	MM advised an EQIA meeting has been carried out. The updated EQIA is out to the group for comment. Further meeting will take place to ensure all included, e.g., groups that speak another language other than English hard of hearing.	
8.	**LINKED COMMITTEE MINUTES**	
8.1	**Draft Regional Cancer Advisory Group (18/06/2021)**	
	This was noted by the group.	
8.2	**Draft Regional Cancer Planning Group (11/06/2021)**	
	This was noted by the group.	
9.	**ISSUES TO BE ESCALATED**	
	CM advised the ECDC update needs to go to EDG,	**KN**
10.	**ANY OTHER BUSINESS**	
10.1	**Cancer Operational Group Update**	
	CM advised and operational group should exist to align with the strategy and core groups. CM advised articulating the remit of the Governance and Strategic Group and Core Groups should facilitate the requirements of the operational group.	**CM/CD**
	Date of Next Meeting:	
	CM advised the group that the next meeting would be on Friday 29th October 2021 at 2.00pm via Microsoft Teams.	

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	14 OCT 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, School of Medicine, University of St. Andrews (FS) Dr Grant Syme, Physiotherapist Consultant (GS) Alistair Graham, Associate Director, Digital & Information (AG) Prof. Colin McCowan, Professor in Health Data Science, School of Medicine, University of St Andrews (CM) Nicola Roberston, Associate Director of Nursing (NR) Benjamin Hannan, Deputy Director of Pharmacy and Medicines (BH) Donna Galloway, General Manager, Women Children and Clinical Services (deputising for Ken Campbell) - acting Head of Laboratory Services (DG) Anne Haddow, Lay Advisor (AH) Cassie Philp, Psychiatry Registrar (CP) shadowing Dr McKenna In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** Dr Mckenna welcomed all. **Apologies;** • Amanda Wong, Associate Director of Allied Health Professions - will be represented by Grant Syme • Maxine Michie, Deputy Director of Finance • Dr Joy Tomlinson, Director of Public Health • Margo McGurk, Director of Finance • Nicky Connor, Director of Health and Social Care Partnership Dr McKenna advised that this was the first meeting of the revised Research Governance Group now known as Research, Innovation and Knowledge Oversight Group which will have a different approach than previously and would refocus attention to more business and strategic matters. All attendees introduced themselves and described their roles.	
	STANDING ITEMS	
2.0	**OVERSIGHT OF R&D OPERATIONAL GROUP (OPS) MINUTE** The Operational Group minutes were taken as read with no amendments**.**	

2.1	**LABORATORIES/MICROBIOLOGY** FQ discussed the attached SBAR with regards to Microbiology support advising that there was a risk to growth and sustainability. DG noted that she is aware of issues regarding the processing of research samples and added that whilst there is commitment and recognition, capacity issues overtake these, there is a need for further discussion. A new Clinical Lead (David Griffith) for Laboratory Services is about to be appointed and will be useful to include in this discussion FS asked if it would be worth engaging with the St Andrews University Medical School laboratory leads and staff. FQ proposed that a meeting would be convened with Laboratory Services leads, including the new Clinical Lead (David Griffith) and St Andrews in the near future and a report on progress brought back to the next RIK Oversight Group meeting	**FQ**
3.1	**TERMS OF REFERENCE R, I & K OVERSIGHT GROUP (SCOPE, MEMBERSHIP, FREQUENCY)** CMcK noted that these were brief and to the point and the main four items did articulate the group's core function, he also asked what the attendees thoughts were, BH thought that these should be revisited in six months time. CMcK advised that there had been a good bit of work done regarding the composition of this group and that it was agreed that it should be senior personnel that were invited. He asked that his title be amended to "Executive Lead for R, I & K" Nicola Robertson (Associate Director of Nursing) would be deputising for Janette Owens. Nicky Connor had given her apologies for this meeting, CMcK felt that it was important H&SCP were represented going forward and would follow up with Nicky. Director of Public Health had given her apologies and there was no deputy in attendance but intended to be present at future meetings Director of Finance and Deputy Director of Finance had both given apologies for this meeting but CMcK thought that the deputy would attend in future. BH is deputising for Scott Garden who is on leave. Scott Garden will attend in future GS has been delegated to attend for Amanda Wong and will be the representative for AHP's. GS is the Chair of the AHP's Research and Innovation Committee.	**CMcK**

	AG will continue to attend this meeting. Head of Quality & Clinical Governance has not attended previous Research Governance Group meetings but should remain on this group membership. Head of Laboratory Services, DG deputised for Ken Campbell in his absence. CMcK said that going forward there should also be representation from the Acute Services as well as Medical Education, Morwenna Wood is to be invited to this group. The Director of Acute Services or deputy should also be invited. CMcK stated that for the group to be quorate there should be eight plus the Chair in attendance. These meetings will take place quarterly and last for one hour. AG asked where this group would exert any influence and would it be taking account of regional and/or national priorities? FQ added that this could be reflected in the ToR's, that members of the Group would be responsible for bringing regional and national issues for their area of responsibility to the Groups attention and influence on these, where relevant. CMcK asked for amendments to be made to the TOR and agreed at the next meeting.	**FQ**
4.1.2	**BRAIN HEALTH AND DEMENTIA RESEARCH BOARD** FQ discussed this national initiative which had come via a discussion with Helen Skinner (Alzheimer Scotland Dementia Nurse Consultant) and had been launched in July with 3 main objectives. 1. Generate and deliver a meaningful research portfolio. 2. Ensure rapid translation of results into practice. 3. Understand the problems faced by researchers in developing their careers and producing a report in 2023 containing recommendations to overcome these. The first two objectives were the main focus for this Group, FQ asked if we supported this initiative in NHS Fife and if yes, where would it be lead from Research, Innovation & Knowledge would support this but not lead. AB asked if this would be an ideal opportunity to involve H&SC as most of these services lie with them. FQ and CMcK had discussed this previously and it was thought it could be lead by the nursing directorate, NR advised that she would be happy to be involved. CMcK fully supported this project to improve outcomes for patients, families and carers.	

	FQ would convene an initial discussion with NR and follow up meetings with relevant stakeholders.	**FQ**
4.2.1	**SCOTTISH HEALTH INNOVATION PROGRAM-DEMAND DRIVEN SIGNALLING** FQ discussed how the innovation landscape has changed with the national structure now being lead by the Scottish Health Innovation Partnership (SHIP), in concert with the Centre for Sustainable Delivery (CfSD). There are three regional test beds, one in the West, one in the North and one in the SE. NHS Fife is a member of the Health Innovation South East Scotland (HISES) regional test bed. SHIP, CfSD and the three regional test beds are supported by Scottish Government and much of the innovation activity will be routed through the three regional test beds. It was important for NHS Fife to continue being a part of this structure through our membership of HISES CMcK agreed it was good to see some cohesion and noted that Fife is receiving resource from HISES to support Innovation staffing, the next HISES Innovation Oversight Committee is taking place this afternoon which he and FQ are attending. CMcK wondered how we could engage with Clinicians and get them involved. FQ thought possibly via a Clinical Innovation fellows programme that is due to be launched next year.	
4.3	**LIBRARY & KNOWLEDGE SERVICES** FQ noted that there was nothing strategic to report.	
5.1.1	**DOCTORAL TRAINING PROGRAMME** CM discussed the paper which had been attached to the agenda, CMcK thought this was a really exciting initiative and was a positive step in the right direction for joint working with the University. He asked where the programme had sufficient clinical support, CM advised that most of the Clinicians have links with St Andrews so did not think there would be any issues.	
5.1.2	**MEDICAL SCHOOL 5 YEAR STRATEGY** FS discussed the paper which had been attached to the agenda, adding that he and FQ are in frequent discussion regarding joint ways of working.	
5.1.3	**JOINT RESEARCH OFFICE** FQ advised that in conjunction with St Andrews we have appointed a Project Officer for 12 months to support the development of the case for a Joint Research Office between the two organisations, conversations are ongoing.	
5.1.4	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP**	

	CMcK noted that Gemma Couser, Head of Quality & Clinical Governance is not at this meeting, she is the lead for the development of a strategic case to cover options for NHS Fife to become a University Teaching Health Board, CMcK added that we are navigating uncertain territory but it was coming together.	
5.1.5	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report which had been attached to the agenda, advising that the membership numbers had increased, a meeting will take place next week and she will have a more comprehensive update at the next meeting.	
6.0	**AOCB** FQ discussed the Research Capacity in Context Tool, RCCT which had been developed to ascertain what NHS Fife staff think about research, an online survey is now ready to be distributed and asked when would be the best time to put this out to staff? CMcK was not sure when would be the best time due to staff pressures and asked for this to be held off perhaps till early November. CMcK thanked all for attending this meeting and if anyone had any thoughts on what has been discussed to feedback to himself, AB or FQ.	
7.0	**DATE AND TIME OF NEXT MEETING** TBA	

MINUTES OF THE PUBLIC HEALTH ASSURANCE COMMITTEE MEETING HELD ON TUESDAY 10 AUGUST 2021 AT 12:30PM VIA MICROSOFT TEAMS

Present:	Joy Tomlinson (JT) (Chair)	Director of Public Health
	Olukemi Adeyemi (OA)	Consultant in Public Health
	George Brown (GB)	Emergency Planning Officer
	Cathy Cooke (CC)	Public Health Scientist
	Esther Curnock (EC)	Deputy Director of Public Health
	Sarah Nealon (SN)	Project Support Officer
	Julie O'Neill (JON)	Public Health Service Manager
Apologies:	Emma O'Keefe (EO'K)	Consultant in Dental Public Health
	Hazel Close (HC)	Lead Pharmacist Public Health
	Lynn Burnett (LB)	Nurse Consultant Health Protection / Immunisation Co-Ordinator
In Attendance:	Stevie Rutherford (Minutes)	PA to Director of Public Health

ACTION

1. WELCOME AND APOLOGIES

JT welcomed everyone to the meeting. Noted that for future meetings the invitation should include Duncan Fortescue-Webb.

2. MINUTE OF THE MEETING HELD ON 08 JUNE 2021

The minutes were agreed as an accurate record of the meeting apart from Risk 2005, final sentence should be taken out.

2.1 Actions from Last Meeting re-instate

See Action Log August 2021 for update to actions from the last meeting.

3. MATTERS ARISING

Annual Workplan to be sent round the group.

4. TESTING REPORT TO CLINICAL GOVERNANCE COMMITTEE

This item will be progressed outwith the meeting, DFW will be included in future meeting invitations.

JT advised that a regular update on testing is provided to the Clinical Governance Committee and NHS Board. This alternates between a verbal update and written update.

5. ANNUAL IMMUNISATION REPORT

Update provided by EC, due to timeline of Clinical Governance Committee and further inputs from colleagues to this document, it was not possible to bring to PHAC for approval prior to submission. Immunisation report is presented for noting. The report was very well received by clinical governance. JT commented to say it was presented alongside wider report on immunisation review, prepared by Carol Bebbington. Both items were presented at the same time. There is a follow up action which will be taken back to Clinical Governance which is the development of the immunisation strategy. It will be taken to the specially convened clinical governance meeting on the 02nd September, 2021. JT noted that there is a differential across our population around uptake associated with deprivation. Further work will take place seeking to understand the reasons for this pattern across Fife.

EC noted that the priorities for immunisation have been agreed and that this will give clarity for the future. The key priority is addressing the inequalities that we see in uptake and the annual report will be a way in which we can monitor this from a governance point of view. The SBAR update on the outcome from the Immunisation review was also presented to the Clinical Governance Committee. EC gave overview of report from last PHAC meeting to the Committee.

Group discussion followed about possible geographical associations with immunisation uptake and whether similar patterns might be seen related to screening uptake. EC agreed that any emerging information would be shared with OA at a later stage.

RISK MANAGEMENT

6. IDENTIFY NEAR MISSES, CRITICAL INCIDENTS & LEARNING

Learning from COVID19

OA asked about the reduction on flu-like illnesses as a result of mask-wearing and during the COVID19 pandemic. Is there anything we can learn or preserve for the future? EC summarised the discussion that there must be a process of weighing up the harms etc in terms of flu reduction, hand hygiene, and where we can improve. JT noted that an unseasonable increase in RSV infections had been noted in North West England and this will be considered further at future NIMT meetings.

6.1 Testing Samples Collected by Member of the Public

JT talked about the learning from the recent testing incident, where a member of the public received a bag containing a small number of samples in error. NHS 24 recordings were reviewed as part of the investigation to ensure there was complete understanding of the advice provided to the member of the public. There were initial concerns about the advice provided however review of the audio tape makes clear that the

correct advice was given.

JON advised that she has spoken with DF-W and S Carruthers to take forward actions relating to this incident.

ACTION JON will provide an update at next meeting which is 20th October. Short life working group will complete investigations and lessons learned will be reported to the test and protect oversight group. **JON**

6.2 DES

OA/CC continues to work with others to find solutions for the Diabetic Eye Screening Programme recovery, regarding clinic space.

6.3 Breast Screening

OA advised that situation for the breast screening programme remains unchanged.

6.4 No Cervix Cervical Screening Incident

OA updated the group on the Cervical Screening no-cervix exclusion incident. Records of 105 Fife residents with post 1997 exclusion have been investigated so far. overall 31 patients out of 105 were contacted with another 18 deceased to be followed up at National Level . CC has carried out an initial review of the cause of death for the 18 deaths and from our internal review there was no suspicion they died as a result of cervical cancer. Out of the 31 patients, 15 of them were required to be reinstated for cervical screening through primary care. It is suspected that a few of these individuals had opted out of screening. The other 16 individuals were to be assessed through Gynaecology for full colposcopy assessment. Out of the 16, 10 attended clinics in July, 6 either DNA'd or cancelled. The outcomes of assessment are not yet available. .

Another 83 patients were investigated as part of the pre 1997 cohort and we will be inviting 8 for Gynaecology assessments. Letters will be sent out before end of week. 26 deceased individuals in this cohort are to be assessed at national level, no one requires to be reinstated due to age. Awaiting feedback from the colposcopy assessments.

JT commented that the no-cervix exclusion has been recognized as a key risk for the cervical screening programme over a number of years, Improving coding of all individuals who have undergone subtotal hysterectomy will strengthen the failsafe process. JT commented that learning from other parts of Scotland it would be helpful to understand if the surgical notes have clearly defined which procedure has been carried out. . It would be helpful to discuss with the clinician who carried out the audit whether she is satisfied with the recording in surgical records.

JT requested a lessons learned paper is prepared for the Clinical Governance Committee. It should be brought to this group first, aiming for

the October meeting. JT happy to accept as a new risk.

ACTION – OA to speak to clinician who carried out no-cervix exclusion audit about accuracy of surgical recording and preparation of lessons learned paper. CC reported that there are process in place to check what is recorded on SCCRS is the same as what is recorded on SCI-store and there is a Quality Manage in Pathology and they now double check everything that the secretary has put onto the system. So we have put some processes in place but there still requires some tightening up on the coding being correct in the first place.

ACTION - OA/CC awaiting to hear back from National team regarding the deceased patients. **OA/CC**

6.5 Wrong Second Covid 19 Vaccination

EC stated that she thought there would be a paper for the Wrong Second Dose presented at today's meeting which will be co- authored by herself and Ben Hannan. EC had had a conversation with Hazel Close about repeating a review of Datix Incidents in general, also with a focus on wrong second doses. Whilst the particular IT issue that was identified at the time we had the IMTs, around the wrong second dose has been resolved, we are still seeing Datix's coming through, where people have been given the wrong second vaccine. EC mentioned that she is keen to review the audit to see if there is anything additional that is required. In addition EC has had conversations with Lynn Campbell, Clinical Lead Nurse and she is also keen to review this. It was noted that it seems to be more user error problems, but we can look at protocols to see if any of this can be avoided going forward. Numbers are small, hopefully there will be a report ready for the next meeting. EC mentioned that the JCVI have said that we should try wherever possible to give the same vaccine, and there is no real but has no concern if wrong dose is given and have also said that it is better to give whatever vaccine they have available than re-arrange the appointment. It was noted that there is no clinical risk from a patient point of view.

7. NEW PROSPECTIVE RISKS

Everyone was reminded that that any new risks should be brought to the group and the agreed template tabled in advance of each meeting. **ALL**

Discussion around a new risk to be brought to the next meeting regarding screening recovery and the backlog since the pause. **OA**

8. REVIEW OF CURRENT RISKS ON PUBLIC HEALTH REGISTER

8.1 518 Resilience

The Resilience training and exercising programme SBAR prepared was presented to EDG and accepted.

A Cyber Threat Workshop, part of the programme, was held and was very successful. Further workshops have been scheduled. The main areas that need to be progressed over the next few months include:

- On Call Procedure for EDG and Senior Managers needs to be developed
- Major Incident procedure need to be updated following the Workshop in May and also because of COP26 taking place in November, there will be an expectation from SG that all Boards Major Incident procedures will be reviewed and updated prior to this event.

The Resilience team currently consists of only the Emergency Planning Officer, but a job for a Head of Resilience position has now been advertised. Until the post is filled the programme will be progressed but may take longer to implement than was originally intended.
Risk Level remains the same i.e. MODERATE

Update was agreed.

EC mentioned incident training for the new staff and in particular the new Consultant and that it would be useful for the team to have sight of any future dates so that they can be scheduled in everyone's diaries. **GB**

8.2 528 Pandemic Flu Planning

As agreed at the last PHAC meeting the risk will remain on the Datix, with a revised wording. A further meeting of the NHS Fife and HSCP Pandemic Flu Group has still to be organised, this will include a discussion about the risk and its description.

Risk Level remains the same i.e. MODERATE

Update was agreed.

ACTION: GB to take it to the next Pandemic Flu meeting for discussion and then bring it back to this committee thereafter. EC mentioned that there is a Scottish Group and EC mentioned this at the NIC 19 meeting last week and asked if PHS were aware of this group which sits underneath the UK level group to look at Pandemic Prepareness and if so can you make sure they have on their radar to link with pandemic coordinator in each Board. EC said that Maria Rossi took this as an action as she was not aware of it . GB agreed to mention this also at the National Resilience meeting and EC will have a look at the action tracker from the NIC 19 and see if there is clarity if there is a Scottish group. **GB** **GB** **EC**

EC asked if they should await to hear what is happening nationally. JT said that she is keen that things are progressed locally.

8.3 1729 Suspicion of Malignancy

IMT members have agreed that the investigation can be closed. The new safeguarding process is being monitored.

No change to risk level.

JT asked if this risk could now be closed since the local investigation has been completed. CC advised that NSD have asked that it remain on local risk registers. JT also asked if the risk level could be reduced, CC advised that although we have a safeguarding process in place it is being monitored closely as there have been a few gaps in the information that has been recorded. Regular meetings are in place.

Update was agreed.

8.4 1837 Pregnancy and Newborn Screening

No change, no additional progress to report due to pandemic.

No change to risk level.

Update was agreed.

8.5 1904 Coronovirus Disease 2019 (Covid-19) Pandemic

JT updated the risk, the score has reduced slightly following roll-out of the vaccination programme.

No update provided as next review not due until 26 August 2021.

8.6 1905 Contact Tracing including TTIS Programme

No update provided as next review not due until 26 August 2021.

JT noted that due to nature of fixed term appointments it is anticipated that there will be staff-turnover in coming months. This workforce risk should be captured within an overarching risk statement for the programme.

8.7 1906 COVID19 Testing Programme

No update provided as next review not due until 26 August 2021.

8.8 1907 Public Health Oversight of Covid-19 in Care Homes

No update provided as next review not due until 26 August 2021.

8.9 1908 Handling of Excess Deaths during the Global Covid-19 Pandemic

No update provided as next review not due until 26 August 2021.

8.10 2005 Covid Vaccinations – Vaccine Effectiveness

EC provided a verbal update, the covid 19 risk register is being closed, therefore this risk can potentially be taken off the FVCV risk register (it can be added back if a new strain emerges), however, this requires a written update to get this agreed. Risk to stay open until the transfer has been completed.
Next review date – 10 September 2021

Update was agreed.

ACTION: EC mentioned that there should be a new public health risk capturing the governance and leadership of immunisations. **EC**

8.11 2025 Covid 19 Vaccinations – Long Term Infrastructure

EC gave verbal update, the covid 19 risk register is being closed, therefore this risk is effectively splitting, and the transferred risk around FVCV management infrastructure will sit with the HSCP. EC will table a new risk for the next PHAC 05/10/21 relating to wider immunisation governance that should sit on PH risk register as a new risk. Risk to stay open until the transfer has been completed.

Next review date – 10 September 2021

Update was agreed.

8.12 2130 Data Flow

SN to liaise with DFW outwith meeting to acquire update.

8.13 2131 Test & Protect

SN to liaise with DFW outwith meeting to acquire update.

8.14 2141 Test & Protect

SN to liaise with DFW outwith meeting to acquire update.

9. ANY ISSUES TO ESCALATE TO CLINICAL GOVERNANCE

Lessons learned from no-cervix incident will be prepared and brought to next meeting prior to submission to Clinical Governance. Update papers will be going to Clinical Governance Committee on Flu Program and Immunisation Strategy.

10. ANY OTHER COMPETENT BUSINESS

OA questioned if mentioned there should be a covid risk for the workforce for the department. SN mentioned that there was not one for the department but thought that there may be a general workforce risk for NHS Fife. **ACTION:** It was agreed that GB will speak to Pauline Cummings to see if there is a general risk and to see how Public Health can be incorporated. **GB**

JON offered to review ToR of this group in advance of the next meeting **JON**

11. DATE OF NEXT MEETING

The next meeting will take place on 20 October 2021. (Post meeting note: meeting was moved from original date 5 October due to annual leave.)