NHS Fife Clinical Governance Committee

Fri 29 April 2022, 10:00 - 13:00

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Christina Cooper

10:00 - 10:00
0 min

2. Declaration of Members' Interest

Christina Cooper

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Thursday 10 March 2022

Enclosed *Christina Cooper*

Item 3 - Clinical Governance Committee Minutes (unconfirmed) - 20220310.pdf (13 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Christina Cooper*

Item 4 - Clinical Governance Committee Action List - 20220429.pdf (3 pages)

4.1. Covid Update

Verbal *Chris McKenna*

10:10 - 11:00
50 min

5. GOVERNANCE MATTERS

5.1. Annual Assurance Statements & Reports from Clinical Governance Subcommittees & Groups

Enclosed *Gillian MacIntosh*

Item 5.1 - SBAR Annual Assurance Statements from Subcommittees.pdf (27 pages)

5.2. Clinical Governance Committee Annual Statement of Assurance 2021/2022

Enclosed *Gillian MacIntosh*

Item 5.2 - SBAR Clinical Governance Committee Annual Statement of Assurance 2021-2022.pdf (24 pages)

5.3. Board Assurance Framework - Quality & Safety

Enclosed *Chris McKenna / Janette Owens*

Item 5.3 - SBAR Board Assurance Framework – Quality & Safety.pdf (4 pages)
Item 5.3 - Appendix 1 - Board Assurance Framework - Quality & Safety.pdf (2 pages)
Item 5.3 - Appendix 2 - Linked Operational Risks.pdf (4 pages)

5.4. Board Assurance Framework - Digital & Information

Enclosed *Alistair Graham*

- Item 5.4 - SBAR Board Assurance Framework – Digital & Information.pdf (4 pages)
- Item 5.4 - Appendix 1 - Board Assurance Framework - Digital & Information.pdf (2 pages)
- Item 5.4 - Appendix 2 - Linked Operational Risks.pdf (3 pages)

5.5. Risk Management Improvement Programme Progress Report

Enclosed *Pauline Cumming*

- Item 5.5 - SBAR Risk Management Improvement Programme Progress Report.pdf (12 pages)

5.6. Review of Annual Workplan

Enclosed *Elizabeth Muir*

- Item 5.6 - Clinical Governance Committee Annual Workplan 2022-23 as at 20220421.pdf (6 pages)

11:00 - 11:50
50 min

6. STRATEGY / PLANNING

6.1. Corporate Objectives 2022/2023

Enclosed *Margo McGurk*

- Item 6.1 - SBAR Proposed Corporate Objectives 2022-2023.pdf (4 pages)

6.2. Emergency / Resilience Planning

Verbal *Emma O'Keefe*

6.3. Governance of Advanced Practitioners

Enclosed *Janette Owens*

- Item 6.3 - SBAR Governance of Advanced Practitioners.pdf (5 pages)

6.4. Early Cancer Diagnostic Centre (ECDC) Report

Enclosed *Chris McKenna*

- Item 6.4 - SBAR Early Cancer Diagnostic Centre (ECDC) Report.pdf (8 pages)

11:50 - 12:10
20 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report

Enclosed *Chris McKenna / Janette Owens*

- Item 7.1 - SBAR IPQR.pdf (3 pages)
- Item 7.1 - IPQR.pdf (44 pages)

7.2. Progress on Annual Delivery Plan (RMP4) 2021/2022

Enclosed *Susan Fraser*

- Item 7.2 - SBAR Progress of Annual Delivery Plan (RMP4) 2021-22 + Appendix 1.pdf (9 pages)
- Item 7.2 - Appendix 2 Review of National Response to Winter 2021-22.pdf (21 pages)
- Item 7.2 - Appendix 3 Winter Report 2021-22 – Data to March 2022 .pdf (5 pages)

7.3. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Owens*

- Item 7.3 - SBAR Healthcare Associated Infection Report (HAIRT).pdf (6 pages)
- Item 7.3 - HAIRT.pdf (26 pages)

12:10 - 12:20
10 min

8. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

8.1. Patient Experience & Feedback

Enclosed *Janette Owens*

- Item 8.1 - SBAR + Appendix 1 - Patient Experience & Feedback.pdf (10 pages)
- Item 8.1 - Patient Experience & Feedback Quarterly Report.pdf (17 pages)

12:20 - 12:30
10 min

9. ANNUAL REPORTS

9.1. Radiation Protection Annual Report

Enclosed *Chris McKenna*

- Item 9.1 - Radiation Protection Annual Report .pdf (4 pages)

12:30 - 12:35
5 min

10. LINKED COMMITTEE MINUTES

10.1. Acute Services Division Clinical Governance Committee Update

Enclosed

- Item 10.1 - Acute Services Division Clinical Governance Committee Update.pdf (1 pages)

10.2. Minutes of the Area Clinical Forum held on 7 February 2022 (confirmed) & 7 April 2022 (unconfirmed)

Enclosed

- Item 10.2i- Cover Sheet for Area Clinical Forum 20220207.pdf (1 pages)
- Item 10.2i - Minutes of the Area Clinical Forum Minutes 20220207.pdf (2 pages)
- Item 10.2ii- Cover Sheet for Area Clinical Forum 20220407.pdf (1 pages)
- Item 10.2ii - Minutes of the Area Clinical Forum Minutes 20220407.pdf (3 pages)

10.3. Minutes of the Area Medical Committee held on 8 February 2022 (unconfirmed)

Enclosed

- Item 10.3 - Minutes of the Area Medical Committee 20220208.pdf (5 pages)

10.4. Minutes of the Area Radiation Protection Committee held on 2 March 2022 (unconfirmed)

Enclosed

- Item 10.4 - Minutes of the Area Radiation Protection Committee held 20220302.pdf (4 pages)

10.5. Minutes of the NHS Fife Clinical Governance Oversight Group held on 15 February 2022 (unconfirmed)

Enclosed

- Item 10.5 - Minutes of the NHS Fife Clinical Governance Oversight Group 20220215.pdf (13 pages)

10.6. Minutes of the Fife Drugs & Therapeutic Committee held on 9 February 2022 (unconfirmed)

Enclosed

- Item 10.6 - Cover Sheet for Fife Drugs & Therapeutic Committee 20220209.pdf (1 pages)
- Item 10.6 - Minutes of the Fife Drugs & Therapeutic Committee 20220209.pdf (5 pages)

10.7. Minutes of the Fife IJB Clinical & Care Governance Committee held on 4 March 2022 (confirmed)

Enclosed

- Item 10.7 - Minutes of the Fife IJB Clinical & Care Governance Committee held on 20220304.pdf (9 pages)

10.8. Minutes of the Health & Safety Subcommittee held on 11 March 2022 (unconfirmed)

Enclosed

- Item 10.8 - Cover Sheet for Health & Safety Subcommittee 20220311.pdf (1 pages)
- Item 10.8 - Minutes of the Health & Safety Subcommittee 20220311.pdf (3 pages)

10.9. Minutes of the Infection Control Committee held on 2 March 2022 (unconfirmed)

Enclosed

- Item 10.9 - Minutes of the Infection Control Committee 20220202.pdf (6 pages)

10.10. Minutes of the Information Governance & Security Steering Group held on 4 March 2022 (unconfirmed)

Enclosed

- Item 10.10 - Minutes of the Information Governance & Security Steering Group held on 20220304.pdf (5 pages)

10.11. Minutes of the Research, Innovation & Knowledge Oversight Group held on 31 March 2022 (unconfirmed)

Enclosed

- Item 10.11 - Cover Sheet for Research, Innovation & Knowledge Oversight Group 20220331.pdf (1 pages)
- Item 10.11 - Minutes of the Research, Innovation & Knowledge Oversight Group 20220331.pdf (5 pages)

12:35 - 12:40
5 min

11. FOR ASSURANCE

11.1. Internal Audit Report B23/22 Resilience - Interim Report

Enclosed *Chris McKenna*

- Item 11.1 - Internal Audit Report B23-22 Resilience - Interim Report.pdf (8 pages)

12:40 - 12:45
5 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPQR Summary

Verbal *Christina Cooper*

12.2. Chair’s comments on the Minutes / Any other matters for escalation to NHS Fife Board

Verbal *Christina Cooper*

12:45 - 12:45
0 min

13. ANY OTHER BUSINESS

12:45 - 12:45
0 min

14. DATE OF NEXT MEETING - FRIDAY 1 JULY 2022 AT 10AM

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE HELD ON THURSDAY 10 MARCH 2022 AT 2PM VIA MS TEAMS

Present:

C Cooper, Non-Executive Member (Chair)
M Black, Non-Executive Member
S Braiden, Non-Executive Member
R Laing, Non-Executive Member
A Wood, Non-Executive Member
S Fevre, Area Partnership Forum Representative
C McKenna, Medical Director
J Owens, Director of Nursing
C Potter, Chief Executive
J Tomlinson, Director of Public Health *(Part)*

In Attendance:

H Bett, Children's Services Projects Senior Manager *(Item 8.6 only)*
S Blair, Consultant in Occupational Medicine *(Item 10.2 only)*
G Couser, Associate Director of Quality & Clinical Governance
F Forrest, Interim Deputy Director of Pharmacy *(deputising for B Hannan)*
A Graham, Associate Director of Digital & Information
G MacIntosh, Head of Corporate Governance & Board Secretary
A MacKay, Deputy Chief Operating Officer *(deputising for C Dobson)*
M McGurk, Director of Finance & Strategy
E Muir, Clinical Effectiveness Manager
M Wood, Interim Associate Medical Director for Surgery, Medicine & Diagnostics
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

The Chair highlighted the easing of restrictions planned in the coming weeks in respect of the pandemic and the significant challenges ahead to adjust to living with Covid and recovering all of our services.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the notes are being recorded with the Echo Pen to aid production of the minutes.

1. Apologies for Absence

Apologies were noted from members A Lawrie (Area Clinical Forum Representative) and Cllr D Graham (Non-Executive Member), and from attendees L Campbell (Associate Director of Nursing), N Connor (Director of Health & Social Care), C Dobson (Director of Acute Services), B Hannan (Director of Pharmacy & Medicines), H Hellewell (Associate Medical Director, H&SCP) and J Morrice (Associate Medical Director, Women & Children's Services).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 10 January 2022

The Committee formally **approved** the minutes of the previous meeting.

4. Matters Arising / Action List

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

In terms of the Clinical Governance framework, members were encouraged to participate in the feedback exercise, which will be circulated by email, along with the framework, on 11 March 2022. The framework will also be circulated to Senior Leadership Teams and Operational Teams for feedback. The framework will then be brought back to the Committee for endorsement.

5. COVID-19 UPDATES

5.1. General Covid Update

The Medical Director provided a verbal update on Covid, noting we continue to deliver healthcare in the presence of the virus. There remains a pressure, on a daily basis, for all services to manage acute issues, or the consequences of acute issues, and also the pressure of staff shortages as a result of the virus. Challenges remain in adaption and ensuring we can continue to deliver quality and timely healthcare to the population of Fife. It was noted NHS Fife are well prepared and in a good position to implement lessons-learned from the pandemic, as we move into the phase of living with Covid.

The Committee **noted** the update.

5.2. Post COVID-19 Syndrome Response Oversight Group: Progress Report

The Medical Director advised that work has been ongoing for over a year. The paper describes progress, to give assurance to the Committee that Fife has taken the issue of post Covid syndrome very seriously.

It was highlighted that the consequences of long Covid can be quite significant and can include permanent organ or lung damage, due to the infection, for those who have been in intensive care. The impact of Covid, even if the illness itself has not been serious, can also be debilitating and have serious consequences for physical and mental wellbeing. For some individuals, after-effects of the illness can also negatively affect their employment.

It was noted that the Scottish Government has not provided funding, to date, for long Covid, and this is being followed up. Further detail on the financial pressures is provided in the paper. S Braiden, Non-Executive Director, noted that debates have been ongoing within the Scottish Government on whether funding should be for Covid-specific services or include in a wider scope an overhaul of all rehab services for long-term conditions.

A Wood, Non-Executive Director, requested the equality and diversity (including health inequalities) impact assessment be completed to take on opportunities to reduce inequalities and increase access. The Medical Director will take the request forward to the team, as this work develops further.

M Black, Non-Executive Director, questioned the potential of long Covid becoming a prescribed disease. The Medical Director explained long Covid is more complex than a post viral fatigue, and a lot more work needs carried out in terms of research.

S Fevre, Area Partnership Forum Representative, questioned if the number of staff who have been diagnosed with long Covid are documented. The Medical Director advised that numbers are currently held in various spaces, and could be collated, however they may be unquantified as the numbers in General Practices may be difficult to retrieve. It was advised the route for this detail would go through the Staff Governance Committee, as part of broader staff wellbeing reporting. In terms of the Occupational Health offering for staff, it was noted the difficulties for staff returning to work, who have long Covid symptoms, are complex. It was noted the route for this discussion would also be through the Staff Governance Committee.

A Wood, Non-Executive Director, noted that activity and demand information would be required for funding. The Medical Director advised there is a national record of statistics available online, however, it is unknown how many of the population affected with long Covid have ongoing needs.

The Committee **noted** the progress report update on Post COVID-19 Syndrome Response Oversight Group.

6. GOVERNANCE MATTERS

6.1. Annual Review of Committee's Terms of Reference

The Board Secretary advised the Terms of Reference (ToR) paper is presented to the Committee annually at the March Committee meetings.

In line with the Committee workplan, the ToR has been updated to reflect the work that has been carried out in relation to avoiding any potential duplication with other Board Committees. A new clause has also been added in relation to the implementation of the new Population Health & Wellbeing Strategy, currently under development.

A Wood, Non-Executive Director, queried if the wording around the Committee's roles & responsibilities section could possibly be strengthened and expanded, and an example was provided of potential topics to include. It was advised that the detail in all Committees ToRs is purposefully high level, to allow for flexibility within each workplans, where the detail on individual agenda items is contained and regularly reviewed.

The Committee **considered** the remit, **agreed** the tracked changes and **approved** a final version for further consideration by the Board.

6.2. Committee Self-Assessment Report 2021/22

The Board Secretary thanked everyone involved for their honest and open feedback in completing the self-assessment survey at a busy time of Covid-related activity, noting the importance of receiving feedback and taking time to reflect on the operations of this Committee.

The paper summarises the main points from the self-assessment report, and it was advised there are common themes apparent across all of the Board's Standing Committees. The main findings from the self-assessment exercise were outlined, including limiting duplication with the newly established Public Health & Wellbeing Committee; enhancing agenda management; completing the IPQR and risk management reviews; and creating regular summaries for NHSScotland strategies.

The Committee welcomed and agreed to have a development session, twice a year, to delve deeper into topics relevant to the Committee's remit. Members and attendees were requested to suggest topics to be covered.

Action: Committee Members & Attendees

6.3. Annual Clinical Governance Committee Workplan 2022/23

The Associate Director of Quality & Clinical Governance advised the workplan will be reviewed periodically throughout the year and be brought back to the Committee at each meeting for consideration. The workplan will be tracked throughout the year to monitor business of the Committee against our intended annual workplan. Also included are items that are ad-hoc and potential items to be added to the workplan in relation to risk profile changes.

Discussion took place, and a number of questions were responded to around the workplan.

An explanation was provided on 'Data Loch', and it was advised it is a programme of work ongoing through the regional innovation work, regarding the collation of Social Care data and the use of the data. It is on the workplan to ensure the development is brought to the attention of the Committee, as there will be changes in the way we use data going forward.

In terms of mental health, most aspects around performance that require Board oversight, now sit within the Public Health & Wellbeing Committee. The Integrated Joint Board (IJB) Care & Clinical Governance Committee are also responsible for aspects of the governance. The Clinical Governance Committee would take a view on high level mental health issues and strategies, including the Mental Health Estate Programme, to ensure it is safe and effective. It was advised further discussions are required to determine exactly where all the various aspects of mental health will sit across the governance structure.

The Associate Director of Quality & Clinical Governance agreed to discuss with key colleagues the Health & Safety workplan and how that will be incorporated into this Committee.

Action: Associate Director of Quality & Clinical Governance

The Clinical Governance Oversight Group receive reports on the Patient Safety Programme, and consideration will be given to how those reports are escalated to this Committee.

The capacity for this Committee was highlighted in terms of being able to have meaningful discussions, scrutiny and provide assurance, when the size of agendas and paper packs was considered. It was advised that Committees and Groups which link into the Clinical Governance Committee are trusted to scrutinise and feed back into this

Committee. Items that overlap need to be considered, in terms of governance leads for each.

The level of detail and data within papers was highlighted, and concern was raised for providing a level of assurance due to the length and number of papers provided to the Committee. It was suggested to add to cover papers, where appropriate, more information in relation to scrutiny already undertaken in other areas and by delegated groups, which will provide assurance and avoid overlapping discussions.

The Committee:

- **Considered** and **approved** the proposed workplan for 2022/2023; and
- **Approved** the approach to ensure that the workplan remains current.

6.4 Board Assurance Framework (BAF) – Quality & Safety

The Medical Director introduced the BAF for Quality & Safety, noting a lot of work has been carried out in relation to the BAF. The Associate Director of Quality & Clinical Governance provided an update on the changes to the iteration of the BAF presented to the Committee and explained the removal of the two linked risks, a change to the level of risk 43, and the new risk description for the 'Cancer Waiting Times Access Standards Risk'. It was advised wording for a new risk description associated with this BAF reflects discussions at the November 2021 Committee meeting.

It was reported a review of high risks across the organisation was carried out, and table 2 within the paper summaries the 12 high risks that were identified. It was advised proposals are set out in the paper for the Committee to consider in relation to amalgamating some risks. Whilst recommendations set out in the paper reflect our current BAF structures, work is underway to review the risk management framework in Fife, and a lot of recommendations within the paper will be superseded by that work.

A Wood, Non-Executive Member, questioned if only red high risks would come to this Committee, and if there is sufficient mitigation in place for those risks. The Director of Finance & Strategy advised that, at a recent Board Development Session, it was agreed that a review would be carried out on the existing BAFs, to determine if they are populated with strategic or operational risks and that this would be taken forward into our risk management improvement work. It is expected that strategic risks would come to Committees and at Board level, however, it was noted that operational risks could escalate and have a strategic impact. The Director of Finance & Strategy also highlighted risk appetite and the potential influence on scoring risks and noted that this also forms part of the risk management improvement work currently underway.

R Laing, Non-Executive member, queried why the 'Emergency Evacuation, VHK Phase 2 Tower Block' risk has been recommended to stay on the Quality & Safety BAF. The Associate Director of Quality & Clinical Governance advised a decision was made following discussions with the Estates Management Team, pending the completion of the Orthopaedic Elective Centre, and the recommendation may change and evolve through the risk management improvement work discussions.

The Committee:

- **Approved** the proposed rewording of the BAF risk;

- **Approved** the recommendations outlined in section 2.3; and
- **Approved** the updated quality and safety component of the BAF

6.5 Board Assurance Framework (BAF) – Strategic Planning

The Director of Finance & Strategy advised that this BAF is also discussed in detail at the Finance, Performance & Resources Committee. The risk level has moved to moderate, in light of the new Public Health & Wellbeing Committee and the new Portfolio Board to support the strategy development work.

A proposal was provided to the new Public Health & Wellbeing Committee offering a phased approach to the strategy development, and timeline for the phased approach to the strategy was explained. The governance route for each part of the strategy will be included in the proposal paper, which will go to the March Board meeting for approval.

It is anticipated that more detailed emerging plans for the strategy development work will support the risk sitting no higher than moderate.

Following a question, the Director of Finance & Strategy advised the Board has ultimate responsibility for managing strategic risks, and that the Board's Standing Committees' responsibilities are to scrutinise individual risks and recommend BAFs for approval at Board level.

The Committee **noted** the current position in relation to the Strategic Planning risk level of moderate and were **content** to take that level of risk.

6.6 Board Assurance Framework (BAF) – Digital & Information

The Associate Director of Digital & Information advised that the BAF is in relation to the Digital & Information strategy and the responsibilities of the Digital & Information Team in the maintenance of technologies and infrastructures.

The changes made to the BAF since the last Committee meeting were outlined, as noted in the paper. The overall rating for the Digital & Information BAF remains high.

Following a question, the Associate Director of Digital & Information assured the Committee that mitigations have still to be put in place in terms of the actions, and a number are still being worked through to reduce the risk rating down to the target. It was highlighted our prioritisation activity and our engagement are being aligned closer to the priorities of our Social Care partnership and emerging strategies.

It was reported the cyber activity attack risk, which is identified as a linked risk, has escalated due to the recent conflict in the Ukraine. Significant destabilisation activity aimed at large organisations is being seen by cyber activity groups and a report is going to the Executive Directors' Group to discuss mitigations to minimise that, working both nationally and within Scotland, to minimise and prevent any impact.

The Committee took **assurance** from the content and current assessment of the Digital & Information BAF.

7. STRATEGY / PLANNING

7.1. Strategic Planning & Resource Allocation (SPRA) (RMP 2022/23)

The Director of Finance & Strategy provided a verbal update on the SPRA and noted the Scottish Government have still to issue the guidance on the full Remobilisation Plan. The development of the financial plan has almost concluded, and this will go to the Finance, Performance & Resources Committee, followed by the March Board meeting. The financial plan has been aligned with all the information available on workforce and organisational planning, however, there is no format available yet to understand what delivery across services is expected.

The Director of Finance & Strategy outlined the timelines from the Scottish Government and advised they have confirmed the full Annual Operating Plan, or equivalent, will not be required until July 2022. Final versions of the financial plans are due by the end of March 2022, and the workforce plans are due in July 2022. The full report on organisational plans for 2022/23 will come to the Committees later than expected this year.

A final version of the corporate objectives is being worked on and will go through the Portfolio Board at their next meeting for initial discussion, followed by submission to the Committees and full Board in May.

The Committee **noted** the update on the Strategic Planning & Resource Allocation.

7.2. Redesign of Urgent Care

The Medical Director advised that the paper is provided to the Committee for assurance on the development of the redesign of urgent care initiative, which is a new way of delivering healthcare in Fife and is now a fully functioning service.

An overview of the new initiative was provided, as described in the paper. It was noted we were already covering the requirements from the Scottish Government in relation to urgent care, and the funding provided enabled us to amplify the work we are doing.

A MacKay, Deputy Chief Operating Officer, provided an update on the day-to-day of urgent care and advised the initiative allows patients to be directed to the right service, and through the Flow and Navigation Hub, this has been of substantial benefit. The Fife Referral Organisational Guidance (FROG) Improvement work complements this further. It was also noted there are a larger number of patients being directed to our Minor Injuries Unit (MIU), which is positive news in reducing pressures at the front door.

It was reported work is underway in other areas, such as discharge without delay, and updates will be provided to the Committee going forward.

The Medical Director praised the collaborative workings between Acute Services and the Health & Social Care Partnership in developing this initiative, and the Committee commended all those involved.

The Committee **noted** the update on the Redesign of Urgent Care.

7.3. Joint Remobilisation Plan 2021/22 – Winter Plan Actions

The Director of Nursing noted the paper reflects an update on the actions from the Joint Remobilisation Plan 2021/22 and focusses on the position at the end of December 2021. A further update is due at the end of March 2022.

The key indicators from the Winter performance analysis were outlined. The completed actions were highlighted, and it was advised positive work has been carried out. It was noted there are still some actions at risk or unable to meet target. A lessons learned discussion has been scheduled to take place in the coming weeks.

The Committee **noted** the progress of deliverables within Joint Remobilisation Plan 4 (RMP4).

8. QUALITY / PERFORMANCE

8.1 Position Statement on Work Underway to Reduce Incidence of Harm for Pressure Ulcers, Falls & Catheter Associated Urinary Tract Infections (CAUTI)

The Director of Nursing presented on the position statement on work underway to reduce incidence of harm for pressure ulcers, falls and catheter associated urinary tract infections (CAUTI). A high-level summary of each of the papers was given, and members were encouraged to contact her with any detailed questions on the specifics of the papers outwith the meeting.

It was questioned if there is evidence to suggest falls occurs more often when there are areas which are short staffed. In response, it was advised that there had been staffing issues previously affecting quality of care, and that this is measured through the safe staffing legislation, which triangulates staffing with quality and safety of care. It was also reported that preventive measures have been put in place, such as electronic tools to ease the collation of data, displaying data in wards for staff awareness, online training, and Falls Champions visible in the wards.

The Committee welcomed the update on this area of activity and took **assurance** from the papers.

8.2 Strategy to Reduce E. Coli Bacteraemia Infections

The Director of Nursing advised that the target to reduce E. coli bacteraemia (ECB) infections will not be achieved and a strategy is being proposed which aims to meet these targets. The proposed strategy was outlined. It was also advised that, at a national level, an infection control reporting system is being explored for all of Scotland's Health Boards to use, for consistency.

In relation to ECB infections due to urinary catheters, it was questioned if all urinary catheters will have a local adverse event review and be reported in Datix. The Director of Nursing explained that urinary tract infections (UTIs) can develop within communities and those affected can attend local pharmacies. ECB infections that require treatment at hospital would be considered for reporting into Datix, however, the time constraints for reporting also needs to be considered, and further discussion would be required on a realistic proposal. The Medical Director highlighted that ECB infections are not the sole reason for contracting UTIs, and that this is only one way in which the ECB infection can develop.

The Committee welcomed more detail on ECB infections, and the implications, to get a better understanding. This will be provided at a future Committee Development Session for questions & answers, and a PowerPoint presentation will be provided at the next Committee meeting.

Action: Director of Nursing

The Committee **discussed** and **noted** the strategy.

8.3 Integrated Performance & Quality Report (IPQR)

The Medical Director introduced this item and noted that most of the quality issues within the IPQR were covered in the presentation at item 8.1.

The Director of Nursing provided an overview on the current status of measures within the IPQR. It was advised that as we come out of the pandemic and learn to live with Covid, there will be some recovery and improvements within our complaint measures. A number of workstreams are underway, and the backlog of responses to complaints is being worked through. A review is also being carried out on the model of complaints handling, along with the development of a dashboard for data and measurements. It was noted complaints reporting will form part of the IPQR review process, and feedback was welcomed on what more could be included within the IPQR in relation to complaints reporting.

A report on the recovery plan for complaints will go to the Executive Directors' Group in the coming weeks, which will include an improvement plan to tackle the backlog going forward. An update on developments of complaints will be brought back to the Committee at the April meeting.

Action: Director of Nursing

It was agreed a sentence be added to the commentary that sits under the metrics within the IPQR, to advise if there is a concern for the Committee to be made aware of.

Delayed discharges and the sustainability around the use of surge beds was questioned. In response it was advised discussions are ongoing on retracting the surge beds that are open, and to date, there has been a slight reduction on the retraction.

The Committee **discussed, examined** and **considered** the NHS Fife performance, with particular reference to the Clinical Governance measures identified in Section 2.3 of the paper.

8.4 Integrated Performance Quality Report (IPQR) Review Process

The Director of Finance & Strategy noted the IPQR review process was agreed at the Board's Active Governance session, where it was accepted that it would be a timely process to put improvements in place. Immediate improvements have been agreed, and more work is required on the medium and long-term activity.

It was a reported that, at the Public Health & Wellbeing Committee, it was agreed that when the IPQR review group are developing the next iteration of the IPQR and the tailored version for the Committees, each of the Committee Chairs, respective Executive Lead and the relevant persons within the Planning & Performance department would be involved. Further Non-Executive involvement would also be welcomed.

The balance between the remit of the Public Health & Wellbeing Committee and the clinical aspects that sit within the Clinical Governance Committee for mental health and the quality indicators were highlighted. It was agreed further consideration will take place.

The Committee took **assurance** from the report and the proposed improvements to the IPQR as part of the IPQR Review.

8.5 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing provided an update and highlighted that the Estates & Facilities standards are at 95.5%, which is very positive. It was also highlighted there have been no ward closures due to influenza, two ward closures due to norovirus, and six Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland reportable incidents.

An update was requested on the hand hygiene ward dashboard. The Director of Nursing agreed to take this forward, and also advised that there was no concern in this area.

Action: Director of Nursing

The Committee took **assurance** from the HAIRT report.

8.6 Implementation of Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021

H Bett, Children's Services Projects Senior Manager, joined the meeting for discussion on this item.

It was reported that there has been a movement towards the self-referral aspect of the Act, and assurance was provided that the necessary arrangements have been put in place, in advance of the implementation date of 1 April 2022.

The Chief Executive advised that the structure and governance of this Act change from 1 April 2022 and a Programme Board will report directly into Scottish Ministers on the strategic delivery of the programme going forward. Linking in will be a National Strategic Network for across the whole of NHS Scotland who will shape and prioritise work as it forms part of our core business.

An update on progress within Fife was provided by H Bett, as detailed in the paper. Demand for the service and workforce will be closely monitored. The holding and retaining of evidence have been identified as a risk, and the measures that have been put in place to mitigate this were explained.

The team were commended for all their hard work.

The Committee took **assurance** that, in line with the readiness self-assessment developments to introduce self-referral for forensic medical examination (FME), NHS Fife are on track to meet the legislative requirements.

8.7 Paediatric Audiology Report

A MacKay, Deputy Chief Operating Officer, provided an update on the Paediatric Audiology Report, and advised feedback has not yet been received, to date, on the response submitted to the Scottish Government as outlined in the paper.

Assurance was provided to the Committee on the work that has been carried out, and the review that has been conducted. Good improvement actions have been identified and will be undertaken by the Audiologist Team. Regular meetings will take place to review the action plan.

A further update will go to the Executive Directors' Group in six months' time, given the sensitivity around the subject and the media attention.

The Committee **noted** the response made to the Scottish Government on behalf of NHS Fife in relation to Paediatric Audiology.

9. DIGITAL / INFORMATION

9.1 Digital Strategy Delivery Update

The Associate Director of Digital & Information advised a measured approach to the Digital Strategy is ongoing, and the update is the second report to the Committee, provided for assurance.

It was reported that the strategy is moving into the final two years of delivery. It has been recognised that the engagement approach has had to be adapted, recognising both the financial and resource constraints. The engagement and prioritisation approach that is being adopted was outlined, along with the five key ambitions.

The Committee took **assurance** of suitable progress for the Digital and Information Strategy 2019-2024.

9.2 Hospital Electronic Prescribing and Medicines Administration (HEMPA) Programme

The Medical Director provided a detailed update on the situation for the HEMPA programme and advised it would not prevent the programme from progressing forward. The plans for next steps in delivery are set out in the paper, and it was advised that this is a priority for the HEMPA Programme Board, who are committed to moving forward with the procurement situation.

The Committee took **assurance** from the HEMPA programme update.

9.3 Information Governance and Security Steering Group Update

The Associate Director of Digital & Information spoke to the paper and highlighted the key points.

The Committee **noted** and **commended** the progress being made with the governance and assurance activities within the revised IG&S Governance framework

10. ANNUAL REPORTS

10.1 Research Development Strategy Review 2020/2021 & Research Strategy 2020-2022

- **Research, Innovation & Knowledge Annual Report 2020/2021**

The Medical Director reported on the substantial work that has been carried out in developing the service, and the work that was contributed to in terms of research, which was highly merited.

The Committee welcomed an opportunity to meet the team, and it was **agreed** they would present to the Committee at a future Development Session.

10.2 Occupational Health and Staff Wellbeing Service Annual Report 2020/2021

S Blair, Consultant in Occupational Medicine, joined the meeting for this item.

The importance of the Occupational Health Service to the health and wellbeing of our staff was highlighted as the key aspect of the report, which also includes details on occupational health clinical activity.

The role of the Occupational Health Service during the pandemic, particularly due to staff related absences due to Covid, and the support provided in that area, was outlined. It was reported two new services have been developed, which have been provided by our Mental Health Nurses and Covid Fatigue Management Occupational Service.

The Occupational Health Service were thanked for all their hard work and contributions during a time of particular pressure on staff.

The Committee **noted** the contents of the report and the Occupational Health and Staff Wellbeing Service Annual Report for 2020/2021.

11. LINKED COMMITTEE MINUTES

The Committee **noted** the following linked Committee minutes.

11.1 Acute Services Division Clinical Governance Committee dated 26 January 2022 (unconfirmed)
11.2 Area Clinical Forum dated 7 February 2022 (unconfirmed)
11.3 Fife Drugs & Therapeutics Committee dated 9 June 2021 (confirmed) & 8 December 2021 (unconfirmed)
11.4 Fife IJB Clinical and Care Governance Committee dated 1 October 2021 (confirmed) & 12 November 2021 (confirmed)
11.5 NHS Fife Clinical Governance Oversight Group dated 26 August 2021 (unconfirmed)
11.6 Health and Safety Sub-Committee dated 10 December 2021 (unconfirmed)
11.7 Infection Control Committee dated 4 August 2021 (confirmed) & 1 December 2021 (unconfirmed)
11.8 Area Medical Committee dated 12 October 2022 (confirmed)
11.9 Information Governance & Security Steering Group Minutes dated 1 December 2021 (unconfirmed)
11.10 Digital & Information Board Minutes dated 19 October 2021 (confirmed)

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no items to escalate to NHS Fife Board.

10. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 29 April 2022 at 10am via MS Teams.

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 29 April 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	13/01/22	**Adult Support and Protection Biennial Report 2018-2020**	The Director of Nursing will keep the Committee updated on progress on the small increase in the number of referrals, in the over 65s, for those who are unable to look after themselves, and that this may be due to the limited number of services and activities available due to Covid.	**JO**	Committee to be kept updated on progress Paper will be prepared for meeting on 29/04/22	03/03/22 - The Scottish Government is co-ordinating data collection regarding the impact of the COVID-19 outbreak in relation to adult public protection. This will enable services to compare and benchmark across local authority partnerships to identify and inform what is happening locally to support vulnerable people because of the crisis; the impact this is having, identify and direct additional actions and support at national and local level as required.	In progress
2.	13/01/22		Further detail to be provided on the number of reported self-harm cases and the link to the Psychological Therapies Services and Addiction Services waiting lists	**JO**	~~29/04/22~~ 01/07/22	03/03/22 – A paper will be brought to the meeting on 1 July 2022.	Deadline not reached
3.	03/11/21	**Clinical Governance Framework**	An update on the framework and delivery plan to be brought back to the Committee.	**GC**	~~29/04/22~~ 01/07/22	04/03/22 – The framework and associated delivery plan has been drafted. The framework, along with a questionnaire, will be shared with members of the committee and other key stakeholders (including Senior Leadership Teams), w/c 7 March 2022. This will provide an opportunity for key stakeholders to provide	In progress

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
						feedback and allow for the framework to be further updated in advance of the CGC on 29 April 2022 for final review and endorsement. 04/04/22 - in view of service pressures the deadline for feedback has been extended to 20th April and as such the document will come to the July meeting.	
4.	10/03/22	**Committee Development Session Topics**	Members and attendees were requested to suggest topics to be covered at a development session, twice a year, to delve deeper into topics relevant to the Committee's remit.	**All**	April 2022	First session: E-Coli Bacteraemia Infections – Presentation / Q&As, and Research & Development Session on 10 June 2022. Second session - TBC	In progress
5.	10/03/22	**Health & Safety Workplan**	To discuss with key colleagues the Health & Safety workplan and how that will be incorporated into the Clinical Governance Committee.	**GC**	29/04/22	22/04/22 – GC to advise if action to be closed.	
6.	10/03/22	**E. Coli Bacteraemia Infections (ECB Infections)**	More detail to be provided at a future Committee Development Session on ECB Infections for questions & answers.	**JO**	CGC Development Session	07/04/22 - Dr Morris will provide a presentation at the Development Session on 10 June 2022.	Closed
7.			A Powerpoint presentation on ECB infections to be provided at the April Committee meeting.	**JO**	29/04/22	07/04/22 – Dr Morris will cover this at the Development Session.	Closed
8.	10/03/22	**IPQR (Complaints)**	A report on the recovery plan for complaints will go to the Executive Directors' Group in the coming weeks, which will include an improvement plan to tackle the backlog going forward.	**JO**	29/04/22	07/04/22 – on agenda.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
			An update on developments of complaints to be provided at the April Committee meeting.				
9.	10/03/22	**HAIRT (Hand Hygiene Ward Dashboard)**	An update on the hand hygiene ward dashboard to be provided to the Committee.	**JO**	29/04/22	07/04/22 – A verbal update will be provided at the meeting.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Annual Assurance Statements & Reports from Clinical Governance Subcommittees & Groups**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

Each of the Committee's sub-groups have considered their annual statements of assurance at recent meetings (or by email circulation in the case of the IG&S Steering Group) and each are formally approved by the respective Chair.

2.4 Recommendation

The paper is provided for:

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

3 List of appendices

The following appendices are included with this report:

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

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

Fife Health & Social Care Partnership

Supporting the people of Fife together

CLINICAL AND CARE GOVERNANCE COMMITTEE

ANNUAL ASSURANCE STATEMENT 2021-2022

1 PURPOSE

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

2 MEMBERSHIP

2.1 During the financial year to 31 March 2022 membership of the group comprised:-

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

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

Nicky Connor	Director of Health & Social Care Partnership
Dr Helen Hellewell	Associate Medical Director
Catherine Gilvear	Partnership Quality Clinical & Care Governance Lead
Lynn Barker	Associate Director of Nursing
Kathy Henwood	Chief Social Work Officer
Scott Garden	Director of Pharmacy & Medicines (until Feb 2022)

Benjamin Hannan	Director of Pharmacy & Medicines (from Mar 2022)
Bryan Davies	Head of Preventative & Primary Care Services (from Aug 2022)
Rona Laskowski	Head of Complex and Critical Care Services (from Aug 2022)
Lynne Garvey	Head of Community Care Services
James Crichton	Divisional General Manager – Fife Wide (until Jun 2022)
Fiona McKay	Interim Divisional General Manager - East (until Aug 2021) Head of Strategic Planning, Performance & Commissioning (from Oct 2021)
Simon Fevre	Staff Side Representative
Paul Madill	Consultant, Public Health
Chris McKenna	Medical Director & Responsible Officer for NHS

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

3 MEETINGS

3.1 The Committee meets bi-monthly (between IJB meetings) to fulfil its remit but not less than four times per year. The Committee may meet more frequently if deemed necessary by the Chair. The Group met on 8 occasions during the year (1 April 2021 to 31 March 2022) on the undernoted dates:-

16th April 2021
2nd June 2021
4th August 2021
8th September 2021
1st October 2021
12th November
7th January 2022
4th March 2022

3.2 The attendance schedule is attached at Appendix 1.

4 BUSINESS

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

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

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

4.4 Adequate and effective Clinical & Care Governance arrangements were in place throughout year 2021 - 2022.

5 BEST VALUE

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

6 RISK MANAGEMENT

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

7 CONCLUSION

7.1 As Chair of the Clinical & Care Governance Committee during financial year 2021 - 2022, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at the meetings has allowed us to fulfill our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective Clinical & Care Governance arrangements were in place across all Divisions of the Fife Health & Social Care Partnership during the year.

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

30.03.22

_____ (signed) _____ (date)

Councillor Tim Brett
CHAIRPERSON 2021-2022
On behalf of Fife Health & Social Care Partnership Clinical & Care Governance Committee

FIFE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL & CARE GOVERNANCE COMMITTEE ATTENDANCE
1 APRIL 2021 TO 31 MARCH 2022

	16 Apr	02 Jun	04 Aug	08 Sept	01 Oct	12 Nov	07 Jan	04 Mar
Cllr Tim Brett (Chair)	√	√	√	√	√	√	√	√
Christina Cooper	√	√	√	√	√	√	√	√
Cllr David J Ross	√	√	√	√	√	√	√	√
Councillor Jan Wincott	√	√	√	√	√	√	√	√
Martin Black	√	√	√	√	√	√	√	Apol
Wilma Brown	√	√	√	Apol	Apol	√	Apol	√
Cllr Rosemary Liewald (from 07.01.22)	-	-	-	-	-	-	√	√

Appendix 2

FIFE HEALTH & SOCIAL CARE PARTNERSHIP
CLINICAL & CARE GOVERNANCE COMMITTEE
SCHEDULE OF BUSINESS CONSIDERED 2021-2022

16 April 2021

Clinical and Care Governance Update
Clinical Quality Report
Primary Care Update
Fife Integration Joint Board Directions Policy
Glenrothes Hospital Action Plan Tarvit Report
Chief Social Work Officer Report
Corporate Parenting
Adult Protection Annual Report 2020: Adult and Older People Social Work Services
Complaints Update
Assurance statement

02 June 2021

Clinical and Care Governance Update
Clinical Quality Report incl Medicines Update
Joining up Care – Urgent Care
Post Winter Plan Review
Suicide Prevention
HSCP C&CGC Risk Register
COVID Risk Register
Duty of Candour NHS and FC
HSCP Commissioning Strategy

04 August 2021

Clinical and Care Governance Update
Clinical Quality Report
GP Cluster Update
Assurance Committees Update

08 September 2021

Professional Lead Update
Mental Health Strategy Direction – Update on Implementation
National Hub for Reviewing and Learning from the Deaths of Children and Young People
CAMHS Resource & Intervention Update
Complaints Update
Fife Immunisation Strategic Framework 2021-24
Flu Vaccination Covid Vaccination Tranche 2 Plan Delivery

01 October 2021

Professional Lead Update
Clinical Quality Report
Mobilisation Plan / Current Situation
Mental Health Strategy Update on Implementation
Care Homes Update
Delayed Discharge

12 November 2021

Professional Lead Update
Clinical Quality Report (incl Medicines Governance)
Delay, Winter and Community Care 2021-2022
Primary Care Improvement Plan MoU2 Update
Integration Scheme Review
Safeguarding the Rights of MH Patients during the Covid 19 Pandemic
Autism Diagnostic Pathway
Fife HSCP Annual Report 2020-2021
Care Inspectorate Report
Covid Risk Register

07 January 2022

Professional Lead Update
Fife HSCP Day Services for Older People
Fife Community Frailty Services Redesign
Fife Alcohol & Drug Partnership Annual Report
Corporate Parenting

04 March 2022

Clinical Quality Report
Primary Care Improvement Plan Update
Mental Health Strategy Implementation Plan
CAMHS Update
Anti-Ligature Report
Adult Protection Biennial Report 2018-2020
HSCP C&CGC Risk Register
Complaints Update
C&CGC Annual Statement of Assurance
Chief Officer's Report
Quality Matters Assurance Group

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE DIGITAL & INFORMATION BOARD

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2021-22, that relates to the effectiveness of the Digital & Information Board and its development and monitoring of the Digital & Information Strategy and resulting delivery plan in line with the National Digital Health & Care Strategy and to support the delivery of the NHS Fife Annual Operational Plan, clinical strategies and policies.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Digital & Information Board

Membership	Role / Designations
Dr Chris McKenna	Medical Director (Chair) (Caldicott Guardian)
John Chalmers	Digital Clinical Lead
Nicky Connor	Director of Health and Social Care Partnership
Claire Dobson	Director of Acute Services
Philip Duthie	GP Sub Committee Representative
Scott Garden	Director of Pharmacy and Medicines
Alistair Graham	Associate Director Digital & Information
Margo McGurk	Director of Finance and Strategy (Co-Chair) (SIRO)
Janette Owens	Director of Nursing

Attendance	Roles / Designations
Andy Brown	Principal Auditor, Internal Audit
Eileen Duncan	Directorate Solutions Manager H&SC
Helen Hellewell	Associate Medical Director, H&SCP
Marie Richmond	Head of Strategy and Programmes
Torfinn Thorbjornsen	Head of Information Services
Margaret Guthrie	Head of Information Governance and Security/Data Protection Officer
Allan Young	Head of Digital Operations

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

2.3 The membership and attendance of the group was sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the group's annual workplan at the April 2022 meeting and remains under annual review.

3. Meetings

3.1 The Digital and Information Board met on four occasions during the financial year to 31 March 2022, on the undernoted dates:

- 20th April 2021
- 21st July 2021
- 19th October 2021
- 25th January 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Digital and Information (D&I) Board reviewed and commented on the annual activity plan that was presented. The Board recognised their responsibilities to ensure progress is made with delivering the strategic ambition, relating to year three of NHS Fife's Digital and Information Strategy (2019-2024) and ensuring the maintenance and improvement in performance across D&I technical and operational teams.

4.2 The Board reflected on the rapid introduction of technologies during the pandemic response period and the impact on D&I baseline operational costs and the current and likely future demand being made through the digital health and care request process. Additional consideration was given to the impact on fixed resource levels across the Digital teams that are now required to run an operate the additional digital capabilities introduced at pace. The Board also heard the challenges associated with the use of temporary, fixed term and contractor resource.

4.3 Over two meetings the Board discussed and developed a revised engagement model that ensured the correct level of clinical and leadership engagement within the organisation. The Board inputted to the considerations on this model, ensuring the lessons from previous engagement attempts were included. The Board also ensured a supporting prioritisation methodology be developed to handle the excess demand and this would be supported by SLTs within the Acute Division and the Health and Social Care Partnership. The Board continue to be updated on the development of this work and draws assurance of alignment with corporate objectives, operational priorities and the developing Population Health and Wellbeing Strategy.

4.4 The Board noted the levels of performance being sustained and improved within operational areas, through the continual review of the performance summary indicators. The removal of legacy and unsecured systems remained an area of priority, given the high rating of the cyber security threat level for the public sector that was evident throughout 2021-22. The readiness of suppliers' system to support the removal of legacy and unsupported operating systems was tracked. This issue being of particular risk within Primary Care.

4.5 Throughout the year the Board heard and supported the development of business cases and proposals for a range of initiatives. These included continuation of the community adoption plans for the implementation of Morse, the introduction of an Endoscopy Management System, development of digital handover within Patientrack for inpatient areas, the Microsoft 365 Phase 2, the development of a business case for

the OpenEyes ophthalmology system, Near Me Phase 2 and the national eRostering programme. As part of its governance and assurance the Board also reviewed the Digital Pathology Business case and requested additional scrutiny and the inclusion of sustainability of service information as part of the case to allow the organisation to consider its appropriate prioritisation. The Board also considered the priority candidates for inclusion in the Strategic Prioritisation and Resource Allocation (SPRA) 2022-23 submission.

4.6 Detailed consideration was given by the Board to the ambition for Paperlite, a key deliverable in the Digital and Information Strategy (2019-2022). Recognising the scope and the requirement to digitise the health record, additional consideration was requested to understand the role of scanning, the ability to provide digital capture at the point of care i.e., eForms and the benefit to be derived through sharing elements of the health record with patients. While the development of the business case was key, the opportunity associated with National Treatment Centre - Fife Elective Orthopaedic Centre (FEOC) recognised the need to prioritise the support for this projects Paperlite ambition and implement a Phase 1 early adoption within this project. It was recognised this would further inform the requirements for the wide scale adoption of Paperlite for NHS Fife and associated Business Case.

4.7 The Board reviewed the summary investment made through the Primary Care Improvement Funding for the year 2020-21, noting the additional number of Laptops and PCs introduced, along with the mechanism to support remote working and assistance to sustaining services, through the pandemic, for Primary Care.

4.8 The Board approved the use and recognised the value of formal business case templates based on the nationally provided Green Book guidance. The four templates were used to define the Strategic Assessment, Initial Agreement, Outline Business Case and Final Business Case. The use of these templates was then endorsed by the Executive Directors Group (EDG) and provided to the Finance, Performance and Resources Committee for assurance. This activity also satisfying actions associated with Internal Audit B28-21.

4.9 During the period there was a specific discussion on the critical role Switchboard services play for staff, patients and their families in speaking to the right person at the right time. The Board noted the changing nature of call types and demand during the pandemic and the impact the dynamic nature of additional services, such as vaccination services, test and protect activity, changes to the visiting arrangements and how people present to all health services, including Primary and Urgent Care. The Board also noted the re-procurement of the telephony system was required in the next couple of years.

4.10 The Board received regular updates on the development of the HEPMA programme and while matters progressed well in the early part of the year, the delays to a contractual agreement being reached resulted in additional discussion and actions, in support of the HEPMA Programme Board, being requested. The Board noted the conclusion of the contract negotiation, without a contract being signed.

4.11 The Board supported the specific prioritisation of activities to develop additional capability within Cyber Resilience, Digital Business Continuity and Disaster Recovery and the introduction of Information Technology Infrastructure Library (ITIL) Version 4 to support strategic planning, design, build activities and the efficient running of operations and service management to further enhance the availability of systems and digital capability. The ITIL work being in direct response to Internal Audit B23-21 – ITIL Processes.

4.12 The Board support the alignment of activities and consideration of clinical effectiveness and safety as part of the prioritisation process. The Board heard how an increasing number of Significant Adverse Event Reviews (SAERs) had identified that existing systems and digital process had not been fully implemented or were note in the awareness of users. The ability for clinical users to make use of the technology available would have had an improved impact on the outcomes. The development of the work associated with this was ongoing and would form considerations for the 2022-23 workplan.

4.13 The Board also agreed to the establishment of a Data and Insight Hub. This collaborative would provide a cohesive group for NHS Fife's data analysts and insight community to come together to share approach, support validation of data, consider priorities and general support and to unify the presentation of data to those that consume it.

5. Risk Management

5.1 The Board supported the early establishment of the risk management approach that provided, where possible, clear segregation of roles and responsibilities with the Information Governance and Security Steering Group. A revised risk management approach and report was developed to support the Board's ability to provide scrutiny and assurance to the management of risk. The Board were supportive of the first iteration of the risk report that was presented to the April 2021 meeting and consistently thereafter.

5.2 The Board supported the development of the report throughout the year.

5.3 Throughout the year the Board were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, that averaged 33 in number in the year, supported the critique and assurance the group were able to offer.

5.4 In addition, the report provided a reporting format that presented additional analysis on the highest ranked risks. This summary detailed the root cause analysis, management actions, impact on the risk rating and timeline for delivery. This provided the Board with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. To date the Board has been able to provide that assurance for the highest ranked risks.

5.5 During the period the Board noted that 13 risks improved their rating, 1 risk deteriorated during the period, 9 moved to the target risk rating and moved to a status of monitoring and 3 risk were closed.

6. Other Highlights

6.1 The Board considered the NISD Review Report – April 2021, which concluded *"that the progress made in controls and recommendations implemented in the period are clear evidence of a commitment by the Board to information and cyber security"*, with an uplift in overall compliance from 53% to 69%. The next NISD audit took place in March 2022 and the 2022 report is expected in May 2022.

6.2 Through the work of the Board and Digital and Information teams the actions associated with Internal Audit Reports were progressed. Report B28-21 (Digital and Information Governance Arrangements) has two actions and are now presented as complete and Report B23-21 – ITIL Process, has 2 actions presented as complete and the remaining 4 on target for completion by June 2022.

7. Conclusion

7.1 As Chair of the Digital and Information Board, during financial year 2021-22, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Digital and Information Board has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

7.3 I would pay tribute to the dedication and commitment of fellow members of the Digital and Information Board and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date: 21 April 2022

Dr Chris McKenna, Chair
Executive Medical Director
On behalf of the Digital and Information Board

Appendix 1 – Attendance Schedule

APPENDIX 1

NHS Fife Digital and Information Board Attendance Record
1st April 2021 to 31st March 2022

	20/04/21	21/07/21	19/10/21	25/01/22
Members				
Dr Chris McKenna (Chair)	✓	✓	✓	✓
John Chalmers	✓	✓	✓	✓
Nicky Connor	Audrey Valente Deputising	√	√	x
Claire Dobson	✓	Andy Mackay Deputising	✓	✓
Philip Duthie	x	✓	x	✓
Scott Garden	Kirsten Smith Deputising	Euan Reid Deputising	x	Sally Tyson Deputising
Alistair Graham	✓	✓	✓	✓
Margo McGurk	✓	✓	Maxine Michie Deputising	x
Janette Owens	✓	✓	x	✓
Jillian Torrens	✓	✓	✓	x
Miriam Watts	x	✓	x	✓
Amanda Wong	✓	✓	✓	✓
In attendance				
Andy Brown	✓	x	x	✓
Eileen Duncan	x	x	✓	x
Helen Hellewell	x	x	x	x
Marie Richmond	✓	✓	✓	✓
Torfinn Thorbjornsen	x	x	x	✓
Margaret Guthrie	x	x	Michelle Campbell Deputising	Craig McKinnon Deputising
Allan Young	✓	✓	✓	✓

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

1. Purpose

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

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Sub-Committee comprised:

Names	Roles / Designations
Neil McCormick	Director of Property and Asset Management (Chair)
Dr Christopher McKenna	Medical Director
Linda Douglas	Director of Workforce (Vice-Chair)
Conn Gillespie	Staff Side H&S Representative
Craig Webster	H&S Manager (Lead officer until 14.09.21)

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

3. Meetings

3.1 The Sub-Committee met on three occasions via Teams during the financial year to 31 March 2022, on the undernoted dates. The June 2021 meeting was cancelled for operational reasons.

- 14 September 2021
- 10 December 2021
- 11 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 Unsurprisingly, the business of the Sub-Committee has been dominated by issues relating to the Covid-19 pandemic. The 2019-2022 Work Plan was ratified at the March 2021 meeting, as was the Terms of Reference for the Sub-Committee. Whilst some aspects of the Work Plan were affected, the policy and procedure reviews scheduled for the year were completed.

4.2 The June 2021 meeting was cancelled due to operational issues.

4.3 Final confirmation was given in September 2021 that the Notice of Contravention in respect to physical distancing (especially in rest/break areas), records management and training with regard to face fit testing and fit testers and concerns with changing and locker facilities had finally been closed by the Health & Safety Executive (HSE). Significant discussions regarding COVID-19 issues were raised at the September 2021 meeting. However, no major concerns were raised, as the national situation seemed to be improving, with changes to the vaccination regime and some changes to social distancing having been made. Updates on several policies including the Health & Safety Policy statement were received by the Sub-Committee.

4.4 In December 2021, the Sub-Committee discussed the potential impact of the new Covid variant and noted that new information had been issued to the organisation based around advice from Public Health Scotland. The Sub-Committee concluded that the organisation had been operating within the rules, guidance and practices that have been set up around COVID-19 and that staff were working incredibly hard to ensure that NHS Fife hospitals and important Health & Social Care services continued to run during the pandemic. The new variant presented a major threat to the running of the organisation through a difficult winter period. The Sub-Committee heard that, following the H&S Manager's secondment to the Infection Prevention & Control Team (IPCT), temporary measures had been put in place for the Violence & Aggression and Manual Handling teams. Meetings had been held with NHS Tayside and other partners, including Fife Council, and they have all offered their support should we need it. An update regarding recruitment within the Health & Safety Services Team was given.

4.5 The March 2022 Sub-Committee meeting included an update to the recruitment process for a Health & Safety Manager, discussions about the easing of the pandemic and the loosening of Covid-19 restrictions in Scotland and the rest of the UK. The sub-committee were reminded of their obligations to escalate any material concerns to the Clinical Governance Committee. There was a discussion about outstanding internal audit actions for Manual Handling and Sharps Management, which were going to be cleared as far as possible before the next meeting. There was also a discussion about data, attendance at meetings and the development of the workplan to review subjects in more detail. The sub-committee approved the Terms of Reference, Workplan and Draft Annual Statement of Assurance for the Sub Committee.

5. Risk Management

5.1 The COVID-19 pandemic and HSE interventions dominated the H&S agenda for 2021-2022 resulting in significant reactive work for the H&S Team. Despite this, the team were able to continue with 'business as usual' support to the organisation as well as managing HSE visits, action plans, meeting support and delivery of fit testing 'clinics' up to three days per week.

This reactive work represented key risks for the organisation and the work undertaken on behalf of the Sub-Committee aligned with the remit to ensure that Fife NHS Board provide a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations in regard to Health & Safety.

5.2 During the pandemic however, routine face-to-face training for manual handling and aggression management have been suspended. This has resulted in a back-log of personnel, including new starts, who will require training support and updates in

2022/23. This will be a key focus for the H&S Manager and Sub-Committee moving forward.

5.3 The Sharps Management Audit raised particular concern regarding difficulties with clinical/nursing attendance at the NHS Fife Sharps Strategy Group, which has hampered efforts for wider implementation of sharps management and training across NHS Fife. Again this, alongside recommendations from the internal audit report, will be a key focus point for the H&S Sub-Committee during 2022-2023.

6. Conclusion

6.1 This annual report has been agreed by Mr Neil McCormick as Chair of the H&S Sub-Committee in discussion with Sub-Committee members.

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

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

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

Signed:  Date: 11 March 2022

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

Appendix 1 – Attendance Schedule

APPENDIX 1

NHS Fife Health & Safety Sub-Committee Attendance Record
1 April 2021 to 31 March 2022

	14 Sept 2021	10 Dec 2021	11 Mar 2022
Members			
Name			
Neil McCormick	✓	✓	✓
Dr Christopher McKenna	×	×	✓
Linda Douglas	×	✓	✓
Conn Gillespie	✓	✓	✓
Craig Webster	✓		
In attendance			
Name			
David Young	✓	✓	✓
Kevin Reith (for Linda Douglas)	✓		✓
Paul Bishop		✓	
Anne-Marie Marshall		✓	✓

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

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2021-22, that relates to the effectiveness of the structures, policies and practice in place to ensure the confidentiality, availability and integrity of the information processed by or on behalf of NHS Fife, including patient records and all corporate records which are pertinent to regulations, and to enable the ethical and safe use of them for the benefit of individual patients and the public good.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Information Governance and Security Steering Group comprised: -

Membership	**Roles / Designations**
Margo McGurk	**Chair/Senior Information Risk Owner** (SIRO) - Director of Finance and Strategy/Deputy Chief Executive
Dr Chris McKenna	**Vice Chair** - Medical Director and Caldicott Guardian
Nicky Connor	Director of H&SCP
Claire Dobson	Director of Acute Services
Linda Douglas	Director of Workforce
Philip Duthie	General Practitioner
Susan Fraser	Associate Director of Planning & Performance
Scott Garden	Director of Pharmacy & Medicines (until February 2022)
Alistair Graham	Associate Director of Digital & Information
Ben Hannan	Director of Pharmacy & Medicines (from March 2022)
Helen Hellewell	Associate Medical Director, H&SCP
Janette Owens	Director of Nursing
Frances Quirk	Associate Director, Research, Innovation and Knowledge
Joy Tomlinson	Director of Public Health

Attendance	**Roles / Designations**
Andy Brown	Principal Auditor, Internal Audit
Michelle Campbell	Information Governance Advisor/ Data Protection Officer Primary Care
Margaret Guthrie	Head of Information Governance & Security / Data Protection Officer
Andrew Lam	Cyber Security Consultant
Gillian MacIntosh	Head of Corporate Governance & Board Secretary
Kirsty MacGregor	Head of Communications
Claire Neal	Personal Assistant to Associate Director of Digital & Information

2.2 The Information Governance & Security (IG&S) Steering Group invited individuals to attend meetings for particular agenda items and the list of attendees detailed in 2.1 have been in regular attendance at meetings. Other attendees, deputies and guests have been recorded in the individual minutes of each meeting.

2.3 The membership and attendance of the group was sufficient to support the work and oversight necessary. The membership and attendance was reviewed as part of the group's annual workplan at the March 2022 meeting and remains under annual review.

3. Meetings

3.1 The Information Governance & Security Steering Group met on four occasions during the financial year to 31 March 2022, on the undernoted dates:

- 19th April 2021
- 2nd June 2021
- 1st December 2021
- 4th March 2022

A planned meeting due to be held on 14th September 2021 was postponed due to the current pressures within NHS Fife at the time.

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Information Governance and Security Steering Group reviewed and commented on the annual activity plan that was presented to the Group. The group recognised the responsibilities across the four domains of Data Protection, Freedom of Information, Public Records and Network and Information Security Directive (NISD). The group discussed and considered the priorities outlined and had an informed view, being able to review these alongside associated risks for the four domains. Priorities were amended where necessary.

4.2 The Group noted the inclusion of Key Performance Indicators and measurements associated with the activity plan, noting areas where reporting or data was not yet available. Some key measures are included in Appendix 2 to this report, the IG&S Performance Summary.

4.3 Further mapping of activities and risks were requested and included in the activity plan along with the ongoing development of measures. The Group benefited from the inclusion of the additional measures and these were consistently reported during the year. Specific comment and actions were sought around training uptake at induction and refresh, policy and procedure compliance, Subject Access Request (SAR) performance, asset register compliance and NISD outcomes. The group also brought scrutiny to areas where data was not available and provided supportive suggestions as to how these gaps may be addressed.

4.4 The Group reviewed and gave assurance to the implementation of the proposed Model Publication Scheme required under Freedom of Information (FOI) legislation. The Group ensured that careful consideration was given and that the Executive Directors Group (EDG) had the opportunity to reach a decision on the inclusion or exclusion of specific financial information prior to issue. The Model Publication Scheme was published on the Board's website in July 2021.

4.5 During the year the Group were aware of the requirement for continuous prioritisation of activities in line with the availability of resources within the IG&S team. Through the year the Group noted inconsistency in FOI performance, the pace of SAR improvement work and the ability to update Policies in line with legislative change and review timescales. The group also noted the mitigation activities being supported by the Associate Director of Digital and Information and Head of Information Governance and Security, noting a resolution was confirmed via the Strategic Prioritisation & Resource Allocation (SPRA) process in March 2022. By the end of the period all Policies had been reviewed and FOI performance was showing some signs of stabilisation.

4.6 Throughout the year the Group received "educational" presentations on the current baseline for Records Management within NHS Fife, the approach and action plan associated with NISD compliance and a summary consideration of the Information Commissioners Office's (ICO) Accountability Framework. The group continue to track progress with these initiatives through the activity plan. Additional scrutiny was given to the development of a records management plan, to ensure a sustainable approach is developed for records management, for corporate and health records, with the expectation this would be established in 2022-23, following feedback from the Keeper of the National Records of Scotland. The group also noted the emerging requirement and establishment of a Short Life Working Group to consider the scope of the COVID 19 Inquiry, noting the linkages to availability and security of records and information.

4.7 The Group noted the additional reporting, via EDG, to the Clinical Governance Committee and the Audit & Risk Committee for items that included Information Governance & Security assurance update reports, and specific items on Cyber Security risk and mitigations. The group supported and championed the approach for raising awareness around the threat and impact of a Cyber Attack and, more recently, acknowledge the changes associated from the geo-political situation in Ukraine.

4.8 The Group considered, at its 1 December 2021 meeting, an incident report following a cyber event that affected a Third Party Supplier within NHS Fife's supply chain. The report detailed the rapid response initiated to protect NHS Fife and the associated reporting to the ICO and other authorities. The Group acknowledge the value and benefit of seeing the detailed report and the assurance included on the appropriate handling of the response and the implementation of additional lessons that were learnt. The incident was considered a moderate categorisation.

4.9 The Group considered the issue of new starter induction training and the frequency of refresher training that staff members are required to undertake for Information Governance and Security. This included consideration of the availability of data to show performance measures, to provide assurance on the uptake of the training modules. The Group noted the challenges associated with the move to the TURAS Learning platform and discussions were encouraged to establish an approach to refresher training that considered the national guidance for mandatory training and any specific guidance that may be provided for Information Governance and Security. Options for data availability in support of assurance would continue to be considered.

4.10 As part of the Group's support to clinical improvement and the benefits associated with data sharing, a presentation on the opportunity to extend GP datasets within the Clinical Portal was given significant consideration. While there was recognition of the clinical benefit, further assurance was sought on the controls that could be provided to protect this data through technical means, supported by policy, procedure and education, each informed by consultation with additional stakeholders. The Group also identified the need for a communication approach that would give patients clear guidance on the necessity to share this information and their rights in this area, should

they wish to be excluded from this sharing. While supporting the initiative, the Group insisted that further assurance be provided to the Group, following additional consultation with stakeholders, before a commitment to implementation is confirmed.

4.11 The Group undertook, as scheduled, its annual review of terms of reference and update to annual workplan.

5. Risk Management

5.1 The Group supported the early establishment of the risk management approach that provided, where possible, clear segregation of roles and responsibilities with the Digital and Information Board and the Group. The SIRO, on behalf of the Group, requested that a revised risk management approach and report be developed to support the Group's ability to provide scrutiny and assurance on the management of risk. The Group were supportive of the first iteration of the risk report, which was presented to the June 2021 meeting and consistently thereafter. The Group supported the development of the report throughout the year.

5.2 Throughout the year the Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, which averaged 26 in number over the year, supported the critique and assurance the Group were able to offer.

5.3 In addition, the report provided a reporting format that presented additional analysis on the highest ranked risks. This summary detailed the root cause analysis, management actions, impact on the risk rating and timeline for delivery. This provided the Group with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. To date the Group has been able to provide that assurance for the highest ranked risks.

5.4 During the period the Group noted that 8 risks improved their rating, 2 risks deteriorated during the period, 3 moved to the target risk rating and moved to a status of monitoring and 3 risks were closed.

6. Other Highlights

6.1 Through the year, 14 incidents were reported to the ICO, an increase of 3 on the previous year. Of the 14, 9 (64%) were reported within the 72-hour requirement. Of the 14 incidents, 12 have been confirmed not to require any further follow up and 2 remain to be confirmed. At present there is no requirement for these to be disclosed in the Board's annual Governance Statement.

6.2 The Group noted that the NISD Review Report (April 2021) concluded *"that the progress made in controls and recommendations implemented in the period are clear evidence of a commitment by the Board to information and cyber security"*, with an uplift in overall compliance from 53% to 69%. The next NISD audit took place in March 2022 and this report is expected to be available for review in May 2022.

6.3 The Group await final feedback from the Keeper of the National Records of Scotland on NHS Fife's draft Records Management plan that was submitted in February 2021. This feedback is due to be received in April 2022 and will inform the records management plan referenced in Section 4.

6.4 Through the work of the Group and Digital and Information operational teams, the Internal Control Evaluation B08/21 single action has been presented as complete. In

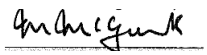
reference to Internal Control Evaluation B08/22, one action is presented as complete and the remaining three are on target for completion in the same timeframe as this annual assurance statement is presented to Clinical Governance Committee on 29 April 2022.

7. Conclusion

7.1 As Chair of the Information Governance & Security Steering Group during Financial Year 2021-22, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Information Governance & Security Steering Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

7.3 I would pay tribute to the dedication and commitment of fellow members of the Information Governance & Security Steering Group and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed:  Date: 21 April 2022

Margo McGurk, Chair
Director of Finance and Strategy/Deputy Chief Executive
On behalf of the Information Governance & Security Steering Group

Appendix 1 – Attendance Schedule

Appendix 2 – IG&S Performance Summary

APPENDIX 1

NHS Fife Information Governance & Steering Group Attendance Record 1st April 2021 to 31st March 2022

	19/04/21	02/06/21	01/12/21	04/03/21
Members				
Margo McGurk	✓	✓	✓	✓
Nicky Connor	Jim Crichton deputising	Jim Crichton deputising	x	x
Claire Dobson	✓	x	✓	x
Linda Douglas	✓	Kevin Reith deputising	✓	Kevin Reith deputising
Philip Duthie	x	x	✓	✓
Susan Fraser	✓	✓	x	✓
Scott Garden	✓	Euan Reid deputising	✓	x
Benjamin Hannan	-	-	-	x
Alistair Graham	✓	✓	✓	✓
Helen Hellewell	x	x	x	x
Dr Chris McKenna	✓	x	✓	x
Janette Owens	✓	Nicola Robertson deputising	✓	Nicola Robertson deputising
Frances Quirk	x	✓	✓	x
Joy Tomlinson		✓	✓	✓
In attendance				
Andy Brown	✓	✓	✓	✓
Margaret Guthrie	x	✓	✓	✓
Kirsty MacGregor	✓	✓	✓	x
Gillian MacIntosh	✓	✓	✓	✓
Allan Young	✓	✓	✓	✓

Appendix 2 – IG&S Performance Summary

	Information Governance & Security Performance Summary	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Performance Indication	Trend
Operational Performance	Cyber Security - Exposure Score*	25%	37	35	31	31	56	25	30	29	37	38	26	24	●	
	FOI's - Responses within target	85%	93.5%	79.2%	88.6%	58.0%	83.3%	74.5%	78.0%	84.1%	85.4%	85.7%	94.2%		●	
	SARs Received (% responded to timeously)	100%	9 (100%)	10 (90%)	20 (99.4%)	35 (97.5%)	28 (96.7%)	135 (94%)	214 (99.5%)	141 (100%)	163 (97%)	152 (96%)	143 (100%)	43(93%)	●	
	Information Governance Incidents		110	128	139	108	95	118	88	136	128	120	88	98	N/A	
	Incidents Reported to ICO		1	1	1	0	0	4	3	1	1	1	1	0	N/A	
	Incidents Reported within 72 Hours		1	0	1	0	0	3	3	0	0	1	0	0		
	Follow up required by ICO		0	0	0	0	0	0	0	0	0	0	0	0	N/A	

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Clinical Governance Committee Annual Statement of Assurance 2021-22**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. The current draft takes account of initial comments received from the Committee Chair, Medical Director, Director of Nursing and the Associate Director for Quality & Clinical Governance.

2.3 Assessment

The content of the annual reports from the Committee's sub-groups has also been considered in the drafting of this report. In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2021-22, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and Executive Leads and has been reviewed by EDG at its meeting on 22 April.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary, for final sign-off by the Chair and submission to the Audit & Risk Committee.

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

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2021/22

1. Purpose

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

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Clinical Governance Committee comprised: -

Christina Cooper	Chair / Non-Executive Member
Martin Black	Non-Executive Member
Sinead Braiden	Non-Executive Member
Wilma Brown	Area Partnership Forum Representative (to July 2021)
Simon Fevre	Area Partnership Forum Representative (from July 2021)
Cllr David Graham	Non-Executive Member
Rona Laing	Non-Executive Member
Aileen Lawrie	Area Clinical Forum Representative
Dr Christopher McKenna	Medical Director
Dona Milne	Director of Public Health (to May 2021)
Dr Joy Tomlinson	Director of Public Health (from May 2021)
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Margaret Wells	Non-Executive Member (to July 2021)
Arlene Wood	Non-Executive Member (from September 2021)

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

2.3 The Clinical Governance Committee's remit permits a Patient Representative to be a member of the Committee. This post has been vacant in the reporting year, whilst an ongoing review is undertaken of the function and appointment route of this role.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2022, on the undernoted dates:

- 30 April 2021
- 7 July 2021
- 2 September 2021 (held as an extraordinary meeting)

- 17 September 2021
- 3 November 2021
- 13 January 2022
- 10 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year continues to have been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. The Committee Chair has liaised closely with the Medical Director, as lead Executive Officer, and the Director of Nursing to identify what business must be considered by the Committee and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred, with the occasional meeting running with a prioritised agenda. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid-surge-related demand within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The Committee's workplan has been regularly reviewed to ensure that specific items related to Covid-19 have been covered appropriately and that the required assurances could be provided to the Board as part of the year-end process.

4.2 In October 2021, the Board established a new Public Health & Wellbeing Committee, which has taken under its remit some public health-related areas previously covered by the Clinical Governance Committee. A review of workplans and terms of reference of Committee's with overlapping agenda topics has attempted to limit any duplication in reporting and enhance clarity about roles and responsibilities. This remains, however, at the time of writing a work-in-progress, as the new Public Health & Wellbeing Committee evolves and develops, and this gives the Clinical Governance Committee an opportunity for more focused agendas and enhanced scrutiny on the key aspects of business aligned to its specific remit.

4.3 The Clinical Governance Committee's first meeting of the 2021-22 reporting year took place in April 2021, with updates given to members on the Covid vaccination programme, including future delivery models and associated governance structure for the immunisation programme. The Committee were assured of the Board's above-average progress in delivery of vaccines to the eligible population, the workforce in place to support the programme, and the inclusivity initiatives being undertaken to reach disadvantaged groups. At the same meeting, members also received up-to-date information on the expansion of Covid-19 testing, particularly asymptomatic testing within the community and the dedicated sites being established to support that across Fife. Given the complexity of the message around testing and isolation for positive cases, the Committee welcomed the clear and practical communications being issued to support the local population.

4.4 Further updates on both testing and vaccine delivery were presented to the Committee at its July 2021 meeting, noting the expansion of both and the transition from a Covid-focused programme to a revised Flu Vaccination & Covid Vaccination (FVCV) programme, beginning in the autumn of 2021. Comprehensive assurance was provided that the Board was actively planning for what would be its biggest immunisation programme to date, and that lessons learned from earlier stages of the vaccination delivery would mitigate any foreseen risks, particularly around the use once again of the national scheduling tool. A new governance and assurance structure has been developed to meet the increasing demands and expectations of all childhood and adult immunisation programmes in Fife, ensuring that the Board has in place

the necessary workforce and logistical expertise, as Covid-related work increasingly transitions into business-as-usual activity.

4.5 The Committee held an Extraordinary Meeting in September 2021 to scrutinise the expanded Winter immunisation programme, covering the planning for delivering both seasonal flu and Covid booster vaccinations. Detail was provided on the governance structures in place (including the appointment of a dedicated Immunisation Programme Director) and the supporting workstreams covering logistics (such as clinic venues and scheduling), workforce and models of care. Members took assurance from the progress made in planning for such a large-scale endeavour. Members also discussed issues ranging from the availability of vaccine, the prioritisation of cohorts, the governance, risk and project management arrangements for the roll-out of the programme, planning for venues, scheduling and appointing mechanisms, and the workforce and financial implications. Also considered at the special meeting was the enhanced Fife Immunisation Strategic Framework for 2021-24, which set out plans for all immunisation programmes for vaccine-preventable disease to be delivered over the period. It was noted that lessons learned from the issues encountered with the 2020-21 Seasonal Flu programme had indicated that improvements in the leadership, management and governance of immunisation programmes were required. The Framework therefore provides the foundation for an integrated strategic approach for planning and delivery of immunisation-related activities, including those related to Covid, clarifying the roles and overlapping responsibilities between the Board, the IJB and the Health & Social Care Partnership. Members greatly welcomed the Framework, recognising this provided helpful clarification and direction over what remains a complex and high-profile programme of work.

4.6 In September 2021, further updates on Covid-related activity were given, with this meeting coinciding with a sharp increase in positive infections within Fife and, as a result, the number of tests being carried out. Assurances were provided on the Board's capacity to manage the high demand, along with efforts being made to minimise staff absence and ensure test sites (both fixed and mobile) were easily accessible to the entire Fife population. The upsurge in cases caused significant pressure on clinical services, with increased Acute admissions and subsequent pressure on flow across the overall system. The Committee took assurance from the selective pausing of elective procedures and outpatient activity, which took due account of clinical prioritisation and planning, to address ongoing high levels of activity.

4.7 Further and ongoing updates on Covid-19 activity, in addition to the roll-out of the Flu Vaccination & Covid Vaccination programme, have been given to members at Committee meetings held over the Winter period, where activity has fluctuated, due to the impact of the Omicron wave of infections and reduction of social distancing prevention measures. The progress of the Seasonal Flu and Covid booster campaign has been actively scrutinised, with assurances given around planning, infrastructure and staffing over what has been a period of extremely high activity. A briefing on the Board's response to 'long' or post-Covid syndrome, which is being led by a specific Oversight Group, was given in March 2022. The long-term effects of Covid can vary widely, with enduring impact on both physical and mental health, and the Committee were assured that a range of support measures were being put in place to support individuals who continue to experience after-effects of the illness.

4.8 The January 2022 meeting of the Committee was prioritised to focus on Covid-related business or items otherwise requiring approval, given the critical pressure then apparent on operational staff and Executive Directors. The Committee were apprised of developments to the testing and tracing programme, including funding for the contact workforce and the introduction of antiviral / immune moderated treatment for the most vulnerable via a dedicated Covid-19 Outpatient Assessment (COPA) unit situated at the Victoria Hospital. It was noted that the success of the Covid booster immunisation programme had had a positive impact on reducing the number of individuals requiring hospital treatment due to Covid, but that there remained

serious pressure on care homes and wards due to the levels of infection, impacting on discharge and flow. The FVCV work had been especially challenging over a busy festive period, though nevertheless the Board exceeded the Scottish Government target for vaccines to be delivered under the 'Boosted by the Bells' campaign. Outreach work had also continued, to mitigate any inequalities and to ensure the vaccine is available to all. The Committee continued to take assurance from this important work, noting the exceptional efforts of all involved in the Winter immunisation activities. The strong performance of the Board when compared with other nationally has given the appropriate assurance that the planning and implementation of such a large-scale programme has taken due cognisance of the lessons learned from the 2020 review of Seasonal Flu immunisation and improvement made in immunisation governance, in addition to benefitting from the expertise, dedication and knowledge of staff from across a range of services.

4.9 The Committee has received regular updates on the initial development stages of the Board's new Population Health & Wellbeing Strategy, which will inform planning for the next five to ten years. Development of the individual workstreams are being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with key stakeholders and members of the public, and updates have been given to the Committee thereon. The Public Health & Wellbeing Committee is the lead Committee for the development of the new Strategy, though the Clinical Governance Committee will continue to have a specific role in the scrutiny and assurance of developments with a defined clinical governance-related impact.

4.10 A draft of the Joint Remobilisation Plan (RMP4), outlining the planning for addressing the backlog of planned care activity following the initial phase of the Covid pandemic, has been reviewed by the Committee and its input welcomed. The Plan detailed the adopted methodology around the planning for resumption of normal services, based around a 'Respond, Recover and Renew' approach, building on earlier iterations of the Plan approved by Scottish Government. For 2021-22, the Winter Plan has been encompassed within the Remobilisation Plan, and this has taken account of the context of levels of demand and staff workforce capacity. A progress update on deliverables has been considered by the Committee at its January 2022 meeting.

4.11 During the pandemic, strategic decisions have been made in relation to both the configuration of services and on which services could reasonably be provided. Changes to service provision have been risk assessed and the Committee has recognised that some patients may be affected by these decisions. As such, any consequences that resulted would not be considered avoidable, given that this was based on the strategic decision to prioritise services to address the pandemic. Importantly, actions to mitigate identified risks were implemented at all opportunity. The Committee considers that the local response to the pandemic was appropriate, considered and aligned to Scottish Government direction. Throughout the pandemic thus far, urgent services such as cancer services and urgent care have been prioritised. The governance route for changing or stopping services has been carefully scrutinised through the pandemic response structures of Bronze, Silver and Gold Command groups. Critically, clinical teams and leaders have been central to decision-making, to ensure that any potential harm resulting from cessation or service change was appropriately mitigated. Examples of mitigation include the nationally-agreed surgical prioritisation framework, use of 'Near Me' for the continuance of remote appointments, and outpatient prioritisation. The dynamic nature of the pandemic and the evolving understanding of the virus has necessitated a continual review of changes, which have been considered through the command structures described and also discussed by the Committee during the year. As services continue to remobilise and recover, the Clinical Governance Committee will continue to offer oversight, to provide assurance in relation to the recovery of services and planning for tackling increased

waiting lists. It has also been decided that the risk to patient safety due to increased waiting times will be captured in a revised Quality & Safety Board Assurance Framework submission.

4.12 An update by the Medical Director on the Redesign of Urgent Care, including the governance structure for undertaking this work, was delivered to members in November 2021, with a further report tabled in March 2022. Details on the design and operation of the Flow & Navigation Hub within the Urgent Care Service was outlined, following Scottish Government guidance for all Boards to establish a local hub to ensure patients are directed to the appropriate point of care. This continues to operate successfully, helping ensure Accident & Emergency attendances are managed and patients are directed to the right forms of support for their own individual needs. A new funding stream, Interface Care, helps support the ambulatory options available to patients, to help reduce the length of stay in hospital for certain conditions and to maximise the use of services such as Hospital@Home. The Committee has received subsequent updates on the impact of the changes on the Emergency Department, including measures in place aimed at reducing the pressure at the front door by redirecting patients to more suitable services, and members have gained full assurance that the Board is addressing the national requirements in this area.

4.13 In September 2021, an assurance report on the benefits and enhancements to the patient experience by the introduction of robotic-assisted surgery was considered by the Committee, outlining the potential transformative nature of this initiative on a number of complex surgical procedures.

4.14 In November 2021, the Committee received a detailed update on this risks around the Primary Care Improvement Plan Memorandum of Understanding 2, focusing on those related to delivery, finance and workforce. Members recognised this was a significant workstream, which would be challenging to deliver in time for the nationally-set deadlines. General Practices remain under pressure due to levels of demand and the need to maintain Covid-distancing measures, thus reducing face-to-face contact with patients. Close working is needed with contractors, including pharmacies, in order to achieve the Plan's ambitions and this will be the subject of future reports to the Committee.

4.15 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events, via the Integrated Performance & Quality Report (IPQR). Specific scrutiny has been given in recent meetings to the increased rate of in-patient falls, which has been attributed to the footprint alteration and staffing changes in the hospital due to the pandemic, and the Committee has received detail on how this will be addressed. A detailed report and presentation on reducing incidents of harm from pressure ulcers, catheter-associated urinary tract infections and E Coli Bacterium has also been scrutinised by the Committee, to address concerns where targets have deteriorated. It has been agreed that a specific Committee Development Session be held in the current year to have a deep-dive into this area, to enhance members' knowledge of this area.

4.16 Stand-alone updates on complaints performance have also been discussed at the Committee, noting the backdrop of a backlog of cases built up during the pandemic and a related increase in complaints as treatment delays have multiplied due to pauses in outpatient and elective surgery appointments. Recovery performance has been variable, with the need to pause some complaint activity at times of extreme pressure, exacerbated also by the issue of staff shortage within the Patient Relations team. Enhancements in reporting to the Committee have been introduced, to provide more meaningful data around patient feedback and experience and analysis / learning from themes and trends, to be progressed by a new Organisational Learning Group. A full-scale review of the IPQR is presently underway, following the Board's Active Governance session held in November 2021, and this will reach its conclusion shortly.

4.17 The Committee noted that robust action plans were developed following Health Improvement Scotland (HIS) Healthcare Associated Infection (HAI) inspection visits to Glenrothes Hospital (7-8 July 2020) and to Adamson Hospital (28 October 2020), with members receiving an update on progress in addressing actions of these inspections at their April 2021 meeting. The Glenrothes Hospital Inspection resulted in the identification of four areas of good practice (particularly around hospital cleanliness and infection control support) and five requirements in areas to be improved (the majority related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic). The Adamson Hospital Inspection highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic and two requirements were in relation to infection control practices supporting a safe environment for patients and staff. At their April 2021 meeting, the Committee were pleased to note that the action plan in relation to the Glenrothes Hospital inspection has been fully completed, and that for Adamson Hospital was awaiting final HIS sign-off. In September 2021, the Committee noted that a Covid-focused HIS inspection of the Victoria Hospital, undertaken in May 2021, had concluded with largely positive findings and a number of good practice areas identified. Two minor requirements for improvements were identified and these had been quickly addressed.

4.18 The Committee has discussed planning for the Winter Period (as part of the Board's Joint Remobilisation Plan) and reflected on Winter performance via a report on the 2020/21 period. It was recognised that, particularly with Covid activity ongoing, planning for pressures and surges was, in essence, a year-round activity, which goes beyond the actual Winter season. Services have been recovering as well as remobilising, and close working relationships particularly with colleagues in the Health & Social Care Partnership have helped to managed delay and flow, with varying results across the year.

4.19 The Committee has received updates throughout the year on the new requirements of various legislative initiatives, including, in April 2021, dedicated reports on the Board's preparedness for the introduction of recent guidance on donation and pre-death procedures for organ and tissue donation (effective March 2021) and also new guidelines on the self-referral to forensic medical services for adults, children and young people who have experienced rape, sexual assault or sexual abuse (effective April 2022). In relation to the latter, the Committee were assured that the Board's facilities and services are trauma-informed, holistic and person-centred, whilst fully integrated with cross-sector partners. An update was provided in November 2021 on the National Hub for Reviewing and Learning from the Deaths of Children and Young People, which will be supported locally by the establishment of a Child and Young Persons' Governance Group, reporting henceforth annually into the Committee. Via these reports, the Committee took assurance that the relevant services were fully prepared for the impact of these legislative changes, ensuring that patients and service users would receive the highest standards of care required.

4.20 Reports to the Committee have further detailed the revised model for participation and patient engagement put in place to support any service developments or change, such as the remodelling work undertaken in the reporting year around access to Urgent Care. The newly established Participation & Engagement Advisory Group (PEAG) has been highlighted as a potential model for other Boards to follow, as detailed in an update to the Committee in April 2021. The Committee noted the linkage of this work to newly released guidance and statutory duties on 'Planning with People: Community Engagement and Participation Guidance for NHS Boards, IJBs and Local Authorities' for healthcare services, with both workstreams being taken forward across relevant partners in tandem. In July 2021, the Committee received a further

updated on patient feedback on the early stages of Urgent Care redesign activities, noting the steps being taken to address some concerns raised in the consultation exercise, to ensure no specific groups were being disadvantaged by the change to the process. Members welcomed this person-centred focus and reflection on the national service changes being introduced for unscheduled care pathways.

4.21 In July 2021, members considered a proposal for Fife to develop and implement a new East Region Formulary, which aims to reduce variation between local Health Boards and therefore unwarranted variation in the medications prescribed to patients, with uniformity of choice for clinicians. The governance structure to be adopted (with a direct reporting line into the Clinical Governance Committee) was also described. Members supported the programme of work. Also at the July 2021 meeting, an update was given to members on an ongoing incident relating to the National Cervical Screening Programme, where an issue had been identified where some patients had been mis-coded, with the potential for the causation of harm. Assurance was given that locally in Fife clinicians were actively reviewing cases, to identify with urgency any patients thought to be affected. In March 2022, the Committee reviewed NHS Fife's response to a Scottish Government request for information, following the publication of the findings of the independent review of Paediatric Audiology Services in NHS Lothian, which identified a number of failings in timely patient care. The Committee gained assurance that NHS Fife was actively reviewing the learning from the Lothian review, to ensure early diagnosis and the best possible outcomes for new-borns with potential hearing impairment.

4.22 The Committee, along with others of the Board, considered the revised Fife Integration Scheme, recommending the revisions made to the Board, thus enabling its submission to Scottish Government for formal approval. The revised Scheme has enhanced clarity around the responsibilities and accountabilities of NHS Fife, Fife Council and Fife Integration Joint Board for clinical and care governance and the professional roles held by the Executive Nurse Director, the Executive Medical Director and the Chief Social Work Officer. The formal sign-off by Scottish Government was achieved in March 2022.

4.23 Annual reports were received on the subjects of the work of the Clinical Advisory Panel; Adult Support & Protection; Fife Child Protection (including an in-year update in July 2021, with a particular focus on the possibly of hidden harm due to the pandemic); Health Promoting Health Service; Immunisation; Nursing, Midwifery & Allied Health Professionals' Assurance Framework; Medical Education; Medical Appraisal & Revalidation; Prevention & Control of Infection; Occupational Staff & Wellbeing Service; Organisational Duty of Candour; Research & Development Strategy & Annual Review; Safer Management of Controlled Drugs; Volunteering; and any relevant Internal Audit reports that fall under the Committee's remit, such as those on Digital & Information Governance arrangements and Manual Handling Training. The findings of the Internal Audit report on the Clinical Governance Strategy & Assurance has also been reviewed in depth, helping provide the background to a refreshed framework and delivery plan, due for finalisation in summer 2022. The Committee has also reviewed the clinical governance-related recommendations of the Annual Internal Audit Report for 2020-21.

4.24 The Committee has received minutes and assurance reports from its three sub-groups, namely the Digital & Information Board, Health & Safety Sub-Committee, and the Information Governance & Security Steering Group, detailing their business during the reporting year. Updates to Terms of Reference and workplans for these groups have also been considered when necessary. As agreed previously, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's April 2022 meeting.

4.25 In reference to the Health & Safety Sub-Committee, whilst Covid has dominated their proceedings, the policy and procedure reviews scheduled for this year have been completed. In November 2020, NHS Fife received a Covid Management 'spot check' visit to the Victoria Hospital site from Health & Safety Executive (HSE) inspectors. The visit resulted in a 'Notice of Contravention' being issued to the organisation with a requirement for actions to be taken around the areas of physical distancing (especially in rest/break areas), records management and training with regard to face fit testing and fit testers, and concerns with changing and locker facilities. Following action to address these recommendations, final confirmation was given in September 2021 that the Notice of Contravention had formally been closed by the HSE. The Sub-Committee have continued to ensure that the Board is meeting all guidance issued around Covid, to ensure the highest levels of protection for staff and patients. Other workstreams considered by the Sub-Committee include oversight of outstanding internal audit points around Manual Handling and Sharps Management and the ongoing recruitment for a new Health & Safety Manager, following the current incumbent's secondment to the Infection Prevention & Control Team.

4.26 The Digital & Information Board has continued to develop the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital & Information Strategy and associated delivery plan. Specifically, this relates to ensuring progress is made with delivering the strategic ambition, relating to year three of NHS Fife's Digital and Information Strategy (2019-2024), and ensuring the maintenance and improvement in performance across Digital & Information technical and operational teams. This work has included consideration of a number of significant and outstanding Internal Audit findings given in previous reports, as well as the action points from previous NIS audits. During the pandemic period, there has been unprecedented change in the areas of digital adoption, for staff, patients and the public in general. This has influenced initiatives such as the national appointment system for Covid vaccinations and the further roll-out and adoption of 'Near Me' virtual appointments. The learning from the pandemic period in particular has highlighted the importance of addressing digital inclusion and inequalities, in addition to maximising digital solutions to tackle the resultant backlog of routine healthcare activities.

4.27 Via a number of updates throughout the year, the Committee were assured that Digital & Information colleagues will take due account of recent learning as the Board continues to deliver the key ambitions of the Digital & Information Strategy, noting that these will be scrutinised and prioritised in accordance with the individual programmes and workstreams of the new organisational strategy. The Digital & Information Board will continue to assess the impact on fixed resource levels across Digital teams, who are now required to run an operate the additional digital capabilities introduced. A revised engagement model has been established, which ensures the correct level of clinical and leadership engagement with digital developments, including the prioritisation of projects reflecting clinical effectiveness and safety issues, to help manage excess demand. The removal of legacy and unsecured systems remains an area of priority, given the high rating of the cyber-security threat level for the public sector that was evident throughout 2021-22. The annual Assurance Statement of the Digital & Information Board provides further detail on the Group's activities and will be considered by the Committee at its May 2022 meeting.

4.28 In relation to specific Digital enhancements, the Committee has received updates on the hospital electronic prescribing and medicines administration system (HEPMA) being introduced in Fife. Contractual negotiations did not proceed as planned, which has delayed the project considerably from its original due date. However, the Committee received assurance that the transformational benefits of the introduction of HEPMA remain undiminished and a new procurement process has begun to move this work forward.

4.29 The Clinical Governance Committee has also considered updates from the Information Governance & Security Steering Group, which has been restructured and refocused on priorities and areas of greatest risk. The Group has reviewed reports detailing the current baseline of performance and controls within the remit of the Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement in data availability and reporting is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. The Group have adopted a set of performance measures and a workplan has been introduced, with projects and deliverables associated across outcomes per quarter. This, in turn, brings assurance to support a strong baseline of performance in the area of Information Governance & Security, with improvement against key controls to better measure performance. Throughout the year, the Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, which averaged 26 in number over the year, supported the critique and assurance the Group were able to offer. Internal Audit have now reduced the level of risk associated with Information Governance & Security compliance and there are no issues identified that require disclosure within the Governance Statement, which is testament to improvements made, including in the Group's reporting to the Clinical Governance Committee and the Executive Directors' Group.

4.30 An annual statement of assurance has also been received and considered from the Clinical & Care Governance Committee of the Integration Joint Board, detailing how Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility.

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

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2021/22.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF) in the areas of Quality & Safety, Strategic Planning and Digital & Information. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to Covid have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care, service delivery and vaccination during peaks of activity during the pandemic.

6.2 During the year, in relation to Quality & Safety, the Committee has specifically considered the overall component of this BAF, along with linked operational risks. In July 2021, it was agreed

that a larger scale review of the Board's risk management processes were required, to ensure that each Committee had a realistic and dynamic understanding of the risks relevant to their particular remits. Members supported the planned programme of improvement work going forward with the Board Assurance Framework (this work is planned to conclude in summer 2022). In November 2021, the Committee reviewed revised wording for the Quality & Safety risk, to ensure this was an accurate reflection of what the risk profile is presently. Additionally, it has been agreed that the active consideration of patient safety deteriorating due to increased waiting times will be reflected in the updated Quality & Safety BAF. Further work has been undertaken to review whether the linked risks and descriptions within the BAF are appropriately strategic, with the proposed removal of those deemed operationally. An additional update on these enhancements was provided to the Committee at its March 2022 meeting. This work will proceed in tandem with the organisation risk management review being led at Board-level.

6.3 The Committee recognised that further work is required around the reporting of risks related to transformation programmes, noting that the ongoing strategy review will bring an overall focus and direction to a number of hitherto individual strands of work. In relation to the Strategic Planning BAF, the core risk has been reviewed to clearly reference the development and the delivery of the Population Health & Wellbeing Strategy and to focus this at a more strategic level. New wording was agreed for this particular risk, which highlights the key role of the Board's governance committees in shaping and influencing strategy development, and thus scrutinising progress delivery once a new strategy has been agreed. Updates have been given to the Committee on the Strategic Planning & Resource Allocation process for 2022-23, now in its second year of operation, which has linkages to the overall Remobilisation / annual financial and workforce planning and definition of Corporate Objectives. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year.

6.4 In relation to Digital & Information risks, the alignment of risks to the two revised governance groups (the Digital & Information Board and the Information & Security Steering Group) has been progressed. Colleagues have worked closely with the Risk Manager and Internal Auditors to pilot a revised BAF for this area, to reflect core operational, strategic and information security risks critical to the organisation and enhanced framing within the overall Digital Strategy. A number of risks have heightened during the year, including those related to the overall cyber threat landscape and the potential for financial costs to increase due to the new nationally negotiated licensing deal for software. It has been recognised that financial prioritisation has to take place, to address those areas that are essential to support the Digital & Information Strategy.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

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

confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

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

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in another most challenging year, set against the ongoing backdrop of the Coronavirus pandemic. All Committee members and I continue to be astounded and humbled by the efforts made by NHS Fife and Fife Health & Social Care staff at what continues to be a difficult period of exceptional demand on our Acute and community services. We all remain in their debt.

Signed: Christina Cooper Date: 29 April 2022

Christina Cooper, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS Fife Clinical Governance Committee Attendance Record
1 April 2021 to 31 March 2022

	30.04.21	07.07.21	02.09.21	17.09.21	03.11.21	13.01.22	10.03.22
Members							
C Cooper, Non-Executive Member **(Chair)**	P	P	P	P	P	P	P
M Black, Non-Executive Member	P	P	P	P	P	P	P
S Braiden, Non-Executive Member	P	P	P	P	P	P	P
W Brown, Area Partnership Forum Representative	X						
S Fevre, Area Partnership Forum Representative		P	P	P	P	X	P
Cllr D Graham, Stakeholder Member, Fife Council	P	P	P	P	X	X	X
R Laing, Non-Executive Member	X	P	P	X	P	P	P
A Lawrie, Area Clinical Forum Representative	X	P	X	P	P	X	X
C McKenna, Medical Director **(Exec Lead)**	P	P	X	P	P	P	P
D Milne, Director of Public Health	P						
J Owens, Director of Nursing	P	P	P	P	P	P	P
C Potter, Chief Executive	X	P	P	P	P	X	P
J Tomlinson, Director of Public Health		P	P	P	P	P	P Item 1 – 8.1
M Wells, Non-Executive Member	P	P					
A Wood, Non-Executive Member					P	P	P
In Attendance							
H Bett, Senior Manager Children's Services Project	P Item 9.2						P Item 8.6
N Beveridge, Head of Nursing	P						
S Blair, Consultant in Occupational Medicine							P Item 10.2
L Campbell, Associate Director of Nursing	X	P	P	X	P	P	X
N Connor, Director of H&SC	X	P	X	x	P	P	X
L Cooper, Immunisation Programme Director			P		P Item 5.2		
G Couser, Associate Director of Quality & Clinical Governance	P	P	X	P	P	P	P

APPENDIX 1

	30.04.21	07.07.21	02.09.21	17.09.21	03.11.21	13.01.22	10.03.22
B Davis, Head of Primary & Preventative Care			P				
E Curnock, Deputy Director of Public Health		P					
C Dobson, Director of Acute Services	P	P	P	x	P	P	x
L Douglas, Director of Workforce			P				
F Forrest, Interim Deputy Director of Pharmacy							P
S Fraser, Associate Director of Planning & Performance	P	P	P	x		P	
S Garden, Director of Pharmacy & Medicines (to March 2022)	P	x	P	P	P	x	
A Graham, Director of Digital & Information	x	P	P	P	P	x	P
B Hannan, Director of Pharmacy & Medicines (from March 2022)		P				P	x
H Hellewell, Associate Medical Director, H&SCP	P	P	x	P	x	x	x
G MacIntosh, Head of Corporate Governance & Board Secretary	P	P	P	P	P	P	P
N McCormick, Director of Property & Asset Management			P	P		P	
M McGurk, Director of Finance & Strategy	x	P	x	P	P	P	P
A McKay, Deputy Chief Operating Officer				P			P
F McKay, Divisional General Manager				P			
M Michie, Deputy Director of Finance & Strategy			P				
J Morrice, AMD, Women & Children Services	P	x	x	x	P	x	x
E Muir, Clinical Effectiveness Co-ordinator	P	P	x	P	P	x	P
M Wood, Interim Associate Medical Director for Surgery, Medicine & Diagnostics						P	P

Best Value Framework

Vision and Leadership

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

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

GOVERNANCE AND ACCOUNTABILITY

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

OVERVIEW

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

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

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

USE OF RESOURCES

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

OVERVIEW

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

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

PERFORMANCE MANAGEMENT

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

OVERVIEW

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

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

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

CROSS-CUTTING THEME – EQUALITY

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

OVERVIEW

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

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

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

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**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 Clinical Governance 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

This paper provides an update on the information presented to the Committee on 10 March 2022.

The Committee has a vital role in scrutinising the risks and where indicated, the Committee chair will seek further information from risk owners.

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.

Update on the Review of the Quality and Safety BAF

Progress of the review is set out below.

BAF Risk Description

Following approval at the Committee on 10/03//22, the risk description has been updated. See Appendix 1.

Linked Risk Changes

The following changes are reported since the last report to the Committee:

Risks unlinked from the BAF

Risk 43: Vascular Access for Haematology/Oncology: Following discussion at the last Committee, and subsequently with the Director of Acute Services, this risk has been unlinked from the BAF. It will remain on the Emergency Care Directorate and Acute Services Division risk registers, with oversight and management provided through the Acute Services Division governance structures.

Risk 1365: Cancer Waiting Times Access Standards: As previously reported to the Committee, this risk has materialised. It has been closed and unlinked from the BAF.

Risks newly linked to the BAF

Risk 2297: Cancer Waiting Times Access Standards: This redefines the risk associated with performance against the Cancer Waiting Times 62-day target and replaces risk 1365.

Risk 2214: Nursing and Midwifery Staffing Levels: This risk is currently linked to the Workforce Sustainability BAF. Following discussion at EDG in February 2022, and further to acceptance of the proposal within Item 6.4 - SBAR Board Assurance Framework - Quality & Safety to the Committee on 10/03/22, in view of the material impacts on patient safety, the Director of Nursing has confirmed that this risk should also be linked to the Quality & Safety BAF.

Risk 1904: Coronavirus Disease 2019 (COVID -19): Following discussion at EDG in February 2022, and further to acceptance of the proposal within Item 6.4 - SBAR Board Assurance Framework - Quality & Safety to the Committee on 10/03/22, the Director of Public Health has confirmed that this risk should be linked to the Quality & Safety BAF.

Risk 1907: Public Health Oversight of COVID -19 in Care Homes: As above, following discussion at EDG in February 2022, and further to acceptance of the proposal within Item 6.4 - SBAR Board Assurance Framework - Quality & Safety to the Committee on 10/03/22, the Director of Public Health has confirmed that this risk should be linked to the Quality & Safety BAF.

Appendix 2 provides details of all linked risks.

Update on Recommendations Previously Presented to the Committee

The Committee previously considered recommendations on risks that should be linked to the Quality & Safety BAF, including a redefined risk around Unscheduled Care.

Since the last report to the Committee, a decision has been taken to replace the BAF with a Corporate Risk Register as outlined in the Risk Management Framework Refresh paper provided separately to members.

The work to confirm risks relating to quality and safety for possible inclusion in a Corporate Risk Register, including an Unscheduled Care risk, is being taken forward in the first instance, through discussions with Senior Leadership Teams. The outputs will then be submitted to EDG and the Standing Committees for consideration and approval. It is intended that risks relating to quality and safety on which this Committee requires assurance, will be reported in the new format to the next meeting on 1 July 2022.

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

There are no equality and diversity issues associated with this BAF.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed through discussions with the Associate Director of Quality and Clinical Governance, the Risk Manager, the Medical Director, the Director of Nursing, and the Director of Public Health.

2.3.8 Route to the Meeting

As at 2.3.7 above.

2.4 Recommendation

The Quality & Safety BAF is presented to the Clinical Governance Committee for assurance.

3 List of appendices

Appendix 1, NHS Fife Board Assurance Framework (BAF) Quality & Safety to NHS Fife CGC 290422 V1.0

Appendix 2, BAF Risks - Quality & Safety - Linked Operational Risks to NHS Fife CGC 290422 V 1.0

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NHS Fife Board Assurance Framework (BAF)

Risk ID	Corporate Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	10 March 2022	29 April 2022	There is a risk that due to failure of clinical governance, performance and management systems (incluing information and information systems), NHS Fife may be unable to provide safe,effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* 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 3/4 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 30.Organisational Learning Group established in August 2021	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. Adverse Event improvement Programme now underway. 3.Weaknesses in related oversight and monitoring processes at operational level 4. Risk Management Framework requires review, update & plan for implementation Risk Management Framework eview and improvement programme now underway. Review and update of Clinical and Care Governance Framework is now underway.	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 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	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 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

organisational themes

17. Further develop and monitor implementation of NHS Fife governance and reporting structure for the review of deaths of children 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
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
1904	Coronavirus Disease 2019 (COVID-19) Pandemic	Active Risk	High Risk	16	Tomlinson, Joy
2297	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1907	Public Health Oversight of COVID-19 in Care Homes	Active Risk	High Risk	15	Tomlinson, Joy

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
43	Vascular access for haematology/Oncology	Active Risk	High Risk	16	Shirley - Anne Savage
528	Pandemic Flu Planning	Active Risk	Moderate Risk	12	Brown, George
637	SAB LDP standard	Active Risk	Moderate Risk	9	Cook, Julia
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
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
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
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
2214	NHSFBD - Nursing Directorate Risk Register	21/10/2021	Nursing and Midwifery Staffing Levels	There is an established and continuing risk that safe nursing and midwifery levels cannot be achieved. NHS Fife is experiencing critical nursing and midwifery shortfalls, similar to other Boards across NHS Scotland. Vacancy rates, sickness absence levels and high activity related to consequences of the pandemic are aligned to the unprecedented demand on clinical services and on nursing and midwifery. There continues to be a heavy demand on supplementary staffing. Impact on quality of care remains a consequential concern.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	08/04/22: No change to current management actions + focus on band 2 - 4 workforce, career framework. Band 4s will be vital in supporting Registrants. Link with NES. 3/02/2022: 1. NURSING AND MIDWIFERY WORKFORCE PLANNING GROUP continues to drive nursing and midwifery workforce planning and development activity across NHS Fife. The Group is responsible for over-seeing the implementation of the Health and Care (Staffing) (Scotland) Act 2019, nursing and midwifery recruitment and retention, and supplementary staffing. 2. RECRUITMENT ACTIVITY: 2.1 NQPs: Uni of Dundee recruitment fair being attended by NHS Fife senior nurses to attract 3rd year students who will become NQPs from Sept 22. Again, final placements will be promoted within area of substantive post and band 4 will be offered whilst awaiting NMC PIN. 2.2 NURSE BANK: .Increase in Bank Team resources, supported by the Director of Workforce, which has facilitated increased recruitment. .A recent advert (jANUARY 2022) for non-registered staff yielded significant number of applicants - 125 have been shortlisted for interview. •The Nurse Bank is targeting AHP students for nursing roles 2.3 HCSW RECRUITMENT: A Bronze Group was established under the Workforce Resilience Silver to oversee the recruitment of the Band 2 and Band 3 clinical workforce across NHS Fife. This met the target of recruiting 68WTE, which are support posts, in addition to normal staffing establishments and have come with recurrent funding. Work is also ongoing to develop the band 4 role across NHS Fife. 2.4 INTERNATIONAL RECRUITMENT: This has progressed well with the first IR nurses arriving in 2 weeks. Funding has been given by SG to cover all costs associated, including refurbishment of accommodation. IR Lead has been appointed and the aim is to progress with 10 nurses per month moving forwards, with a view to include midwives once training measures are comparable to UK requirements. 2.5 RECRUITMENT OF WARD ADMIN ASSISTANTS: 44 ward admin assistant	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	Owens, Janette	Robertson, Nicola	08/04/2022	08/07/2022

ID	1904
Position of Risk (Risk Register)	NHSFBD – COVID-19 Risk Register
Opened	20/08/2020
Title	Coronavirus Disease 2019 (COVID-19) Pandemic
Description	As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality in the Fife population due to a lack of immunity to this novel disease. This could result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease (including death) in a minority of the population, particularly among the elderly and those with underlying health risk conditions. The potential impacts for NHS Fife include increased deaths, increased pressure on healthcare and support services affecting service delivery, reduced capacity for non-urgent services, disruption to supply chains and high levels of employee absence due to personal illness and caring responsibilities.
Likelihood (initial)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	5 - Extreme
Risk level (initial)	High Risk
Rating (initial)	25
Current Management Actions	Update agreed at PHAC on 09/02/22 J Tomlinson: Community transmission rates plateaued in late January and worst case modelling predictions have not been fulfilled. Over 80% of the eligible adult population have received booster vaccination doses. Testing and contact tracing remain in place and there is greater awareness of infection prevention control measures across the population. There are new treatments available for those individuals at higher risk of adverse outcomes. Change to Risk Level: consequence from 5 to 4 and likelihood from 5 to 4.
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	4 - Major
Risk level (current)	High Risk
Rating (current)	16
Likelihood (Target)	4 - Likely - Strong possibility this could occur
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	12
Risk Owner	Tomlinson, Joy
Handler	Nealon, Sarah
Previous Review Date	09/02/2022
Next Review	08/04/2022

ID	2297
Position of Risk (Risk Register)	Acute Services - ACUTE SERVICES DIVISION RISK REGISTER, NHSFBD - Cancer Services Risk Register, NHSFBD – COVID-19 Risk Register
Opened	25/03/2022
Title	Cancer Waiting Times Access Standards
Description	In view of increasing patient referrals and complex cancer pathways there is a risk that NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standard.
Likelihood (initial)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	3 - Moderate
Risk level (initial)	High Risk
Rating (initial)	15
Current Management Actions	25/03/2022 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 SG Effective Cancer Management Framework which is due to be rolled out November 21 with SG visit being arranged. Contributing to national discussions with collaborative working with Boards through Cancer Managers' Forum. Regular review of the Data & Definitions (D&D) Manual to ensure up to date and appropriate waiting times adjustments are consistently applied across Scotland. The Cancer Strategy and Governance Group is now overseeing local performance and taking forward the Cancer Recovery Plan. A 3 year Cancer Framework and delivery plan will be launched for 2022-23. A key cancer commitment is optimal and timed cancer pathway review. An Acute Cancer Services Delivery Group has been established to provide operational oversight and management of CWT performance. including improvement activities
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	3 - Moderate
Risk level (current)	High Risk
Rating (current)	15
Likelihood (Target)	4 - Likely - Strong possibility this could occur
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	12
Risk Owner	Dobson, Claire
Handler	Nicoll, Kathleen
Previous Review Date	25/03/2022
Next Review	15/06/2022

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
1296	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register	22/08/2016	Emergency Evacuation, VHK Phase 2 Tower Block	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	09/03/2022 - All the doors in ward 10 fire compartment boundary have been inspected and are planned for a repair and replacement programme in March 2022, completion by end of March to be achieved	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	McCormick, Neil	Ramsay, Jimmy	09/03/2022	31/05/2022
1907	NHSFBD – COVID-19 Risk Register	20/08/2020	Public Health Oversight of COVID-19 in Care Homes	As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality. It is recognised that adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. Many are inevitably at greater risk of poorer outcomes if they were to contract COVID-19 due to conditions such as frailty, multiple co-morbidity, pre-existing cardio-respiratory conditions or neurological conditions. Care homes are environments that have proved to be particularly susceptible to Coronavirus and require whole system support to protect residents and staff. The potential impacts for care home include increased morbidity and mortality, increased pressure on care home staff, high levels of employee absence due to personal illness and caring responsibilities. The COVID-19 vaccination has proved to be effective at reducing the most severe impacts of the virus. This continues to be monitored closely.	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25	Update agreed at PHAC on 09/02/22 provided by F Bellamy: No change to risk management or rating. Risk of infection in the wider community remains high, this, alongside new emerging variants of the virus therefore care home residents remain a vulnerable population group. We are still not yet in a position to fully understand the impact of the 3rd dose of vaccination for residents and care home staff against new and emerging strains of the virus. An increase in visiting in care homes as well as trips out of the care home for residents continue which given the rising prevalence may have an impact on cases/outbreaks in care home settings. This remains under regular review. This risk continues to be monitored at the weekly directors care home meeting.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	4 - Likely - Strong possibility this could occur	3 - Moderate	Moderate Risk	12	Tomlinson, Joy	Nealon, Sarah	09/02/2022	08/04/2022

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**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 Clinical Governance 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 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 16 March 2022.

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:

No new linked operational risks.

Previously Linked Operational Risks:

No changed to linked operational risks.

Other Changes

Risk 1338 – NHS Fife at increased cyber attack risk

During the reporting period this risk, while remaining high, has seen an increase in the risks current rating score. This is due to the highetened risk of malicious cyber incidents in and around the Ukraine situation

The BAF's 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

Digital & Information 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.

Submission of requirements has been made through the SPRA Process for 2022-23.

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

Executive Directors Group Meeting

2.4 Recommendation

- **Assurance** – the content and current assessment of the Digital & Information BAF is provide to the Group for assurance. The BAF risk remains rated as High Risk.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - BAF Digital & Information March 2022
- 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	11/03/2022	20 May 2022	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	1_HIGH	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	1_HIGH	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	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 and presented via SPRA process 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 Agreed - Phase 2 underway) 2. Organisation to consider the gaps in current operating financial commitments and assessment of financial implementation of Digital Strategy presented through SPRA process. 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Completed - 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 complete (October 2021) Findings presented via SPRA 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	2_MOD/	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
1338	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Active Risk	High Risk	25	Graham, Alistair
885	Digital & Information Financial Position	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	16	Graham, Alistair
1934	Loss of Cloud based Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	16	Graham, Alistair
537	Failure of the Network causing widespread 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
1576	Risk of not meeting Software as a Medical Device full compliance	Active Risk	Moderate Risk	9	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1932	T4 - User error in use of O365 products (including those supporting system)	Active Risk	Moderate Risk	12	Fowles, Malcolm
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1424	End of support lifecycle for Microsoft Server Products	Closed Risk	High Risk	16	Young, Allan
1927	Deliberate unauthorised data access or misuse by insiders (staff, contractors etc.)	Closed Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Closed Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

ID	1338	885
Position of Risk (Risk Register)	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	NHSFBD - Digital and Information Directorate Risk Register
Opened	23/02/2017	31/10/2014
Title	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Digital & Information Financial Position
Description	There is a risk of increased cyber security vulnerability levels because NHS Scotland remains reliant upon legacy systems and versions and the external threat level. Although legacy products will continue to function outside of support lifecycle, there may no longer be patches available for security vulnerabilities identified in these products, require out of lifecycle OS or they rely upon out of date protocols etc.	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.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance	4 - Likely - Strong possibility this could occur
Consequence (initial)	4 - Major	5 - Extreme
Risk level (initial)	Moderate Risk	High Risk
Rating (initial)	12	20
Current Management Actions	11/3/22 Risk rating revised due to NCSC alert relating to Ukraine conflict. Increased levels of general communications. Some specific actions being progressed nationally and requested locally for Boards to undertake. These include Patching, Verify Access controls, review resilience, communications, supply chain awareness, monitor legacy systems Introduction of new technology to support recovery to be implemented by March 2022. Executive presentations, including Audit and Risk Committee (Dec 2021) ongoing. Time frame is now possibly by 31st March 2022 for Microsoft 2007. 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. 7/3/22 - Financial planning for 5 year period included in SPRA process 2022/23. Key priorities to be agreed due to the number of initiatives identified linked to the Digital Strategy and mandated Nationally. Await SPRA outcome.	
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Likely - Strong possibility this could occur
Consequence (current)	5 - Extreme	5 - Extreme
Risk level (current)	High Risk	High Risk
Rating (current)	25	20
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	2 - Minor	2 - Minor
Risk level (Target)	Low Risk	Low Risk
Rating (Target)	4	4
Risk Owner	Graham, Alistair	Graham, Alistair
Handler	Young, Allan	Marshall, Shelley
Previous Review Date	28/02/2022	25/02/2022
Next Review	23/05/2022	09/05/2022

ID	1934	1422	2192
Position of Risk (Risk Register)	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register	NHSFBD - Digital and Information Directorate Risk Register
Opened	08/09/2020	19/02/2018	15/09/2021
Title	Loss of Cloud based Email & Collaboration Services	Unable to meet NIS & Cyber Essentials compliance	Risk that Digital & Information Service Management activities are not aligned to ITIL
Description	There is a risk that NHS Fife users and services could be prevented from using Email and Collaboration solutions (such as Teams / SharePoint), also online MS Office Products due to a loss of connectivity to the Internet or Microsoft Azure Infrastructure, resulting in a negative impact upon services, collaboration and communication.	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.	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
Likelihood (initial)	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	4 - Major	4 - Major	4 - Major
Risk level (initial)	High Risk	High Risk	High Risk
Rating (initial)	16	20	20
Current Management Actions	February 2022 - Situation continues to be monitored. Work continues to find funding for secondary Internet connectivity.	11/3/22 - Action plan being progressed in line with NISD recommendations / priorities using appropriate resources vs run commitments. Plan presented to IG&S Operational and Steering Group meetings for scrutiny and assurance. Pressure also being put on suppliers heedless of lifecycle management.	7/3/22 - Cost benefit analysis agreed at the Digital and Information Board - October 2021. Recruitment of key roles (within Budget) underway. ITIL standards for all IT service management areas e.g. Labs and Radiology - through reinstatement of Labs/Digital Meetings Consider the opportunity presented through the implementation of Service Now supports improved change management processes
Likelihood (current)	4 - Likely - Strong possibility this could occur	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	4 - Major	4 - Major	4 - Major
Risk level (current)	High Risk	High Risk	High Risk
Rating (current)	16	16	20
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	3 - Moderate	4 - Major	3 - Moderate
Risk level (Target)	Low Risk	Moderate Risk	Low Risk
Rating (Target)	6	8	6
Risk Owner	Young, Allan	Graham, Alistair	Graham, Alistair
Handler	Fowles, Malcolm	Young, Allan	Young, Allan
Previous Review Date	11/03/2022	28/02/2022	11/03/2022
Next Review	23/06/2022	23/05/2022	26/05/2022

ID	1996	537
Position of Risk (Risk Register)	NHSFBD - Digital and Information Directorate Risk Register	NHSFBD - Digital and Information - Information Technology Risk Register, NHSFBD - Digital and Information Directorate Risk Register
Opened	17/11/2020	02/05/2006
Title	Office 365 - Unknown Financial Consequence and so risk to licence availability	Failure of the Network causing widespread loss of access to IT systems
Description	There is a risk that the cost to NHS Fife of adopting M365 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.	There is a risk of localised or widespread extensive and persistent IT network failure caused by failure of any of Local Area Networks, Wide Area Network connections 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.
Likelihood (initial)	4 - Likely - Strong possibility this could occur	3 - Possible - May occur occasionally - reasonable chance
Consequence (initial)	4 - Major	5 - Extreme
Risk level (initial)	High Risk	High Risk
Rating (initial)	16	15
Current Management Actions	7/1/22 - Revised internal governance arrangements established - M365 Programme Board - included clear establishment of NHS Fife Phase 2 and Business Case requirement for Phase 3 Additional representation on national governance groups from NHS Fife team members Business Case for future Phase in development - March 2022	7/3/22 - Additional funding received from SG to allow some replacement and upgrade of Network infrastructure to take place. Orders placed and wait for delivery and installation of equipment. Longer term financial plan provided to FCIG.
Likelihood (current)	4 - Likely - Strong possibility this could occur	3 - Possible - May occur occasionally - reasonable chance
Consequence (current)	4 - Major	5 - Extreme
Risk level (current)	High Risk	High Risk
Rating (current)	16	15
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists	1 - Remote - Can't believe this event would happen
Consequence (Target)	1 - Negligible	5 - Extreme
Risk level (Target)	Very Low Risk	Low Risk
Rating (Target)	2	5
Risk Owner	Graham, Alistair	Young, Allan
Handler	Granger, Claire Louise	Fowles, Malcolm
Previous Review Date	11/03/2022	11/03/2022
Next Review	13/05/2022	16/06/2023

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Risk Management Improvement Programme Update**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance and Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper sets out a record of the progress made since the risk management improvement programme was approved by the NHS Fife Board in March 2022.

2.2 Background

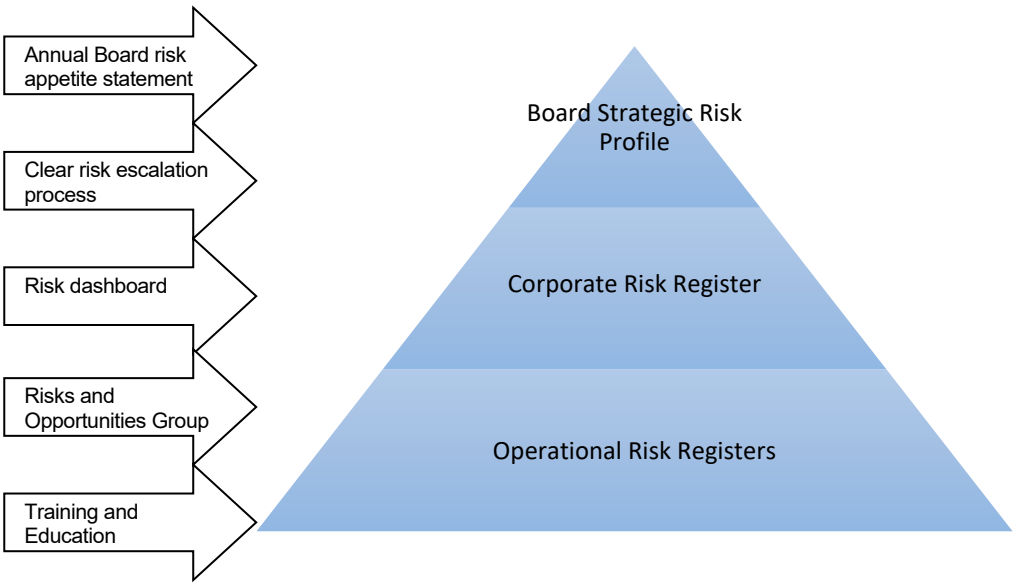
NHS Fife is committed to delivering this agreed improvement programme in relation to risk management.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach is paramount in supporting the organisation to achieve strategic priorities. The objective is to deliver:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

The current Risk Management Framework will be replaced with the following structure:



A summary of the Risk Management Improvement plan is summarised below:

	Workstream	Description/ Actions	Status update	By when
1	Board Strategic Risk Profile	Development of a risk profile against our strategic priorities: 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	Initial feedback has indicated the requirement to include environmental sustainability and inequality risks. Work is underway to develop these risks.	Draft complete (see Appendix 1)
2	Corporate Risk Register to replace Board Assurance Framework	A Corporate Risk Register (CRR) - contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate*. The register will be routinely reviewed and monitored by Executive Directors. The CRR will be comprised of the following components: 1. Clinical Quality and Safety 2. Property and Infrastructure (including Digital and Information) 3. Workforce 4. Finance There will be a containment of number of risks on the CRR to ensure focus and impact Engagement sessions will be held in April and May with Senior Leadership Teams (SLT) for Acute Services, Health & Social Care Partnership, Workforce, Finance, Pharmacy, Medical Director's Directorate (including Digital and Information and Research & Development), Property	Risks for inclusion in CRR are being identified through discussions with SLTs; review of existing risks; and identification of new risks which meet criteria*. Engagement sessions planned. Meetings are underway.	June 2022

		and Asset Management , Public Health and the Nursing Directorate. Sessions will include the review of risks to clarify strategic risks v corporate risks v operational risks. A FORMS questionnaire to be issued to EDG members to complete on behalf of their SLTs. Questions cover the focus of team discussions about risk, their use of risk information e.g.to inform decision making or plan services, and the support that teams need to effectively manage risk including education and training. Feedback will be used to develop an effective and visible framework that connects with and is used by staff from ward to board.	FORMS questionnaire issued March 2022.	
3	Risk Dashboard	This will support a proactive risk management culture that is integral to performance and quality management. The dashboard will align to the refreshed Integrated Performance & Quality Report (IPQR) and will include metrics related to corporate risks. Purpose: • Enable oversight of risk level of corporate risks • Provide assurance that adequate controls are in place to proactively manage risks • Align to improvement actions contained within the IPQR • Integrate with Key Performance Indicators (KPIs) & Quality Performance Indicators (QPIs) • Risk is linked to an assurance committee Principles: • Provide simple, visual high level overview for	An outline of proposed risk content for the IPQR is in development and will be submitted to EDG as part of an update paper on the IPQR review.	May 2022

		assurance • Weave risk management into business as usual (BAU) • Corporate risks will be contained and regularly scrutinised The dashboard will capture current and target risk levels, related improvement or deterioration, and consider risk mitigation and anticipated timescales to achieve risk reduction. For risks which are deteriorating, it is proposed a 'deep dive' summary profile will be provided. It is proposed that risk content is integrated as follows: • The dashboard features at the start of the IPQR before the Indicator Summary • Narrative related to the risks is woven into respective components of IPQR		
4	Escalation Process	All staff throughout the organisation have a responsibility for identifying risk. To ensure that risks are managed effectively, they must be escalated to the appropriate levels in the organisation and to external stakeholders where necessary. Directors will have overall responsibility for establishing effective risk escalation procedures supported by: • Risk reviews • Governance group risk reviews; and Risk Leads who chair the Management Groups and provide advice on risk under the following broad categories :Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance	Being developed for submission to EDG in May 2022	June 2022

		• EDG review risks and escalate to the Board any strategic risks **ESCALATION PROCESS** This will include consideration of the following: EDG • Discuss risk at EDG or proposed Risk & Opportunities Group • Develop action plan • Manage through risk register and Directorate or equivalent Management Group Executive Risk Owner • Can this risk be managed with directorate? • Does the risk impact on the wider organisation? • Share with EDG Line Manager, Risk Owners, Portfolio, Project and Programme leads • Can this risk be managed locally? • Is the risk on the register? • Who is the risk owner? Other directorate? Escalate to appropriate Directorate senior manager • Escalate to Executive risk owner All Staff • Can the risk be managed as part of Business As Usual (BAU)? • What is the impact and likelihood of the risk? • Escalate to line manager		

5	Risks and Opportunities Group	A Risks and Opportunities Group will be established. This will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. The Group's broad remit is expected to: • Provide leadership to ensure the organisation gives risk management the appropriate priority; and facilitates and delivers effective risk management arrangements • Promote effective risk management and seek opportunity for the organisation • Link risks and opportunities to the strategic objectives of the organisation • Review aggregation of risk across the organisation to determine the most appropriate response on behalf of the whole organisation • Based on changing risk levels, provide beneficial direction / focus to the assurance functions • Horizon scan for future opportunities, threats and risks aligned to the strategic priorities • Ensure continuous improvement of the internal control environment	Terms of Reference are being drafted and will be presented to EDG in May 2022	August 2022

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will support the further development of the quality and patient safety agenda through improved operational governance and strategic planning.

2.3.2 Workforce

There is a requirement to ensure that the appropriate workforce is in place to support the changes to the framework including updates to the Datix system. Arrangements for this are currently being explored.

The refresh of the Risk Management Framework will also include a training needs analysis to design an effective training and education strategy to support this change.

2.3.3 Financial

Once the workforce arrangements to support this change are confirmed an update to summarise the financial impact will be provided.

2.3.4 Risk Assessment/Management

This paper summarises actions to enable NHS Fife to progress an effective risk management framework and culture to support the achievement of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

None

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with key stakeholders.

2.3.8 Route to the Meeting

An earlier version of this paper was considered and supported by:

- EDG, 17 February 2022
- Audit & Risk Committee, 17 March 2022
- Fife NHS Board, 29 March 2022

2.4 Recommendation

The Committee is asked to take assurance from this update on the plan to refresh and improve the Risk Management Framework.

Report Contact
Gemma Couser
Associate Director of Quality and Clinical Governance
Email gemma.couser2@nhs.scot

Appendix 1

DRAFT STRATEGIC PRIORITIES AND RISKS

STRATEGIC PRIORITY	Comments
To Improve Health and Wellbeing	
RISKS	
1.There is a risk that after more than 2 years of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures	
2. There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care; Integrated Planned Care; Place and Wellbeing; and Preventative and Proactive Care.	
3. There is a risk that if the Population Health & Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.	
STRATEGIC PRIORITY	
To Improve the Quality of Health and Care Services	
RISKS	
1. There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information	

security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: o increased clinical risk including healthcare associated infection and deconditioning o reduced number of downstream beds o delayed patient pathways and negative impacts on safe capacity and patient flow o financial and workforce impacts due to the need to open and staff additional beds o increased Emergency Department (ED) attendances o unmet performance targets including those relating to: • 4 hour ED access • patients in delay • waiting times • treatment times • Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm	
3.There is a risk that if we do not implement effective strategic workforce planning (including aligning funding requirements), we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver business as usual services, respond to the ongoing challenges of COVID-19, and implement necessary transformation, resulting in sub optimal delivery, reputational harm, and further impacts on staff wellbeing and recruitment / retention rates.	
4. There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation including Cyber Essentials	

and Network & Informations Systems Regulations, and future proofed as far as reasonable and practicable.	
STRATEGIC PRIORITY	
To Improve Staff Experience and Wellbeing	
RISKS	
1. There is a risk that because of current pressures and capacity challenges, staff may be unable to fully engage with the development of the Population Health and Wellbeing Strategy which underpins our aspiration to be an Anchor Institution i.e. one that positively influences the health and wellbeing of our communities. This may result in a strategy which does not: • recognise staff opinions and experiences • reflect staff values and motivations • reinforce the vital contribution of staff to creating a listening and learning organisation • relate to staff understanding of how we will achieve our ambition to develop and deliver a person-centred health and care system that reduces health inequalities and improves health and wellbeing for all citizens across Fife	
2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in result in: • sub optimal working relationships • staff feeling isolated • reduced staff resilience • increased staff absence • impact on safety and quality of patient care and services	
3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in: • staff feeling unsupported and vulnerable due to not having the correct competencies • reduced staff resilience • reduced job satisfaction • negative impacts on role performance and the safety and quality of patient care and services • reputational damage	

• impacts on retention and recruitment rates	
STRATEGIC PRIORITY **To Deliver Value and Sustainability**	
RISKS	
1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.	
2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.	
3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may: • affect compliance with statutory obligations in relation to environmental & sustainability legislation • limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand • impede delivery of the Population Health and Wellbeing Strategy	

CLINICAL GOVERNANCE COMMITTEE
PROPOSED ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Covid-19 Update							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
General Covid-19 Update	**Director of Public Health**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Assurance Statements from sub-committees	**Board Secretary**	✓					
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg – CGOG not met yet**	✓				✓
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Board Assurance Framework - Quality and Safety	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Board Assurance Framework - Strategic Planning	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓	✓	✓	✓	✓	✓

Governance Matters (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Board Assurance Framework - Digital and Information	**Medical Director**	✓	✓	✓	✓	✓	✓
Strategy / Planning							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Clinical Governance Framework	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg**	✓				✓
Clinical Governance Framework Delivery Plan	**Medical Director / Associate Director of Quality & Clinical Governance**				✓		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓			✓		
Cancer Strategy	**Medical Director**					**TBC**	
Data Loch	**Medical Director / Associate Director for Research, Development & Innovation**	**Deferred to next mtg**	✓				
Emergency / Resilience Planning	**Director of Public Health**	✓	✓				
Governance of Advanced Practitioners	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**				✓		
Redesign of Urgent Care	**Medical Director**				✓		✓
Strategic Planning Resource Allocation (RMP 2022/23)	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Postponed (awaiting national guidance)**	✓ **TBC**	✓			
Quality / Performance							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Winter Plan / Winter Performance Report	**Associate Director of Planning & Performance**	✓			✓	✓	✓

Quality / Performance (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Safer Management of Controlled Drugs	**Director of Pharmacy & Medicines**			✓			
Digital / Information							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Digital and Information Strategy Update	**Medical Director / Associate Director of Digital & Information**		✓			✓	
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓		
Annual Reports							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Adult Support & Protection Annual Report *(also goes to PHWC)*	**Director of Nursing**					✓	
Annual Review of Deaths of Children & Young People	**Director of Nursing/Associate Director of Quality and Clinical Governance**						✓
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Digital and Information Annual Report	**Medical Director**		✓			✓	

Annual Reports (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Director of Public Health Annual Report (also goes to PHWC)	**Director of Public Health**	**Deferred to next mtg (due to timings)**	✓				✓
NHS Fife Equality Outcomes Progress Report	**Director of Nursing**	✓					
Fife Child Protection Annual Report	**Director of Nursing**					✓	
Integrated Screening Annual Report *(also goes to PHWC)*	**Director of Public Health**			✓			
Medical Education Report	**Medical Director**	**Deferred to next mtg**	✓				
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework	**Director of Nursing**		✓				✓
Organisational Duty of Candour Annual Report	**Medical Director**				✓		
Participation & Engagement Report *(also goes to PHWC)*	**Director of Nursing**		✓		✓		
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Quality Framework for Participation & Engagement Self-Evaluation	**Director of Nursing**			✓			
Linked Committee Minutes							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Acute Services Division Clinical Governance Committee	**Acute Services Director**	23/03 **Mtg cancelled**	✓ 18/05	✓	✓ 20/07	✓ 16/11	✓ 18/01

Linked Committee Minutes (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Area Clinical Forum	**Chair of Forum**	✓ 03/02 & 07/04	✓ 09/06	✓ 04/08	✓ 06/10	✓ 01/12	✓ 02/02
Area Medical Committee	**Medical Director**	✓ 08/02	✓ 12/04	✓ 14/06	✓ 09/08	✓ 11/10	✓ 13/12
Area Radiation Protection Committee	**Medical Director**	✓ 02/03			✓ 31/08		
Cancer Governance & Strategy Group	**Medical Director**	✓ 01/04	✓ 03/06	✓ 19/08		✓ 04/11	
NHS Fife Clinical Governance Oversight Group	**Medical Director**	✓ 15/02	✓ 19/04	✓ 14/06	✓ 16/08	✓ 18/10 & 06/12	
Digital & Information Board	**Medical Director**		✓ 19/04	✓ 28/07	✓ 18/10		
Fife Drugs & Therapeutic Committee	**Medical Director**	✓ 09/02	✓ 27/04	✓ 22/06	✓ 24/08 & 12/10	✓ 07/12	
Fife IJB Clinical & Care Governance Committee	**Associate Medical Director**	✓ 04/03	✓ 26/04	✓ 05/07	✓ 09/09	✓ 08/11	
Health & Safety Subcommittee	**Chair of Sub-Committee**	✓ 11/03	✓ 10/06		✓ 09/09	✓ 09/12	
Infection Control Committee	**Director of Nursing**	✓ 02/02 06/04 **mtg cancelled**	✓ 08/06	✓ 03/08	✓ 05/10	✓ 05/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**			✓ Date tbc			
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 04/03	✓ 08/04	✓ 06/07	✓ 04/11		✓ 10/01
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 31/03	✓ 24/05	✓ 31/08		✓ 24/11	

Ad Hoc Items							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Neonatal Adverse Events Update	**Medical Director**	✓					
Early Cancer Diagnostic Centre (ECDC)	**Medical Director**	✓					
RMP4 Update	**Associate Director of Planning & Performance**	✓					
Edinburgh Cancer Centre Reprovision-Regional Service Model	**Associate Director of Quality & Clinical Governance**	Private Session					
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Proposed Corporate Objectives 2022/2023**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Authors:	**Margo McGurk, Director of Finance & Strategy, Linda Douglas, Director of Workforce**

1 Purpose

This paper sets out the proposed corporate objectives for 2022/23.

This is presented to the Clinical Governance Committee for:

- Endorsement and Assurance

This report relates to:

- Annual Operational Plan
- Government policy/directive
- 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 committee requires to consider the corporate objectives annually, these objectives have been derived from the SPRA process and will inform the Annual Operational Plan or RMP for 2022/23.

2.2 Background

This is the second year of the SPRA process and the joint consideration of corporate objectives across the organisation and directorate functional areas.

2.3 Assessment

The corporate objectives of any organisation normally reflect the in-year, highest level actions which will inform the objectives of the Chief Executive. In that context, this paper

proposes a refinement of the SPRA generated objectives to reflect those at that corporate level. This is our second year of generating our corporate objectives in this way and we continue to develop and embed this process.

The corporate objectives are linked to one of the 4 NHS Fife agreed strategic priorities, there may be a number which span more than one however they have been initially linked to what is considered to be the “primary” strategic priority.

In setting corporate objectives it is important to ensure individual director role clarity within the executive team. The lead roles have been confirmed through EDG discussion. Directors will determine the allocation of the other roles and confirm this by the end of April. The table below sets out the categories of involvement proposed (LSCI).

Lead - Executive Lead, accountable for delivery of objective
Critical - critical role in supporting the delivery of objective
Supporter - actively engaged in supporting those with executive lead and others with critical roles
Informed - not actively involved in delivery of objective but informed and supportive.

Annex 1 presents 25 corporate objectives for Committee consideration.

2.3.1 Quality/ Patient Care

NHS Fife corporate objectives link directly to the strategic priorities to either “Improve Health and Wellbeing” or “Improve the Quality of Health and Care Services”.

2.3.2 Workforce

NHS Fife corporate objectives link directly to the strategic priority to “Improve Staff Experience and Wellbeing”.

2.3.3 Financial

NHS Fife corporate objectives link directly to the strategic priority to “Deliver Value and Sustainability”.

2.3.4 Risk Assessment/Management

Each corporate objective has an appropriate risk and opportunities assessment as detailed through the SPRA process.

2.3.5 Equality and Diversity, including health inequalities

Each corporate objective either has a completed Impact Assessment or is in the process of completing one.

2.3.6 Other impact

Each corporate objective has a range of impacts which are documented through the SPRA process.

2.3.7 Communication, involvement, engagement and consultation

Directors have been involved in the SPRA process which has generated this initial proposal.

2.3.8 Route to the Meeting

EDG reviewed and approved the corporate objectives on 21 April 2022.

2.4 Recommendation

The committee is asked to consider and endorse the corporate objectives.

3 List of appendices

The following appendices are included with this report:

- Annex 1, Draft Corporate Objectives.

Report Contacts

Margo McGurk Director of Finance & Strategy Email margo.mcgurk@nhs.scot	Linda Douglas Director of Workforce

Annex 1 : Proposed Corporate Objectives

	NHS FIFE STRATEGIC PRIORITIES - *(Objectives are linked to a primary strategic priority but will contribute directly and indirectly to others)*								
	To Improve Health and Wellbeing	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
1	Develop the Population Health and Wellbeing Strategy				L					
2	Develop the strategic plan to secure teaching Health Board Status with the University of St Andrews	L								
3	Develop and deliver the Fife COVID Recovery and Rehabilitation Framework		L							
4	Deliver the OBC for the Mental Health Services Programme	L								
5	Refreshed mental health strategic plan informed through collaborative working with people with lived experience and trauma informed practice									L
6	Deliver the OBC and progress to FBC for both the Kincardine and Lochgelly Health Centres			L						
	Improve the Quality of Health and Care Services	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
7	Deliver the National Treatment Centre Fife and ensure operational readiness for opening		L							
8	Develop and implement a system wide medicines safety programme with initial focus on high-risk pain medicines						L			
9	Develop and deliver an enhanced model of care in the Emergency Department								L	
10	Develop and deliver an augmented ambulatory, interface care model (RUC) supporting early and appropriate discharge Integrated Unscheduled Care Programme								L	
11	Develop and implement an integrated planned care programme to address waiting list backlog, including the optimisation of day surgery at QMH								L	
12	Oversight of NHS Fife Anchor Institution delivery plan for 2022/23			L						
13	Deliver Home First to enabling Prevention of admission, person centred transfers of care and a responsive integrated system									L
14	Deliver an approved Integrated Primary and Preventative Care Strategy to set the strategic direction supporting early intervention									L
15	Increase the pace of delivery in the localities of Fife in line with in line with the Plan for Fife.									L
16	Develop and implement an NMAHP Care Assurance Framework		L							
	Improve Staff Experience and Wellbeing	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
17	Deliver high quality systems to support staff health and wellbeing					L				
18	Deliver corporate and system leadership that contributes to system wide activities including Plan 4 Fife					L				
19	Develop and deliver the Faculty for Excellence in NMAHP education, training and professional development		L							
20	Develop and deliver strategic and career frameworks for NMAHP Bands 2 - 4		L							
	Deliver Value & Sustainability	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
21	Develop and deliver the medium-term financial plan including the implementation of the Financial Improvement and Sustainability Programme				L					
22	Develop the Workforce Strategy to support Population Health & Wellbeing Strategy					L				
23	Implement the Climate Emergency and Sustainable Development Policy including agreed Net Zero commitments							L		
24	Develop the business case and commence implementation of Paper lite systems across NHS Fife	L								
25	Develop the Initial agreement (IA) and Outline Business Case (OBC) for Robotics in Pharmacy						L			

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Governance of Advanced Practitioners**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Mairi McKinley, Senior Practitioner (PPD) Advanced Practice**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Local Policy
- Workforce Update

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Further to the report presented to EDG on 11 May 2021, an update on the progress of the development of Advanced Practice (AP) roles in NHS Fife and the HSCP, specifically Advanced Nurse Practitioners (ANPs) is provided for consideration. The publication of a Scottish Government Transforming Roles for Advancing Practice in the Allied Health Professions (AHPs) is expected imminently; therefore this paper focuses on ANPs whilst awaiting publication of the TR AHP paper.

A secondment post of Senior Practitioner (Practice and Professional Development (PPD)) Advanced Practice was created within the PPD team and appointed to from 1 October 2021 – 31 March 2022. The purpose of this post is primarily to progress and implement the guidance published in CNOD Advanced nursing practice - transforming

nursing roles: phase two paper[1], progress NMaHP AP governance and assurance across the organisation and facilitate the publication of the AP toolkit.

Following the realignment of budgets within PPD, the Senior Practitioner (PPD) Advanced Practice post is being supported substantively with the development of an AP support practitioner post at band 6 in order to take forward the AP agenda.

2.2 Background

Significant progress has already been made within Fife towards meeting the CNOD transforming nursing roles recommendations including the development of generic job descriptions/person specifications, competency frameworks, and the initial development of the AP toolkit.

The AP toolkit is designed for use by managers, trainee and qualified Advanced Practitioners and includes key documents for managers e.g. service needs analysis tool, business case and pre-recruitment checklists; key trainee ANP (tANP) documentation such as the competency frameworks, learning needs analysis tool; and annual appraisal, clinical supervision and ongoing professional development appraisal tool documentation for qualified APs.

2.3 Assessment

Whilst significant progress was made by the AP Steering Group to progress the publication of the AP toolkit, work stalled primarily due to the impact of Covid-19 and associated clinical pressures. In the interim period, the publication of the CNOD Advanced nursing practice - transforming nursing roles: phase two paper necessitates further work within Fife to standardise the implementation, governance, and assurance of ANP roles.

2.3.1 Quality/ Patient Care

The environment in which ANPs work remains complex and demanding. Within Fife, ANPs work in all Directorates and many services including Neonatal and paediatrics; Mental Health; Urgent Care; Community and GP practices; and Acute services. To meet the needs of these services, the ANP must work across all four pillars of advanced practice:

- Clinical Practice
- Facilitation of Learning
- Leadership
- Evidence, Research and Development.

To facilitate safe, effective and person-centred care by enabling ANPs to retain/further develop their level of practice across all pillars, the following are recommended:

[1] https://www.gov.scot/publications/transforming-nursing-roles-advanced-nursing-practice-phase-ii/

- **Non-Clinical Time -** ANPs require dedicated non-clinical time to work across the remaining 3 pillars. Therefore, it is recommended that a minimum of **3.75 hours (pro rata) per calendar week** be allocated as non-clinical time on an ongoing basis.

- **Clinical Supervision -** All ANPs should have a named clinical supervisor and actively engage in supervision throughout the year.

- **Continuous Professional Development (CPD) -** All ANPs should have the opportunity to access high quality CPD to ensure that they continue to deliver robust, current, evidence-based care.

- **Supporting Professional Activities (SPA) -** Specific SPAs should be negotiated with the ANP's line manager and such activities should be resourced accordingly.

2.3.2 Workforce

A 100% data cleanse of ANP posts was undertaken in January 2022. Table 1 illustrates the number of ANPs across NHS Fife has increased by **36.91 WTE** with a further **24.44 WTE** trainee ANPs in post since 2016. The total number of WTE ANPs and trainees across NHS Fife is approaching 90 and is anticipated to be close to 100 by the end of 2022. Given that the Scottish Government pledged to increase the number of ANPs in Scotland by 500 over a period of 5 years (2016-2021), we have exceeded our NRAC target of 35 WTE.

Table 1

	Acute ANPs	HSCP ANPs	Total ANPs	Acute Trainees	HSCP Trainees	Total Trainees
2016	24.18	0	24.18	0	0	0
2021*	39.67	27.97	67.64	10.84	20.32	31.16
2022**	40.24	20.85	61.09	11.84	12.6	24.44
Increase since 2016	**16.06**	**20.85**	**36.91**	**11.84**	**12.6**	**24.44**

*Inconsistencies in the recording of data may have resulted in incorrect results, therefore 100% data cleanse undertaken in 2022.

**This data includes 1.8 WTE ANPs employed within General Practice. The ongoing governance, supervision and support offered to these post holders will require additional consideration.

As identified previously, job plans will need to include a minimum of 3.75 hours per week (pro-rata) non-clinical time. This non-clinical time already features in some ANP job plans, but not in others, therefore a consistent approach is required.

The creation of this non-clinical time is likely to have a highly positive impact on the ANP, enabling them to pursue activity that is restorative and developmental for them as individuals, but also provides the opportunity to enhance service delivery through effective leadership, quality improvement/research and education activity.

This activity is also likely to enhance the service delivery of the wider healthcare team including clinical supervision and educational development of the nursing team and medical trainees.

Initially many of the ANPs will require a level of support/training to enable them to enhance their less developed pillars of practice, but it is expected that over time, ANPs within the various services will sustain activities within their areas as further trainees are employed.

To support this activity, an ANP forum/network will be established creating an environment to share best practice across all services in Fife. Overall, it is anticipated that this will have a positive impact on job satisfaction, and health and wellbeing. Activity undertaken as part of the non clinical pillars is also likely to enhance an individual's professional development and help facilitate career progression.

2.3.3 Financial

Funding for ANP posts is secured following successful business cases or realignment of medical budgets. ANP posts are not funded from existing nursing establishment.

To accommodate the CNOD recommendations, there may be a financial impact for some services due to the small reduction in clinical hours provided by ANPs on behalf of the service and the requirement to support CPD and SPA. As such, this should be considered when creating a business case for new ANP posts and considered during future workforce planning.

2.3.4 Risk Assessment/Management

Previously, tANPs have identified varying levels of clinical mentorship and supervision. There is currently no formal or standardised ongoing CPD or clinical supervision within NHS Fife for ANPs. ANPs have identified there is a tendency for mentorship and supervision to cease once they are no longer trainees.

Most ANPs state they receive no protected time for CPD or activities in the non-clinical pillar. The recommendations in section 2.3.1 established in policy and an ANP strategic framework, once implemented will minimise the risk across the organisation.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment will be included in the proposed Advancing Practice Policy document.

2.3.6 Other impact

Similar policies and procedures already exist in other Scottish Health Boards, therefore this work will align Fife with other Boards, ensuing that the highest standard of advanced care and treatment is delivered to patients and their families, whilst supporting ANPs' ongoing development requirements.

2.3.7 Communication, involvement, engagement and consultation

The report's author has engaged with NHS Greater Glasgow and Clyde, NHS Grampian, NHS Lothian and NHS Tayside ANP Leads to seek examples of best practice. NHS Fife is a member of the East of Scotland Advanced Practice Academy and continues to engage with regional and national AP discussions.

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.

- EDG, 11 May 2021
- Strategic Workforce Planning Group, 18 May 2021
- Nursing and Midwifery Workforce Planning Group, 28 February 2022
- EDG, 24 March 2022

2.4 Recommendation

- For information and assurance

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Early Cancer Diagnosis Centre (ECDC) Update Report**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author(s):	**Kathy Nicoll, Cancer Transformation Manager**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

Fife is one of three pilot sites to successfully roll out a Scottish Government funded Early Cancer Diagnosis Centre service. £297,394 was awarded to support the project for one year and a further £282,131 has been allocated for a further year (2022-23), further funding to complete the evaluation period of the ECDC will be considered and will be dependent on impact demonstrated and measurable outcomes. This is one of the four flagship areas in the publication Recovery and Redesign: An Action Plan for Cancer Services, December 2020. A pathway for patients with vague but concerning symptoms who do not meet tumour specific Scottish Referral Guidelines has been developed with the aim of seeing, assessing and referring on/discharging as appropriate within 21 days.

2.2 Background

Around 40% of patients are not diagnosed through the existing urgent suspicion of cancer (USC) pathway in Scotland. The Scottish Government has committed to the introduction of Early Cancer Diagnostic Centres (ECDCs) in Scotland, to provide equity of access for all patients with symptoms suspicious of cancer, shorten the diagnostic pathway and support earlier detection.

Previous pathways for this group of patients often resulted in delayed diagnosis, onward referrals to a variety of specialties, unnecessary examinations with poor patient experience and outcomes. Formation of the ECDC has therefore provided Primary Care with an alternative route to refer their patients.

2.3 Assessment

Referral Activity

From 7 June 2021, 568 referrals have been received to date (13/04/22) with 400 being accepted on to the pathway (70% eligible referrals). Of the 93% of eligible patients have completed pathway to date, patient outcomes following first line investigation are as follows:

- 52% (191 patients) discharged back to GP
- 32% (120 patients) have had significant benign pathology identified requiring onward referral to secondary care specialties
- 6% (23 patients) require further tests to exclude cancer
- 16% (59 patients) cancer diagnosis (breakdown shown below)

Cancer Type	Total
Upper GI	13
Lung	10
Urology	10
Haematology	5
Gynaecology	5
Cancer of Unknown Primary	5
Colorectal	4
Breast	4
Neuroendocrine Tumour	2
Head & Neck (ENT)	1
Grand Total	**59**

Endoscopy and Radiology continue to make up the majority of onward referrals.

Patient Pathways

Standard Operating Procedures and referral pathways, including onward referral pathways have been agreed. A test of change recently implemented to determine most appropriate follow on appointment post scan to ensure cancers can be accommodated face to face is working very well.

ECDC Team
The team is fully appointed. The GP ECDC lead role for 1 PA has been appointed.

ECDC Team	
Mr Neil Cruikshank	ECDC Consultant Lead
Katie Wilkin	ECDC Advanced Clinical Nurse Specialist (trainee)
Lorna Muir	Patient Navigator
Mairi Bowlerwell	GP ECDC Lead
Murdina Macdonald	Lead ECDC/Cancer Nurse
Kathy Nicoll	Cancer Transformation Manager
Greg Fearn	Project Manager
Carron Waterson	Project Support

Access to Radiology
Radiology has increased the previous five protected slots to 10 reserved CT scans per week. The process is working very well with all slots being fully utilised. In addition, ECDC can also utilise any short notice CT slots due to last minute cancellations.

Communication
A specific ECDC website has been set up to provide information about the service to patients https://www.nhsfife.org/services/all-services/cancer-services/ecdc/. Guidelines on FROG pages are currently in development to assist Primary Care colleagues.

ECDC has been accepted on to the NSS Scotland Poster Event for June 2022.

Governance
The pilot has moved into business as usual with monthly project meetings. Project Status Reports are provided to senior teams and updates are provided to the Senior Leadership Team; assurance is given to Clinical Governance, Cancer Governance & Strategy Group and EDG.

A weekly ECDC MDT has been put in place to discussion challenging patients and onward referrals. There is a national Early Cancer Diagnostic Centre - Oversight Group (ECDCOG) meeting which is held every 2-3 months.

Evaluation
A set of metrics has been determined by Scottish Government to measure the success of the project: general patient information, frailty and performance status along with signs and symptoms, appointment dates, time on pathway and outcome of referral is recorded.

Quarterly reports continue to be forwarded to Scottish Government.

Strathclyde University have been appointed to provide independent evaluation of the Pilot sites and the team are currently awaiting contact from them to commence stakeholder feedback interviews.

Patient Feedback
Patients are asked to complete a Patient Evaluation questionnaire following completion of the pathway and this data will be utilised by both Strathclyde University but also by the team to drive improvements in care at operational level.

There has been excellent feedback from patients through Care Opinion, for example:

"I was amazed at the speed of the service, but also the serious ability of the ECDC team to arrange follow up with the necessary specialties"

"My story is one of amazement at the reaction speed of the ECDC & being very impressed by their professionalism, care and efficiency. Having been referred to the ECDC by a GP following weight loss, fatigue and stomach pain and nausea, I was contacted the very next day by the ECDC and had a CT scan completed within 5 days of the referral, with the results following after a further 2 days. This is incredibly swift, especially in the midst of a pandemic!"

Next Steps
ECDC will be embedded within the development of the cancer framework and has been identified as one of the key priorities for the 2022-2023 delivery plan.

Work is underway to explore expansion of ECDC into the upper and lower GI tumour specific sites. A paper is currently being written.

A further flagship area within the Recovery Plan is Single Point of Contact (SPOC) which closely aligns with ECDC. Fife has been successful in securing funding to support the implementation of a Single Point of Contact Hub to improve experience for patients referred urgent suspected or diagnosed with cancer; this will be achieved by enhancing the Central Referral Unit (CRU) and the Cancer Tracking Team to support patients. Secondary benefits seen would be to reduce the CNS burden of administrative work and increase resilience for ECDC with cover for the Pathway Navigator and also improve communications between Primary and Secondary Care

National discussions are underway to determine if the name of the ECDC should be changed. The NHS Fife ECDC Project Team are currently in the process of targeting a cohort of 40-50 patients who have completed the pathway, to receive their feedback regarding 18 options for a name change. The outcome of which will be discussed at Government/Cabinet level.

NHS Borders have expressed an interest in our model and a visit is arranged for 20 April 2022

2.4 Recommendation

This report is presented to the Clinical Governance Committee for:

- Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Fife Data for Scottish Government

Report Contact
Kathy Nicoll
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Appendix 1

NHS Fife ECDC - SG Quarterly Data Report (01/12/21 – 28/02/22)

NHS FIFE- EARLY CANCER DIAGNOSTIC CENTRE (ECDC)

SG Quarterly Data Report (referrals received 01/12/2021 to 28/02/2022)

Referrals	**185**	
Primary Care	184	
Secondary Care	1	
Accepted	**125**	
Rejected	**60**	
Pathway terminated (started pathway but did not complete due to emergency admission)	3	
Number on current pathway	29	
Completed pathway (as at 28/02/2022)	**116**	
Patients remaining on pathway for further test **(as recommended by Radiology)** Patients requiring further testing remain on pathway until SLI complete	**24**	
(Cancer confirmed - requires further testing - 2)		
(Indeterminate - requiring SLI to rule out cancer - 14)		
(Cancer excluded - significant benign pathology, requires further test - 8)		

Of those who have completed the pathway		
Personal Attributes		
Male	44	38%
Female	72	62%
Symptoms	**% Pts**	
Weight loss	52%	
Abdominal pain	26%	
Bone pain	19%	
Abnormal bloods	28%	
% with 2+ non specific symptoms	62%	
	No.	
Frailty Score (where completed)	**Pts**	
0	3	
1	0	
2	10	

3	22
4	38
5	32
6	9
7	2
8	0
9	0
Total	**116**

Performance Score (where completed)	**No. Pts**
0	52
1	40
2	23
3	1
4	0
Total	**116**

Diagnostic Tests

**Indeterminate FLI - requires further test to exclude cancer - some patients required multiple further tests*

	No. Pts	
Additional tests	**14**	12%

Breakdown of additional tests arranged by ECDC:

CT	9
MRI	1
USS	3
Endoscopy	3
Total no. of additional tests required	16

Outcome

	No. Pts	
Conversion rate to cancer	16	14%
Conversion rate to significant but non ca diagnosis	44	26%

Timed Pathway

Median w/time from referral to first direct contact	1	days
Longest w/time from referral to first direct contact	12	days - due to xmas holiday period
Median w/time from referral to first diagnostic test	9	days
Longest w/time from referral to first diagnostic test	37	days - pt cancelled initial scan app
Median w/time from referral to patient review	14	days
Longest w/time from referral to patient review (pt cancelled initial appointment)	40	days - pt cancelled initial scan app

Onward Referral

Referred back to Primary Care **56**

No. of Patients Referred on to another Specialty **44**

A total of 7 patients required onward referral to multiple Specialties

Endoscopy	11
Radiology	10
Bloods	4
MoE	4
Vascular	3
Gastroenterology	3
Urology	2
MentalHealth	2
Respiratory	2
Cardiology	2
ENT	2
Rheumatology	1
Respiratory	1
Breast	1
Dieticians	1
ECG	1
Gynaecology	1
Total no. of onward referrals made	51

Referred to site-specific cancer pathway **16**

Cancer Diagnosis **16**

Lung	3
Haematology	3
UGI HPB	3
Urology	3
Gynaecology	2
CUP	2

FEEDBACK

PATIENTS

"My 88 year old mum has been losing weight for some time now. Recently her GP referred her to the ECDC.We hear so much about how the NHS is struggling to cope, and I know it may put some people off coming forward for treatment, believing they either will not be seen for ages, or that their concerns are not 'important' enough to burden an already-struggling health service.
But this new diagnostic department provides such a fantastic service, which is delivered quickly and efficiently by knowledgeable, patient and empathic staff, that we would encourage anyone to take up any offer of a referral. Both my mum and I (and the rest of the family) are extremely grateful for everything they've done for us. Thank you"

STAFF/SERVICE
Referrals for site specific pathways continue to make up a large number of rejections (which are onward referred appropriately). This will be addressed by our GP lead.

Operational clinical team have been linking with secondary care specialties in raising awareness of the service (Dietetics and Palliative Care most recently).

Visit by NHS Borders is planned for April and we are awaiting a visit from National Centre for Sustainable Delivery (Prof Korsah) to be rescheduled (cancelled due to rise in covid numbers).

LEARNING
Number of referrals is increasing resulting in slight rise in median time for patient ECDC journey down to slightly lengthier wait for CT scan. This is having a moderate impact but not resulting in additional breachers.

GP Lead now in post who we will be utilising for raising awareness and addressing issues in primary care.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to the:

- Performance Management
- RMP4

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 Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of February 2022.

Activity performance in FY 2021/22 is being assessed against RMP4 (the plan which has superseded the original 1-year re-mobilisation plan for this year, RMP3). This focuses on the actual number of diagnostics, new outpatient and mental health appointments completed, and the number of patients treated under the patient Treatment Time Guarantee (TTG). Activity related to Delayed Discharges and the Emergency Department are also included, with actual figures being reported at the end of each month. A summary of this is provided in the table on Page 4 of the report.

We continue to report on the suite of National Standards and Local Targets.

From January 2022 onwards, measures identified as being relevant to the Public Health & Wellbeing Committee are reported in a separate, new section.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board, and is produced monthly. It is presented at the bi-monthly meetings of the Clinical Governance, Staff Governance, Finance, Performance & Resources and Public Health & Wellbeing Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

2.3 Assessment

The April report comprises a full update to the performance data, Exec Summary and drill-down Improvement actions, along with a summary of remobilisation activity.

Performance against the 4-Hour Standard was the highest since August 2021, with NHS Fife being in the top 3 Mainland Health Boards and above the Scottish average. Unplanned attendances from October to February were 11% lower than projected in RMP4.

Within Acute Services, performance against the National Standards for New Outpatients, and TTG continued to fall in February, to their lowest levels since early 2021. However, there was a small improvement in Diagnostics waiting times.

The Waiting Lists for New Outpatients, TTG and Diagnostics were generally stable, but activity in all areas between October and February was less than forecast in RMP4, by 14% for Diagnostics (26% Endoscopy, 13% Imaging), 13% for New Outpatients and 22% for TTG.

In Cancer Services, there were no breaches against the 31-Day DTT measure, for the 5th consecutive month, while the 62-Day RTT performance was 12% higher than in January. The number of patients starting treatment within 62 days of referral in October through to February was slightly higher than forecast in RMP4. However, for the 31-day measure, the number of patients starting treatment was 25% lower than forecast.

Performance within both reported areas of Mental Health (CAMHS and Psychological Therapies) showed similar trends in February – performance against the 90% Standard fell slightly, Waiting Lists increased and Activity (particularly with regard to long waits) was less than forecast in RMP4 (16% for CAMHS and 25% for Psychological Therapies).

2.3.1 Quality/ Patient Care

Quality/Patient Care indicators are included in the IPQR.

2.3.2 Workforce

Workforce indicators are included in the IPQR.

2.3.3 Financial

Financial reporting is covered in the specific section of the IPQR.

2.3.4 Risk Assessment/Management

Risk Management is considered and will be included in future IPQRs.

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 and Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

2.3.8 Route to the Meeting

- EDG – 21 April 2022

2.4 Recommendation

- For assurance

3 List of appendices

- IPQR

Report Contact
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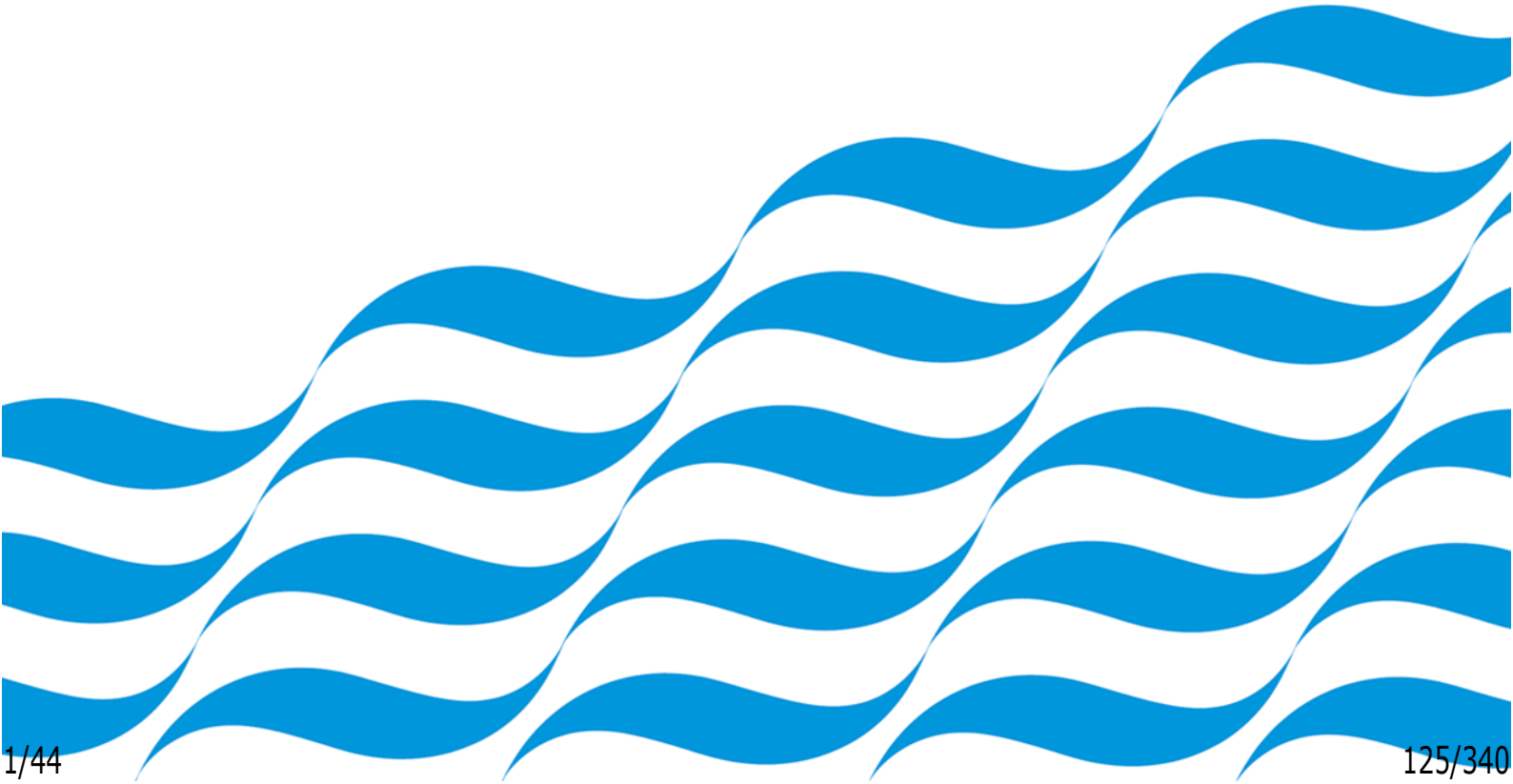
Fife Integrated Performance & Quality Report

Produced in April 2022



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

d. Public Health & Wellbeing

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

MARGO MCGURK
Director of Finance & Strategy
19th April 2022

Prepared by:
SUSAN FRASER
Associated Director of Planning & Performance

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 agreed its Joint Remobilisation (RMP3) for 2021/22 at the start of 2021, and this effectively replaced the previous 1-year or 3-year Annual Operational Plans. It has now been superseded by RMP4, addressing the status and forecasts for the second half of the FY. Both RMP3 and 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 12 (41%) classified as **GREEN**, 2 (7%) **AMBER** and 15 (52%) **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 were notable improvements in the following areas in February:

- Rate of Falls and Falls with Harm both reducing to be below their targets for FY 2021/22
- Closure of FOI requests above the local target after several challenging months
- % bed days lost due to patients in delay continuing a downward trend towards target

Additionally, it has now been 22 months since the Cancer-31 DTT performance fell below the 95% Standard, with 7 months out of 11 this FY reporting no breaches.

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 (●). This benchmarking information indicates that whilst a number of areas continue to experience significant levels of challenge, in over 85% where we are able to compare our performance nationally we are delivering performance within either the upper quartile or the mid-range.

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	Feb-21	24	Jan-22	23	Feb-22	36	↓		N/A			
	HSMR	N/A	Year Ending	Sep-20	1.01	Jun-21	1.03	Sep-21	1.04	↓		YE Sep-21	1.04	●	1.00
	Inpatient Falls	7.68	Month	Feb-21	9.51	Jan-22	8.33	Feb-22	7.30	↑		N/A			
	Inpatient Falls with Harm	1.65	Month	Feb-21	1.87	Jan-22	2.02	Feb-22	1.59	↑		N/A			
	Pressure Ulcers	0.42	Month	Feb-21	1.44	Jan-22	1.32	Feb-22	1.23	↑		N/A			
	Caesarean Section SSI	2.5%	Quarter Ending	Sep-20	2.2%	Jun-21	3.6%	Sep-21	2.5%	↑		QE Dec-19	2.3%	●	0.9%
	SAB - HAI/HCAI	18.8	Quarter Ending	Feb-21	19.4	Jan-22	15.0	Feb-22	15.4	↓		QE Dec-21	12.8	●	17.3
	SAB - Community	N/A	Quarter Ending	Feb-21	10.8	Jan-22	9.6	Feb-22	8.7	↑		QE Dec-21	8.5	●	9.9
	C Diff - HAI/HCAI	6.5	Quarter Ending	Feb-21	5.2	Jan-22	5.8	Feb-22	4.7	↑		QE Dec-21	4.6	●	13.3
	C Diff - Community	N/A	Quarter Ending	Feb-21	5.4	Jan-22	1.1	Feb-22	1.1	↔		QE Dec-21	1.1	●	5.0
	ECB - HAI/HCAI	33.0	Quarter Ending	Feb-21	33.6	Jan-22	28.9	Feb-22	27.3	↑		QE Dec-21	33.6	●	34.1
	ECB - Community	N/A	Quarter Ending	Feb-21	29.3	Jan-22	37.3	Feb-22	39.3	↓		QE Dec-21	39.2	●	39.8
	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Feb-21	88.5%	Jan-22	61.2%	Feb-22	69.2%	↑		2020/21	80.2%	●	79.5%
	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Feb-21	31.1%	Jan-22	12.2%	Feb-22	12.8%	↑		2020/21	32.8%	●	57.8%
Operational Performance	IVF Treatment Waiting Times	90%	Month	Feb-21	100.0%	Jan-22	100.0%	Feb-22	100.0%	↔		N/A			
	4-Hour Emergency Access	95%	Month	Feb-21	91.1%	Jan-22	76.1%	Feb-22	83.0%	↑		Feb-22	83.0%	●	74.2%
	Patient TTG (% of Total Waits <= 12 Weeks)	100.0%	Month	Feb-21	48.6%	Jan-22	56.6%	Feb-22	52.7%	↓		Dec-21	64.5%	●	34.6%
	New Outpatients (% of Total Waits <= 12 Weeks)	95%	Month	Feb-21	48.0%	Jan-22	50.1%	Feb-22	48.8%	↓		Dec-21	53.7%	●	46.5%
	Diagnostics (% of Total Waits <= 6 Weeks)	100%	Month	Feb-21	76.2%	Jan-22	52.7%	Feb-22	61.2%	↑		Dec-21	57.9%	●	49.6%
	18 Weeks RTT	90%	Month	Feb-21	73.6%	Jan-22	77.3%	Feb-22	71.4%	↓		QE Dec-21	71.2%	●	74.2%
	Cancer 31-Day DTT	95%	Month	Feb-21	97.5%	Jan-22	100.0%	Feb-22	100.0%	↔		QE Dec-21	100.0%	●	97.1%
	Cancer 62-Day RTT	95%	Month	Feb-21	80.7%	Jan-22	71.2%	Feb-22	83.6%	↑		QE Dec-21	82.3%	●	79.0%
	Detect Cancer Early	29%	Year Ending	Jun-20	22.0%	Mar-21	19.6%	Jun-21	21.4%	↑		2019, 2020	22.5%	●	24.1%
	Freedom of Information Requests	85%	Quarter Ending	Feb-21	85.8%	Jan-22	84.3%	Feb-22	86.9%	↑		N/A			
	Delayed Discharge (% Bed Days Lost)	5%	Month	Feb-21	6.2%	Jan-22	5.6%	Feb-22	7.0%	↓		QE Sep-21	10.4%	●	6.7%
	Delayed Discharge (# Standard Delays)	N/A	Month	Feb-21	54	Jan-22	50	Feb-22	55	↓		Feb-22	18.20	●	26.85
	Antenatal Access	80%	Month	Dec-20	85.7%	Nov-21	88.4%	Dec-21	90.0%	↑		2021	90.1%	●	88.5%
Finance	Revenue Resource Limit Performance	(£13.7m)	Month	Feb-21	N/A	Jan-22	(£13.7m)	Feb-22	Breakeven	↑		N/A			
	Capital Resource Limit Performance	£33.9m	Month	Feb-21	N/A	Jan-22	£13.8m	Feb-22	£19.2m	↑		N/A			
Staff Governance	Sickness Absence	3.89%	Month	Feb-21	5.03%	Jan-22	5.93%	Feb-22	5.63%	↑		YE Mar-21	4.77%	●	4.67%
Public Health & Wellbeing	Smoking Cessation	473	YTD	Dec-20	48.6%	Nov-21	57.1%	Dec-21	52.5%	↓		QE Sep-21	58.9%	●	82.0%
	CAMHS Waiting Times	90%	Month	Feb-21	88.1%	Jan-22	69.4%	Feb-22	68.0%	↓		QE Dec-21	71.9%	●	70.3%
	Psychological Therapies Waiting Times	90%	Month	Feb-21	84.0%	Jan-22	81.8%	Feb-22	79.2%	↓		QE Dec-21	80.6%	●	84.4%
	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	Dec-20	96.5%	Nov-21	88.4%	Dec-21	87.9%	↓		QE Dec-21	93.4%	●	93.1%
	Dementia Post-Diagnostic Support	N/A	Annual	2018/19	93.4%	2019/20	93.2%	2020/21	94.6%	↑		2019/20	93.2%	●	81.3%
	Dementia Referrals	N/A	Annual	2018/19	61.0%	2019/20	58.5%	2020/21	50.6%	↓		2019/20	58.5%	●	42.9%

d. NHS Fife Remobilisation Summary – Position at end of March 2022

Better than Projected | Worse than Projected | No Assessment
(NOTE: Better/Worse may be higher or lower, depending on context)

		Quarter End Jun-21	Quarter End Sep-21	Quarter End Dec-21	Month End Jan-22	Month End Feb-22	Month End Mar-22	Quarter End Mar-22
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,981	3,120	3,400	1,203	1,269	1,268	3,740
	Actual	3,260	2,953	2,792	756	1,012	1,169	2,937
	Variance	279	-167	-608	-447	-257	-99	-803
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	17,100	19,125	20,905	7,286	7,287	7,288	21,861
	Actual	19,488	20,161	19,600	5,073	6,358	7,501	18,932
	Variance	2,388	1,036	-1,305	-2,213	-929	213	-2,929
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,801	1,833	1,840	613	613	614	1,840
	Actual	1,406	1,511	1,257	446	433	497	1,376
	Variance	-395	-322	-583	-167	-180	-117	-464
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,850	11,250	13,642	4,480	4,605	4,607	13,692
	Actual	12,971	12,629	11,733	3,962	4,149	4,569	12,680
	Variance	2,121	1,379	-1,909	-518	-456	-38	-1,012
CT Scan	Actual	3,580	3,567	3,446	1,230	1,393	1,426	4,049
MRI	Actual	2,841	3,014	2,626	927	918	936	2,781
Non-obstetric Ultrasound	Actual	6,550	6,048	5,661	1,805	1,838	2,207	5,850
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	17,110	19,110	20,620	7,110	6,450	6,780	20,340
	Actual	20,729	20,814	18,554	5,883	5,997	7,326	19,206
	Variance	3,619	1,704	-2,066	-1,227	-453	546	-1,134
A&E 4-Hour Performance (%) : ALL A&E and MIU (Definitions as per Core Sites, unplanned attendances only)	Projected			80.0%	85.0%	86.0%	87.0%	83.0%
	Actual			77.4%	77.1%	83.0%	79.6%	79.9%
	Variance			-2.6%	-7.9%	-3.0%	-7.4%	-3.1%
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	8,040	8,320	10,680	3,520	3,190	3,410	10,120
	Actual	10,085	10,001	9,975	3,275	2,923		6,198
	Variance	2,045	1,681	-705	-245	-267		-3,922
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	Projected	5.82	5.85	5.63				5.73
	Actual	5.55	6.17	6.34				
	Variance	-0.27	0.32	0.71				
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,450	2,610	2,610	870	870	870	2,610
	Actual	2,885	3,047	2,820	973	928	1,044	2,945
	Variance	**435**	**437**	**210**	**103**	**58**	**174**	**335**
31 Day Cancer – Decision to treat to first treatment (Definitions as per published statistics)	Projected	415	435	384	128	128	128	384
	Actual	305	337	306	84	93		177
	Variance	-110	-98	-78	-44	-35		-207
62 Day Cancer - Referral to First treatment (Definitions as per published statistics)	Projected			200	70	70	70	210
	Actual			215	66	67		133
	Variance			15	-4	-3		-77
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)(Definitions as per published statistics)	Projected			405	130	143	120	393
	Actual			350	126	150		276
	Variance			-55	-4	7		-117
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			68	20	10	0	30
	Actual			13	8	6		14
	Variance			-55	-12	-4		-16
CAMHS - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			69.3%	70.0%	75.0%	80.0%	75.0%
	Actual			71.9%	69.4%	68.0%		71.9%
	Variance			2.6%	-0.6%	-7.0%		-3.1%
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral) (Definitions as per published statistics)	Projected			1,941	768	799	630	2,197
	Actual			1,750	600	559		1,159
	Variance			-191	-168	-240		-1,038
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			234	85	70	55	210
	Actual			113	22	29		51
	Variance			-121	-63	-41		-159
Psychological Therapies - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			73.2%	67.5%	65.9%	70.9%	67.9%
	Actual			80.1%	81.8%	82.1%		80.1%
	Variance			6.9%	14.3%	16.2%		12.2%

		Month End Jun-21	Month End Sep-21	Month End Dec-21	Month End Jan-22	Month End Feb-22	Month End Mar-22	Month End Mar-22
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	65	63	84	81	73	66	66
	Actual	127	112	69	79	91	91	91
	Variance	62	49	-15	-2	18	25	25
Code 9 Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	28	27	23	21	21	20	20
	Actual	47	29	26	29	36	45	45
	Variance	19	2	3	8	15	25	25
Standard Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	37	36	61	60	52	46	46
	Actual	80	83	43	50	55	46	46
	Variance	43	47	-18	-10	3	0	0

[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**	**1.04**
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.			
Inpatient Falls (with Harm)	*Reduce falls with harm rate by 10% in FY 2021/22 compared to rate in FY 2020/21*	**1.65**	**1.59**
Falls data/trends are reviewed continuously, and currently show a broadly static picture in the number of falls with harm over the last year, with a small decrease since December. As noted in the position paper at last CG committee a range of improvement work is ongoing in the continued challenges that the current pandemic presents and as previously described. Data continues to be reviewed with supported improvement action in focussed areas as required.			
Pressure Ulcers	*50% reduction by December 2020, continued for FY 2021/22*	**0.42**	**1.23**
Acute: Over the past year hospital acquired pressure ulcer rate has shown a random pattern, with no signs of improvement or deterioration to the process. Data over time continues to be monitored by senior nursing team and shared with clinical teams for discussion at a variety of forums, in order to drive improvement. Access to the newly developed Data and Insight Hub is being arranged for senior nurses, to assist with triangulation of data in order to develop a comprehensive understanding of the system. Clinical Teams continue to follow the process for Major and Extreme Adverse Events for shared learning. HSCP: The rate of hospital acquired pressure ulcers has increased from the last quarter. Data continues to be monitored weekly via the Quality Matters Assurance Safety Huddle, allowing for early identification of emerging themes. This is shared with services and teams across the partnership to inform change and improvement. Actions from LAERs also support key learning in relation to hospital and community acquired pressure ulcers.			
Caesarean Section SSI	*We will reduce the % of post-operation surgical site infections to 2.5%*	**2.5%**	**2.5%**
Mandatory SSI surveillance has been paused since the start of the Covid-19 pandemic. This remains the case until further instruction from the Scottish Government. Maternity services continue to monitor the SSI cases locally, and, where necessary (i.e Deep or Organ space infection), carry out Clinical Reviews. The performance data provided should be interpreted with caution as it is non-validated and does not follow the NHS Fife Methodology. There has been no national comparison data 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**	**15.4**
NHS Fife continues to be on target to achieve the 10% reduction. There have been no Renal haemodialysis line SABs since October and no PVC SABs since August. There have been 2 PWID SABs in 2022 to date.			
C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**6.5**	**4.7**
NHS Fife is on target to achieve the 10% reduction. There have been only 3 health care associated CDI in 2022 to date. Reducing the incidence of CDI recurrence is pivotal to achieving the HCAI reduction target, and continues to be addressed. There has not been a recurrence of infection since August.			
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2022*	**33.0**	**27.3**
The target for NHS Fife is to achieve an initial 25% reduction of HCAI ECBs by March, and we are currently on target to achieve this. There were 17 ECBs in total for February, of which only 7 were HCAI and with no CAUTIs. Reducing CAUTI incidence remains the quality improvement focus to achieve a further 25% reduction of HCAI SABs, required by March 2024.			

CLINICAL GOVERNANCE		Target	Current
Complaints – Stage 2	*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*	**65%**	**12.8%**

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 and number of complaints received and numbers received continue to be high. PRD have seen a significant decrease in the number of concerns and Stage 1 complaints relating to COVID-19 vaccination appointments and/or booster vaccinations; however, the overall delays caused by managing the pandemic continues to feature within complaints.

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%**	**83.0%**

Attendance has continued to be high, impacting on the 4-hour access target. Escalation actions include additional support through the Flow and Navigation Centre with additional primary care triage. Assessment pathways in AU1 continue to see high numbers compounding whole site high occupancy and demand for bed capacity. The emergency department continue with plans for remodelling to allow for expanded assessment provision.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**52.7%**

Performance in February has deteriorated further. Elective activity has been significantly less than projected with inpatient surgery in particular being restricted to urgent and cancer patients only in response to significant pressures in unscheduled care and the emergence of the Omicron variant. The waiting list continues to rise with 4,283 patients on list in February, 27% greater than in March 2021. There is a continued focus on clinical priorities whilst reviewing long waiting patients. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. It is anticipated that there will be a gradual resumption in non-urgent core activity in April, but this is heavily dependent on our ability to maintain access to beds for elective activity.

New Outpatients	*95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment*	**95%**	**48.8%**

Performance continued to deteriorate in February following the decision to cancel routine outpatients to support the response to the emergence of the Omicron variant and significant pressures in unscheduled care. The waiting list has increased with 21,654 on the outpatient waiting list which is 10% higher than in March 2021. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks. The number waiting over 52 weeks has risen to 444 in February but has reduced by 55% since March 2021. Due to the ongoing need for physical distancing and the pressures of unscheduled care our outpatient capacity and therefore activity continues to be restricted. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. There has been a gradual resumption in routine activity and it is anticipated that this will continue, but this is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from the Omicron variant.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**61.2%**

Performance improved slightly in February. The improvement has been in Radiology with 63.9% waiting less than 6 weeks whilst the performance in endoscopy has deteriorated to 44% of patients waiting less than 6 weeks. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. The overall waiting list for diagnostics has stabilised at 6,607 in February although the number waiting for an Endoscopy and Ultrasound has increased whilst the number waiting in CT and MRI has decreased. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver the additional capacity in the plan. It is anticipated that performance will continue to be challenged due to the demand for urgent diagnostics and the pressure from unscheduled care along with continued restrictions in activity due to enhanced infection control measures and staff absence due to COVID.

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%**	**83.6%**

February continued to see challenges in the 62-day performance. The number of USC referrals remains high, consistently exceeding pre pandemic numbers. Breaches are attributed to staffing issues in relation to COVID-19 and lack of resources, particularly radiology capacity over the festive period. Breast, Oncology and Urology (Prostate) are our current most challenged pathways. The majority of breaches continue to be seen in Prostate. The range of breaches was 4 to 55 days (average 18 days).

OPERATIONAL PERFORMANCE		Target	Current
FOI Requests	*At least 85% of Freedom of Information Requests are completed within 20 working days*	**85%**	**86.9%**

There were 62 FOI requests closed in February, 5 of which were late, a monthly closure performance of 91.8%.

The performance figure above reflects the performance for the 3-month period from December 2021 to February 2022 and is the highest 3-month figure since the period from April to June 2021. Provisional figures for March show a further improvement.

Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay is to reduce*	**5%**	**7.0%**

The number of bed days lost due to patients in delay in the last 3 months has reduced significantly from the previous quarter, but has remained above the target of 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 65 downstream beds over the last 6 months to mitigate against the lack of care at home, care home and ward closures, and continue to recruit for care at home and commission additional interim beds. At the February census, approximately half of delays were coded as 51X (Adults With Incapacity) or 100 (Commissioning/Reprovisioning).

FINANCE		Forecast	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**Breakeven**	**Breakeven**

At the end of February the board's reported financial position is a **B**reak **E**ven position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.4m and £2.2m for External Health Care Providers, offset by favourable variances across Corporate Functions of £6m and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. The exceptional demand on unscheduled care capacity within Acute Services continues to be a challenge to available financial resources coupled with increased costs of External Health Care Providers. The savings target of £8.2m the board committed to delivering in year was delivered in full at the end of December with additional savings of £1.4m secured in January taking total savings secured to £9.6m.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£33.9m**	**£19.2m**

The overall anticipated capital budget for 2021/22 is £33.9m. The capital position for the period to February records spend of £19.2m. The full capital budget is on track to be delivered in full by 31 March 2022.

STAFF GOVERNANCE		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**3.89%**	**5.63%**

The sickness absence rate in February was 5.63%, a reduction of 0.30% from the rate in January 2022. The average rate for COVID-19 related special leave, as a percentage of available contracted hours for the financial year to date was 1.71%.

Given on-going workforce pressures and service challenges, the March 2022 target set in relation to NHS Circular PCS (AfC) 2019/2 will not be achieved and we anticipate further NHSScotland guidance on sickness absence targets, which will reflect the circumstances of the last two years.

PUBLIC HEALTH & WELLBEING		Target	Current
Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**186**

Service provision continues to be delivered remotely by phone, Near Me appointments and use of translation service. We are regularly in contact with all the GP practices where we previously delivered a service. It has been a fluid situation over the last 3 months with practices keeping in touch with updates on clinic space, and we have two practices which are keen to have us start delivering a service starting in the first week of May. We are continuing to support pregnant mums as both midwives have retired. In March we tested some outreach work to assess community appetite to engage in community activity; both sessions were successful so plans to increase community outreach activity have been progressed. No Smoking Day activity saw a small uptake of interest and engagement in the service.

CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**68.0%**

Work on the CAMHS Referral to Treatment (RTT) continues with a lowered RTT as work on the longest waits increases. The amount of activity is increased as new staff capacity improves however is lower than projected due to ongoing vacancies, persistent levels of staff absence and patient cancellations as a result of Covid-19. Urgent and priority referrals remain high with an increased proportion of staff activity allocated to this client group. The process to fill vacant posts continues with a total of 21 posts either in development or out to advert.

Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**79.2%**

The demand for PTs increased significantly in the latter half of 2021 compared to the first 6 months of the year and this remains the case in the first 2 months of 2022. This has resulted in an increase in numbers on the waiting list including, in February, an increase in the number of people waiting over 53 weeks. Issues of workforce availability have negatively impacted the increase in activity that was anticipated from October onwards.

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources: Operational Performance

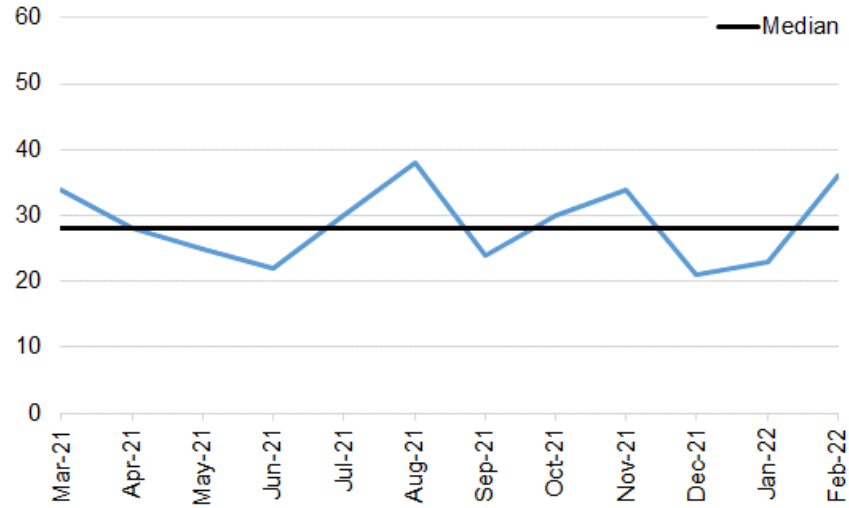
Finance, Performance & Resources: Finance

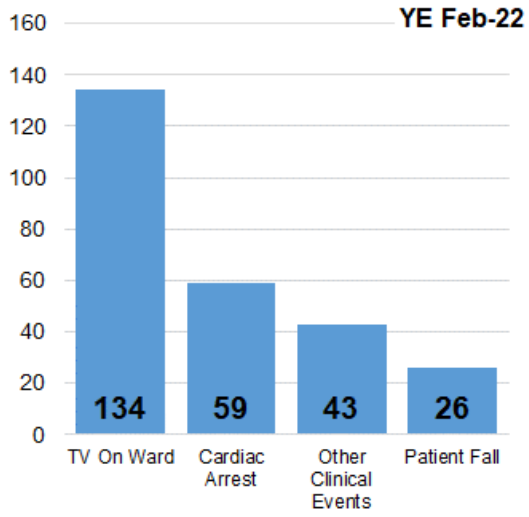
Staff Governance

Public Health & Wellbeing

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
ALL	NHS Fife	1365	1358	1373	1351	1420	1453	1397	1392	1437	1492	1495	1230
	Acute Services	630	594	649	606	629	616	609	646	632	596	611	491
	HSCP	708	725	682	694	741	799	746	690	746	834	851	698
	Corporate	27	39	42	51	50	38	42	56	59	62	33	41
CLINICAL	NHS Fife	954	937	1012	936	1009	956	964	948	1015	974	938	842
	Acute Services	588	547	600	547	568	551	536	567	581	536	564	439
	HSCP	353	372	388	365	412	384	401	351	405	399	360	383
	Corporate	13	18	24	24	29	21	27	30	29	39	14	20

Commentary

Incident numbers in January were in keeping with normal variation, but although there was a significant overall decrease in February the number of incidents reported as Major or Extreme in this month increased.

The main categories of events showing decreases were:

- Other Clinical events – the most notable reduction is in 'Hypoglycaemia (BM<4)' which have seen a consistent reduction from 50 in March 2021 to 19 in February 2022
- Medication incidents decreased to <100 per month for the first time in this 12-month period, however the number of Major/Extremes in this category increased

Focused improvement work continues in relation to falls, pressure ulcers and deteriorating patient. Adverse Events improvement work is ongoing. A dedicated Adverse Events resource folder has been created within Blink, and this holds resources to facilitate adverse events incident management as well as including links to human factors training. Collaborative work on the adverse events improvement plan is ongoing.

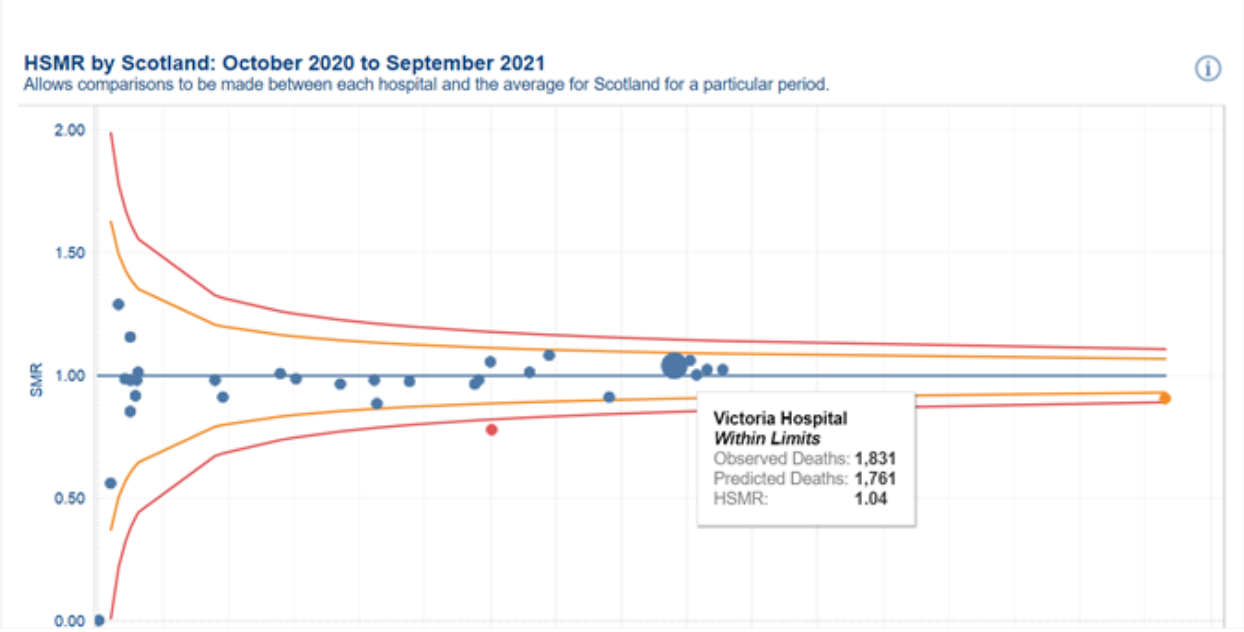
HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

Reporting Period; October 2020 to September 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 rate for Victoria Hospital is shown within the Funnel Plot.



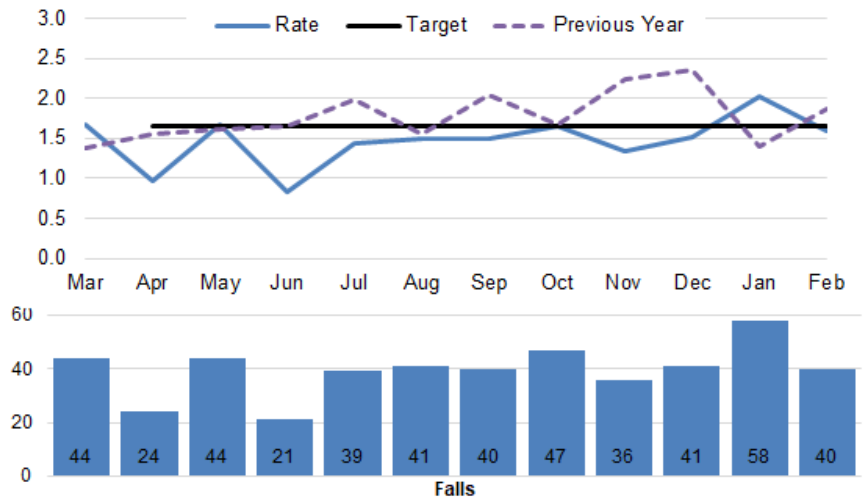
Commentary

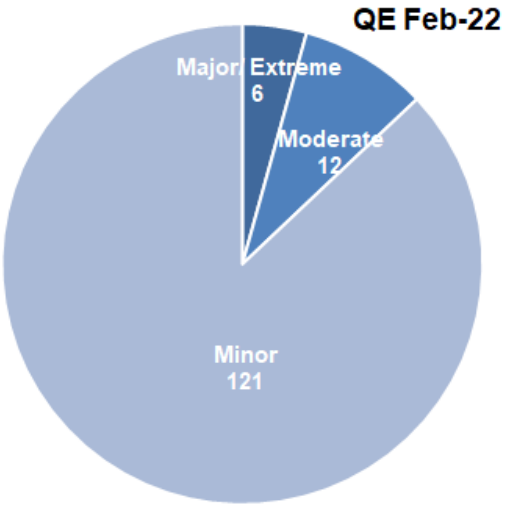
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.

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										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	1.68	0.98	1.68	0.82	1.45	1.50	1.50	1.66	1.33	1.52	2.02	1.59
Acute Services	0.98	0.35	0.88	0.33	0.79	1.26	0.81	1.44	1.11	0.64	1.80	1.14
HSCP	2.29	1.54	2.40	1.27	2.03	1.72	2.11	1.84	1.52	2.27	2.21	1.95
Target		1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65

KEY CHALLENGE(S) IN 2021/22

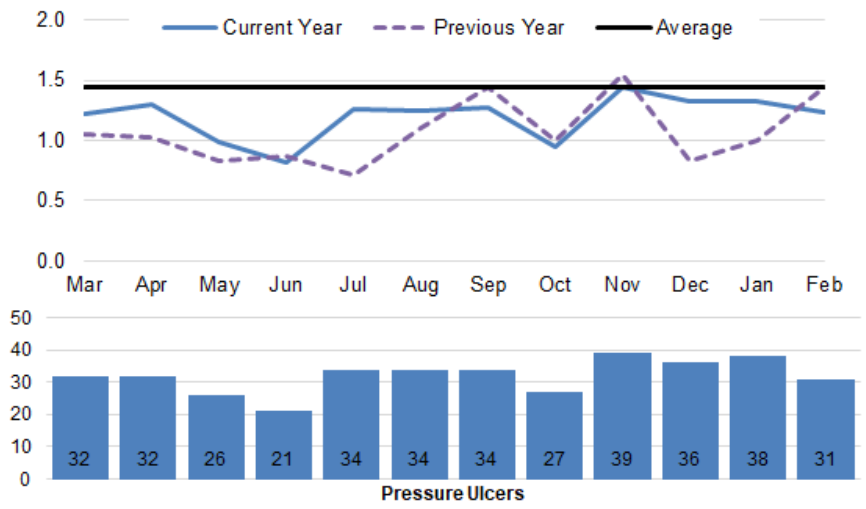
- Continued challenges in in-patient settings with patient placement, social distancing - the falls toolkit is continuing to be used to support assessment and local plans on care delivery and this will be reviewed in line with the national work expected later this year
- Ongoing combined challenges of 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

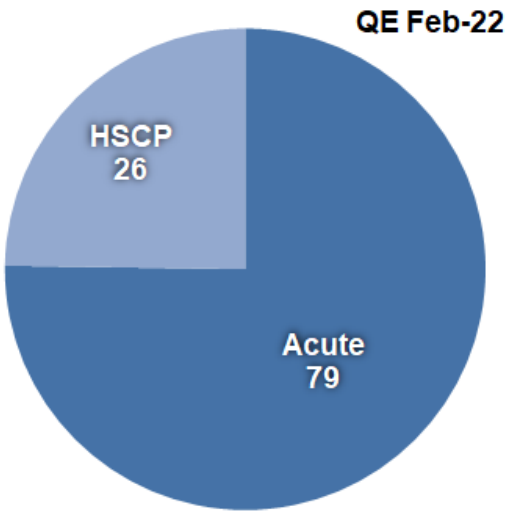
IMPROVEMENT ACTIONS	
20.3 Falls Audit	***By Aug-22***
As previously noted the expected new national driver diagram and measurement package are not yet finalised and the local audit programme will be fully developed following receipt of this; if further delayed, an interim audit programme will be commenced. This will be reviewed again in the Summer.	
20.5 Improve effectiveness of Falls Champion Network	***By Aug-22***
This work remains on hold due to staffing challenges, with contact being maintained with existing champions	
21.2 Falls Reduction Initiative	***Complete Nov-21***
21.3 Integrated Improvement Collaborative	***Complete Jan-22***

Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2022) = 0.42 per 1,000 OBD

Local Performance





Performance by Service Area

		2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grade 2 to 4	NHS Fife	1.22	1.30	0.99	0.82	1.26	1.25	1.28	0.95	1.44	1.33	1.32	1.23
	Acute Services	2.12	2.51	1.60	1.58	2.13	2.36	2.18	1.44	2.54	2.24	2.25	1.84
	HSCP	0.43	0.23	0.44	0.15	0.49	0.27	0.49	0.53	0.49	0.55	0.52	0.72

KEY CHALLENGE(S) IN 2021/22

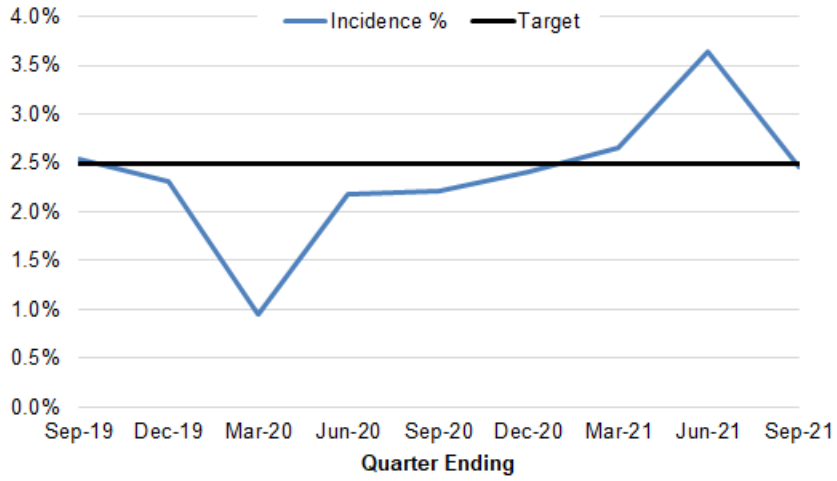
Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

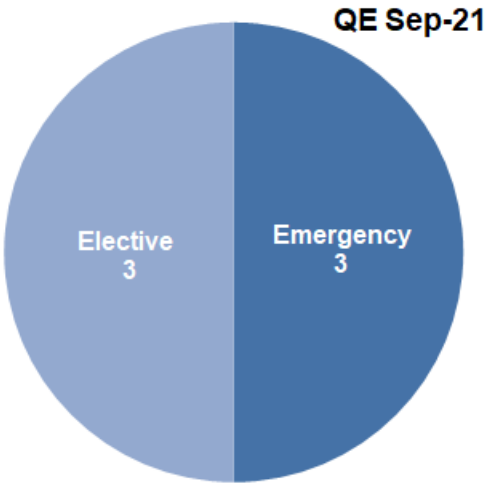
IMPROVEMENT ACTIONS	
21.2 Integrated Improvement Collaborative	**Complete Jun-21**
21.3 Implementation of robust audit programme for audit of documentation	**Complete Jun-21**
22.1 Improvement Collaboratives - HSCP	**Complete Mar-22**
The Tissue Viability Steering Group are reviewing the reporting framework. This involves forming an operational sub-group that will report directly into the Tissue Viability Steering group on developments and progress against key quality indicators, standards, relevant guidance and policies and quality improvement programmes. A number of improvement ideas have been identified, to be discussed and developed further at the next Tissue Viability Group meeting.	
22.2 Community Nursing QI Work	**Complete Mar-22**
One of the community nursing teams has implemented a focused piece of improvement work to ensure that all relevant skin and risk assessments are completed. This is having a positive impact on patient outcomes. Joint adverse event reviews and sharing learning have increased between services, including working collaboratively with care homes.	
22.3 ASD Pressure Ulcer Improvement Programme	**Complete Mar-22**
Due to the continued and significant workforce pressures and therefore inability to use a collaborative model for continuous quality improvement, a decision has been taken to terminate this programme and for clinical teams to own their own improvement activity.	
22.4 Implementation of Focused Improvement Activities	**Complete Mar-22**
ICU continue to test change ideas to prevent Medical Devise Related Pressure Ulcers, including prophylactic use of barrier creams and the development of a poster depicting preventative techniques. All mattresses have been replaced with specialist mattresses that have the technology to deflate individual cells under targeted areas of the body at particular risk. Ward 31 and ED continue to discuss pressure ulcer incidences at the Hip Fracture Meeting.	

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 Ending	2018/19				2019/20		
	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19
NHS Fife	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%
Scotland	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	**Complete 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/SAER) any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop.

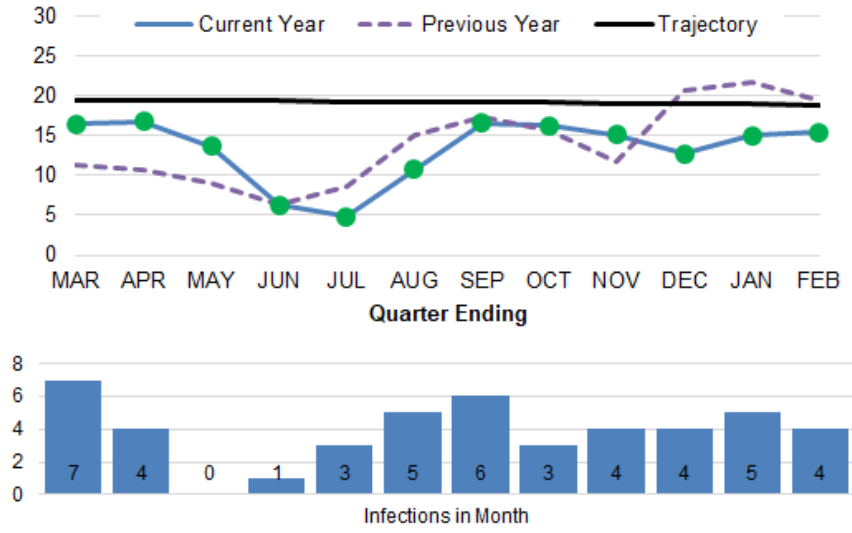
Due to the ongoing Covid-19 pandemic, there is currently no date (set by ARHAI) for resumption of SSI surveillance. Until such time, Maternity services will continue to monitor infection rates locally and will maintain links with the Infection Control Surveillance Team, for support and guidance.

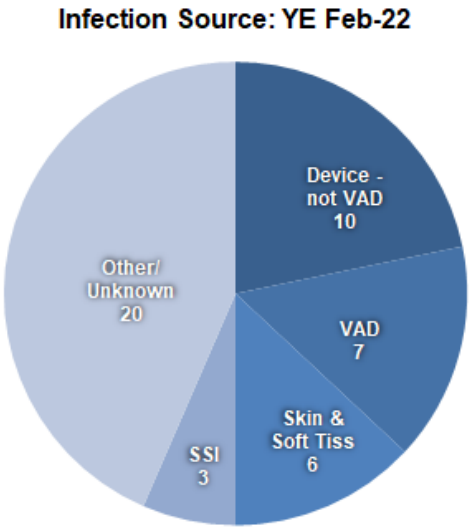
On resumption of the C-section SSI surveillance programme, the IPCT will review the surveillance methodology to capture any practice/patient pathway changes due to the pandemic response and/or any alterations to the case definition. This will ensure that the surveillance methodology remains the most 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	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	6.3	18.7	20.6	17.8	6.3	16.6	12.8
Scotland	20.3	17.3	18.9	18.4	18.6	18.3	17.3

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

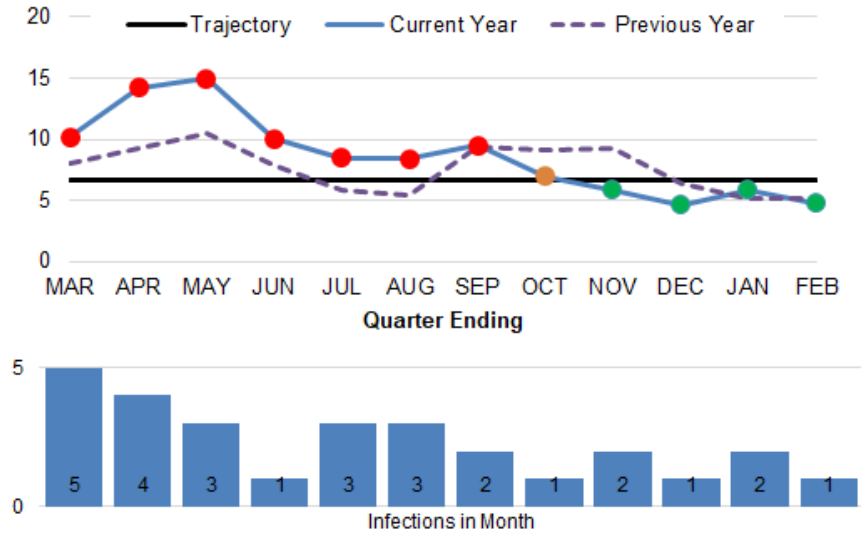
IMPROVEMENT ACTIONS

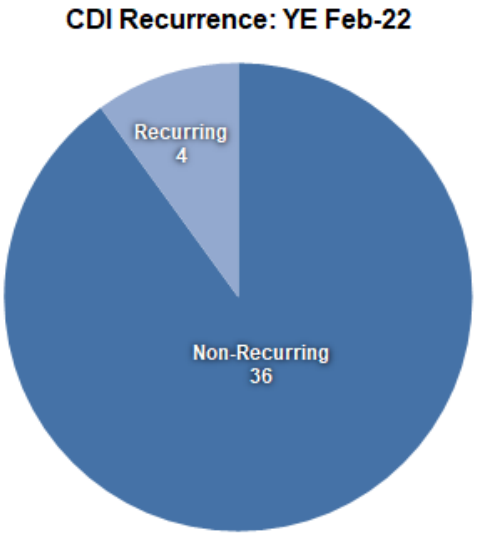
20.1 Reduce the number of SAB in PWIDs	***Complete Mar-22***
The incidence of SABs in PWIDs has continued to reduce although there has been 2 cases identified in 2022 up to February. IPC will continue to support Addiction Services with their QI work to reduce the rate further.	
20.2 Ongoing surveillance of all VAD-related infections	***Complete Mar-22***
Monthly charts are 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	***Complete Mar-22***
Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions in regard to catheter and urinary care with ECB data presented to indicate CAUTI incidence and trends. The UCIG Driver Diagram continues to be reviewed. eCatheter insertion & maintenance bundles on Patientrack are currently being trialled within Urology services, before being rolled out across the whole AS & HSCP, to ensure optimum catheter care delivery.	
20.4 Optimise comms with all clinical teams in ASD & the HSCP	***Complete Mar-22***
Monthly SAB reports are 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. 'Days since last SAB' data is emailed out to each directorate monthly for wards to display for public assurance	
22.1 Use Electronic insertion and maintenance bundles for PVC, CVC, urinary catheters	***Complete 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. Similar electronic insertion and maintenance bundles are being trialled currently for in-dwelling urinary catheters and planned for 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	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	7.9	9.3	7.7	14.0	10.0	9.5	4.6
Scotland	15.4	17.4	16.4	15.8	14.6	16.8	13.3

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

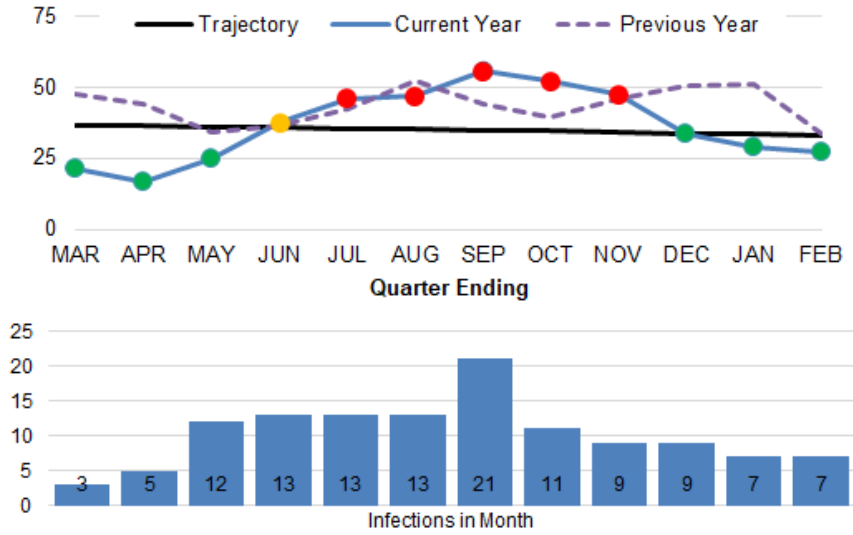
IMPROVEMENT ACTIONS

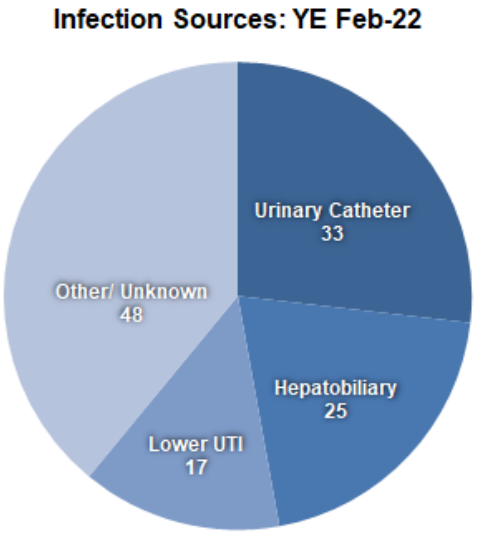
20.1 Reducing recurrence of CDI	***Complete Mar-22***
Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection. To reduce recurrence of CDI Infection for patients at high risk of recurrent infection, two treatments are utilised in Fife, Fidaxomicin and Bezlotoxumab. The latter can be prescribed whilst faecal microbiota transplantation is unavailable during the COVID-19 pandemic.	
20.2 Reduce overall prescribing of antibiotics	***Complete 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	***Complete 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. 'Days since last CDI' data is emailed monthly by IPC surveillance to each directorate for all wards to display 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	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	36.4	45.3	50.3	21.6	37.6	60.3	33.6
Scotland	39.7	42.0	40.9	34.7	38.2	41.4	34.1

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-24***

Monthly ECB reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB undergoes IPC surveillance and a DATIX is submitted for all catheter associated ECBs, prompting an LAER by the patient`s clinical team. ECB rates reduced in Q4 of 2021 following NHS Fife receiving an exception report for HCAI & CAI rates in Q3, for which an Action Plan was submitted to ARHAI.
NHS Fife is currently on target for achieving the 25% target reduction by the end of March; a further 25% reduction of HCAI ECBs is to be achieved by March 2024.

20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG)	***By Mar-24***

The UCIG meeting last met in November, two further meetings having been 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.

A new eCatheter insertion & Maintenance bundle on Patientrack is currently being trialled by Urology before being rolled out across the AS & HSCP to ensure optimum catheter care is delivered across NHS Fife.

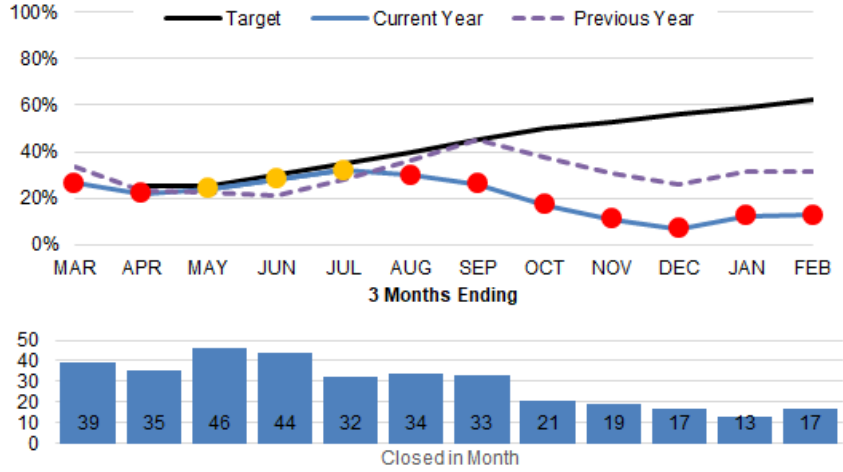
22.1 Develop ECB Strategy	***Complete Mar-22***

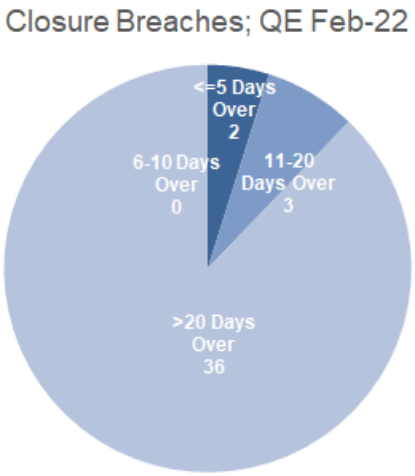
NHS Fife are collaborating with NHS Shetland and NHS Grampian to pioneer an enhanced ECB CAUTI surveillance tool. The aim is to gather data on all CAUTIs, identify risk factors and, where appropriate, make subsequent improvements to practice.

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										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	26.3%	21.9%	24.2%	28.0%	32.0%	30.0%	26.3%	17.0%	11.0%	7.0%	12.2%	12.8%
Ack <= 3 Days (Monthly)	94.9%	100.0%	93.5%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%
ASD	19.3%	15.9%	15.7%	22.5%	23.5%	25.7%	26.2%	19.3%	14.0%	7.5%	17.1%	17.6%
HSCP	50.0%	38.1%	48.3%	31.4%	38.7%	23.3%	20.8%	13.0%	5.9%	8.3%	0.0%	0.0%

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 Sep-22**

Patient Relations have yet to recommence in-house QA checks on draft final responses; however, it is hoped we will be in a position to recommence this in the near future.

Review of the current complaint handling process by Clinical Governance and Patient Relations also continues to be on hold due to the ongoing response to COVID-19 and current capacity issues. This will be recommenced in the future.

In March, there was a focus within the Patient Relations team to work on the backlog of complaint response, which had been created due to the pressures on clinical services whilst managing Covid-19 measures. Over the course of 14 days, the team were able to clear the backlog of responses that were ready to draft and move these cases onward through the complaint's procedure.

22.2 Improve education of complaint handling — **By Sep-22**

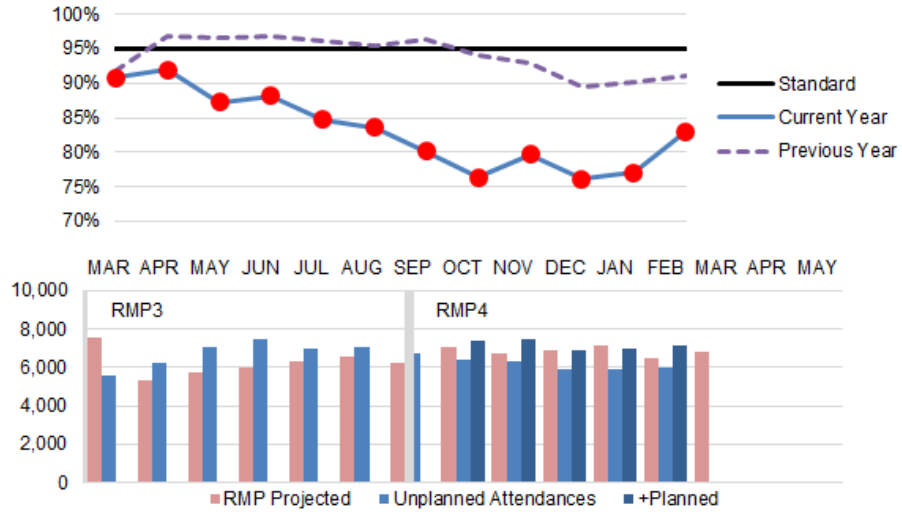
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. Unfortunately, training remains on hold due to the ongoing response to COVID-19 and current capacity issues; however, there have been some training sessions delivered virtually during the pandemic. It is hoped to recommence training once the picture in regard to Covid-19 settles somewhat and face-to-face training in large groups can be accommodated once again.

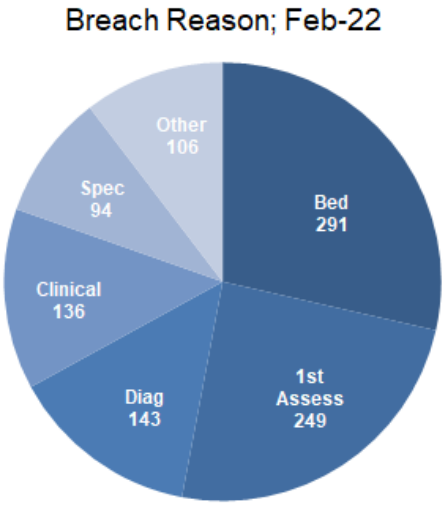
Although bespoke training sessions were due to be undertaken with Fife Wide & Fife East in May in 2021, this has not been possible to achieve for the reasons above. It is hoped there will be capacity to recommence this soon.

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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	90.8%	91.9%	87.2%	88.2%	84.7%	83.6%	80.1%	76.3%	79.7%	76.1%	77.0%	83.0%
Scotland	88.5%	88.7%	87.2%	85.0%	81.5%	77.8%	76.1%	73.5%	75.9%	75.7%	76.0%	

KEY CHALLENGE(S) IN 2021/22

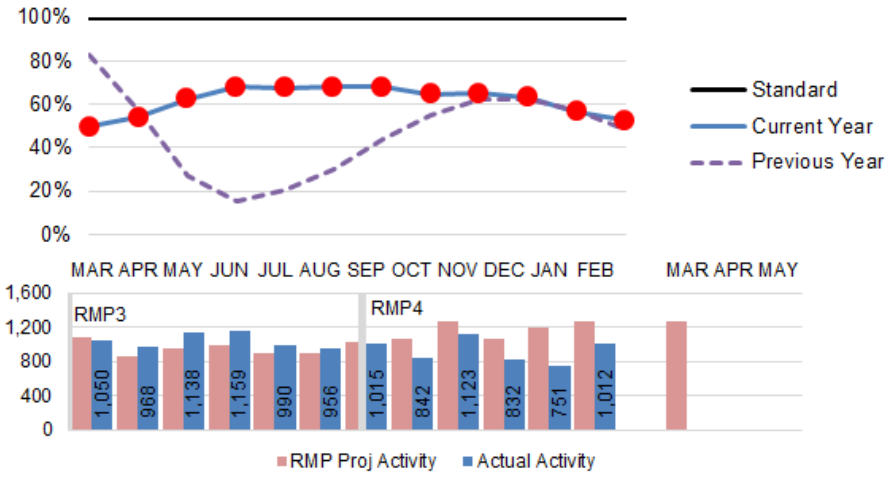
- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

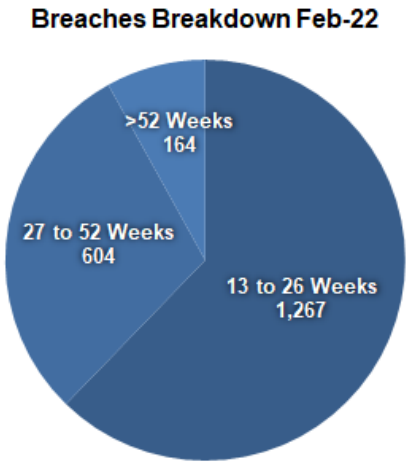
IMPROVEMENT ACTIONS	
21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub	**Complete Mar-22**
Virtual Flow and Navigation appointments to ED are now in place and the Hub has expanded to handle GP calls previously taken by ANPs into AU1. Early indication shows decreased number of referrals with a re-direction rate of 26%. Expansion for 24/7 handling is in planning and the Clinical Director for Planned Care is reviewing surgical pathways through FNC with a focus on a more streamlined urology pathway. This will be picked up again in the refreshed IPQR.	
22.1 Co-produce (with NHS 24) patient criteria for access to ED via 1-hr and 4-hr pathways	**Complete Nov-21**
22.2 Reduce number of patients breaching at 4 hrs, 8 hrs, and waits for beds	**Complete Mar-22**
February saw an improvement in performance, however bed waits continue to be the principal reason for breaches with the knock on effect of holding patients within the department further impacting time to first assessment due to lack of space. Flow to downstream wards impacted on high acuity of patients and the impact that COVID staff absence has had on ward staffing numbers and management of workload to enable discharges. OPEL escalation tool now in daily use with actions in place for escalation and formal action cards under development. This will be picked up again in the refreshed IPQR.	
22.3 Develop re-direction policy for ED	**Complete Dec-21**

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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	49.7%	54.1%	62.7%	67.9%	67.6%	68.2%	68.2%	64.9%	65.1%	63.1%	56.6%	52.7%
Scotland	34.7%	35.5%	37.2%	38.6%	36.7%	36.5%	34.0%	37.5%	37.3%	34.6%		

KEY CHALLENGE(S) IN 2021/22

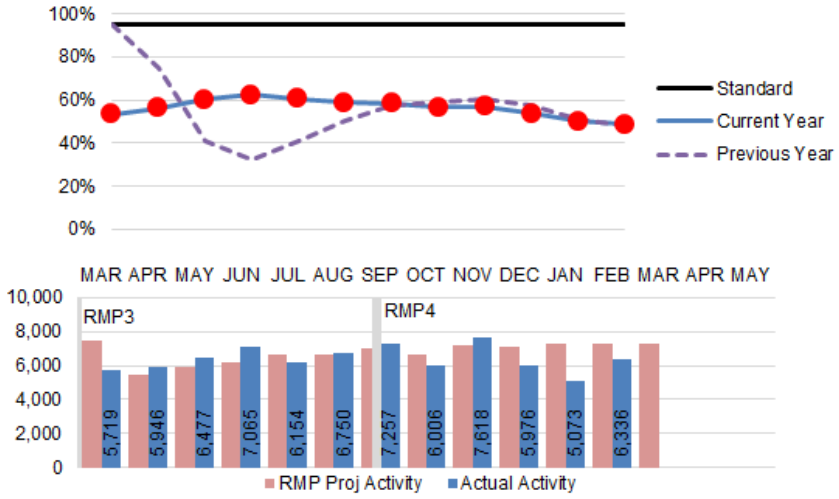
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

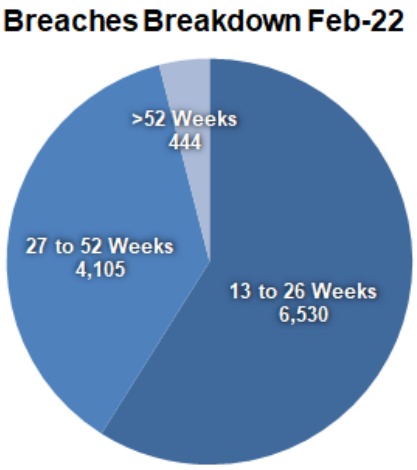
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Sep-22**
Business case delayed awaiting decision on suitable IT system	
22.3 Undertake waiting list validation against agreed criteria	**Complete Mar-22**
Clinical teams continue to review lists and prioritise patients, Clinical Prioritisation Group meets regularly. This work will continue as clinical prioritisation remains essential when elective capacity is restricted due bed capacity and unscheduled care demand.	
22.4 Develop and deliver improvement actions in line with CFSD priority projects overseen by Integrated Planned Care Programme Board	**Complete Mar-22**
ACRT in place for 3 specialities and PIR in place for 6 specialities. The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	

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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	53.4%	56.4%	60.3%	62.4%	60.7%	58.6%	58.3%	56.5%	57.1%	53.8%	50.1%	48.8%
Scotland	48.3%	50.5%	52.3%	53.4%	51.6%	49.7%	48.1%	48.0%	48.4%	46.5%		

KEY CHALLENGE(S) IN 2021/22

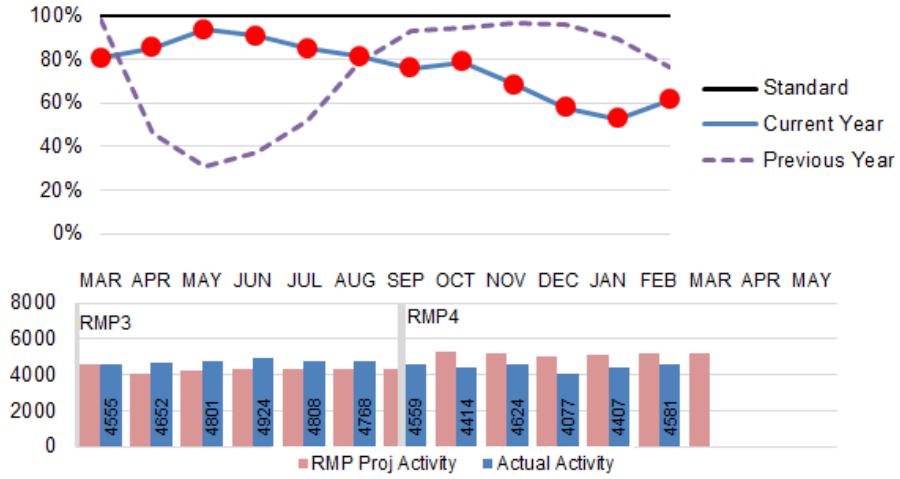
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

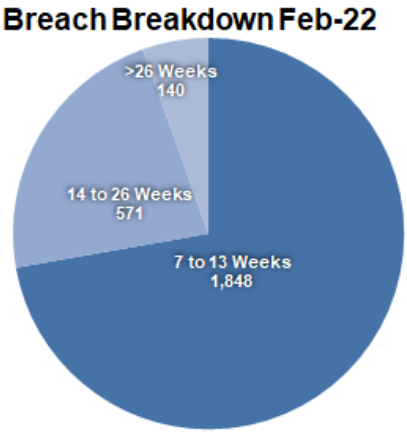
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Deliver appropriate elements of Modernising outpatients and unscheduled care redesign to reduce and manage demand and sustain capacity	**Complete Mar-22**
The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Understand impact of potential changes to guidance on social distancing and actions needed to implement	**Complete Dec-21**

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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.6%	85.3%	93.5%	90.6%	84.9%	81.2%	75.7%	78.7%	68.3%	57.8%	52.7%	61.2%
Scotland	61.4%	61.8%	64.1%	62.6%	57.2%	56.5%	57.8%	55.2%	56.9%	49.6%		

KEY CHALLENGE(S) IN 2021/22

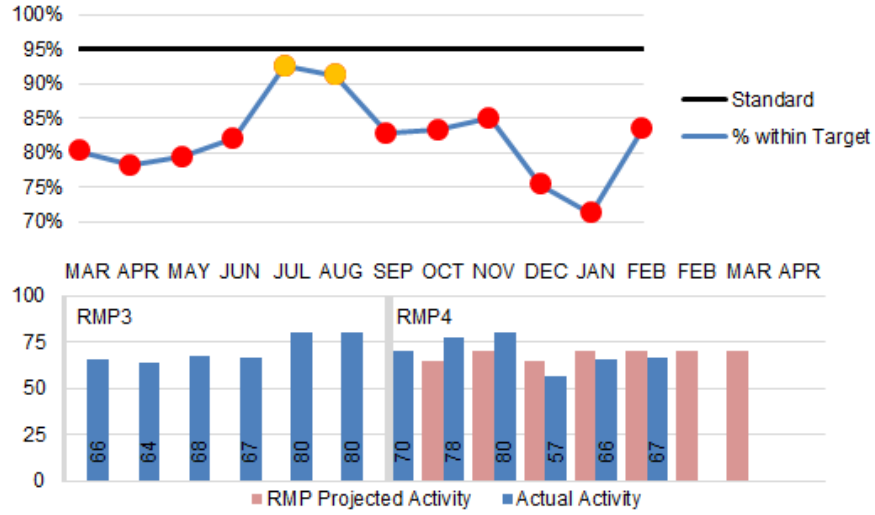
- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence and fatigue

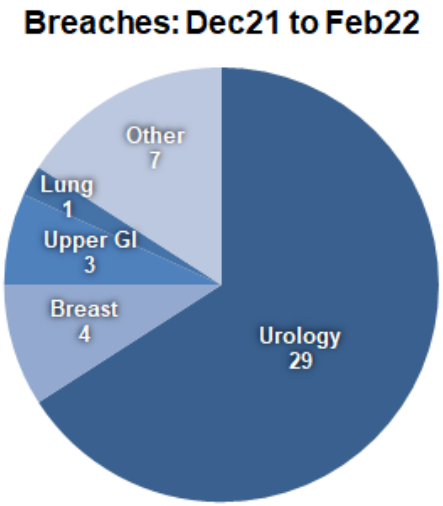
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Explore implementation of point of care testing in endoscopy	**Complete Mar-22**
System implemented	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Actively seek alternative sources of additional CT capacity to manage increasing waiting times for routine patients	**Complete Jan-22**

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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.3%	78.1%	79.4%	82.1%	92.5%	91.3%	82.9%	83.3%	85.0%	75.4%	71.2%	83.6%
Scotland	83.0%	84.5%	83.0%	83.6%	82.8%	83.5%	83.1%	78.8%	78.1%	78.3%	76.3%	77.4%

KEY CHALLENGE(S) IN 2021/22

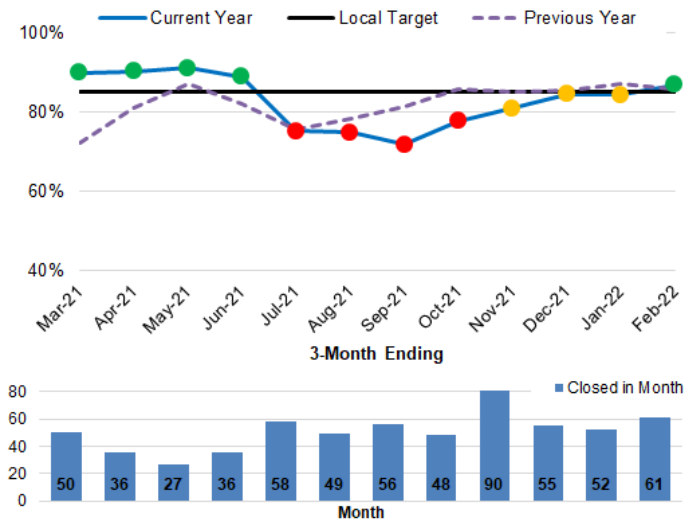
- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Introduction of the robot may impact on waits to surgical treatment due to training requirements

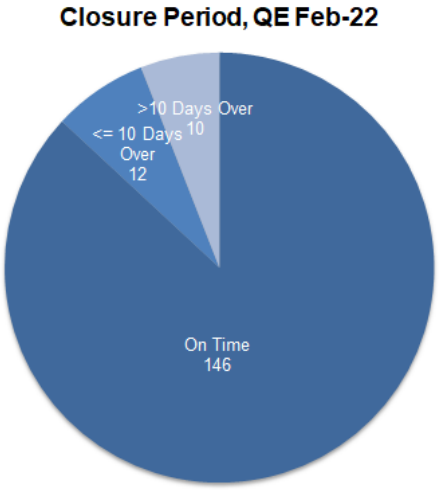
IMPROVEMENT ACTIONS	
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-23**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-23**
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 May-22**
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. Engagement sessions have been completed and the Framework and delivery plan is currently being drafted. The Framework is out for consultation.	
22.1 Effective Cancer Management Review	**By May-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. The Scottish Government will be visiting NHS Fife to introduce the reviewed Framework. An action plan has been drafted and is to be sent to the relevant groups for ratification.	

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										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Health Board	93.5%	93.5%	79.2%	88.6%	58.0%	83.3%	74.5%	78.0%	84.1%	85.4%	85.7%	94.2%
IJB	100.0%	100.0%	100.0%	100.0%	100.0%	42.9%	77.8%	100.0%	87.5%	100.0%	60.0%	77.8%

KEY CHALLENGE(S) IN 2021/22

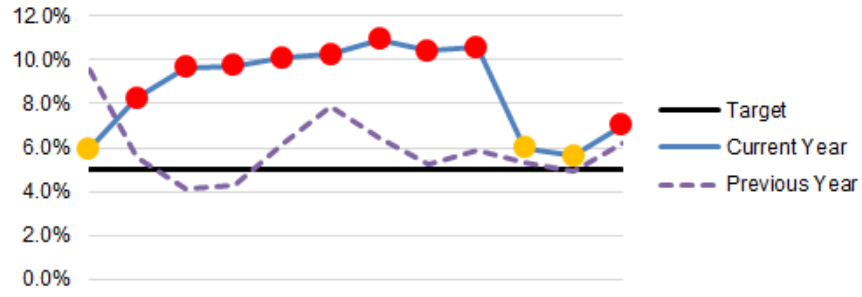
Establishment of a permanent resource level for all Information Governance and Security activities. Within the area of Freedom of Information, the temporary appointment has left the organisation and an Information Governance and Security Advisor is overseeing FOI administration. The route to a permanent post is still going through Human Resources and it is hoped that this will be ready for advertisement soon.

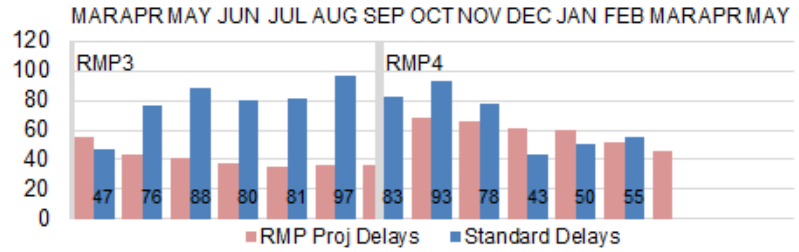
IMPROVEMENT ACTIONS	
21.1 Organisation-wide Publication Scheme to be introduced	**Complete Jun-21**
21.2 Improve communications relating to FOISA work	**Complete Dec-21**

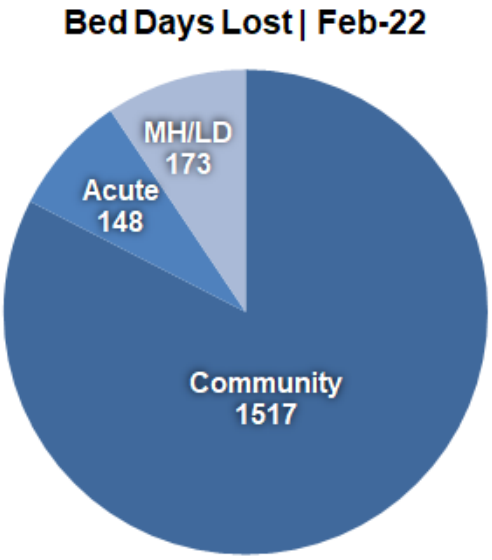
Delayed Discharges (Bed Days Lost)

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	2019/20			2020/21				2021/22	
	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	8.0%	7.2%	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%	10.4%
Scotland	7.2%	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%	6.7%

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-22**
The Oversight "Home First" group continue to meet on a regular basis, and Project Management Office (PMO) support is in place. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Monthly meetings take place, and this action will continue for the remainder of 2022.	
22.1 Fully implement the "Moving On" Policy in Acute and Community Hospitals	**Complete Jul-21**
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**By Sep-22**
The test of change is ongoing, however, the number of STAR beds available has been limited due to care home closures (COVID). This has resulted in a slip to the initial target completion date.	
22.3 Reduce number of delays due to awaiting the appointment of a Welfare Guardian	**Complete Mar-22**
A review of the guardianship paperwork and templates is complete, and the refreshed document has been approved by H&SC and NHS Fife (Acute). It will be held within patient notes to provide an overview and audit trail.	
22.4 Develop capacity within START plus additional investment to develop a programme of planning with the private agencies supported by Scottish Care	**Complete Mar-22**
Development of Care at Home Collaborative, supported by Scottish Care, started in late 2021, bringing together 10-12 Care at Home providers to work together, to maximise resources and capacity to help service user return to their own home, following a period in a care home interim placement. Commissioning of this resource is now complete.	
22.5 Surge capacity established to support admission demand	**Complete Mar-22**
Surge capacity has been established in QMH (Ward 3/8/8A), Glenrothes (Ward 1/2/3), Cameron (Balgonie/Balcurvie/Letham) and VHK (Ward 6/9)	

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

1. Executive Summary

At the end of February the board's reported financial position is a balanced position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.433m and £2.224m for External Health Care Providers, offset by favourable variances across Corporate Functions and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. Included in the Acute Services overspend is an adverse variance for Set Aside budgets of £5.8m and, as NHS Fife have current responsibility for the set aside budgets, this places additional financial pressure on the board and non-IJB health care services. The health services delegated to the Health & Social Care Partnership (H&SCP) report an underspend of £2.980m for the 11 months to February (following a non-recurring budget realignment payment made from Health Board to Fife Council of £3.734m in December).

Revenue Financial Position as at 28th February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
NHS Services (incl Set Aside)				
Clinical Services				
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**501,458**	**447,767**	**447,767**	**0**
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**
TOTAL	**935,327**	**793,252**	**790,272**	**2,980**

1.2 Cost pressures within Acute Services continue to increase reflecting the exceptional demand on unscheduled care capacity and challenges with delayed discharges. The many actions being taken to manage demand pressures have increased the requirement for temporary staffing. Increasing expenditure across medicines budgets continues to add to the significant cost pressures within clinical directorates particularly with Haematology/Oncology drugs budgets and Biologics.

1.3 The financial impact of COVID-19, including direct additional costs for vaccination, testing and remobilisation plus indirect costs associated with the managing the wider impact and recovery measures continues to be regularly updated and shared through established reporting mechanisms through quarterly reporting returns. Details are contained within Appendix 1. A Scottish Government letter received in February 2022 set out details of a further tranche of Covid-19 funding available to Boards and Integrated Authorities. The available balance of funding remaining at year end, which is expected to total £34m subject to final review, will be carried forward

into 2022/23 as an earmarked Covid recovery reserve within Integration Joint Boards. Further guidance is expected on how the funding will require to be deployed in 2022/23 against key priorities in supporting Covid-19 recovery.

1.4 The February allocation letter was issued on 9 March 2022 and included ADP Task force funding of £0.409m, out of hours additional urgent support £0.168m and CSO support for Covid research infrastructure. We also received notification of further Covid funding of £64.908m on 25 February 2022 for both Health Board and HSCP additional costs. Anticipated core allocations total -£0.712m and, as is often the case as we near year end, reflects additional top slicing for services to NSD. Further allocation details are contained within Appendix 2.

1.5 At the beginning of the financial year the board was committed to delivering cost improvements in year of £8.181m which are now confirmed as delivered in full. Despite the challenges the pandemic has created in the delivery of cost improvement plans, the board has delivered savings totalling £9.618m at the end of February. Appendix 3 sets out the savings achieved including an analysis of recurring and non-recurring sources, and forms the basis of our additional monthly reporting to Scottish Government.

1.6 The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to February records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11. The full capital programme is expected to deliver in full with significant activity in the final month of the year and a balanced capital position is expected.

2. Health Board Retained Services

Clinical Services financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**301,551**	**277,226**	**296,638**	**-19,412**

2.1 Costs directly attributable to Covid-19 have been identified and matched with budget, on a non-recurring basis and work continues to develop the projected covid impact into the new financial year. The Quarter 3 financial return and projections included an update on the financial impact of Covid 19 and informed Scottish Government further funding allocations per 1.5 above.

2.2 The Acute Services Division reports an **overspend of £17.433m.** Acute Services are experiencing particularly challenging capacity pressures at the front door and downstream wards on top of existing historic cost pressures. Measures are underway to ease the pressures including increasing temporary over recruitment to unregistered nursing posts, admin posts and international recruitment. A significant proportion of the reported overspend to February relates to unachieved savings of £11.489m. As reported in other sections of this report, non repayable funding has been received from Scottish Government which is included within financial flexibility. The decision not to attribute to individual budget areas was made to retain focus on delivery of savings targets. The remainder of the reported overspend continues across Nursing, Senior and Junior Medical Pay budgets, non-pay pressures within Haematology/Oncology medicines budgets and growth demand on diabetic pumps. Growth in spend on Acute medicines has accelerated beyond available funding significantly and is an issue being reported across boards in Scotland. In preparation for next year, cost improvement programmes are being identified and documented which will help to close the financial gap.

2.3 The IJB Non-Delegated budget reports an **underspend of £0.171m.** This is mostly being driven by a pay underspend in the Daleview Regional Unit, resulting from occupational therapy and learning disabilities nursing vacancies.

2.4 The budget for healthcare services provided out-with NHS Fife is **overspent by £2.224m** and is broadly in line with the position reported last month. Further detail is contained in Appendix 4.

Corporate Functions and Other Financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
SUB TOTAL	**199,907**	**170,541**	**151,129**	**19,412**

2.5 The Estates and Facilities budgets report an **underspend of £2.914m.** This comprises an underspend in pay of £0.809m which is continuing the trend of previous months across several departments including estates services, catering, and portering. Non-pay costs continue to perform well except for property maintenance. The ongoing increases in energy prices will continue to be monitored, as will general price inflation and its resulting impact.

2.6 Within the Board's corporate services there is **an underspend of £1.345m**. The main driver for this underspend is the level of vacancies across the Finance Directorate (£0.296m), the Nursing Director budget (£0.297m), Medical Director (£0.211m) and Other (£0.351m). The latter covers areas such as legal, early retirements and injury benefits - which in the main are financial transactions.

2.7 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 £15.153m** has been released at month 11, and includes receipt of non-repayable support received from SG. Further detail shown in Appendix 5.

3. Health & Social Care Partnership

3.1 Health services in scope for the Health and Social Care Partnership report an **underspend of £2.980m.** This underspend is net of a non-recurring payment on account of the Health Delegated in-year underspend to Social Care made in December.

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**

The Health and Social Care Partnership budget detailed above are Health budgets designated as in scope for HSCP integration, excluding services defined as Set Aside. The financial pressure related to 'Set Aside' services is currently held within the NHS Fife financial position. These services are currently captured within the Clinical Services areas of this report (Acute set aside £5.8m overspend to month 11 per 1.1 above).

4. Forecast

4.1 Our forecast outturn to the year end is a balanced position following receipt of non recurring funding support of £13.7m for Health Board retained services (representing our in-year deficit in our opening financial plan of £13.656m unachieved). Our forecast position assumes ADEL (Additional Departmental Expenditure Limit) funding of £0.950m re the replacement of obsolete equipment; and property and vehicle repair expenditure which we expect to receive in our final allocation letter this year.

4.2 The Health delegated underspend position is forecast at £3.748m following the non-recurring budget realignment transfer of £3.734m to Fife Council in December. It is anticipated the final year end underspend will be transferred as a non-recurring payment later in March. The H&SCP projected year end position is an underspend of c£0.573m as confirmed by the Chief Finance Officer following the roll out of the recovery plan and receipt of further funding.

4.3 Whilst details of funds held within Delegated Health Earmarked Reserves (created last financial year) are noted at Appendix 6; work is ongoing to finalise an additional significant Health Delegated earmarked reserve for the current financial year.

4.4 The projected NHS Fife forecast does not include any risk share with the Health and Social Care Partnership given Integration Authorities will also be provided with Scottish Government support to a balanced position. A cash transfer has been actioned in December from Health to Council to allow both organisations to report a balanced position; with a further transfer planned towards the end of the financial year.

5. Recommendation

5.1 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 reported core breakeven position for the 11 months to date for Health Board retained;
- **Note** the forecast balanced position for Health Board retained, following non recurring, non repayable funding SG funding support;
- **Note** the Health delegated forecast core underspend position (net of a cash transfer made to Fife Council of £3.7m in December) of a further £3.7m which will be transferred to Fife Council as we approach the financial year end.

Appendix 1: 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	
Allocations Q2	6,815	6,831	192	13,838	
Final allocation in January	20,947	9,945		30,892	
HSCP ear marked reserve		3,399		3,399	
Additional		34,017		34,017	
Total funding	**36,464**	**57,070**	**192**	**93,726**	**0**
Allocations made for April to February					
Planned Care & Surgery	1,393			1,393	
Emergency Care & Medicine	8,144			8,144	
Women, Children & Clinical Services	2,838			2,838	
Acute Nursing	0			0	
Estates & Facilities	1,321			1,321	
Board Admin & Other Services	1,860			1,860	
Public Health Scale Up	957			957	
Test and Protect	4,881			4,881	
Primary Care & Prevention Serv		635		635	
Community Care Services		1,672		1,672	
Complex & Critical Care Serv		286		286	
Professional/Business Enabling		182		182	
Covid Vaccine/Flu		11,640		11,640	
Social Care			192	192	
Non-repayable support	13,656				
Exclude additional		34,017			
Total allocations made to M11	**35,050**	**48,432**	**192**	**36,001**	**0**
Balance In Reserves	**1,414**	**8,638**	**0**	**57,725**	**0**
Remaining funding c/fwd to 2022/23	**34,017**				

Appendix 2: 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	20,964	42,472	
	July Letter			8,002	8,002	
	August Letter	141	230	1,522	1,893	
	September Letter	-135	59,994	-1,931	57,928	
	October Letter		3,390	14,908	18,298	
	November Letter	2,042	1,704	4,333	8,079	
	December letter		23	3,126	3,149	
	January Letter reported at month 10	-178	6,274	2,995	9,091	
25 Feb 2022	Amendment to January letter					
	PPE			130	130	As per SG Correspondence
	Further Covid Funding 2021-22			61,147	61,147	As per SG Correspondence
	Covid & Extended Flu Vaccinations			3,979	3,979	As per SG Correspondence
	Test & Protect			-347	-347	As per SG Correspondence
Letter 9 March 2022	Task Force Funding to ADPs			409	409	As per SG Correspondence
	Distinction Awards for NHS Consultants		139		139	Annual Allocation
	CSO support for Covid research infrastructure			60	60	Additional Allocation
	Improvements to forensic medical services			2	2	Additional Allocation to previous allocation
	Afghan refugee healthcare provision			62	62	As per specific allocation letter
	Audiology Equipment			12	12	Specific Allocation
	Remote blood pressure monitoring (InHealthCare)			15	15	Specific Allocation
	Out of Hours additional Urgent Support 2021-22			168	168	As per specific allocation letter
	ScotSTAR Topslice	-345			-345	Annual Adjustment
	Purchase of audiology equipment			5	5	Specific Allocation
	GJNH - Top slice adjustment - Boards			-11	-11	Annual Adjustment
	National Distribution Centre - Top-slice		-780		-780	Annual Adjustment
	Total Core RRL Allocations	**723,323**	**83,218**	**119,550**	**926,091**	
Anticipated	Capital to Revenue			277	277	
Anticipated	NSD Adjustments		-989		-989	
		0	**-989**	**277**	**-712**	
Anticipated	IFRS			8,900	**8,900**	
Anticipated	Donated Asset Depreciation			115	**115**	
Anticipated	Impairment			1,333	**1,333**	
Anticipated	AME Provisions			-400	**-400**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**9,948**	**9,948**	
	Grand Total	**723,323**	**82,229**	**129,775**	**935,327**	

Appendix 3: Savings Position at 28 February 2022

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 February £'000	Unachieved to March £'000
Health Board	21,837	8,181	13,656	5,779	3,839	9,618	0
					0		0
Total Savings	**21,837**	**8,181**	**13,656**	**5,779**	**3,839**	**9,618**	**0**

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		-607	393		-41	959
Pay Vacancy Factor (1%)	3,015	Medium		-3,015	0		-3,015	0
Repatriation of Services	500	Low		-500	0		-500	0
External Commissioning Cost Review	1,000	Medium		-1,000	0		-1,000	0
Medicine Utilisation	500	Medium		-640	-140		-595	-95
Contracts	1,500	Low		-284	1,216		0	1,500
Procurement - Non pay	500	Medium		0	500		0	500
Other	166	Low		-3,572	-3,406		-628	-462
	8,181			**-9,618**	**-1,437**		**-5,779**	**2,402**

Appendix 4: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	99	91	88	3
Borders	45	42	52	-10
Dumfries & Galloway	25	23	52	-29
Forth Valley	3,227	2,958	3,365	-407
Grampian	365	334	259	75
Greater Glasgow & Clyde	1,680	1,540	1,534	6
Highland	137	126	187	-61
Lanarkshire	117	107	198	-91
Lothian	31,991	29,327	30,859	-1,532
Scottish Ambulance Service	103	94	92	2
Tayside	40,084	36,741	38,167	-1,426
Savings				0
	77,873	**71,383**	**74,853**	**-3,470**
UNPACS				
Health Boards	10,801	9,900	8,679	1,221
Private Sector	1,151	1,057	1,293	-236
	11,952	**10,957**	**9,972**	**985**
OATS	721	661	400	261
Grants	65	65	65	0
Total	**90,611**	**83,066**	**85,290**	**-2,224**

Appendix 5: Financial Flexibility & Allocations

	£'000	Flexibility Released to Feb-22 £'000
Financial Plan		
Junior Doctor Travel	17	14
Consultant Increments	232	213
Cost Pressures	3,656	2,035
Developments	2,054	1,240
Sub Total Financial Plan	**5,959**	**3,502**
Allocations		
Waiting List	1,300	0
AME: Impairment	73	0
AME: Provisions	126	0
Pay Award:AfC	1,664	1,522
Test & Protect	784	0
Covid General	629	0
Winter	661	0
Cancer Waiting Time	225	92
Distinction Award	3	3
Unscheduled Care Summer	180	0
Support to build recruitment capacity	27	0
Building Capacity for international recruitment	11	0
Young Patients Family Fund	38	29
Emergency Cancer Diagnostic Centre	196	0
Pregnancy Anaemia Management	28	0
Workforce Wellbeing	200	0
Discharge Without Delay Pathfinders	256	0
Interface Care Programme	480	0
Nurse Director Support	403	0
Fleet Decarbonisation	54	0
R&D	12	11
2020/21 Surplus	340	312
Chronic Pain	9	0
Additional CT & MRI Capacity	44	0
Mental Health Pharmacy recruitment	64	0
Additional Band 2-4	845	0
Capital to Revenue	355	0
International Recruitment	378	0
Diabetic Technologies	999	0
Audiology Equipmet	18	0
Funding Support	13,656	9,682
CSO Covid Research	60	0
Sub Total Allocations	**24,118**	**11,651**
Total	**30,077**	**15,153**

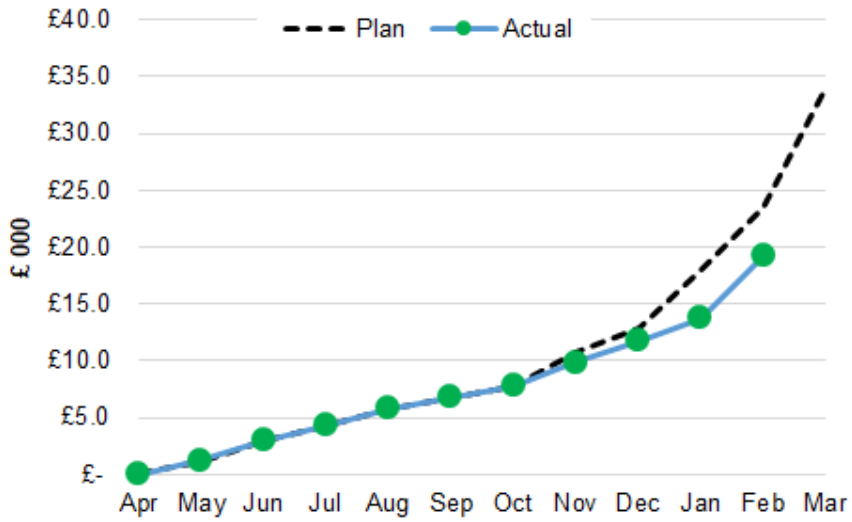
Appendix 6: Anticipated Funding from Health Delegated Earmarked Reserve

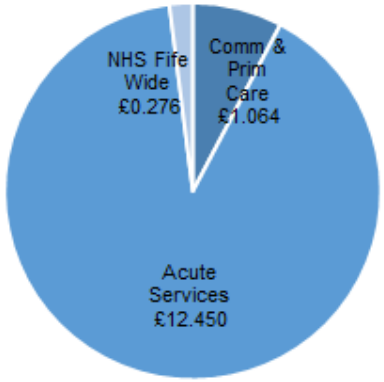
Health Delegated Earmarked Reserve	Total £000's	Health Delegated Budgets To M11 £000's	Anticipated £000's	Balance £000's
Vaccine	740	740		0
Care homes	526	82		444
Urgent Care Redesign	935	408		527
Flu	203	203	0	0
Primary Care Improvement Fund	2,524	1,011		1,513
Action 15	1,315	505		810
RT Funding	1,500			1,500
FSL	500	500		0
District Nurses	30			30
Fluenz	18			18
Core run rate	1,767	1,206	0	561
Core (covid offsets)	1,250	1,250		0
Total	**11,308**	**5,905**	**0**	**5,403**

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance





Commentary

The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to January records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11; with significant activity underway in the final month of the year which will inform a balanced capital position.

1. Annual Operational Plan

The capital plan for 2021/22 was approved by the FP&R Committee in July and was subsequently tabled at the NHS Fife Board. NHS Fife has assumed a programme of £33.942m detailed in the table below.

Capital Plan	£'000
Initial Capital Allocation	7,394
National Equipping Funding	1,537
Elective Orthopaedic Centre	15,907
Mental Health Review	22
Lochgelly Health Centre	348
Kincardine Health Centre	207
Energy Scheme Funding	1,457
Pre Capital Fund Grant	50
Covid Capital	1,878
QMH Theatre	1,000
CT Scanner	700
Louisa Jordan Equipment	22
Laundry Equipment	655
2nd Tranche NIB Equipment	1,176
National Eyecare Workstream	228
Capital to Revenue Transfer	- 277
SG Extra Funding Request	591
Decontamination Room	350
Colposcope	12
Extra National Eyecare Workstream	51
Audiology Equipment	97
Additional Equipment Funding	136
Decontamination Equipment	241
Additional Equipment Funding PH2	160
Total	**33,942**

There has been a reduction in the expected funding to be allocated for the Energy Grant this year. Originally, expenditure was planned to be £1.8m, however, this has now been reduced to £1.457m, and the remaining balance of £0.343m will be provided for next financial year.

Despite being a challenging year in terms of supply chain issues, availability of materials and price increases on materials the capital plan and achievement of the capital resource limit remains on target.

Capital Receipts

1.1 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. The Developers have provided other plans in order to move forward, however, the GP's are still objecting.

2. Expenditure / Major Scheme Progress

2.1 The summary expenditure position across all projects is set out in the dashboard summary above. The expenditure to date amounts to £19.233m, this equates to 56.66% of the total capital allocation, as illustrated in the spend profile graph above.

2.2 The main areas of spend to date include:

Statutory Compliance	£3.851m
Equipment	£3.241m
Digital	£0.343m
Elective Orthopaedic Centre	£10.658m
Health Centres	£0.424m
Clinical Prioritisation	£0.711m

3. Recommendation

3.1 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 28 Febuary 2022 of £19.233m and the year-end spend of the total anticipated capital resource allocation of £33.942m.

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	218	158	218
Statutory Compliance	364	303	364
Capital Equipment	151	147	151
Condemned Equipment	23	23	23
National Infrastructure Equipment Funding	6	0	6
Kincardine Health Centre	207	173	207
Lochgelly Health Centre	348	250	348
Decontamination Room	350	0	350
Total Community & Primary Care	1,666	1,055	1,666
ACUTE SERVICES DIVISION			
Statutory Compliance	2,953	2,301	2,953
Capital Equipment	1,981	1,639	1,981
Clinical Prioritisation	763	292	763
Condemned Equipment	88	63	88
National Infrastructure Equipment Funding	3,407	1,288	3,407
Elective Orthopaedic Centre	15,907	10,658	15,907
Laundry Equipment	655	0	655
National Eyecare Workstream	279	0	279
Colposcope	12	0	12
QMH Theatre	1,000	242	1,000
Extra SG Funding Request	591	82	591
Audiology Equipment	97	0	97
Total Acute Services Division	27,734	16,565	27,734
NHS FIFE WIDE SCHEMES			
Equipment Balance	3	0	3
Information Technology	1,200	343	1,200
Clinical Prioritisation	0	0	0
Statutory Compliance	0	0	0
Condemned Equipment	1	0	1
Fire Safety	60	60	60
Scheme Development	0	0	0
Vehicles	142	0	142
Covid Capital	1,325	260	1,325
Mental Health Review	22	5	22
Total NHS Fife Wide Schemes	2,753	667	2,753
TOTAL CAPITAL ALLOCATION FOR 2021/22	**32,154**	**18,288**	**32,154**

ANTICIPATED ALLOCATIONS 2021/22			
Energy Funding Grant	1,457	945	1,457
Pre Capital Grant Funding	50	0	50
ECG Machines - Louisa Jordan Equipment	22	0	22
Capital to Revenue Transfer	-277	0	-277
Additional Equipment Funding	136	0	136
Decontamination Equipment	241	0	241
Additional Equipment Funding PH2	160	0	160
Anticipated Allocations for 2021/22	**1,788**	**945**	**1,789**

Total Anticipated Allocation for 2021/22	**33,942**	**19,233**	**33,942**

Appendix 2: Capital Plan - Changes to Planned Expenditure

Capital Expenditure Proposals 2021/22 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to January £'000	February Adjustment £'000	Total February £'000
Community & Primary Care				
Capital Equipment	0	151	0	151
Condemned Equipment	0	24	-1	23
Clinical Prioritisation	0	252	-34	218
Statutory Compliance	0	329	35	364
Lochgelly Health Centre	0	0	207	207
Kincardine Health Centre	0	0	348	348
National Infrastructure Equipment Funding	0	6	0	6
Decontamination Room	0	0	350	350
Total Community & Primary Care	**0**	**762**	**905**	**1,666**
Acute Services Division				
Capital Equipment	0	1,971	10	1,981
Condemned Equipment	0	88	0	88
Clinical Prioritisation	0	727	36	763
Statutory Compliance	0	2,945	8	2,953
National Infrastructure Equipment Funding	0	3,407	0	3,407
Elective Orthopaedic Centre	0	15,907	0	15,907
National Eyecare Workstream	0	228	51	279
Laundry Support	0	600	55	655
Colposcope	0	0	12	12
Audiology Equipment	0	0	97	97
Extra SG Funding Request	0	0	591	591
QMH Theatre	0	0	1,000	1,000
	0	**25,874**	**1,860**	**27,734**
Fife Wide				
Backlog Maintenance / Statutory Compliance	3,500	-3,476	-43	-18
Fife Wide Equipment	1,805	-1,792	-10	3
Digital & Information	1,000	200	0	1,200
Clinical Prioritisation	500	-480	-2	18
Condemned Equipment	90	-90	1	1
Fife Wide Asbestos Management	0	0	0	0
Fife Wide Fire Safety	0	60	0	60
General Reserve Equipment	94	-94	0	0
Pharmacy Equipment	205	-205	0	0
Fife Wide Vehicles	0	142	0	142
Covid Capital	0	1,325	0	1,325
Mental Health Review	0	0	22	22
Total Fife Wide	**7,194**	**-4,409**	**-31**	**2,753**
Total Capital Resource 2021/22	**7,194**	**22,226**	**2,733**	**32,153**

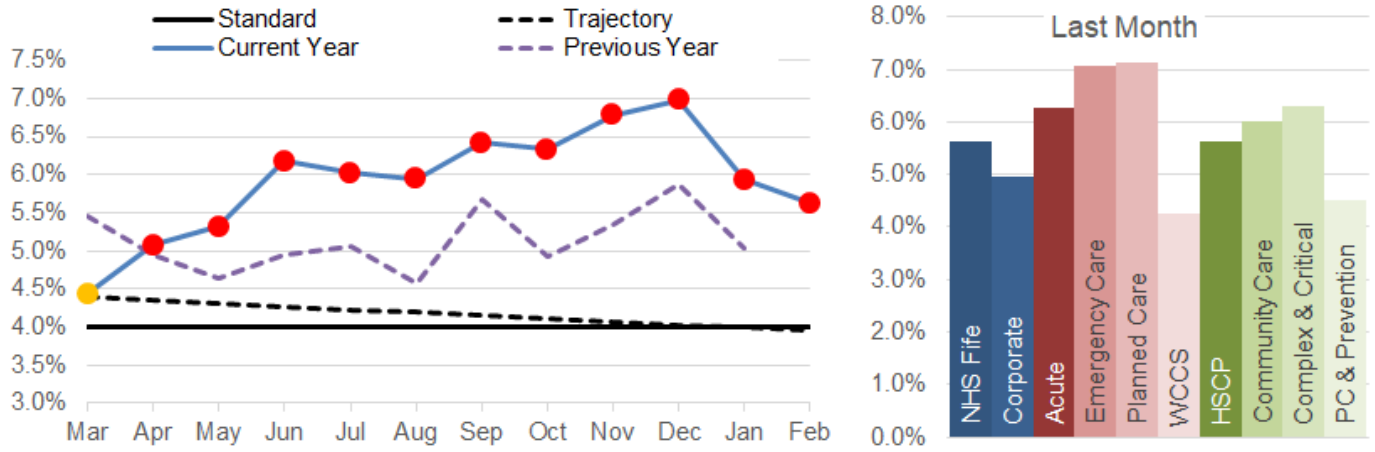
ANTICIPATED ALLOCATIONS 2021/22				
Energy Funding Grant	1,457	0	0	1,457
Pre Capital Grant Funding	50	0	0	50
ECG Machines - Louisa Jordan Equipment	22	0	0	22
Capital to Revenue Transfer	-277	0	0	-277
Additional Equipment Funding	136	0	0	136
Decontamination Equipment	241	0	0	241
Additional Equipment Funding PH2	160	0	0	160
Anticipated Allocations for 2021/22	**1,788**	**0**	**0**	**1,788**

Total Planned Expenditure for 2021/22	**8,982**	**22,226**	**2,733**	**33,942**

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										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	4.43%	5.07%	5.31%	6.17%	6.03%	5.95%	6.42%	6.34%	6.79%	6.98%	5.93%	5.63%
Scotland	4.56%	4.59%	5.04%	5.52%	5.62%	5.76%	6.12%	6.30%	6.37%	6.23%	5.37%	4.96%

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-23**

The additional OH Physician is providing specific support for staff affected by Mental Health and training is available for managers. This is in addition to the individual case work being progressed by local managers and HR staff, with input when necessary from the specialist OH Mental Health Nurse. The new OH Occupational Therapist is providing support to staff resuming work following diagnoses of long COVID, and this will continue into 2022/2023.

Additional staff support is being provided via a variety of services and initiatives, alongside the introduction of new eLearning Modules on resilience and wellbeing and access to the National PROMiS resources. This is complemented by a range of supporting materials, including a new “Benefits of Being Outdoors” poster and desktop campaign.

Additional monies to support staff during the winter months have been allocated and include improved access to meals out of hours, additional resources for Spiritual Care, Values Based Reflective practice, Psychology Staff support and Health Psychology, alongside bespoke wellbeing sessions for specific staff groups (e.g. H&S, ICU).

On line Fuel Poverty sessions took place in March, with additional on site sessions being arranged for April. Plans have been completed in terms of the use of the extra Scottish Government funding allocation for Staff Health and Wellbeing with a range of staff support activities during 2022/2023.

22.2 Continue existing managerial actions in support of achieving the trajectory for the Board and the national standard of 4% for sickness absence	**By Mar-23**

In addition to routine activities, a questionnaire is being circulated to managers in advance of the Promoting Attendance training sessions to identify areas for provision of support, both within and outwith the training sessions. The new Once for Scotland eLearning module is being promoted to complement our internal training and to assist managers and staff with their understanding of the policy.

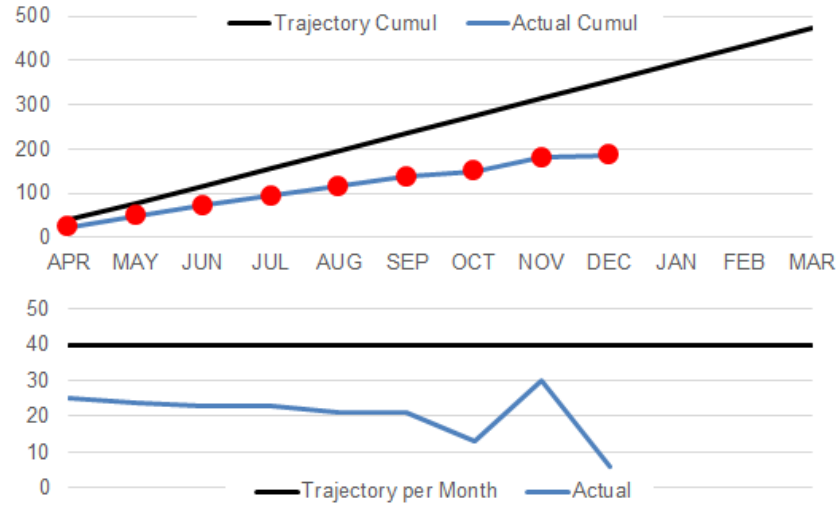
Feedback received following a programme to reinforce attendance management processes undertaken between May and July 2021 was discussed in partnership at the Attendance Management Workforce Review Group held in December, with a series of actions being progressed by key stakeholders. Promoting attendance at work is a regular agenda item at LPF and APF meetings ensuring regular discussion and suggestions/actions for consideration.

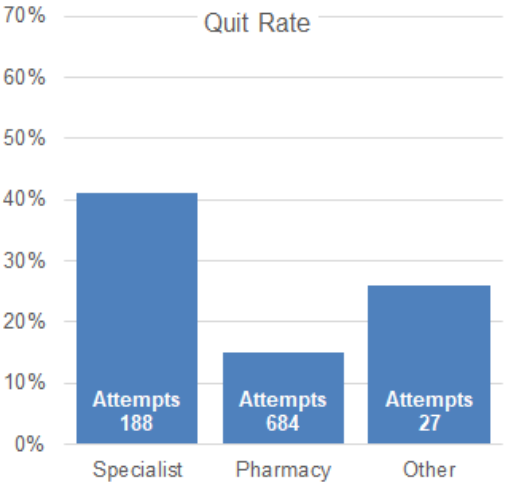
22.3 Consider refinements to COVID-19 absence reporting, including short-term manual data capture from SSTS and eESS in preparation for any change to self-isolation guidance and to support ongoing workforce resourcing actions, acknowledging that systems development is required to support MI reporting	**Complete Nov-21**

Smoking Cessation

In 2021/22, 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	23	23	21	21	13	30	6			
	Actual Cumul	25	49	72	95	116	137	150	180	186			
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	62.5%	62.0%	61.0%	60.1%	58.9%	58.1%	54.3%	57.1%	52.5%			
Scotland	Achieved			92.4%			82.0%						

KEY CHALLENGE(S) IN 2021/22

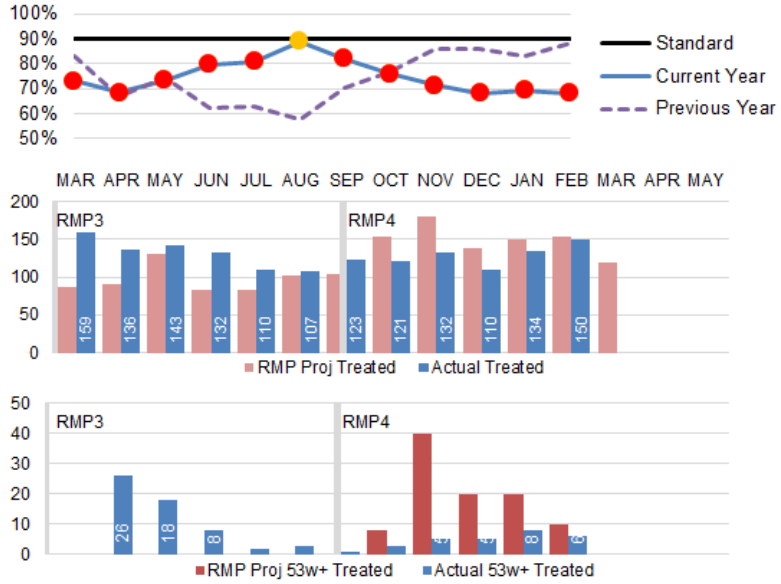
- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust in the brand
- Re-establishment of outreach work

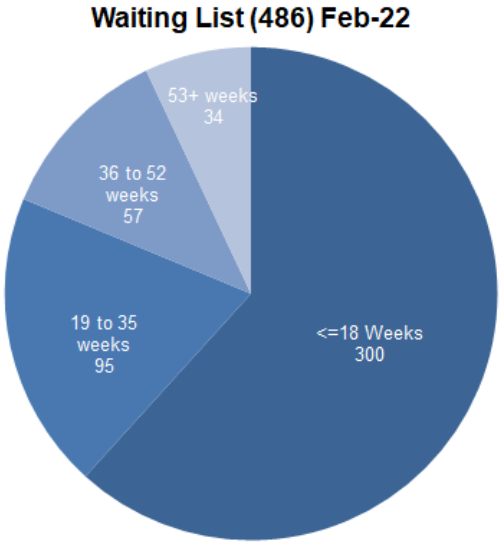
IMPROVEMENT ACTIONS	
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	**Complete Oct-21**
20.3 'Better Beginnings' class for pregnant women	**Complete Oct-21**
20.4 Enable staff access to medication whilst at work	**Closed Mar-22**
This action has been paused due to the pandemic, but may be revisited in FY 2022/23. Action closed at this stage.	
21.1 Assess use of Near Me to train staff	**Complete Jul-21**
21.2 Support Colorectal Urology Prehabilitation Test of Change Initiative	**Complete Sep-21**
22.1 Test face to face provision in two GP practices and one community venue	**Complete 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. Early discussions with 2 GP practices were due to restart in the second week of January, while the remobilisation plan was scheduled to go to the remobilisation committee on 9th December. However, both activities were paused due to the impact of the COVID Omicron strain. Ongoing discussions with GP practices have taken place, and we have an agreed start date of week beginning 2nd April.	

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	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	73.0%	68.4%	73.4%	79.5%	80.9%	88.8%	82.1%	76.0%	71.2%	68.2%	69.4%	68.0%
Scotland	67.5%	71.3%	71.8%	74.8%	75.9%	77.4%	82.1%	71.5%	70.5%	68.9%		

KEY CHALLENGE(S) IN 2021/22

- Implementation of additional resources to meet demand; development of workforce to meet National CAMHS Service Specification
- COVID-19: relaxation on referrals and delivery of 'models' to reflect social distancing

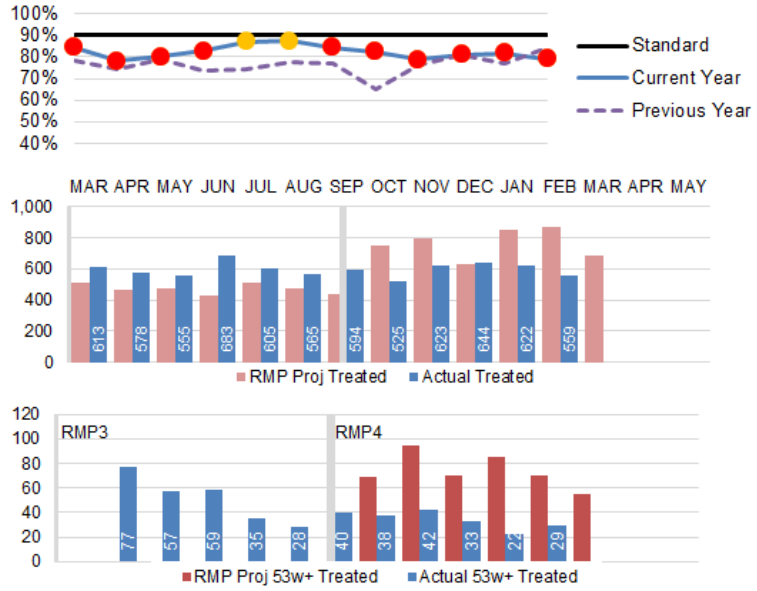
IMPROVEMENT ACTIONS

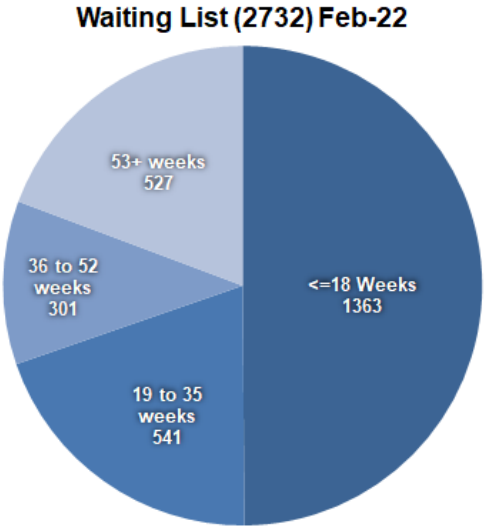
21.1 Re-design of Group Therapy Programme	**Complete Jul-21**
21.3 Build CAMHS Urgent Response Team (CURT)	**By Jun-22**
The CURT model is in place. Responsiveness to A&E and Paediatric inpatient unit has been extended with same day assessments available if young people are considered fit for assessment. Presentations to Emergency department due to self harm/suicidal ideation remain high with a 180% increase through 2022. Recruitment is underway to increase the existing CURT staffing capacity from 2.8 wte to 6.6 wte to address the increasing referral trend for urgent presentations. Review of activity and effectiveness of the model is ongoing utilising improvement methodology.	
22.1 Recruitment of Additional Workforce	**By Jun-22**
Recruitment is ongoing across multiple service areas to improve RTT, Longest waits and CAMHS service provision. From the 12 staff identified to address immediate capacity issues, 9 have been appointed with remaining posts re-advertised at lower banding to improve uptake. All new staff have worked through induction programme to ensure they are competent to take on caseloads and are incrementally increasing clinical activity towards full capacity. This is balanced against staff departures and retirements which have created 6 additional posts for recruitment. Phase 1 and Phase 2 recruitment as part of the SG Recovery & Renewal fund is underway. Currently Fife CAMHS has 21 wte posts either out to recruitment or in development with additional roles in admin (5.0 wte) and AHP (3.0 wte) working through the recruitment process.	
22.2 Workforce Development	**Complete Mar-22**
A revised development and training programme, which was originally postponed in January due to high Covid-19 absences, is now underway. Three Programmes have been developed to suit different levels of CAMHS experience. A Training needs analysis has been completed to ensure the right skills and competencies exist across the range of teams in 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										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	84.3%	78.2%	80.0%	82.6%	86.9%	87.4%	84.5%	82.3%	78.8%	81.1%	81.8%	79.2%
Scotland	80.9%	81.3%	82.5%	84.3%	88.5%	87.0%	86.1%	85.5%	83.0%	85.1%		

KEY CHALLENGE(S) IN 2021/22

- Recruitment of staff required to achieve waiting times standard 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**
22.1 Increase access via Guided self-help service	**Complete Sep-21**
22.2 Expansion of skill mix model to increase delivery of low intensity interventions	**Complete Jan-22**
22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Jun-22**
There remain significant national issues with workforce availability for staff who can provide highly specialised PTs - required to address our WL backlog. The service has been successful in recruiting other grades of staff to increase delivery of PTs for people with less complex problems and free some capacity amongst staff qualified to work with the more complex presentations. The NHS Education for Scotland national recruitment campaign has been less successful than hoped but we do have some applicants for highly specialist posts, with interview dates for end of April. However, we shall not be able to recruit to all of the posts that were identified as required within the PT Recovery Plan.	
22.4 Waiting list management within General Medical Service in Clinical Health	**By May-22**
Staff are undertaking a focused piece of work to clear the backlog on the assessment waiting list. A key driver is the need to differentiate patients with functional neurological disorder from those with other needs in order to inform development of appropriate clinical pathways. The work will ensure that only those for whom psychological therapy is the best option remain on the waiting list. It will also inform next steps in development of clinical pathways.	
22.5 Programme of training to increase capacity for work with more complex patients	**Complete Mar-22**
The AMH psychology service have implemented a structured programme of training and supervision to increase the skills of the Clinical Associates in Applied Psychology. This will reduce the demand upon the Clinical Psychologists in the service who are able to work with people with more complex presentations.	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Progress of Annual Delivery Plan (RMP4) 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy** **Janette Owens, Director of Nursing**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to the:

- Remobilisation Plan 4 2021/22 – Update to end of March 2022
- Review of National Response to Winter 2021/22
- Winter Report 2021/22 – Data to March 2022

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The fourth Joint Remobilisation Plan for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) was submitted to Scottish Government on 30th September. This plan is considered as a review of the Remobilisation Plan 3, reflecting on progress and set out what is expected to be delivered over the remainder of 2020/21.

This paper reports on the actions of the Remobilisation Plan 4 and has been renamed as NHS Fife's Annual Delivery Plan (including the winter actions) 2021/22.

2.2 Background

The Scottish Government letter dated 20th July 2021 titled *Remobilisation Plans 2021/22: Mid-Year Update (RMP4)* commissioned the next iteration from NHS Boards of the Remobilisation Plan.

The feedback letter from Mr John Burns, Chief Operating Officer, Scottish Government was received on 19th November 2021 confirming that the RMP4 for the second half of 2021/22 can be taken through NHS Fife's governance process.

Progress against deliverables is to be reported to the Scottish Government on a quarterly basis. This paper focusses on status at end of March (to be submitted by 29th April).

This paper also covers the submission following the letter received 14th February from Scottish Government titled *Review of National Response to Winter 2021/22* which asked Boards for their winter lessons and reflections on collective planning and response arrangements.

2.3 Assessment

This assessment reports on three aspect of strategic planning and covers: update to the Remobilisation Plan 4, Review of national response to Winter 2021/22 and Winter Report (data).

Remobilisation Plan 4 2021/22 – Update to end of March 2022

The guidance document issued in July 2021 described a different approach and requirements for RMP4 since the submission of RMP3. We were required to provide a shorter strategic organisational overview with specific delivery action plans to be delivered by March 2022.

Action Status (31/3/2022)	
Unlikely to complete on time/meet target	12
At risk - requires action	20
On Track	61
Complete/ Target met	52

The summary status above shows that the majority of the action for 2021/22 are completed or on track to be completed by the target date. The key themes of actions that are unlikely to be completed are: delivery of elective care and diagnostics and improvements in cancer performance and early diagnosis.

The full delivery action plan of the Remobilisation Plan 4 can be found in Appendix 1 and is being monitored and documented quarterly. Any incomplete actions will be carried over into next year's Annual Delivery Plan 2022/23.

Review of National Response to Winter 2021/22

Following the request from Scottish Government, NHS Fife submitted the Review of the National Response to Winter 2021/22 on 18 March 2022 – the full response can be found in Appendix 2.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSCP) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSCP to lead and manage the health and care system are described in this section.

Emergency Command Structure
NHS Fife managed the emerging Covid-19 position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership. The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce.

Development of Escalation Framework
The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Each operational team now have an accurate overview of the pressures on their systems to be able to focus and plan to release or maintain capacity and flow in the system.

Informed Decision Making
A winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute to community ward stays and onwards to social care capacity.

Impact on HAI standards
Constant pressures on the health and care system have impacted on the bed capacity in ward bays. The number of beds was reduced in ward bays to meet the HAI standards; however, additional beds were reintroduced in wards in acute and community settings. The demand for beds is such that these have remained open longer than expected.

Workforce
Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure and the group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity.

Fife has experienced daily staffing challenges, so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained.

A number of initiatives have been introduced to support staff wellbeing including wellbeing hubs, pastoral care, peer support and psychological support and these will continue to be in place to support our workforce.

Themes
Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services were gathered and a detailed list of the responses received can be found in table below, which summarises the high-level themes. A further winter review workshop in April has been arranged with the wider clinical and

operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described.

Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process
Escalation and Surge Plans	Command structure in place Development of OPLE framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

Winter Report 2021/22 – Data to March 2022

The Winter Report highlights the following key indicators for Winter – the full report can be found in Appendix 3:

A&E

The 95% Standard has not been met in the last 26 weeks. The Redesign of Urgent Care Program has had an impact on performance, and this affects all boards across Scotland. The board average has maintained within 5% of the Scotland average for the majority of the Winter Period.

Covid-19

The number of Covid-19 positive patients in Acute has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within a community setting the numbers have also risen increasing with the highest level seen causing many wards to close during this period.

Occupancy
VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%).

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

Occupancy in Community Hospitals has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout. The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

Delayed Discharges
The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.

Health & Social Care Placements
The number of referrals to H&SCP is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 week ending 23rd January and has gradually declined since thanks to the high discharges

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the heart of the Remobilisation Plan. The Remobilisation Plan was endorsed by NHS Fife Board on 30 November 2021.

2.3.2 Workforce

Oversight to workforce implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan was endorsed by NHS Fife Board on 30 November 2021.

2.3.3 Financial

Oversight to financial implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan was endorsed by NHS Fife Board on 30 November 2021.

2.3.4 Risk Assessment/Management

A Risk Assessment is contained within the Remobilisation Plan.

2.3.5 Equality and Diversity, including health inequalities

Remobilisation Plan included the appropriate equality and diversity impact assessment process as part of the restart 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 and with key external stakeholders is integral to the implementation of the Remobilisation Plan.

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.

- Executive Directors' Group by email (22/4/22)

2.4 Recommendation

The Committee is asked to:

- **Note** progress of deliverables within Joint Remobilisation Plan 4 (RMP4)
- **Assurance** from the lessons learned from Review of National Response to Winter 2021/22
- **Note** the performance in the Winter Report 2021/22 – Data to March 2022

3 List of appendices

- Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22
- Appendix 2: Review of National Response to Winter 2021/22
- Appendix 3: Winter Report 2021/22 – Data to March 2022

Report Contact
Susan Fraser
Associate Director of Planning & Performance
Email Susan.Fraser3@nhs.scot

Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22

Complete Actions (those in **bold** since previous update)

Pandemic Response

- ✓ ICU capacity

Primary, Community and Social Care

- ✓ Development of a Specialist Respiratory team to support a wide range of respiratory conditions to work collaboratively with the wider Community Teams to support patients, both acutely and long term with COVID.
- ✓ Develop a new Fife laryngectomy service in collaboration with Acute Services.
- ✓ Working towards reinstatement of the diagnostic pathway for Children and Young People, subject to restrictions and guidance.
- ✓ **Phase 3 (return to majority of previous service provision) will be implemented when safety measures such as social distancing can be relaxed.**

Mental Health

- ✓ Resumption of activity in AMH Day Hospitals.
- ✓ Re-development of the Moodcafe website to facilitate information-giving and support self-help across the life span and for people with long term health conditions.
- ✓ **Increasing the delivery of group PTs.**

Cancer Performance and Early Diagnosis

- ✓ Continue implementation of 'Framework for Recovery of Cancer Surgery' and 'National Approach to Clinical Prioritisation'.

Planned Care, Electives and Diagnostics

- ✓ Introduce PIR (Patient Initiated Review) within Medical Paediatrics.
- ✓ Continue to increase the number of Nurse Endoscopist posts which is one of the priorities to creating a future sustainable workforce.
- ✓ Review the model of collection for issuing repeat prescriptions for patients on ADHD/sleep medication.
- ✓ Introduction of home spirometry.
- ✓ Developmental assessments for Global Developmental Delay to be re-established.
- ✓ **Near Me Phase 2 - Further develop communication and stakeholder engagement strategy.**

Workforce

- ✓ **Harness the benefits of the latest NHS Education and Public Health Scotland (PHS) developments on workforce modelling to support our service planning arrangements and delivery of workforce plans.**
- ✓ Potential long term COVID-19 health issues for staff to be addressed through incorporating national guidance from developing evidence into our policy, practice, and service delivery arrangements.
- ✓ **Consolidation of our Staffing Bank management arrangements.**
- ✓ Continue to ensure Workforce Mobilisation Hubs are robust and flexible to adapt to future challenges.
- ✓ Workforce Planning & Mobilisation Silver Group to continue into 2021/2022 and review workforce deployment mechanisms to address the changing workforce needs across the year.
- ✓ Adapt our onboarding and development delivery approach through the use of e-enabled fast-track induction and other training.
- ✓ **Staff personal/professional development needs that have been delayed or restricted due to COVID-19 response to be prioritised as restrictions are eased through Directorate development delivery plans.**
- ✓ **Provision of staff support and wellbeing initiatives which meet staff needs and contribute to workforce sustainability.**

Digital

- ✓ ServiceNow - Migration to joint South-East activity to modernise the IT Service Management suite offering improved automation and slicker processes for activities such as ‘Joiners, movers and leavers’ consistent SLA/OLA’s and much improved self-help solutions.
- ✓ ITIL Process Maturity Improvement - Assess and benchmark our maturity against the 5 lifecycles and 27 processes of ITIL.
- ✓ Digital Business Continuity and Disaster Recovery (BC/DR) Plan.
- ✓ Infrastructure and Network Connectivity - Initiate an architectural review of our infrastructure to support remobilisation including a review of licensing to ensure we have sufficient capacity to support the increase in digital usage.
- ✓ Paperlite - Subject to agreed funding, the ambition is to accelerate the Paperlite programme. Reducing paper to the patient and clinician.

Corporate Services

- ✓ **Deliver the NHS Fife Prevention and Control of Infection Annual Work Programme for 2021-2022. Provide a structured delivery programme with priorities for nursing staff, clinical support staff, clinicians and managers to minimise the spread of infection, support the reduction of HCAI and to meet the NHS Healthcare Improvement Scotland (NHS HIS) Standards (2015).**
- ✓ **Develop a framework for Innovation adoption, generation, development, monitoring and evaluation.**
- ✓ **Investment secured for Programme Management Office (PMO) and embedded as part of the strategic planning arrangements to ensure corporate focus on progressing the service redesign required to release both cash savings and productive opportunities over the medium-term.**

Unscheduled Care

- ✓ Seamless GP Admission Pathways
- ✓ Increased scheduling for patients accessing ED
- ✓ Increased capacity within ED Resus
- ✓ Safe and timely discharges – COVID STATUS
- ✓ Lack of physical capacity in Admissions Unit 1
- ✓ Effective HALO resource to support front and back-door flow
- ✓ Minimise delays across the in-patient bed base through the systematic use of the Moving on Policy.
- ✓ HSCP Escalation to support daily decision making at HSCP huddles aligned to joint escalation plan with Acute services.
- ✓ Review current clients who have packages of care and require a renewed assessment.
- ✓ Community ANPs will return to General Practice from the COVID Hub and Assessment Centre to support workload
- ✓ **Public Engagement to ensure people are enabled to access the right care at the right time**
- ✓ Pharmacy support to safely manage discharge and transfer medications within the SUMPP parameters
- ✓ **Public facing information - Public messaging on right place right care, and how / when to access ED distributed through a wide range of established communications platforms including; NHS Fife Website, NHS Fife Social Media Channels, Local Press and Media, Partner organisation communications channels – these will be issued on a regular basis to reflect demand on ED, urgent and primary care services.**
- ✓ NHS 24 – 4-hour pathways for minor illness triaged via FNH from 13/5/21
- ✓ Urgent Care Services and ED have revisited the OOH redirection policy and reviewed pathways between ED and OOH
- ✓ **Identify and establish resources to support new pathways.**
- ✓ An urgent need for Paediatric escalation planning which cannot wait until Autumn/Winter.
- ✓ Review of red pathway into acute paediatrics that ensures that all referrals have been assessed by another health care professional (GP, ED, Unscheduled Care) which will filter out the patients currently being seen with mild symptoms.
- ✓ Increase in HDU/ITU Paediatric Demand
- ✓ Protecting the most vulnerable babies
- ✓ **Delivery of the adult seasonal influenza vaccination programme.**

Actions at risk (those in **bold** since previous update)

Primary, Community and Social Care

- Review the arrangements to Primary Care 'Care Home Local Enhanced Service' during 2021-22 including strengthening good quality anticipatory care planning.
- **Podiatry Services to be made available in all community and hospital sites including domiciliary and care homes**
- Working towards a return to this routine therapeutic support as soon as restrictions allow e.g. securing of IPC compliant clear masks, vaccination of staff.
- Redesign by recruiting Advanced Nurse Practitioners who can support the Consultant Rheumatologists in the delivery of the service. This will reduce the reliance on agency medical locum staffing.
- **Review of GIRFEC practices and wellbeing pathway to increase effectiveness and impact**

Planned Care, Electives and Diagnostics

- ACRT and PIR - Continue rollout throughout 2021/22 to all appropriate services.
- Patient Self- Booking - Support Patient Self-Booking across acute and community services. Linked to the Digital Hub is also the emerging capability for pathways to be enhanced by Remote Health Pathways, with COVID discharge and Pre-operative Assessment being identified as high impact areas for consideration.
- **Digital Pathology - Support creation of a business case, which if approved will lead to the Introduction of digital pathology to support a more resilient and sustainable service by improving efficiency, patient safety and delivering value for money.**

Unscheduled / Elective Care

- Review of Business Continuity/Resilience
- Workforce planning - planning for surge capacity to include a robust Medical, Nursing & AHP model.
- Sustainable Workforce – ED & AU1
- Maximise discharges from inpatient wards within VHK before 12 noon and move discharge profile to earlier in the day. Improve weekend discharge profile for Emergency Care Directorate.
- Capacity available for pre-assessment and pre-admission for front door areas of the hospital.
- Develop appropriate alternatives to attendance at A&E, minimise the need for admission, and reduce length of stay and increase options and processes for timely and appropriate discharge
- Develop a Home First Strategy
- Reduce hand offs in discharge processes
- Promote interim care home moves for people waiting on PoC.
- **Additional coordinating role in social care to ensure transfer of patients from hospitals. Test the trusted assessor model.**
- Ensure timely access to UCAT and addiction services for patients within the Acute Services Division in crisis's

Actions unlikely to meet target (those in **bold** since previous update)

Public Health

- Improve the health of the Black and Minority Ethnic Community.
- Take forward the recommendations from the Independent Expert Reference Group on COVID-19 and Ethnicity on behalf of NHS Fife.

Unscheduled / Elective Care

- Reducing length of stay on CAMHS
- The development of an app to support the Moving on Policy and help with decision making of moving on patients. This will include care home videos, staff messages.
- Winter elective plan to minimise the impact on elective activity as far as possible.
- Optimise digital healthcare where possible.

Mental Health

- Community Wellbeing Hubs across Fife to support delivery of mental health interventions and integrated care

Pharmacy

- **Implementation and roll out of HEPMA.**

Planned Care, Electives and Diagnostics

- Secure additional Waiting Times funding to increase capacity and enable waiting list reduction.
- T&O to achieve 100% of pre covid activity with progression to 110% by March 2022 in line with national commitment.
- **Exploring Locum Consultant recruitment options.**
- Remobilisation of Elective pathway in a phased manner with the need to maintain adequate red and amber capacity.

Winter Lessons and Reflections 2021/22

18 March 2022

1 Introduction

Winter 2021/22 came with significant challenges due to the impact of COVID on the past 2 years as well as running efficient vaccination and test and protect programmes.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSPC) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Leadership is the key to the successful whole system collaboration in place over this time.

2 Winter 2021/22

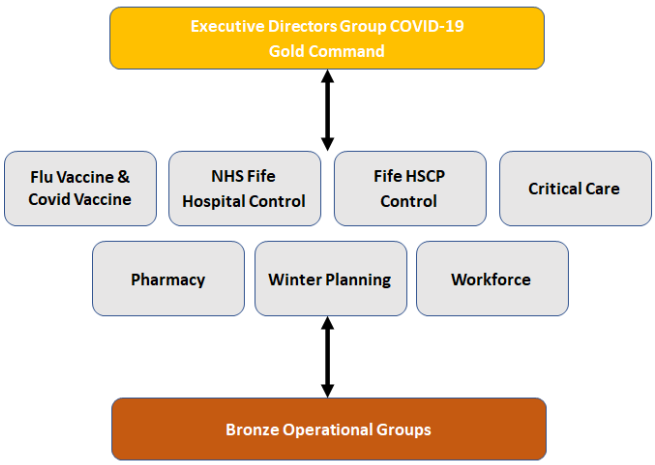
Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSPC to lead and manage the health and care system are described in this section.

2.1 Emergency Command Structure

As emergency planning measures were still in place, NHS Fife managed the emerging COVID position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership.

The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce. The reporting structure went to Gold Command that met at least twice a week and was made up of the Executive Directors' Group – the Chief Executive, Executive Directors and strategic senior managers.

The reporting and escalation structure provided clear lines of responsibility and decision making as shown below.



Chair: NHS Fife Chief Executive

- *Receive briefings from the Silver Command groups*
- *Approve operational acute health and social care service delivery priorities*
- *Approve NHS Fife Communications*

Chair: Executive Director

- *Receive briefings from the Bronze Command groups*
- *Escalate issues and challenges to Gold Command*

Chair: Senior Manager

- *Set up by each Silver Command group on an 'on demand' basis*
- *Aligned to specific workstreams*
- *Stood down when no longer required*
- *Reporting to Silver Command Groups*

2.2 Development of Escalation Framework

The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Initially development to manage early decision making and support to Acute's demand and capacity, it was then adapted to reflect the challenges in the HSPC. Each operational team now have an accurate overview of the pressures on their systems at least daily to be able to focus and plan to release or maintain capacity and flow in the system.

Testing has been a critical part of the implementation process. Multiple testing of the tool over daily cycles for the past 5 weeks has ensured the tool is reliable and sensitive to changes in pressure across the site to enable pro-active cross site and whole system actions to be undertaken to ensure a timeous de-escalation.

The OPEL tool has been demonstrated at the Executive Directors' Group and the Board and has been praised as being very positive and innovative. The operational and clinical teams have welcomed its introduction and is now part of their daily business. An example of the OPEL tool can be found in Appendix 1.

2.3 Informed Decision Making

Historically, during the winter period but over the last 3 years, a winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute and community ward stays and onwards to social care capacity.

The scorecard is discussed at the Winter Capacity and Flow Bronze group with escalations, where appropriate, to Winter Silver Group. This provides the operation teams to discuss changes and monitor their impact on the whole system. An example of this can be found in Appendix 2.

The OPEL escalation framework works at an operational level, the Winter scorecard is used at a tactical level and at a strategic level, the Executive Directors' Group (Gold) received COVID report weekly and over the winter period, this was refined to a whole system monitoring report. The report provided an overview of COVID admissions and projections, planned and unplanned activity and delayed discharges. An example of this report can be found in Appendix 3.

2.4 Impact on HAI standards

The constant pressures on the health and care system have impacted on the bed capacity in ward bays. Previous work undertaken reduced the number of beds in ward bays to meet the HAI standards, however, there was such a strain on the system that additional beds were reintroduced in wards in acute and community settings. Although the situation is reviewed on a daily basis, the demand for beds is such that these additional beds have remained open longer than expected.

The current estate in Fife is such that in the older hospitals, the conditions are not optimal with investment into the older estate required to upgrade wards and improve ventilation.

2.5 Workforce

Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure which has coordinated a range of activity to support short, medium and longer term workforce supply and demand solutions and escalate workforce issues to our Gold group as required. The combination of operational, corporate, support and staff side representatives has allowed us to remain as responsive as possible during the changing context. The group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity; additional ward administration support; rapid recruitment to Healthcare Support Worker roles and bank utilisation and deployment of volunteers. Lessons learned have included reviewing how we improve workforce data, faster deployment of staff, better definition for support roles and enhancing communication methods and channels.

NHS Fife and Fife Health and Social Care Partnership have taken a number of actions to support workforce supply and these include:

- Accelerated recruitment to Nurse Staff Bank, including recruitment of medical, nursing and AHP students; returners (to support vaccination programme
- Early recruitment of nursing students who are graduating, employing them at Band 4 level as they await their registration from the NMC, in areas where they have secured permanent registered posts
- Accelerated recruitment processes supported by Workforce Directorate
- International recruitment: supported by the Centre for Workforce Supply and in collaboration with Yeovil Trust; 40 registered nurses and 3 radiographers will join our workforce over the coming months, with the first nursing recruits taking up posts in February 2022
- Participation in national recruitment campaign, although recognising that it is unlikely to attract a significant number of staff to work in Scotland

Fife has experienced staffing challenges on a daily basis so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained:

- Establishment of workforce hubs, monitoring staffing levels on shift by shift, on occasion hour by hour, basis
- Daily staffing huddles, led by senior nurses

- Development of 'Safe to Start Guidance' which forms part of the OPEL framework
- Development of Guiding Principles to support registered staff working in extremely challenging times
- Deployment of staff utilising Community Guidance in relation to Children's Services, Community Nursing and AHP
- Training modules adapted, which can be accessed online, rather than face to face sessions

Staff wellbeing continues to be vitally important and there has been a focus on staff wellbeing throughout the pandemic. A number of initiatives have been introduced including wellbeing hubs, pastoral care, peer support and psychological support and these will continue to be in place to support our workforce.

2.6 Winter Review themes

Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services including Public Health were gathered and a detailed list of the responses received can be found in Appendix 4 – the table below summarises the high level themes with examples of positive and negative feedback and suggestions for next year. Lessons learned from the Vaccination Programme have not been included as they have been submitted separately.

A further winter review workshop in April has been arranged with the wider clinical and operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described. As in previous years, this will bring together teams from across health and social care as well as partner agencies to gather multi agency feedback.

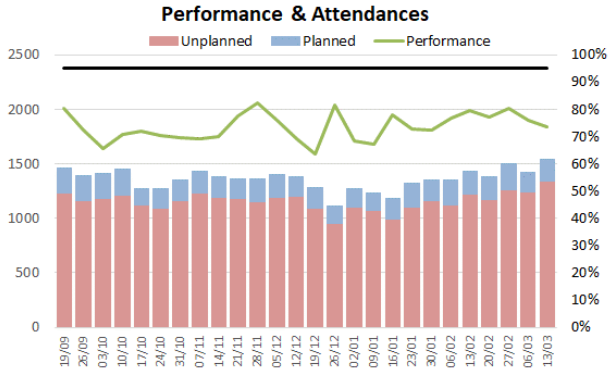
Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process

Theme	What went well	What did not go well?	What could be done differently?
Escalation and Surge Plans	Command structure in place Development of OPLE framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

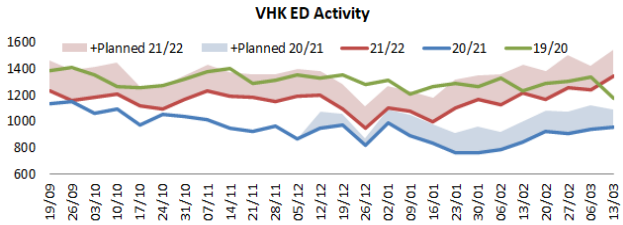
3 Analysis of Key Metrics

3.1 Emergency Department

Performance within Victoria Hospital against 4-hour standard averaged below 75% for the 26-week period to 13th March, achieving excess of 80% on four occasions. There was 1177 unplanned attendance on average per week up until festive period and have been rising since mid-January with last 8-week average over 1200. Week of 13th March exceeded 1300 unplanned attendances. Planned activity averaged just below 200 per week over the same time period.

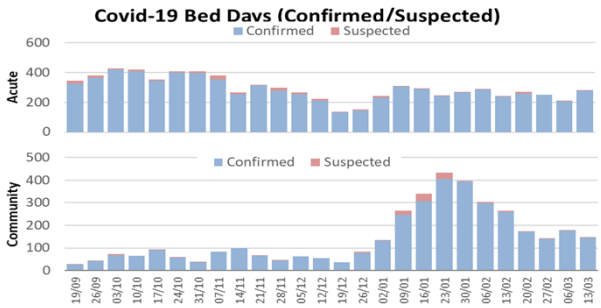


Unplanned attendances for this winter were below 2020 levels every week apart from the latest. However, when including planned activity, totals were similar up to mid-December and have been above since mid-January. Latest week was also higher than weekly average for winter 2020.



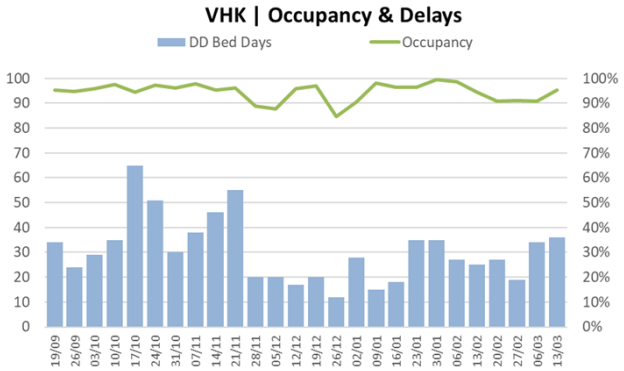
3.2 COVID-19 Hospital Activity

Bed days attributed to COVID-19 within Victoria Hospital peaked at 422 in early October. Steady decrease from then until Christmas period to below 150. This has risen since and has fluctuated between 250 and 300.



Bed days within Community and Mental Health Hospitals had been below 100 throughout winter until week ending 2nd January. Outbreaks within these settings led to an increase to 400 by mid-January leading to ward closures that placed significant pressure on the whole system.

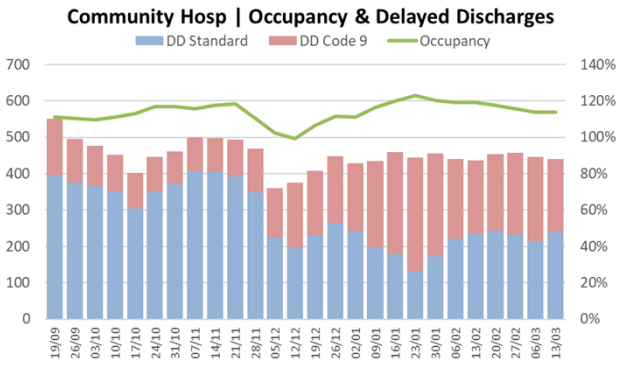
3.3 Acute Occupancy and Delays



Occupancy pressures have been extreme, driven by significant increases in admission demand leading to the requirement for the use of contingency inpatient capacity, over and above surge capacity to accommodate demand. This significantly disrupted the urgent elective programme, particularly Orthopaedics, with occupancy levels continuing to impact activity.

Delayed discharge bed days have come down because of the discharge profile to HSCP with enough flex in the system to accommodate additional flow during times of significant pressure.

Site pressures have been compounded by staffing challenges, with high absence rates eroding staff ratios and placing additional strain across teams. Pre-emptive service retraction, based on clinical priority, enabled staffing resource to be consolidated based on greatest need.



Occupancy across HSCP MoE wards is higher than what it has ever been due to number of beds open over and above the MoE normal covid bed base.

Bed days for standard delays has significantly dropped. We are seeing a sustained discharge profile to care at home and interim beds which has attributed to this reduction. Increase in Code 9 delays in early 2022 was due to ward closures due to COVID-19.

4 Financial Position

Winter monies made available to the Health Board and Integrated Joint Board in November 2021 have been used to support the delivery of key winter priorities. All the funding allocated has been utilised in full with additional costs underwritten by the Health Board and the Integrated Board. Monies received into Fife has been used by the board and the H&SCP to fund additional delayed discharge coordinators, medical locum cover, discharge vehicles and multiple reviews of packages of care, all monies spent with the focus being to take discharges out of Fife hospitals and support increasing demand.

In addition, further winter monies announced in October 2021 to support the board and the H&SCP with a focus to improved delayed discharges have enabled NHS Fife

to move forward with a successful International recruitment programme with the first members of staff recruiting from overseas joining NHS Fife in February 2022 with other new recruits expected in the coming months. A successful recruitment campaign has also enabled to board to recruit the minimum 68 new band 2-3 support staff roles to support delayed discharges. Several staff are already in post with others to join the board in the next couple of months. Monies allocated for staff wellbeing measures have also been spent in full providing much needed support to staff.

Despite significant ongoing recruitment challenges other winter monies have been utilised by the H&SCP to enhance service provision with a firm focus on improvement in delayed discharges.

5 Summary

NHS Fife and Fife HSPC have shown leadership and collaborative working over this period and the integrated actions described have demonstrated the benefits of whole system working with the patient at the centre. The challenges continue to be felt across the system and we will continue to work together across agencies.

Appendix 1: Example of OPEL reporting

NHS Fife Acute Services
Escalation Plan 2021/22

				Criteria Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	
	OPEL	**83**	**5**		**4**	**1**	**3**	**2**	**12**	
	Back Door	**26**	**5**		**1**	**0**	**2**	**1**	**3**	**ACTIONS**
1	Hospital Occupancy	3	90-97%		80-85%	86-89%	90-97%	>97% or more	>100% plus	1 Amber Action
2	Additional Bed Capacity	5	DIU or SSSU in use		0 wards open	Surge planned	Ward 6 open	Ward 6 / 9 over capacity	DIU or SSSU in use	2 Purple Action
3	Delayed Discharge / DToC	4	25-34		0-5	6 to 18	19-24	25-34	35 or more	3 Red Action
4	Boarding Patients	5	19 or more		0-4	5 to 9	10 to 14	15-18	19 or more	4 Purple Action
5	Total number of discharges at 13.00	3	66-80 planned		95 or more planned	81-94 planned	66-80 planned	51-65 planned	50 or less planned	5 Amber Action
6	Predicted Bed Balance	5	≤10		≥10 / in balance	≥5/in balance	In balance	≤5	≤10	6 Purple Action
7	Ward closures due to infection	1	0 Wards		0 Wards	1 - 2 bays closed	3 bays closed	1 ward closed	2 wards closed	7 Green Action
	Front Door	**49**	**5**		**0**	**1**	**1**	**1**	**8**	
8	Ambulances Waiting	2	1 ambulance holding & at risk of not off-loading in next 15 mins		0	1 ambulance holding & at risk of not off-loading in next 15 mins	2 ambulances holding & at risk of not off-loading in next 15 mins	3 ambulances holding & at risk of not off-loading in next 15 mins	4 or more ambulances holding & risk of not off-loading in the next 15 mins	8 Yellow Action
9	ED resus Capacity	4	Resus full with no availability for a standby		>2 resus bays available	2 resus bay available	1 resus bay available for standby	Resus full with no availability for a standby	Resus full + patients in overcapacity	9 Red Action
10	Total patients in ED / Majors capacity	5	No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area		≥2 majors cubicles available and ≤30 pts in ED	1 majors cubicle available or >30 pts in ED	No majors cubicle availability & no majors patients in waiting room	No majors cubicle available, over capacity in majors area or up to 3 majors patients in waiting area	No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area	10 Purple Action
11	Total Number of DTA (Unallocated)	5	7+ patients		No patients waiting	1-2 patients	3-4 patients	5-6 patients	7+ patients	11 Purple Action
12	Longest LoS - DTA	5	Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission		All patients <4hrs from DTA	Any DTA patient >4hrs from admission	2-3 DTA patients >4hrs from admission	1 patients >8hrs or 4-6 DTA patients >4hrs from admission	Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission	12 Purple Action
13	Total patients in AU1 (in patients)	5	32 (full)		≥25	26-27	28-29	30-31	32 (full)	13 Purple Action
14	AU1 (RV) Assessment space	5	Minus 3+ adjusted bed balance		4+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	14 Purple Action
15	AU1 (N RV) assessment space available	5	Minus 5+ adjusted bed balance		6+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2-4 adjusted bed balance	Minus 5+ adjusted bed balance	15 Purple Action
16	Total patients in AU2	5	22 (full)		≤15	≤17	≤19	≤21	22 (full)	16 Purple Action
17	AU2 assessment space available	5	Minus 3+ adjusted bed balance		2+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	17 Purple Action
18	Staffing levels (RNs)	3	Amber		Green	Yellow	Amber	Red	Black	18 Amber Action
	Other Capacity	**8**	**2**		**3**	**0**	**0**	**0**	**1**	
19	Elective Cancellations	5	Cancellations at P2 Level		Full access to elective programme	Full access to elective programme - managed case-by-case	Decision taken not to appoint at P3 Level for ≥9 cases	Decision taken not to appoint at P3 Level for 10+ cases	Cancellations at P2 Level	19 Purple Action
20	Critical care Capacity	1	Full access to all pathways		Full access to all pathways	Full access to all pathways with 8 patients	10 level3 patients with bed availability in 4 hrs	11 level3 patients with bed availability tomorrow	No beds avaialble and none predicted > 24 hrs	20 Green Action
21	Business Continuity Event (defined as IT, PACS, utilities failure)	1	No critical issues identified		No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	21 Green Action
22	Paediatric Capacity Escalation level	1	Level 1 - access to all pathways		Level 1 - access to all pathways	Level 1 - access to all pathways but no HDU Capacity	Level 2 - 2 SR available & 9 RV beds occupied	Level 3 - 2 SR available & 12 RV beds occupied	Level 4 - 0 SR available and 14 RV beds occupied	22 Green Action

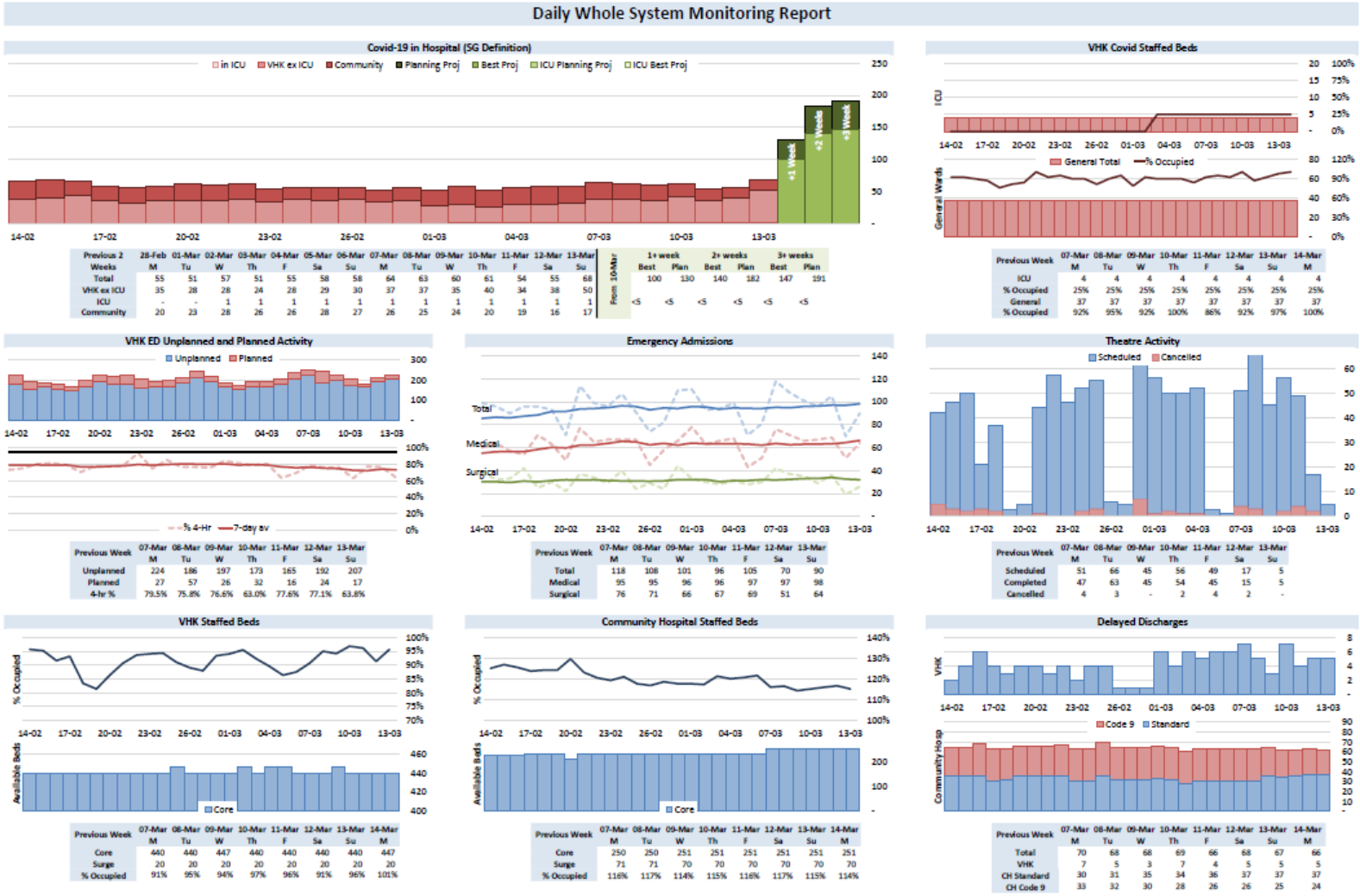
Fife HSCP
Escalation Plan 2021/22

			Criteria Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	
	OPEL	**65**		**4**	**7**	**8**	**1**	**6**	**3**	
	Flow	**41**		**4**	**4**	**4**	**1**	**4**	**2**	**ACTIONS**
1	Hospital Occupancy (H&SC MH Wards)	4		>95%	<85%	85-89%	90-95%	>95%	>100%	Facilitate daily capacity huddle
2	Patients clinically fit for next stage of care from VHK (with a confirmed pathway)	1		21-25	21-25	26-30	31-35	36-40	>40	ensure normal flow - 12 per day
3	VHK Patients to be assessed (Discharge Hub)	1		0 to 10	0 to 10	11 to 15	16 to 20	21-25	>25	ensure normal flow - 12 per day
4	Community Hospital Social Work waits (24B, 24C, 27A - official delay codes minus 51x / MH&LD)	1		<25	<25	25 to 29	30 to 34	35-40	>40	Continued Normal Service Provision
5	Official delay 51X codes	5		>25	0 to 10	11 to 15	16 to 20	21 to 25	>25	Escalate to Scottish Government
6	Community Hospital Social Care (25D, official delay codes minus 51x / MH&LD)	1		0-15	0-15	16-20	21-25	26-30	>30	normal business activity
7	Community SW / SC In Planning (51, 52)	2		21-25	0-20	21-25	26-30	31-35	>35	Verification meetings
8	Planned Community Hospital discharges	4		5 to 9	>15	12 to 14	10 to 11	5 to 9	<5	Emergency SW/SC meeting to expedite discharges
9	Down Stream Beds Available	2		12 to 14	>15	12 to 14	10 to 11	5 to 9	<5	early conversations re surge opening system wide
10	Hospital Occupancy Normal Bed Base (H&SC MoE Wards)	5		100% Normal Bed Base	93% or below Normal Bed base	94-95% Normal Bed Base	96-97% Normal Bed base	98-99% Normal Bed Base	100% Normal Bed Base	Initiate business continuity plan
11	Surge Beds added (Medical & Nursing Pressure held)	4		23-50 beds open Planning for next tranche started	No Surge beds open and none in planning	Initial surge in planning	14-22 beds open Planning for next tranche started	23-50 beds open Planning for next tranche started	51-65 beds open	Assess all beds open and ongoing need based on numbers and length of stay
12	Ward closures due to infection	4		1 ward closed	No closures	2 bays closed - 2 in 1 ward or 1 in 2 wards closed	3 bays closed	1 ward closed	2 wards closed	Undertake PAG risk assess bed loss from system and implement any mitigation
13	H@H (figures are caseloads)	2		21 – 25	<20	21 – 25	26 – 30	31 -35	>35	Cross Cover H@H neighbouring team
14	ICT (Waiting list Community & VHK)	2		3-4 waits	2 or less	3-4 waits	5-6 waits	7-8 waits	9+waits	Cross Cover neighbouring ICT
15	Care Home Closures	3		10-19 closed	No closures	1-9 closed	10-19 closed	20-25 closed	>25 closed	Daily meeting with Commissioning Team, Patient Flow Coordinator, Health Protection Team and Care Home Support and Assurance Team to review patients awaiting discharge to closed care homes and carry out individual risk assessments to facilitate patient flow where safe to do so.
	Wider System	**11**		**3**	**2**	**2**	**0**	**0**	**1**	
16	GP Appointment availability	2		Individual GP practices declaring they are unable to deliver F2F appointments within own Practice	All GP practices operating as normal	Individual GP practices declaring they are unable to deliver F2F appointments within own Practice	Buddy Practices declaring they are unable to provide F2F patient care	One Cluster declaring unable to provide F2F appointments, or three or more declaring they are close to being unable	Clusters unable to provide F2F appointments even with Covid Assessment Centre open	Buddying system involving two practices invoked when unable to deliver face to face appointments as a single practice
17	Community Pharmacy Service	1		No closures up to 4x Half-day or 2x Full-day closures	No closures up to 4x Half-day or 2x Full-day closures	Up to 8x Half-day or 4x Full-day closures	Up to 16x Half-day or 8x Full-day closures	Up to 40x Half-day or 20x Full-day closures	Up to 80x Half-day or 40x Full-day closures	normal business activity
18	Urgent Care Services Fife	1		Normal staffing levels	Normal staffing levels	Staffing levels ≥91%	Staffing 90-81% and or demand 110-120% of normal seasonal activity	80%-71% staff coverage and 110-120% seasonal activity	<70% staffing and / or demand beyond capacity	normal business activity
19	Public Dental Service	2		Staffing at 81-94% - reduced service still including routine but fewer appts and no risk	Staffing 95% and above full operation	Staffing at 81-94% - reduced service still including routine but fewer appts and no risk	Staffing at 80-51% - urgent care only	Staffing at 50-41% - emergency care only	Staffing at 40% or below - restricted and prioritised emergency care only	normal business activity with identified contingency in place.
20	Hospital Occupancy (H&SC LD Wards)	5		No beds available and no out of area beds	Four or more local beds available	Three local beds available	Two local beds available	One local bed available	No beds available and no out of area beds	Check out of area admission capacity; Consider accessing independent health care facility via CAP application
	Workforce	**13**		**3**	**1**	**2**	**0**	**2**	**0**	
21	SW Hospital Discharge Team Staffing	2		Staffing 80-60%	normal staffing levels	Staffing 80-60%	Staffing 60-50% (supported by community team)	<50% staffing in team supported by busines continuity	<50% staffing and failure of business continuity plan	manage staffing within services
22	MHO Team Staffing	1		<10% absence	<10% absence	>80% staffing	80-50% staffing	<50% staffing and business continuity plan triggered	<50% staffing and statutory functions critically impacted	normal function
23	Wider HSCP Safe to Start position	2		>80% of services safe to start	All Areas Safe to Start	>80% of services safe to start	>60% of services safe to start	>40% of services safe to start	<20% of services safe to start	manage staffing within services
24	Business Continuity	4		Reduced functional service - severe impact/delay	No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	50% of staff on deployable list mobilised
25	Workforce Hub (declared staffing position)	4		Red	Green	Yellow	Amber	Red	Purple	Discuss req'd actions at workforce assurance/ escalation huddle

Appendix 2: Whole System Scorecard

Area	Indicator	Trend	19-Sep	26-Sep	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar
Urgent Care	Contacts		2312	2243	2339	2823	1993	2138	2218	2190	2257	2360	2223	2352	2312	2354	1920	3117	2897	2252	2341	2245	2174	2139	2229	2133	2134	2206
	Home Visits		101	124	120	152	107	125	134	104	98	108	116	118	107	83	98	247	179	124	124	131	108	120	121	112	114	121
	COVID Outcome		426	396	383	530	370	391	308	385	411	431	369	398	358	422	359	666	556	337	308	289	291	315	296	299	304	324
	NHS24 Outcome		326	338	344	414	323	351	376	365	359	351	369	398	399	342	308	522	440	367	383	396	359	362	397	358	342	368
VHK ED	All		1462	1392	1411	1450	1268	1267	1350	1434	1377	1357	1359	1398	1380	1283	1114	1267	1227	1177	1319	1348	1355	1433	1385	1504	1424	1543
	Planned		228	235	231	242	148	176	185	201	181	171	211	209	181	189	163	161	150	180	214	184	230	213	216	244	187	199
	Unplanned		1234	1157	1180	1208	1120	1091	1165	1233	1196	1186	1148	1189	1199	1094	951	1106	1077	997	1105	1164	1125	1220	1169	1260	1237	1344
	Performance		80.4%	72.5%	65.6%	70.8%	72.1%	70.4%	69.6%	69.3%	69.9%	77.4%	82.1%	75.9%	69.0%	63.7%	81.5%	68.4%	67.1%	78.0%	72.9%	72.4%	76.8%	79.3%	77.0%	80.5%	76.0%	73.5%
MIU	Total		484	414	419	377	361	339	347	353	375	374	370	305	352	295	197	204	199	320	367	325	382	347	317	403	383	436
	Unplanned		405	348	346	322	311	290	299	293	308	315	304	250	292	242	146	179	158	267	306	271	317	291	267	332	325	372
VHK	Admissions		696	730	729	709	705	703	683	714	702	689	705	767	716	750	649	715	639	667	730	737	693	677	707	730	743	770
	Emergency		589	640	636	628	624	650	611	626	621	601	619	674	628	658	586	687	611	616	657	653	617	597	641	657	651	686
	Medical		355	356	351	360	358	407	355	351	378	355	357	402	366	387	363	424	364	367	366	370	347	335	354	371	362	405
	Surgical		234	284	285	268	266	243	256	275	243	246	262	272	262	271	223	263	247	249	291	283	270	262	287	286	289	281
	Discharges		615	678	648	648	644	649	630	659	660	636	686	679	616	726	653	561	605	637	653	668	684	644	693	674	697	661
Theatre Activity	Scheduled		224	255	258	245	217	213	207	244	280	225	267	265	242	273	141	51	96	182	200	227	260	257	218	272	293	303
	Cancelled		14	16	16	15	14	16	15	16	15	11	11	13	15	19	4	1	11	7	7	20	19	7	15	7	12	15
	Hospital Cancelled		0	1	3	3	8	1	0	3	4	1	0	1	3	2	0	0	3	0	0	0	6	0	3	2	0	1
VHK Bed Utilisation	Occupancy		95%	95%	96%	98%	95%	97%	96%	98%	95%	96%	89%	88%	96%	97%	85%	91%	98%	96%	97%	99%	99%	95%	91%	91%	91%	95%
	COVID Bed Days		346	380	430	420	352	408	408	379	268	318	297	265	224	138	152	241	308	292	245	270	291	242	271	252	208	279
	DD Bed Days		34	24	29	35	65	51	30	38	46	55	20	20	17	20	12	28	15	18	35	35	27	25	27	19	34	36
Community Hospital	Admissions		54	51	52	52	53	42	52	59	59	50	65	52	40	59	57	55	46	71	34	55	73	53	56	50	50	52
	Discharges		55	52	55	46	45	36	68	53	48	48	78	53	41	55	57	51	33	60	37	57	69	55	51	60	45	57
	Occupancy		111%	110%	110%	111%	113%	117%	117%	116%	118%	118%	110%	102%	99%	107%	111%	111%	117%	120%	123%	120%	119%	119%	118%	116%	114%	114%
	COVID Bed Days		28	45	73	65	95	60	37	84	98	67	48	64	54	37	84	136	264	340	433	397	303	265	173	143	180	149
	DD Bed Days		551	496	476	452	401	445	462	499	498	493	469	359	376	408	448	428	434	459	443	456	440	436	454	458	446	440
	DD Standard		397	376	365	352	305	351	372	405	405	392	349	225	195	231	265	242	196	179	132	173	220	234	241	233	215	240
	DD Code 9		154	120	111	100	96	94	90	94	93	101	120	134	181	177	183	186	238	280	311	283	220	202	213	225	231	200

Appendix 3: Whole System Monitoring Report



Appendix 4: Themed responses

Business Continuity/Emergency Planning

What went well?

- Resilience in primary care in relation to Covid assessment.
- Local Resilience Partnership arrangements were rapidly put in place in response to Storm Arwen 'red' warning
- Local Resilience Partnership activated to consider social care pressures and concurrent risks and coordinated offers of assistance.

What did not go well?

- The Fife Equipment Loan Store has also had to deal with other external factors: Covid, Brexit which has led to a lack of supply of equipment.
- Consideration needs to be taken for the additional staffing and equipment needs for an increased number of community beds (Surge).
- Availability of 4 x 4
- Partner agencies were only able to offer limited support when additional social care was requested.

What should be done differently/changed?

- Could transport department take a role in providing 4 x 4 transport for all community services if required in severe weather?
- Strong contingency plans- Identified Winter surge capacity (winter wards that provide appropriate accommodation in line with national guidance) with HCWs recruited to staff these areas.

Whole System Working

What went well?

- Command structure (Bronze/Silver/Gold) in place for operational teams in Acute, HSCP and system wide. Clear actions and accountability relating to decisions
- Cross system working and flexibility in use of clinical space
- Launch of nMAB treatment for clinically vulnerable outpatient treatments

- Transition of Medical Admissions Controller GP function to Flow and Navigation Hub
- System wide working through huddles to manage flow through pathways for both care at home and care homes. Ensuring collaborative commissioning with providers to meet the needs of patients.
- Commitment of all teams to manage workforces across all sectors to work in an agile way has been very apparent – not only via deployment but also through prioritisation of work, responding to tight time scales and rapidly changing circumstances as well as being solutions focused. Staffing BRAG scoring and whole system approach to site safety including critical care bronze/silver daily reviews
- Increased integration and collaborative working between teams
- Multi-disciplinary approach to working under significant pressure to support hospital discharges and appropriate care placements. Regular multi-disciplinary meetings to ensure management oversight of service users' journey in as timely a way as is possible.
- Agile working from **all teams** clinical and support teams (domestics, facilities, portering and volunteers etc)
- Community Pharmacy remained open as a frontline clinical service to all patients. Use of Pharmacy First was significantly above previous years, allowing patients to access treatment quickly and flexibly.
- COVID POCT ability for clinical assessment and patient placement
- Staff rapid COVID testing for business-critical areas

What did not go well?

- While Board wide uptake of serial prescribing has been a success, there are a limited number of teams who have not engaged with this important service which is of benefit to workload management and clinical care.

What should be done differently/changed?

- Need to feed lessons learned from whole system working into workforce strategy and development as well as work on service re-design
- Consolidation of platforms for respiratory testing
- Improved route for COVID-19 reporting to deliver better TAT.
- Better deployment and management of the poct team.
- Increased availability of point of care testing (POCT) for **all** admissions (As NHS Fife is not 100% single room occupancy, this would support patient placement, and reduce number of hospital bay contacts from asymptomatic patients)

Demand and Capacity Planning

What went well?

- Use of Live Discharge tool for wards and hub whiteboard patient discharges
- Integrated HALO within front door
- Use of elective orthopaedic ward for screened trauma overflow
- Use of data intelligence and modelling to anticipate and plan acute service delivery
- Remodelling of ED resus area to allow for increased capacity whilst meeting IPCT requirements for COVID
- Commitment by all staff to provide the best service they possibly could during a period of working under extreme pressures with, at times limited resources available to them.
- Quick responses by most providers to ensure assessments were undertaken as quickly as possible and discharges arranged.
- Constant review of delayed discharges for up-to-date position.
- Use of interim/assessment/STAR bed placements to await the completion of care assessments/decision on pathway of care.
- Good dissemination of information about ward status.
- Daily care home huddle to address challenges and ensure optimal discharges
- Existing Pharmacy service core priorities provided an effective framework for targeting of resource. This supported the wider system appropriately and staff responded with flexibility and professionalism to the revised ask.
- Pathways for new COVID treatments were developed and deployed rapidly following exemplary multi-professional response. New pathways through Flow and Navigation Hub for Acute Admissions and nMAB Treatment.
- Rapid development of urgent COVID-19 pathways such as staff testing, discharge and surgery in spite of resource restrictions.
- Board-wide uptake of serial prescribing has improved across the last six months – this is important as a government priority supporting management of workload pressures in Community Pharmacies and General Practice.
- Public Health teams managed the pressures of Omicron through supportive practices established during earlier stages of the pandemic

What did not go well?

- Capacity challenges resulting in ambulance queues for ED
- Delays in transfers of care through Downstream Beds and Social Work pathways
- Use of planned care beds for emergency care patients with significant impact on patients requiring urgent surgery

- The daily request for sitrep reports to Senior Management and Scottish Government left staff feeling overwhelmed with providing data. This included for the first time the Social Work Hospital Discharge Team.
- Opportunity to reflect on transfers of care to support good relationship and safe optimal hand over. Interim beds – high numbers and length of stay due to lack of capacity in Care. More evidence to be gathered on this going forwards in respect of Service User outcomes.
- Restricted access to appointments at GP Practices
- Management of discharge pathways placed additional pressure on Microbiology and were too reactive.
- Challenges with adequate surge capacity (and staff for these areas) leading to increased number of patients in bays, which increases the risk of transmission of COVID-19
- An Increase in waiting times for support services (e.g. Fife Council Community OT Service) despite staff working to capacity.

What should be done differently/changed?

- Need to link Demand and Capacity Planning to transformation programme as demand outstripped the capacity available
- The Moving on Policy brought to the attention of the families/representatives as soon as possible rather than waiting until their family member has been delayed in hospital for a number of days without any decision made on care home choices/pathway agreed.
- Ensure families/representatives understand and are in agreement that staying in hospital is not an option or in the best interest of the patient while care home choices are made.
- Front door model is being developed – this will be in place for next winter, again, time needed to develop this model in light of what we know and what we need the model to achieve.
- Indicative guidance regarding policy would be helpful when Boards are required to rapidly stand-up new services or pathways. A proactive approach to planning for most likely scenarios would be beneficial, managed both locally and nationally – this would resolve concerns linked to reactive responses where there are time constraints.
- A review of use of resources such as surge wards and proactively planning for likely scenarios, allowing for proactive identification of staff and required processes etc. Review of data around organisation status may reveal patterns in demand levels across the system. More broadly, a proactive review of surge planning and assurance that all relevant areas, including clinical support teams, have visibility of them is important.
- Adequate Roll out time for New Processes i.e. training and system updates.
- System data reporting for specific services.
- Improved process and control on discharge across the hospital.

Escalation and Surge Plans

What went well?

- Development of OPEL escalation tools and live working for early warning and operational actions. Use of OPEL to have a shared language and understanding of operational pressures across Acute and HSCP
- Agility in retracting from services in Omicron wave
- Daily SLT meeting to provide a forum for escalation
- Authorisation for funding to increase GP resource.
- Continual assessment and redesign of the Urgent Care Service

What did not go well?

What should be done differently/changed?

- Earlier agreement of escalation plans before the start of Winter.

Staffing Levels

What went well?

- Unwavering passion and commitment from all teams across all services – inspiring!
- Dedicated consultant cover for additional capacity at VHK removing 'boarding' culture as per previous years
- Availability of up-to-date data through the workforce dashboard
- Staffing inpatient surge wards was achieved through the whole MDT approach which allowed sourcing of staff to cover the wards from Agency, Bank, extra hours OT/PT.
- Additional temporary staff through Health Improvement Scotland for Hospital at Home. This gave us the opportunity to secure permanent funding.
- Securing continuous permanent funding for OT/PT across ICASS and Nursing for Hospital at Home will have a significant positive impact for the future.
- Teams working across disciplines to support Care Homes have added huge value and support to struggling staff teams within care homes
- A lot of admin staff now have laptops and can work from home

- Team leads supported implementation of changes at pace and kept morale of staff high despite escalating numbers
- Based on previous year's activity we were able to forecast projections to put adequate staffing levels in place.
- Re-deployment staff from Partnership into Flow and Navigation Hub between January 2022 - April 2022.
- Recruitment to enhance Nursing and Admin Establishment.
- Availability of wellbeing resources for all staff.
- Re-deployment of 3 x Band 5 TUCP's to QMH to support Ward 8 at Queen Margaret Hospital Dunfermline.

What did not go well?

- Despite an ongoing recruitment drive, challenges remained with staffing (COVID related whether additional resources required for the vaccination programme, new streams of work such as the monoclonal antibody treatments as well as COVID related sickness/absenteeism)
- It is notable that staff across the service are feeling increasingly fatigued following pressure over the last two years.
- Plans for staff to rest over Christmas and New Year were not fully realised and we had to ask staff to work extra hours.
- Extended redeployment of staff to support Omicron response and impact of staff morale
- Temporary staff with a quick turnaround, as the availability of OT/PT staff is very difficult to access even through agency.
- Staff being redeployed to surge wards which meant teams were continuously working at critical function. This inevitably means there is a backlog of work to pick up when staff return e.g. CDM reviews
- Time taken to extend contracts for fixed term staff caused uncertainty and increased turnover
- Patient Conveyancing issues – due to staffing levels

What should be done differently/changed?

- Cultural changes in the way teams respond and commit to ensuring staffing as a whole system is safe and responsive to need i.e. flexing up capacity and staff movement
- To consider the positive impact that adequate staffing on wards will have on reducing length of stay and reducing level of dependency to decrease the demand on care services required on discharge
- Increased staffing resource to accommodate increased care of patients who are palliative or have complex health conditions and wishing to remain at home
- Debriefing for clinical teams to allow reflections over the last few months.
- There is a need to ensure staff have sufficient capacity to undertake the core parts of their jobs to a high standard and reviewing activities which do not add appropriate value.

- Funding for winter assurance should be released earlier to allow for recruitment processes to be followed ahead of winter, rather than reacting to it. A review of winter spends incurred across departments would allow for flexible use of resource across the organisation, focussing on key areas affected by winter.

Elective Activity

What went well?

- Maintenance of P1 and P2 surgery
- Use of QMH facilities to maintain activity

What did not go well?

- Cessation of all planned orthopaedic elective surgery in ward 10 due to demand for emergency patients.

Infection Prevention and Control

What went well?

- Adaptability with ARHAI guidance to improve flexibility of ward areas and minimise ward closures
- Good availability of PPE (supported by excellent collaboration with H&S, procurement and IPCT)
- Stepping up of HCT, Bronze, Silver meetings over winter months
- NHS Fife went live with the new ARHAI Scotland Winter 2021/22 Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum, in line with the revised dates
- Local pathways and implementation of the above guidance supported by excellent leadership from Deputy COO, ADoN, clinical teams and IPCT.
- IPC training on new guidance and outbreak management available over the winter months
- Care home hub/care home safety huddle/care home oversight group (a multidisciplinary group to support best practice in care homes)- service found to be supportive.

What did not go well?

- Very late publication of the ARHAI Scotland Winter 2021/22 Respiratory pathway guidance (with revised launch/implementation dates as guidance was incomplete)

What should be done differently/changed?

- A full comprehensive National IPC winter guidance published with sufficient time for boards to develop and implement pathways locally
- Earlier MRSA screening for trauma patients anticipating ward 10 usage next year, but this won't be available as we will be in the FEOC by then.

Test and Protect

What went well?

- Agreed national protocols for Contact Tracing were implemented and there was clear focus on more vulnerable settings
- Local protocol developed to manage admissions into Care Homes with COVID19 outbreaks

What did not go well?

- Impact of changing isolation and testing requirements for staff and subsequent staffing pressures
- Lack of OH support over weekends to allow for use of Cameron for staff testing
- Lack of available resources due to care staff being unable to work due to contracting covid or waiting for test results – both of these being unavoidable.
- OH resources did not match demand for TAT of urgent staff testing.
- IT connectivity caused delays due to high demand for new interfaces and extended pathways developed to feed information back to T&P teams

What should be done differently/changed?

- A rapid response workforce for T&P needs to be retained to manage pressures given the likelihood of winter pressures next year. We recognise this may look different for winter 22/23 but there does need to be careful thought put to the retention of an agile emergency response for future COVID19 pressures and other infectious diseases.

Communications

What went well?

- Command structure in place (Bronze, Silver, Gold) which ensures optimal communication and clear lines of decision making.
- Staff engagement in recognising clinical need for redeployment
- Strong communications at a local, organisational and national level
- Regular communication to all staff regarding developments has been valuable.

What did not go well?

- Changing position with regards to care home closures due to Covid outbreaks – this led to delays in discharges taking place or alternative providers being sourced.

What should be done differently/changed?

- Improved national communications to the general public that the guidance is different in healthcare premises.
- Consider national policy for visitors- will requirements continue to be for LFD tests to be performed prior to visiting? Will these continue to be free? If not will boards have to provide the tests and an area for these to be performed?

Winter Planning

Monthly Report

Week Ending 31st January to 3rd April 2022

Contents

Introduction

The purpose of this report is to assure the Chief Executive, IJB and EDG that the Winter Plan is being delivered in accordance with the submission to Scottish Government and against agreed performance targets.

In 2021/22, the Winter Plan is integrated in the Remobilisation Plan and describes the actions that will be taken forward by NHS Fife and the Health and Social Care Partnership to optimise service resilience during the winter months and beyond in a COVID-19 sensitive environment. Executive leadership sits with the Director of Nursing and delivery lies with both the Directors of Acute Services in NHS Fife and the Health and Social Care Partnership.

A Silver Command has been established for winter planning which meets weekly and agrees actions, supported by the Winter Planning Bronze Command that monitors the dashboard weekly and escalates issues to Silver Command where appropriate. A bi-monthly report is provided to the board for assurance. The weekly reporting will cease at the end of March with the monthly report going to the NHS Fife Board in May 2022. Weekly reporting has commenced in October 2021 as part of the Winter Plan 2021/22.

The Winter Planning Performance Review Summary will be considered by the Finance, Performance and Resources and Clinical Governance Committees and for performance measures relating to the HSCP via Finance and Performance and Clinical and Care Governance Committees.

Section A: Executive Summary

This is the third bi-monthly report summarising performance against key indicators and actions for Winter 2021/22. The key points to note this month are as listed below.

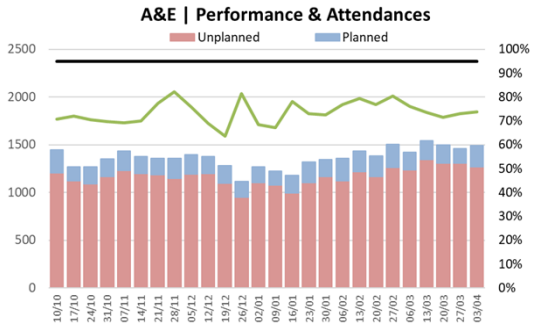
A&E

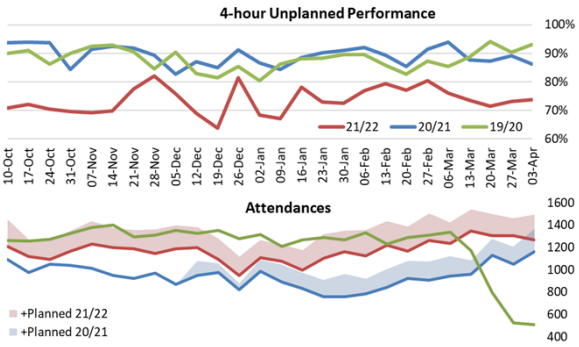
Narrative

The 95% Standard has not been met in the last 26 weeks. The board average has maintained above the Scotland average since w/e 6th February, and within 5% of the Scotland average throughout the Winter period with only week ending 19th December as the exception.

Planned attendances are not included within the numbers used to calculate the emergency access 4-hour target. The Redesign of Urgent Care (RUC) programme will transfer a portion of what previously would have been unplanned (minor) attendances into planned attendances. These patients would have been less likely to breach the 4-hour target, removing them has caused a negative effect on the performance.

Attendances including planned since the ed of January are now at the highest levels they have ever been and are trending much higher than pre pandemic levels now.



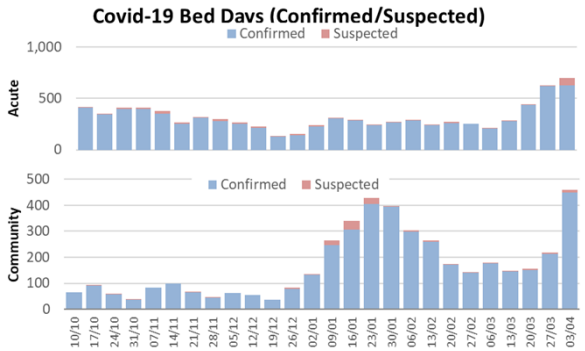


Covid-19 Bed Days

Narrative

The number of Covid-19 positive patients in Acute has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within a community setting the numbers have also risen increasing with the highest level seen causing many wards to close during this period.



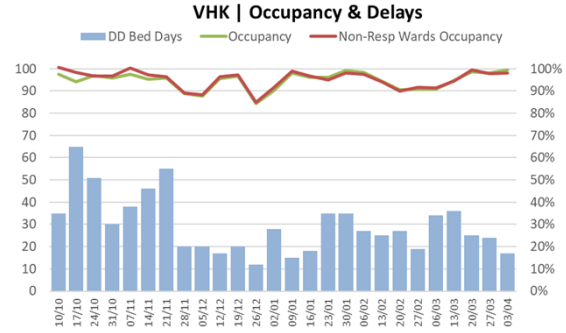
Acute Occupancy & Delays

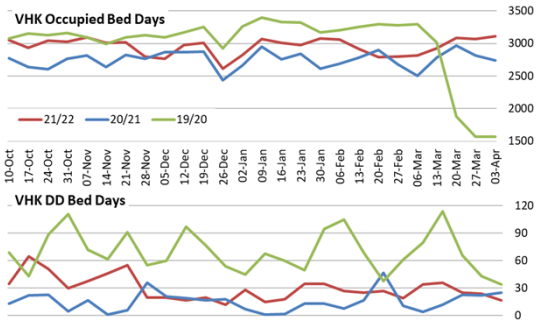
Narrative

VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%), this coincides with the high covid numbers which will put a squeeze on beds available.

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.





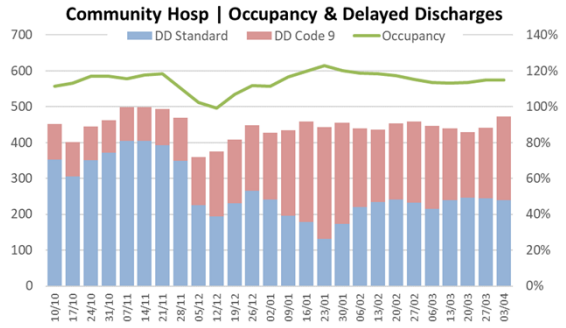
Community Occupancy & Delays

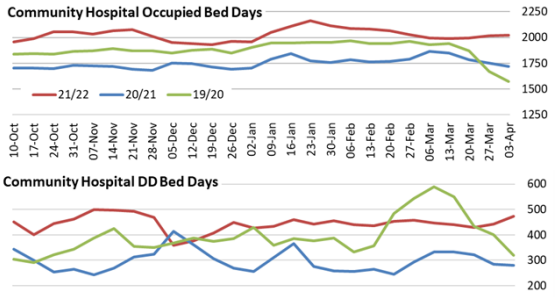
Narrative

Occupancy has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout.

The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.



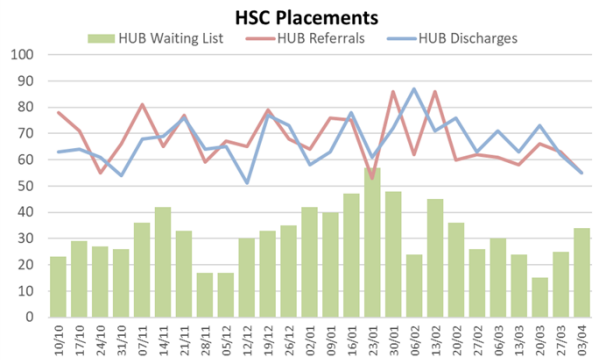


H&SCP Placements

Narrative

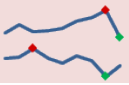
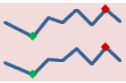
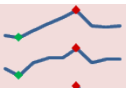
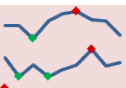
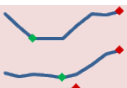
The number of referrals to H&SCP is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 week ending 23rd January and has gradually declined since thanks to the high discharges.



Section B: Performance Summary to Wk Ending 3rd April 2022

Weekly Unscheduled Care Monitoring Report

Area	Indicator	Trend	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar	03-Apr
Urgent Care	Contacts		2174	2139	2229	2133	2134	2206	2150	2111	2296
	Home Visits		108	120	121	112	114	121	112	92	136
	COVID Outcome		291	315	296	299	304	324	336	357	277
	NHS24 Outcome		359	362	397	358	342	368	351	292	335
VHK ED	All		1355	1433	1385	1504	1424	1543	1501	1459	1493
	Planned		230	213	216	244	187	196	194	153	223
	Unplanned		1125	1220	1169	1260	1237	1347	1307	1306	1270
	Performance		76.8%	79.3%	77.0%	80.5%	76.0%	73.6%	71.5%	73.1%	73.9%
MIU	Total		382	347	317	403	383	436	371	440	385
	Unplanned		317	291	267	332	325	373	311	381	325
VHK	Admissions		696	687	709	731	745	769	722	718	724
	Emergency		617	595	639	651	651	684	639	650	647
	Medical		348	333	355	369	363	404	368	354	350
	Surgical		269	262	284	282	288	280	271	296	297
	Discharges		683	646	692	670	697	663	683	667	661
Theatre Activity	Scheduled		260	257	218	272	294	304	277	274	231
	Cancelled		19	7	15	7	12	15	25	14	16
	Hospital Cancelled		6	0	3	2	0	1	3	0	4
VHK Bed Utilisation	Occupancy		98%	95%	91%	91%	91%	95%	99%	98%	99%
	COVID Bed Days		291	242	271	252	208	279	441	621	698
	DD Bed Days		27	25	27	19	34	36	25	24	17
Community Hospital	Admissions		72	54	57	49	50	51	57	45	39
	Discharges		70	55	51	59	45	56	55	35	36
	Occupancy		119%	118%	117%	115%	114%	113%	113%	115%	115%
	COVID Bed Days		303	265	173	143	180	149	155	218	458
	DD Bed Days		440	436	454	458	446	440	429	442	472
	DD Standard		220	234	241	233	215	240	247	244	239
	DD Code 9		220	202	213	225	231	200	182	198	233

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Owens**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for April 2022 committee to provide assurance that all IP&C priorities are being and will be delivered.

This is presented to the Clinical Governance 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 April 2022 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 circulated to the Infection Control Committee April 2022 (meeting cancelled).

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 3 2021 (July-September) NHS Fife was below the national rate for healthcare associated infection (HCAI) and community associated infection (CAI). Quarter 4 2021 national data awaited.

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.
- Liaise with Drug addiction services re PWID (IVDU) SABs. IPCT are currently awaiting an update from the Addictions service Manager.

CDI

- For Quarter 3 2021 (July-September) NHS Fife was below the national rate for HCAI and CAI. Quarter 4 2021 national data awaited.
- NHS Fife had a total of 44 CDI cases reported for 2021. This was higher than in 2020, when there were 34 cases, but less than 2019 when 47 cases were reported. Overall, 2022, is looking more promising as there have only been 3 CDI cases so far (Jan – Feb

2022), compared with 7 during the same time period in 2021. However, the number of Healthcare associated CDIs (HAI, HCAI and Unknown) during that time is equally comparable for 2021 and 2022 (3 in total).

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 3 2021 (July- September) NHS Fife was above the national rate for HCAI and CAI. This has resulted in NHS Fife being issued with an Exception Report from ARHAI (Antimicrobial Resistance and Healthcare Associated Infection, National Services Scotland). The data is being examined locally and an action plan is being developed, to be returned to ARHAI by 8.2.22.
- During Q4 2021 (Oct-Dec), there were 60 ECB cases reported for NHS Fife. This is an improvement compared to the previous quarter, when there were 85 ECBs. Currently awaiting national reporting for Q4 2021.

Current ECB Initiatives

- 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

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.

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 (January – February 2022)

- **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**

Sixteen ARHAI Scotland reportable 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

Ward Dashboard is no longer available as a link on Intranet. Hand Hygiene audit results are still accessible via LanQIP dashboard as shown in the report card.

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 3 (October - December 2021) was **95.9%**.

National Cleaning Services Specification

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (October - December 2021) shows NHS Fife achieving **Green** status.

Estates Monitoring

- The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 3 (October - December 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 April 2022

2.4 Recommendation

- **Assurance** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- HAIRT report

Report Contact
Julia Cook
Infection Control Manager
Email Julia.Cook@nhs.scot

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 6th April 2022.

(Validated Data up to February 2022)

April 2022

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**

During Q4 2021 (Oct-Dec), there were 20 SAB cases reported for NHS Fife. This is an improvement compared to the previous quarter, when there were 23 SABs. National reporting for Q4 2021 board comparison is awaited.

***Clostridioides difficile* Infection (CDI)**

There were 5 CDI cases reported for Q4 2021 (Oct-Dec), which is a vast improvement on the 12 cases reported in NHS Fife for Q3 2021. Currently awaiting national reporting for Q4 2021.

1.2 Challenges:

SABs

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.

ECBs

During Q3 2021 (Jul-Sep), NHS Fife was above the national rate for HCAI & CAI. This resulted in NHS Fife being issued with an Exception Report from ARHAI (Antimicrobial Resistance and Healthcare Associated Infection, National Services Scotland). The data was examined locally and an action plan was developed and returned to ARHAI for 8.2.22.

During Q4 2021 (Oct-Dec), there were 60 ECB cases reported for NHS Fife. This is an improvement compared to the previous quarter, when there were 85 ECBs. Currently awaiting national reporting for Q4 2021.

CDI

NHS Fife had a total of 44 CDI cases reported for 2021. This was higher than in 2020, when there were 34 cases, but less than 2019 when 47 cases were reported. Overall, 2022, is looking more promising as there have only been 3 CDI cases so far (Jan – Feb 2022), compared with 7 during the same time period in 2021. However, the number of Healthcare associated CDIs (HAI, HCAI and Unknown) during that time is equally comparable for 2021 and 2022 (3 in total).

Whilst Fife's CDI Year ending Q3 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 2021/22 has been paused due to the COVID-19 pandemic.

COVID-19

Following changes in the Covid-19 Case definition and changing testing policies since 5 January 2022, hospital and ICU occupancy figures now include patients with Covid-19 cases confirmed by either PCR or LFD. Historical figures have been updated retrospectively from 9 January 2022.

In Scotland, the percentage of people testing positive for Covid-19 increased in the two weeks up to mid February 2022, but the trend was (statistically) uncertain in the following weeks (Scottish Government, *State of the Epidemic in Scotland* – February 2022).

The UK Health Security Agency's (UKHSA) consensus estimate for R in Scotland as at 1 February is between 0.8 and 1.0.

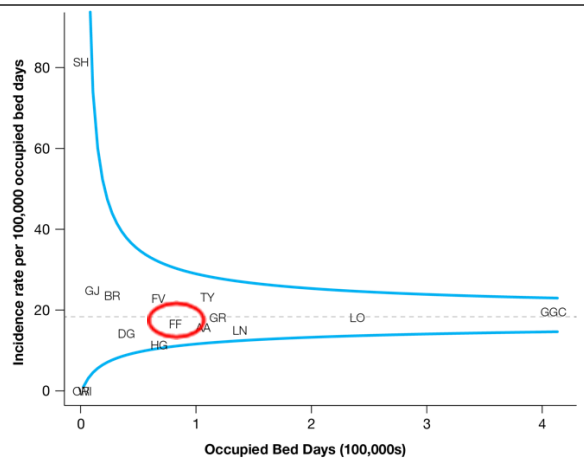
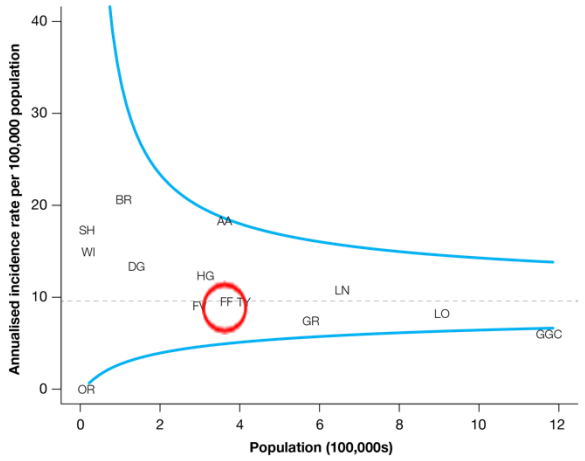
January and February saw an increase in number of nosocomial infections and clusters across Scotland and NHS Fife.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q4 2021 (Oct-Dec) **(Q4 2021 National comparison awaited)**				
In Q4 2021 NHS Fife had:	20 SABs	11 HCAI/HAI 9 CAI	This is **DOWN** from	23 Cases in Q3 2021

Q3 2021 (Jul-Sep) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **16.6**	Per 100,000 bed days	CAI SABs rate: **9.5**	Per 100,000 Pop
No of HCAI SABs: 14		No of CAI SABs: 9	
This is **BELOW** National rate of 18.3		This is **BELOW** National rate of 9.6	
			
NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.			

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 September 2021 (HPS)		
SAB by rate 100,000 Total bed days	**15.3** per 100,000 TBDs	
SAB by Number of HCAI cases	**49**	

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 no further dialysis line related SABs since the most recent case on 15/10/21. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

As of **08/03/2022** the number of days since the last confirmed SAB is as follows:	
CVC SABs	177 Days
PWID (IVDU)	16 Days
Renal Services Dialysis Line SABs	144 Days
Acute services PVC (Peripheral venous cannula) SABs	207 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. IPCT are currently awaiting an update from the Addictions service 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 **93%** compliance with the **MRSA** CRA in Q4 (Oct-Dec) 2021
This was **UP** on Q3 2021 (88%) & **ABOVE** the compliance target of 90%.
It was **ABOVE** the national average of 82%.
MRSA Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	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	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec
Fife	93%	83%	98%	88%	98%	95%	98%	88%	93%
Scotland	88%	88%	87%	86%	82%	83%	84%	81%	82%

CPE (Carbapenemase Producing Enterobacteriaceae)
From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **98%** compliance with the **CPE** CRA for Q4 2021 (Oct-Dec)
This is **DOWN** from 100% in Q3 2021
It is **ABOVE** the national average of 80%

Quarter	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	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec `
Fife	80%*	93%	95%	85%	98%	88%	90%	100%	98%
Scotland	85%	85%	80%	85%	79%	82%	83%	82%	80%
	CPE CRA screening KPI compliance Summary- Commenced from April 2018								

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 2022

3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dec 2021 **(Q4 2021 HPS National comparison awaited)**				
In Q4 2021 NHS Fife had:	5 CDIs	4 HCAI/HAI/Unknown 1 CAI	This is **DOWN** from	12 Cases in Q4 2021

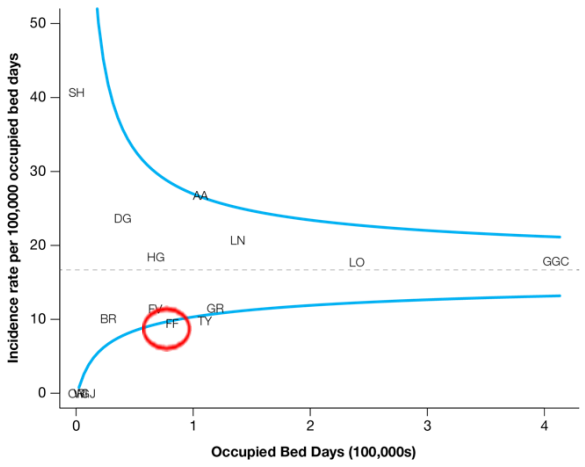
Q3 (July-Sep) 2021 ARHAI validated data with commentary

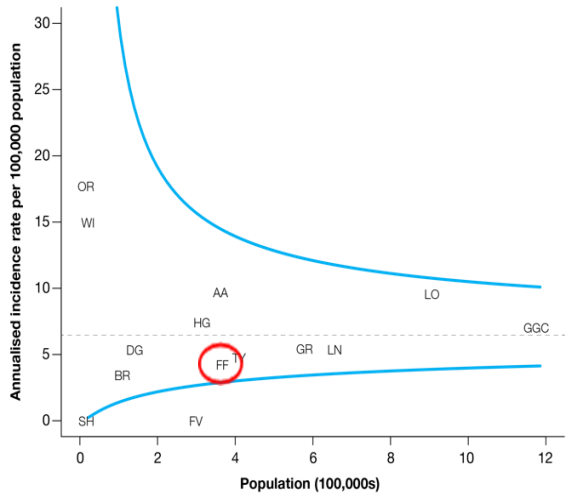
With ARHAI Quarterly epidemiological data Commentary

*Please note for ARHAI 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: **9.5**	Per 100,000 bed days	CAI CDIs rate: **4.2**	Per 100,000 Pop
No of HCAI CDIs: 8		No of CAI CDIs: 4	
This is **BELOW** National rate of 16.7		This is **BELOW** National rate of 6.5	





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 June 2021 (HPS)		
CDI by rate 100,000 Total bed days	**10.3** per 100,000 TBDs	
CDI by Number of HCAI cases	**33**	

3.2 Current CDI initiatives

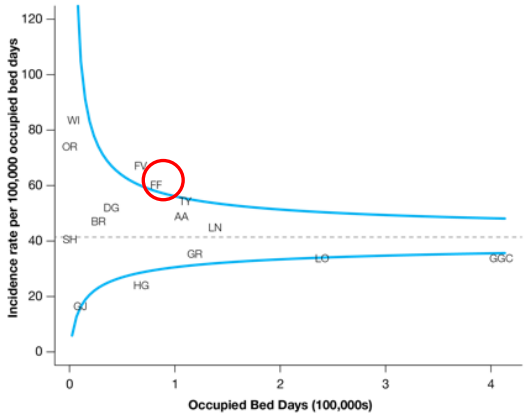
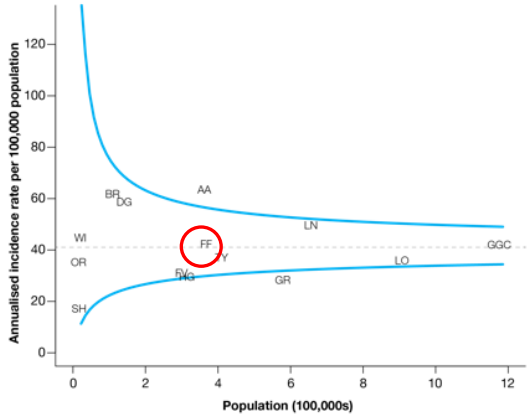
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high risk patients.
- Bezlotoxumab for recurrent CDI currently used in Fife.

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q4 (Oct-Dec) 2021 **(Q4 2021 HPS National comparison awaited)**				
In Q4 2021 NHS Fife had:	60 ECBs	29 HAI/HCAIs 31 CAIs	This is **DOWN** from	85 Cases in Q3 2021
Q4 2021 There were 7 Urinary catheter associated ECBs (6x HCAI, 1xHAI). This is an improvement on Q3 2021, when there were 14 ECBs There were 2 trauma related CAUTIs in Q4 2021.				

Q3 (Jul-Sep) 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: **60.3**	Per 100,000 bed days	CAI ECBs rate: **42.4**	Per 100,000 Pop
No of HCAI ECBs: 51		No of CAI ECBs: 40	
This is **ABOVE** National rate of 41.4		This is **ABOVE** National rate of 41.1	
			
For HCAI ECBs: NHS Fife was **OUTWITH** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

1) 25% reduction ECBs - 2021/2022		
New standards for reducing all Healthcare Associated ECB by 25% by 2021/22 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2022**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending September 2021 (HPS)		
ECB by rate 100,000 Total bed days	**42.7** per 100,000 TBDs	
ECB by Number of HCAI cases	**137**	

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 Q4	TBC	***9.1%**	* Locally calculated data- TBC by HPS when Q4 data published on Discovery
2021 Q3	TBC	**19.0%**	
2021 Q2	23.4%	**25%**	
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 Q4	TBC	***33.3%**	* Locally calculated data- TBC by HPS when Q4 data published on Discovery
2021 Q3	TBC	**33.3%**	
2021 Q2	32.5	**40.9%**	
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 Improvement Group work was commissioned following raised ECB CAUTI incidence. The IPC Surveillance team continue to liaise with the Urinary Catheter Improvement Group although the most recent meetings on 19/01/22 & 18/3/22 have been cancelled. This group aims to minimize urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheter insertion/maintenance/removal and self-removal, furthermore, to establish catheter improvement work in Fife.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a LAER to provide further learning from all ECB CAUTIs..

Monthly ECB reports and graphs are distributed within HSCP and Acute services
There were four trauma associated CAUTIs in 2021. None have been reported, so far, for 2022 (Jan & Feb).

CAUTI bundles have now been installed onto Patientrack in February 2022 and are currently being trailed on V54 before being rolled out across the board. This bundle should ensure that the correct processes are adhered to for the implementation and maintenance of all urinary catheters within NHS Fife inpatient wards.

CAUTI QI project at Kelty practice continues

Other NHS Fife Initiatives to reduce ECB incidence;

NHS Fife collaborated with NHS Shetland and NHS Grampian Infection control surveillance teams to trial an enhanced surveillance tool for all CAUTI associated ECBs, to collate all data to identify risk factors for onset of infection.

5. 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.
- Reporting of Hand Hygiene performance is based on data submitted by each ward via LanQIP
- 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 should be viewed on Ward Dashboard.
- From October 2021 it was noted that Ward Dashboard is no longer widely available. However, Hand Hygiene audit results are still accessible via LanQIP dashboard as shown in the report card.

5.1 Trends

- Unable to report

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 3 (Oct-Dec 2021) was **95.9%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the National Monitoring Framework for NHS Scotland National Cleaning Services Specification. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

Domestic Location	Q3 Oct-Dec 21	Q2 Jul-Sep 21
Fife	95.9% ↑	95.7%
Scotland	95.3%	95.5%

- The National Cleaning Services Specification – quarterly compliance report result for Q3 (Oct-Dec) 2021 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 21	Q2 Jul-Sep 21
Fife	96.6↑	96.0
Scotland	96.4	96.3

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct-Dec) 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.

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7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place.

Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any) & how many days the closure lasted.

A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda.

All ward/ bay closures due to Norovirus & Influenza are reported to HPS weekly plus all closures due to an Acute Respiratory Illness (ARI).

All Influenza patients admitted to ICU are also notifiable to HPS

January – end of February 2022

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 8 2022 (Week ending 2^{7th} of February 2022)

- The provisional total of laboratory reports for norovirus in Scotland up to the end of week 8 of 2022 is 72.
- In comparison, to the end of week 8 in 2021 PHS received 4 laboratory reports of norovirus. In 2020 PHS received 140 laboratory reports of norovirus to the end of week 8. The five-year average for the same time period between years 2015 and 2019 was 258.

Seasonal Influenza

There has been no new closures due to confirmed Influenza since the last reporting period.

Weekly national seasonal respiratory report- week 08 2022 (Week ending 2^{7th} of February 2022)

- Influenza was at **Baseline** activity level. There were 79 influenza cases: 62 type A (subtype unknown), 16 type A(H3) and one type A(H1N1). This compares with 57 influenza cases reported in week 7.
- Coronavirus (non-SARS-CoV-2), HMPV, parainfluenza, RSV, rhinovirus, and Mycoplasma pneumoniae were at **Baseline** activity level. Adenovirus 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 January – February 2022, there has been 16 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

COVID-19 outbreaks/incidents reported to ARHAI Scotland Jan/Feb 2022	
Hospital	Ward
Queen Margaret Hospital	Ward 3 Ward 4 Ward 7 Ward 8 Ward 16
Lynbank Hospital	Levendale
Cameron Hospital	Balfour Unit Letham ward Balgonie ward
Glenrothes Hospital	Ward 1 (January) Ward 1 (February) Ward 3
Stratheden Hospital	Radernie ward Dunino ward
Victoria Hospital	Ward 32 Ward 5

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 was higher in 2021 than during the previous year (44 cases in 2021, 34 cases in 2020). However, it was less than in 2019, when 47 cases were reported for Fife. So far, the cumulative total for 2022 (Jan and Feb) is lower than during the same time period for the previous 2 years (2020 and 2021). However, with respect to the HCAI target reduction, the number of HCAI cases so far for 2022 (3 cases) is equally comparable to the same time period in 2021. 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 device infections and dialysis line infections have been effective but remains a challenge, with local surveillance continuing
- **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.

Summary

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.

Report Cards

	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
Sep-21	6	4	10	2	2	4	21	8	29
Oct-21	3	4	7	1	0	1	11	13	24
Nov-21	4	3	7	2	0	2	9	9	18
Dec-21	4	2	6	1	1	2	9	9	18
Jan-22	5	4	9	2	0	2	7	17	24
Feb-22	4	2	6	1	0	1	7	10	17

Cleaning Compliance (%) TOTAL FIFE											
	Apr-21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov-21	Dec-21	Jan 22	Feb 22
Overall	95.6	94.9	95.6	95.6	96.0	95.6	95.8	95.7	96.2	96.1	96.4

Estates Monitoring Compliance (%) TOTAL FIFE											
	Apr-21	May21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov-21	Dec-21	Jan 22	Feb 22
Overall	96.3	95.7	96.4	95.7	96.3	96.1	96.0	96.6	97.1	96.3	97.4

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
Sep-21	2	2	7
Oct-21	3	0	4
Nov-21	2	2	5
Dec-21	3	0	1
Jan-22	2	0	0
Feb-22	1	0	3

Cleaning Compliance (%) Victoria Hospital												
	Mar-21	Apr-21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Overall	96.1	95.9	95.3	95.8	95.5	96.0	95.9	95.7	95.4	96.4	95.2	96.2

Estates Monitoring Compliance (%) Victoria Hospital												
	Mar-21	Apr-21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Overall	95.2	96.5	96.4	97.2	96.5	96.8	96.8	96.5	97.3	97.7	96.3	98.0

Hand Hygiene Audits VHK: LanQIP Dashboard VHK

Hospital	Ward	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Victoria Hospital	Accident and Emergency	100%	95%	96%	100%	100%	92%	95%	100%	92%	93%	96%	93%
	Admissions Unit 1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Admissions Unit 2	100%	100%	100%	95%					100%		100%	100%
	Childrens Ward	100%	95%	95%	95%	95%	95%	95%	95%	93%	95%	95%	100%
	Day Intervention Unit	100%	100%	100%	100%	95%	100%	100%	100%	90%		100%	
	Dermatology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	ENT					100%	100%	100%	100%	100%	95%	100%	100%
	Hospice		90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Maternity Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Maternity Ward		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Neonatal Unit	100%	100%		100%	100%	100%	100%	100%	100%	100%		
	OPD	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
	Orthodontics								100%				
	Renal Outpatients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Surgical Pre-Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Urology Centre	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Ward 10	96%	100%	100%	85%	95%	100%	100%	100%	100%	100%	100%	100%
	Ward 21	99%	100%	100%	100%	100%	100%	100%					
	Ward 22	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	
	Ward 23	100%	100%	100%	100%	100%	100%						
	Ward 31	100%	100%	100%	90%	95%	100%	100%	100%	100%	100%	100%	100%
	Ward 32	100%	100%	96%	100%	100%	100%	100%	100%	96%	100%	100%	95%
	Ward 33	100%	100%	95%	100%	95%	100%	100%	100%	100%	95%	100%	100%
	Ward 34	90%	100%	100%	100%	100%							
	Ward 41	100%	100%	100%	95%	100%	100%	95%	95%	88%	100%	100%	100%
	Ward 42	100%	99%	100%	100%	100%	100%	100%	100%	100%			
	Ward 43	87%	95%	100%	100%	95%	96%	100%	90%	95%	100%	100%	100%
	Ward 44	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 51	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 52	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 53	100%	100%	100%					100%	100%			
	Ward 54	93%	100%	100%	96%	100%	100%	95%	100%	96%	100%	100%	100%
	Ward 9	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%

Queen Margaret 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
Sep-21	1	0	0
Oct-21	0	0	0
Nov-21	0	0	1
Dec-21	0	0	0
Jan-22	1	0	0
Feb-22	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Mar-21	Apr-21	May 21	Jun-21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Overall	96.5	96.0	96.7	96.7	96.3	97.0	96.3	96.7	97.0	96.9	97.5	97.8

		Estates Monitoring Compliance (%)Queen Margaret's hospital										
	Mar-21	Apr-21	May 21	Jun-21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Overall	97.1	95.5	94.3	95.3	94.6	95.3	95.5	95.7	97.0	97.4	96.4	96.5

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
Sep-21	0	0	0
Oct-21	0	0	0
Nov-21	0	0	0
Dec-21	0	0	0
Jan-22	0	1	0
Feb-22	0	0	0

Hand Hygiene Audits VHK: LanQIP Dashboard HSCP

Hospital	Ward	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Adamson Hospital	MIU_OPD	95%	100%	95%	93%	90%	95%	93%	100%	100%	96%	95%	100%
	Tarvit Ward	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cameron Hospital	Balcurvie	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Balgonie	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	
	Letham	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SGSU	100%	100%		100%	96%	100%		100%	100%	100%	100%	
Glenrothes Hospital	Ward 1	100%	100%	100%	100%	100%	100%			96%	100%	100%	
	Ward 2	97%	95%	100%	95%	100%	100%	100%	93%	100%	100%	100%	90%
	Ward 3	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Queen Margaret	CIU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Colposcopy		100%	100%	100%	100%			100%	100%		100%	
	Dermatology	100%	100%	100%	85%	100%	100%	100%	100%	100%	100%	96%	100%
	DSU	90%	100%	95%	100%	100%	100%	87%	100%	95%	100%	95%	100%
	Endoscopy		100%	100%	100%	100%	100%	100%		100%	100%	100%	100%
	Haematology Day Bed Unit	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	OPD	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%
	Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Plastics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Radiology	100%	100%	100%	100%	100%	90%	80%	100%	90%	100%	100%	100%
	Renal Outpatients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 1	100%	100%										
	Ward 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 3			100%	100%	100%	100%	100%	100%	100%	96%	100%	100%
	Ward 4	76%	90%	76%	80%	85%	92%	85%	80%	76%	80%	90%	
	Ward 5	96%	100%	95%	96%	95%	95%	96%	95%	95%	96%	96%	100%
	Ward 6	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 7	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
	Ward 8	100%	100%	100%						100%	100%	100%	100%
Randolph Wemyss Memorial Hospital	CRU	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%
STACH	MIU_OPD	100%	100%	100%	100%	100%	100%		95%	100%	100%	100%	100%
	Renal Unit	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward 2	100%	100%	92%	100%	100%	90%	90%	100%	100%	96%	100%	100%

Compliance with Hand Hygiene Bundle - GWP5

Hospital	Ward	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Stratheden Hospital	Bayview	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	
	Cairnie											100%	100%
	Dunino	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Elmview	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	IPCU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Lindores	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Lomond	100%	100%	100%	100%	100%	100%	100%					
	Muirview	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Radernie	95%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%
	Weston Day Hospital	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%

Out 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
Sep-21	3	4	0	2	14	8
Oct-21	0	4	1	0	7	13
Nov-21	2	3	0	0	3	9
Dec-21	1	2	1	1	8	9
Jan-22	2	4	1	0	7	17
Feb-22	3	2	1	0	4	10

Appendix 1 References and Links

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/**

Appendix 2 Categories of Healthcare & Community Infections

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 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

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
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 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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report author	**Janette Owens, Director of Nursing** **Nicola Robertson, Associate Director of Nursing**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This is presented to the Clinical Governance 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

Patient feedback is reported on a monthly basis through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 65%)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to

ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model

Moving forward, we will also make use of:

- Surveys
- Focus groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
    - Shadowing / observation
    - Walkarounds
    - 15 step challenge

IMPROVING THE EXPERIENCE
It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
    - Framework
    - Leadership
    - Education and training
- Engage staff, patients, families and carers in improvement work

2.3 Assessment

A Recovery and Improvement Plan (Appendix 1) has been developed to guide the redesign of the Patient Relations service, focussing on patient experience and feedback.

A quarterly report (Appendix 2) has been developed for the Clinical Governance Committee which captures information on 'Measuring the Experience' and 'Improving the Experience'. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in the report.

2.3.1 Quality/ Patient Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group is reviewing themes, trends and lessons learned from complaints and adverse events and this can be triangulated with activity and staffing resource.

2.3.2 Workforce

Workforce planning
The Patient Relations Team establishment is under review, examining workload and workforce planning. Understanding the complexity of complaints and the time required to draft a response, for example, will support workforce planning and the model of complaints management.

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.

The post of Head of Patient Experience (HoPE) has been successfully recruited to, and should be in post May / June. This post will provide leadership and oversight to the Patient Relations Team.

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

- Presented to the Clinical Governance Committee for **assurance**

Report Contact

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NHS Fife

Patient Experience and Feedback

Recovery and Improvement Plan

April 2022

Published Month Year

www.nhsfife.org

CONTENTS

ISSUE: 1	RECOVERY
OBJECTIVE	**Backlog of 'ready to draft' complaints responses is addressed**. 40 responses to be drafted by PR officers as at 01/02/22. This number will inevitably increase as more statements from services are received. Aim is to have no backlog, to allow PR officers to focus on managing new complaints within the Model CHP timescales, and support services to provide statements.

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.1	Provide weekly report on complaints in system to share with operational teams: ECD, PCD, W&CS, CCS, PPCS, C&CS, corporate services	PRT Admin	31/03/22	Weekly report produced providing information on number of complaints within 15 days (green); 15 – 20 days (amber); >20 days (red); status (awaiting statements, for approval etc).	complete
1.2	Prepare complaint information, statements to draft	PRT Admin	31/03/22	Packs prepared for weekend drafting	complete
1.3	Identify staff, experienced in complaints management, to support focussed drive on drafting responses	ADoN	31/03/22	Senior nurses working additional hours at weekends to reduce backlog, supporting PRT	complete
1.4	Focus on 'ready to draft' responses by PROs	PR Lead	31/03/22	PROs prioritised drafting backlog of responses	complete
1.5	Highlight 'ready to draft' responses: number, complexity	PRT Admin	31/03/22	Backlog of 'ready to draft' responses cleared	complete

OBJECTIVE	**Define timeline / trajectory for improvement in complaints response times**

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.6	Re-establish weekly meetings with service SPOC	PR Lead	8/4/22	Weekly meetings being re-established	In progress
1.7	Reduce backlog of statements from services and expedite Final Responses awaiting approval	PR Lead / SPOC	31/5/22		In progress
1.8	Analyse data from process mapping exercises and agree improvement trajectory with services	PR Lead / HoPe	30/6/22		In progress
1.9	Establish focus groups to discuss complaints management with services	PR Lead / HoPe	30/6/22		Not started

ISSUE: 2	'MEASURING THE EXPERIENCE': ANALYSIS AND REPORTING				
OBJECTIVE	Provide clear analysis of patient experience and feedback data, designing effective format for reports which promotes discussion and learning				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
2.1	Collaborate with Risk Management Coordinator to broaden use of DATIX in Complaints Management, coding themes, capturing lessons learned, actions planned	ADoN	1/8/22	Initial meeting taken place to identify potential 'addition' to DATIX system	In progress
2.2	Data collection and analysis systems to be developed to facilitate 'live' status of complaints, avoid duplication and enable bottlenecks to be identified	ADoN / HoPE	1/5/22	Data systems being developed	In progress
2.3	Arrange meeting with Digital and Information Services to ensure systems are not being duplicated	DoN / ADoN	1/5/22	ADoDI highlighted issue at EDG – DoN to follow up in first instance	In progress
2.4	Capture data required for 9 KPIs in the Model Complaints Handling Procedure	PR Lead	8/6/22	Data systems to be developed to capture requirements for KPI measurements	In progress
2.5	Develop criteria against which quality of statements are assessed	PR Lead	22/4/22		Not started
2.6	Develop criteria against which quality of draft responses are assessed	PR Lead	22/4/22		Not started
2.7	Develop criteria against which complaints are assessed as being upheld, not upheld or partially upheld	PR Lead	22/4/22		Not started
2.8	Design template for EDG and CGC SBARs reporting	ADoN	8/6/22	Draft report template has been designed	In progress
2.9	Design quarterly report template for CGC, including MCHP which will inform Annual Report	DoN	8/6/22	As above	In progress
2.10	Complete Annual Report for SG	HoPE	30/9/22	Utilise template and data from quarterly reports	Not started

ISSUE: 3	COMPLAINTS HANDLING SERVICE MODEL				
OBJECTIVE	Review and redesign service model to improve effectiveness and efficiency of processes				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
3.1	Carry out detailed process map of PRO work	PR Lead	22/3/22	Process mapping undertaken	Complete
3.2	Carry out detailed process map of PR administrators' work	PR Lead	22/4/22	Date arranged to undertake process mapping	In progress
3.3	Review outcomes and implement recommendations from process mapping sessions	ADoN	1/5/22	Date to be arranged	Not started
3.4	Benchmark complaints management teams / processes across other Boards and public sector agencies	ADoN	1/5/22	Contact to be made with all Boards	Not started
3.5	Process mapping analysis to elicit gaps, duplication, more efficient way of working	PR Lead	22/4/22	Process mapping underway with Quality Improvement project manager	In progress
3.6	Proactively seek feedback from complainants re the complaints handling process (as per KPI) (will also support QI)	PR Lead	22/4/22	Questionnaire developed, to be piloted for validation	In progress

ISSUE: 4	'IMPROVING THE EXPERIENCE': QUALITY IMPROVEMENT				
OBJECTIVE	Ensure that lessons learned from all forms of patient feedback are used to inform quality improvement and promote patient safety				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
5.1	Link with Organisational Learning Group	ADoN	1/6/22	OLG in early stages of development. ADoN co-Chair. Systems and processes being worked through	In progress
5.2	Identify small Tests of Change in department	ADoN	1/4/22	Blended approach to office working has been established, minimum 50% office-based	Complete
5.3	Identify small Tests of Change in Complaints Handling	ADoN	1/5/22	Identify ToCs following review of outcomes and recommendations from process mapping	Not started
5.4	Ensure feedback loop with services	PR Lead	1/5/22	Processes to ensure effective feedback to be indentified	Not started
5.5	Capture data / action plan / lessons learned on Datix	HoPE	1/8/22		Not started

ISSUE: 5	WORKFORCE				
OBJECTIVE	Ensure that PRT is supported and developed. Ensure that workload and workforce planning is considered in design of team				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
4.1	Support staff well-being	ADoN	22/4/22	'Spaces for listening' session arranged with Chaplain	In progress
4.2	Appoint additional PR officer via bank contract to focus on expediting draft responses	ADoN	1/5/22	Telephone interview conducted, bank recruitment in progress	In progress
4.3	Leadership: recruit Head of Patient Experience (HoPE)	ADoN	7/4/22	Post appointed to	Complete
4.4	Ensure PDPs undertaken to support staff development	PR Lead	1/5/22	ADoN to confirm progress with PR Lead	In progress
4.5	Source training opportunities for PRT	PR Lead	1/5/22	ADoN to confirm progress with PR Lead	In progress
4.5	Develop system to categorise complaints from 'simple' to 'complex' to provide approximate time to draft response	HoPE / PR Lead	1/5/22		Not started
4.7	Measure workload to support workforce planning	PR Lead	1/5/22	ADoN to confirm progress with PR Lead	In progress

Patient Experience and Feedback

PEaF Quarterly Report (Q4) for Clinical Governance Committee

January - March 2022

CONTENTS

Introduction

Person-centred Care

Person-centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How Do We Know We Are Getting It Right?

Defining the patient experience

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.
We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes and the environment

Measuring the experience

'Patient experience and feedback' is captured by a number of different methods, including:

- Care Opinion
- Compliments and comments
- Complaints
- Care Assurance processes, for example: Shadowing / observation; Walkarounds; 15 step Challenge
- *Surveys (2022/23)*
- *Post discharge phone calls (2022/23)*

Improving the experience

It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Lessons learned, improvement actions developed, successes celebrated
- Create an enabling infrastructure: Framework; Leadership; Education and training
- Engage staff, patients, families and carers in improvement work
- *'Warm welcome / fond farewell' (2022/23)*
- 'You said… We did'
- *Focus groups (2022/23)*
- Initiatives, such as the Care Experience Improvement Model

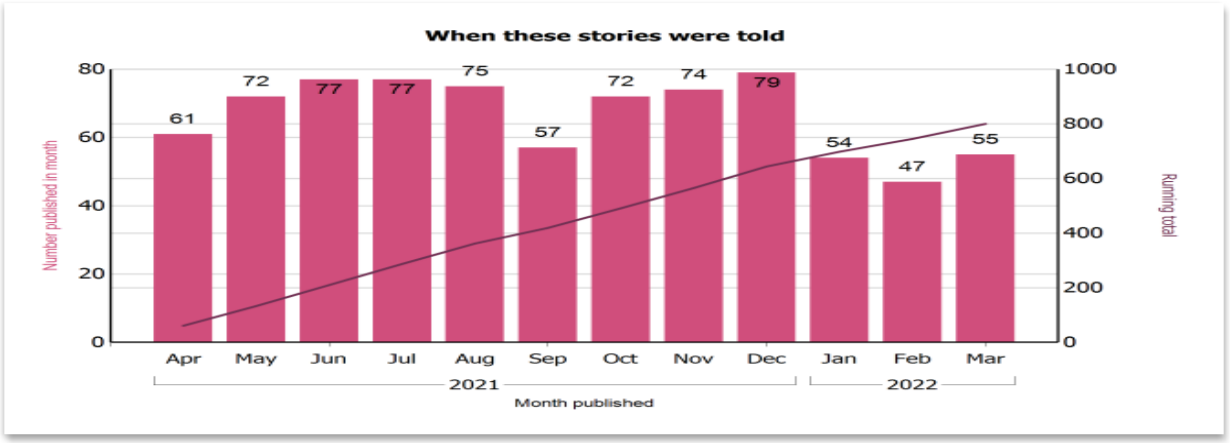
Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning and making changes. NHS Fife is the top performing NHS Scotland Board.

NHS Fife's **Care Opinion** highlights for Q4 include:

- **156** stories, viewed **10,609** times in all:
  - January 54 stories
  - February 47 stories
  - March 55 stories

The graph below shows the distribution of stories received since April 2021.



In Q4, Care Opinion moderators rated the stories as:

- Not critical 83% (130)
- Minimally critical 3% (5)
- Mildly Critical 8% (13)
- Moderately critical 5% (8)

In 2021/22 Care Opinion moderators rated the stories as:

- Not critical 83% (666)
- Minimally critical 4% (35)
- Mildly Critical 8% (65)
- Moderately critical 4% (33)
- Strongly critical 0% (1)

An important aspect of Care Opinion is the ability to feedback information to patients on **changes** which have been made. **Recent changes**, following patient feedback, includes improved signage at Clinic 4, Colposcopy, in QMH and improved staff / public interaction at Glenrothes vaccination centre

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.

It is hoped that the 'compliments' module will become more widely used as staff are encouraged to record compliments, celebrating and learning from success.

Compliments	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Compliments	177	170	216	174	737
Learning from Excellence (Greatix)	21	23	21	21	86
Comments and Feedback	5	1	7	6	19
Total	203	194	244	201	842

Compliments	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Planned Care & Surgery	42	63	85	95	285
Community Care Services	10	10	64	47	131
No value	19	19	21	8	67
Community Services (Fife-Wide)	31	27	0	0	58
Community Services (West)	33	23	1	0	57
Community Services (East)	17	13	1	0	31
Primary and Preventative Care	0	2	15	12	29
Emergency Care & Medicine	12	3	6	3	24
Women Children & Clinical Services	2	6	14	1	23
Corporate Directorates	11	4	2	1	18
Complex and Critical Care Services	0	0	7	7	14
Total	177	170	216	174	737

Comments:

HOLLYVIEW: Letter received from patient: Thank you to all staff and students who have helped me by distracting me, talking to me and played cards with me, I've been less than an angel but I know you can see the good in me. If I hadn't been brought here kicking and screaming I would be in a whole world of a mess and in trouble with the police no doubt. Its taken me to be here to see I needed help for all im reluctant to accept help. I just need to continue the journey when I get out. All I can say is a heartfelt Thank you to all staff.

VHK HOSPICE: To all the staff: I would like to thank you for looking after my mum so well during the last week of her life. From first to last, everyone treated her with kindness, gentleness, dignity and respect. You kept her comfortable and gave her a place of quietness and peace which was what she wanted. In addition every member of staff we encountered had time for us as relatives. Even though visits during this period must have made your work more difficult, we were always welcomed and treated as though we mattered. Once again thank you for everything.

Complaints:

Trends

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution
The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.
Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation
Complaints might be handled at stage 2 because:

- They are complex, serious or high-risk issues and are not suitable for early resolution
- early resolution has failed
- the complainant was unhappy with the outcome of stage 1 and asked for an investigation.

The complainant should receive a written response within 20 working days.

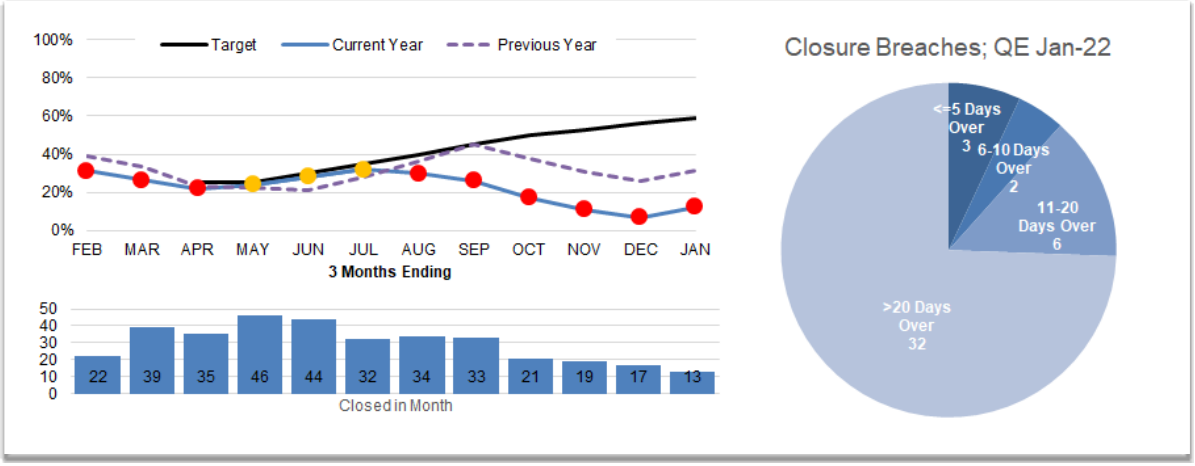
This table presents the total number of Enquiries, Concerns, Stage 1 and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 010421-310322	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Stage 1 Complaint	146	156	174	113	589
Enquiry	111	81	149	104	445
Stage 2 Complaint	105	110	102	118	435
Concern	102	46	84	132	364
Total	464	393	509	467	1833

The pressures encountered in services because of the pandemic, has led to difficulties in achieving the Model Complaints Handling Procedure timescales. Communication with complainants has been maintained by the Patient Relations Team over this difficult period. A Recovery and Improvement Plan has been developed to improve performance. The Model Complaints Handling Key Performance Indicators are appended to this report.

Stage 2 closed complaints and % closed within timescale

STAGE 2	2021 Feb	2021 Mar	2021 Apr	2021 May	2021 Jun	2021 Jul	2021 Aug	2021 Sep	2021 Oct	2021 Nov	2021 Dec	2022 Jan
Closed Complaints	22	39	35	46	44	32	34	33	21	19	17	13
% closed within timescales	**31.1**	**26.3**	**21.9**	**24.2**	**28**	**32**	**30**	**26.3**	**17**	**11**	**7**	**12.2**



Themes

The quarterly ranking of each theme is highlighted in brackets.

Issue noted in Complaint		Q1	Q2	Q3	Q4
1	Disagreement with treatment / care plan	64	50 (2)	47 (1)	32 (1)
2	Co-ordination of clinical treatment	62	54 (1)	28 (4)	16 (3)
3	Staff attitude	46	32 (3)	31 (2)	21 (2)
4	Unacceptable time to wait for the appointment / admission	41	24 (4)	31 (2)	16 (3)
5	Lack of support	26	22 (5)	16 (6)	10 (5)
6	Telephone	24	0		
7	Poor nursing care	18	16 (8)		
8	Face to face	15	27 (7)		
9	Lack of a clear explanation	15	22 (5)	23 (5)	10 (5)
10	Insensitive to patient needs			12 (7)	
11	Patient has been sent no communication			11 (8)	

The top 4 themes each quarter are:

- Disagreement with treatment / care plan
- Coordination of clinical treatment
- Staff attitude
- Unacceptable time to wait for admission / appointment

These issues have been addressed at an individual level, but organisational learning must take place to improve practice and to improve the patient experience. The establishment of the Organisational Learning Group will support this endeavour.

Positive and Negative Themes

Positive themes (Care Opinion) Q4	Negative Themes (Care Opinion) Q4	Negative Themes (Complaints) Q4
Staff	Communication	Disagreement with treatment / care plan
Friendly	Delays	Co-ordination of clinical treatment
Professional	Not being listened to	Staff attitude
Care	Staff attitude	Unacceptable time to wait for the appointment / admission
Nurses	Long wait	Lack of support
Reassuring	Food	Poor nursing care
Helpful	Treatment	Face to face
Caring	Accessibility	Lack of a clear explanation
Kind	Agreed timeframes	Insensitive to patient needs
Efficient	Apathy	Patient has been sent no communication

Locations receiving most complaints:

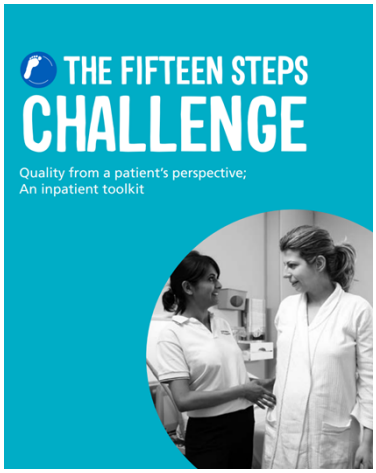
1. MoE *(care and treatment; communication; treatment plan disagreement)*
2. Emergency Department *(care and treatment; treatment plan disagreement: staff attitude)*
3. Mental Health (*treatment plan disagreement; communication; waiting times)*
4. District Nursing *(care and treatment; communication; staff attitude)*
5. Urology and cardiology

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

Each quarter, this section will include feedback from patient / family surveys, complainant survey, patient and staff focus groups, and care assurance processes, including leadership walkrounds; 15 steps challenge; shadowing / observation; 'warm welcome / fond farewell' initiative; care experience improvement model.

Again, the impact of the pandemic has delayed the structured introduction of these processes although they have been happening on an ad hoc basis.



"The 15 Steps Challenge" is a suite of toolkits that explore different healthcare settings through the eyes of patients and relatives. With an easy-to-use methodology and alignment to NHS strategic drivers, these resources support staff to listen to patients and carers and understand the improvements that we can make. The toolkits help to explore patient experience and are a way of involving patients, carers and families in quality assurance processes.

The 15 steps challenge has been utilised in Glenrothes Hospital but, as we strive to improve patient experience, we will ask patients and their relatives to undertake the challenge.

The Model Complaints Handling procedure, KPI 2 relates to the **Complaint Process Experience.** A survey has been developed to capture the experience of the person making the complaint in relation to the complaints service provided. The survey will be reported through Datix. 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 is to obtain feedback each month by contacting a random selection of complainants who have opted in.

'Warm Welcome… Fond Farewell' is an initiative to standardise admission information and ensure consistent discharge planning. It will help address some of the themes identified in complaints around communication, lack of clear explanation.

The newly appointed Head of Patient Experience will take forward these examples of patient experience improvement and will report on them in future reports.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2021	Jul to Sep 2021	Oct to Dec 2021	Jan to Mar 2022	2021 / 2022	Apr to Jun 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023
New SPSO cases	6	3	2	5	16					
SPSO decisions	4	3	4	3	14					
SPSO cases fully upheld	1	0	2	1	4					
SPSO cases partly upheld	0	0	0	1	1					
SPSO cases not upheld	2	3	2	1	8					
Cases not taken forward	1	1	0	2	4					

New SPSO cases this quarter	**New SPSO decisions this quarter**
This quarter, 5 new information requests have been received. These relate to the following services: • Emergency Care: 4 • Community Care Services: 1	There were 3 new decisions received from the SPSO this quarter. • 1 complaint was partially upheld (PCD). This relates to care and treatment during and following surgery. • 1 complaint was not upheld (ECD) • 1 complaint was upheld (CCS). This relates to care and treatment

NHS Scotland Model Complaints Handling Procedure

Introduction

Empowering people to be at the centre of their care and listening to them, their carers' and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- to take a consistently person-centred approach to complaints handling across NHS Scotland
- to implement a standard process
- to ensure that NHS staff and people using NHS services have confidence in complaints handling
- encourage NHS organisations to learn from complaints in order to continuously improve services.

Complaints Performance Indicators

The CHP introduced nine key performance indicators by which NHS Boards and their service providers should measure and report performance. These indicators, together with reports on actions taken to improve services as a result of feedback, comments and concerns will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

Quarterly Reports

In accordance with THE PATIENT RIGHTS (FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS (SCOTLAND) DIRECTIONS 2017 (the 2017 Directions) relevant NHS bodies have a responsibility to gather and review information from their own services and their service providers on a quarterly basis in relation to complaints. Service providers (Primary Care) also have a duty to supply this information to their relevant NHS body as soon as is reasonably practicable after the end of the three month period to which it relates.

This quarterly report represents NHS Fife's response to the 2017 Directions and will form part of the Feedback and Complaints Annual Report for the Scottish Government. This section of the report is structured around the nine Key Performance Indicators.

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

- *Information being collated and will be a feature of reports going forward*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided.
NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *Work will resume in this process in the coming quarter*

Indicator Three: Staff Awareness and Training

A statement to report on levels of staff awareness and training. Training on adverse events and duty of candour may also be included under this heading, as well as training on root cause analysis and human factors.

Subject Title	No. of staff	Notes
Good conversations (Gc)	-	Engagement figures have been requested from training providers as no record of these sessions in eESS
Gc Foundation Management	41	Good Conversations training is also provided as a half-day session on the 5 day Foundation Management programme
Adverse Events	-	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Duty of Candour	791	
Root Cause Analysis	-	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Human Factors	-	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.

Indicator Four: The total number of complaints received

	Q1	Q2	Q3	Q4
4a. Number of complaints received by the NHS Fife Board	270	263	219	155
4b. Number of complaints received by NHS Primary Care Service Contractors	198	220	186	
4c. Total number of complaints received in the NHS Board area	**468**	**483**	**405**	

NHS Fife Board - sub-groups of complaints received

	Q1	Q2	Q3	Q4
NHS Board managed Primary Care services:				
4d. General Practitioner	6	3	8	
4e. Dental				
4f. Ophthalmic				
4g. Pharmacy				
Total - Board managed Primary Care services	**6**	**3**	**8**	
Independent Contractors - Primary Care services:				
4h. General Practitioner	142	146	125	
4i. Dental	0	4	1	
4j. Ophthalmic	1	0	0	
4k. Pharmacy	49	67	52	
Total – Independent Contractors	**192**	**217**	**178**	
4l. Combined total of Primary Care Service complaints	**198**	**220**	**186**	

Indicator Five: Complaints closed at each stage

	Number				**As a % of all NHS Board complaints closed (not contractors)**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of complaints closed by the NHS Board *(do not include contractor data, withdrawn cases or cases where consent not received).*	**270**	**263**	**219**	**155**				
5a. Stage One	145	164	162	87	54%	62%	74%	56%
5b. Stage two – non escalated	104	80	44	59	39%	30%	20%	38%
5c. Stage two - escalated	21	19	13	9	8%	7%	6%	6%
5d. Total complaints closed by NHS Board	**270**	**263**	**219**	**155**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld and not upheld

Stage one complaints	**Number**				**As a % of all complaints closed by NHS Board at stage one**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6a. Number of complaints upheld at stage one	35	48	62	16	24%	30%	39%	19%
6b. Number of complaints not upheld at stage one	76	73	65	53	52%	45%	41%	63%
6c. Number of complaints partially upheld at stage one	34	40	31	15	23%	25%	20%	18%
6d. Total stage one complaints outcomes	**145**	**161**	**158**	**84**	**100%**	**100%**	**100%**	**100%**

Stage two complaints **Non-escalated complaints**	**Number**				**As a % of all non-escalated complaints closed by NHS Boards at stage two**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6e. Number of non-escalated complaints **upheld** at stage two	13	11	6	1	14%	22%	20%	6%
6f. Number of non-escalated complaints **not upheld** at stage two	45	14	13	9	49%	27%	43%	53%
6g. Number of non-escalated complaints **partially upheld** at stage two	34	26	11	7	37%	51%	37%	41%
6h. Total stage two, non-escalated complaints outcomes	**92**	**51**	**30**	**17**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints **Escalated complaints**	**Number**				**As a % of all escalated complaints closed by NHS Boards at stage two**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6i. Number of escalated complaints **upheld** at stage two	6	4	0	1	29%	25%	0%	14%
6j. Number of escalated complaints **not upheld** at stage two	13	8	8	3	62%	50%	62%	43%
6k. Number of escalated complaints **partially upheld** at stage two	2	4	5	3	10%	25%	38%	43%
6l. Total stage two escalated complaints outcomes	**21**	**16**	**13**	**7**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times

	Q1	Q2	Q3	Q4
7a. the average time in working days to respond to complaints at stage one	14.9	13.9	8.0	7.2
7b. the average time in working days to respond to complaints at stage two	42.4	42.9	51.1	69.4
7c. the average time in working days to respond to complaints after escalation	29.2	26.0	49.3	84.1

Indicator Eight: Complaints closed in full within the timescales

	Number				**As a % of complaints closed by NHS Boards at each stage**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
8a. Number of complaints closed at stage one within 5 working days.	101	104	96	52	74%	80%	96%	87%
8b. Number of non-escalated complaints closed at stage two within 20 working days	27	19	4	8	20%	15%	4%	13%
8c. Number of escalated complaints closed at stage two within 20 working days	8	7	0	0	6%	5%	0%	0%
8d. Total number of complaints closed within timescales	**136**	**130**	**100**	**60**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorised

	Number				**As a % of complaints closed by NHS Boards at each stage**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
9a. Number of complaints closed at stage one where extension was authorised	15	23	28	10	17%	37%	47%	27%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	73	39	31	27	83%	63%	53%	73%
9c. Total number of extensions authorised	**88**	**62**	**59**	**37**	**100%**	**100%**	**100%**	**100%**

**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

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Radiation Protection Annual Report
March 2022

1. Introduction

The IR(ME)R Board covering IR(ME)R compliance and the Radiation Protection Committee covering all other aspects of Radiation safety are both chaired by the Medical Director for NHS Fife and have met in line with its agreed role and remit. Minutes of these meetings are included in the appendix. IR(ME)R Board 25/08/2021, Radiation Protection Committee rescheduled from 16/12/2021 to 02/03/2022

2. Radiation Protection Advisors (RPA) reports

The Committee has received reports from the nominated Radiation Protection Advisors.

The highlights from these reports are as follows

- **Staff Dose report**
  - No monthly investigation levels were exceeded; therefore no further action is required.
  - Staff doses appear to be well controlled in NHS Fife, indicating good working practices and appropriate use of PPE.
- **RISK ASSESSMENTS**
  - Radiation risk assessments have been reviewed and updated, will be distributed across all services once the environmental monitoring is complete and results included in the RA's. No issues
  - Radiation risk assessment for temporary use of plaster room in ED for extremity imaging has been reviewed. The workload remains within acceptable limits and the imaging procedures continue to be limited to upper and lower limb . No issues
  - All pregnant staff risk assessments are up to date, robust procedures in place for identifying staff that require a RA.
- **PPE**
  - All personal protective equipment is properly maintained and tested at regular intervals.

- **TRAINING**
  - CPD talks will be arranged for the coming months on a number of topics: Radiation Incidents, Environmental monitoring, PPE, Personal Dose Monitoring, Dose Audits and

DRLs. These will be over Teams and recorded and made available for view at a later time.
    - There is a requirement under IRR17 for regular update training to be carried out which covers the following:
        a. IRR17
        b. Basic Radiation Physics
        c. Biological Effects and Radiation Risk

    - A Scotland-wide approach to this has been taken and three TURAS modules developed which can be taken by any staff with a planned repeat rate of every three years. All radiographers and radiologists now complete these as part of their mandatory training every three years.

- All areas have appointed RPS's

- IR(ME)R Updates-
    - The employer's procedure will be updated to detail that a verbal request for fluoroscopic imaging can be made to the IR(ME)R operator and the IR(ME)R operator can add the electronic referral on behalf of the referrer.
    - The employers' procedures will be update to reflect inclusive pregnancy check
    - Clinical Audit forms show compliance to the regulations

3. Radiation Incidents

2021

Radiation Incidents and Near Misses

There were 108 radiation incidents reported in NHS Fife in 2021, with 9 Notifiable incidents. This is comparable with previous records.

- Detailed RPA report attached and this demonstrates a positive reporting culture in NHS fife
- Good interaction with (HIS) inspectorate, team were praised for level of investigation and demonstration of learning and improvement
- Contingency plan for NM equipment fault, regional support and risk assessment has been performed.
- 6 referrer errors, investigated in partnership with referrers.
- Operator errors- staff have developed their own PAUSE procedure to minimise process errors

4. Staffing

All staff competencies are up to date

There remains a national shortage of Radiologists which is compounded by an increasing workload.

5. Nuclear Medicine

The ARSAC license has been updated to reflect the retirement of Dr Reid and the recruitment of Dr Patel and Dr Ramaesh. Both have written letters of entitlement.

Cobalt flood source has been replaced; this is required for daily QA within Nuclear Medicine.
Replacement Radio Pharmaceutical calibrator in nuclear medicine as per guidance from ARSAC licensing board

No other issues.

6. SEPA

Single permit issued by SEPA would need to be amended if the service is extended to include DAT scanning. This will be considered within the business case for service development

7. RADIATION EQUIPMENT

- Inventory of equipment up to date and all equipment requiring replacement has been escalated through the capital equipment replacement programme with supporting SBAR's
- All faults/downtime is recorded on datix

Radiology Equipment Replacement 2020/21

The following equipment has been replaced / purchased since the last report:

- Fuji DR X-ray room
- Mammography Unit
- MRI scanner QMH
- Obstetric Ultrasound scanners NHS Fife wide

We are currently in the process of replacing

- CT phase 3
- CT phase 2
- Room 2 General QMH
- General Ultrasound machines VHK/QMH

All equipment is under service contract and maintained by the respective manufacturers or alternative under contract with NSS to their specification.

8. Local Rules

A review of the local rules will take place in quarter 1 of 2022/23. Radiation protection supervisors are preparing a CPD session to communicate and test contingency plans.

9. MRI safety

MRI site safety audits were performed for both VHK and QMH MRI departments on the 4th of February 2022. Overall, the sites show excellent compliance with the MHRA guidelines and best safety practice and the MR Lead Radiographer and the team should be commended.

There were 4 incidents recorded in the period 1/10/2020 to 30/9/2021, all of which related to undeclared passive implanted devices (3 aortic valve replacements, 1 aneurysm clips). These were only identified at final screening when the patient attended the department, leading to a delay in the patient pathway. The MR Responsible Person sent a letter to the referrers in question highlighting the error and additionally pointing them to the TURAS MRI Safety for Referrers module. An organisation wide communication was sent with a quick guide for referrers to improve awareness and minimise risk.

9. Laser Safety

No issues

There are 8 lasers in Fife 4 at VHK 4 at QMH, one additional from 2019. Laser reviews of the 3 QMH lasers took place in January, the outcome of the reviews demonstrated excellent laser safety. The other 4 reviews will take place in April 2022

17 LPA's in NHS fife each have been formally appointed to their role.

Local Rules and Risk Assessment are in place.

10 Recommendation

The Committee is asked to **note** the contents of the Radiation Annual report

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**29 April 2022**
Title:	**Acute Services Division Clinical Governance Committee Update**
Responsible Executive:	**Professor M Wood/Mrs L Campbell**
Report Author:	**MW/LC/LG**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Emerging issue (Covid 19 mobilisation)

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

- Safe

2 Report summary

2.1 Situation

ASD CGC meeting scheduled for 23rd March 2022 was cancelled due to COVID19 and Capacity pressures. An attempt to reschedule also had to be postponed for the same reasons.

2.2 Background

Whilst this meeting was postponed, significant ongoing clinical governance activity has been maintained, and the relevant papers and directorate reports were prepared and submitted for this meeting illustrating this. This is shared with the aim of providing assurance to the board that monitoring of quality and safety within the division has been maintained.

2.3 Assessment

- Directorate Clinical Governance structures and discussions have been maintained with escalation where required
- Continuous real time review of major and extreme incidents by senior leadership team.
- Papers scheduled on annual plan will be moved to next scheduled meeting for review

2.4 Recommendation

- **Assurance** – For Members' information only.

Report Contact

Professor M Wood
Associate Medical Director

Lynn Campbell
Associate Director of Nursing

Area Clinical Forum

Area Clinical Forum 7 February 2022
No issues were raised for escalation to the Clinical Governance Committee.

Confirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 7 FEBRUARY 2022 AT 2PM VIA MS TEAMS

Present:
B Hannan, Deputy Director of Pharmacy & Medicines (Chair)
P Duthie, General Practitioner
A MacKay, Speech and Language Therapy SLT Operational Lead
Dr C McKenna, Medical Director

In Attendance:
A Graham, Associate Director of Digital & Information *(agenda items 1 – 5)*
N Robertson, Associate Director of Nursing *(deputising for J Owens)*
H Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from S Bailey (Consultant Clinical Psychologist), A Lawrie (Associate Director of Midwifery), D Galloway (General Manager Women, Children & Clinical Services), S Garden (Director of Pharmacy & Medicine), J Hornal (Medical Education Pharmacist), P Madill (Consultant in Public Health Medicine), E O'Keefe (Consultant in Dental Public Health), J Owens (Director of Nursing) and D Platt (Optometrist).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 9 December 2022

The Minutes from the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum noted the updates on the action list.

5. Digital Information Presentation

A Graham gave a presentation on Digital Information.

A MacKay questioned if there is a possibility of the re-introduction of a patient self-booking system. In response, A Graham advised that this is being actively pursued, and the infrastructure is ready and discussions are ongoing.

P Duthie questioned if there is an ability to share specified parts of data into secondary care. A Graham advised the system is there, however, there are challenges with supplier engagement, and this was explained.

A MacKay commented that the service within her department has very recently moved to Morse. A MacKay noted the team were supported, and continue to be supported, and a majority of services were able to be continued throughout the pandemic to a high standard.

A Graham was thanked for joining the meeting and presenting.

6. Nursing & Midwifery Leadership Group Update

N Robertson provided an update on the Nursing & Midwifery Leadership Group and advised the group has been established and had their first meeting on 11 January 2022. The membership and purpose of the group was outlined. An annual workplan will be developed and current pressures across each of the clinical areas will be included as a standing item. Other areas of the workplan were described.

N Robertson advised the Nursing & Midwifery Advisory Group is in the process of being formed, with representation from Registrants and all specialities.

Minutes from the Nursing & Midwifery Leadership Group will come to this Forum.

Action: Board Committee Support Officer will add to the workplan

7. Subcommittee Minutes

The Forum noted the following subcommittee minutes:

7.1 Allied Health Professionals Clinical Advisory Forum dates 1 December 2021

A MacKay advised the membership of the Allied Health Professionals Clinical Advisory Forum has been reviewed and refreshed to better reflect clinical leadership across different areas.

7.2 General Practitioners Subcommittee dated 16 November 2021 and 21 December 2021

8. ANY OTHER BUSINESS

None.

9. DATE OF NEXT MEETING

The next meeting will take place on Thursday 7 April 2022 at 2pm via MS Teams.

Area Clinical Forum

Area Clinical Forum 7 April 2022
No issues were raised for escalation to the Clinical Governance Committee.

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 7 APRIL 2022 AT 2PM VIA MS TEAMS

Present:
A Mackay, Speech and Language Therapy SLT Operational Lead (Chair)
J Fearn, Consultant Clinical Psychologist
D Galloway, Women Children & Clinical Services General Manager
B Hannan, Director of Pharmacy & Medicines
C McKenna, Medical Director
C Notman, Practice Pharmacist
J Owens, Director of Nursing

In Attendance:
N McCormick, Director of Property & Asset Management *(Item 1 – 5 only)*
M Richmond, Digital & Information Head of Strategy *(item 6 only)*
H Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting, and extended a warm welcome to J Fearn and C Notman who have both joined the Forum.

Apologies were received from S Bailey (Consultant Clinical Psychology), P Duthie (General Practitioner), A Lawrie (Associate Director of Midwifery), E O'Keefe (Consultant in Dental Public Health) and P Madill (Consultant in Public Health Medicine).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 3 February 2022

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The closed actions were noted.

There were no matters arising.

5. Anchor Institution (Environmental) Presentation

The Director of Property & Asset Management gave a presentation on the environmental aspect of the Anchor Institution.

Discussion took place on hybrid working and how this would fit into the Greenspace Strategy. It was advised sustaining improvements and changes made throughout the

pandemic could be challenging, particularly whilst dealing with backlogs created due to the pandemic.

Following a question on alternatives to medical gases, an expansion on the alternatives available and their use was provided. It was noted nitro oxide is not in the new Elective Orthopaedic Centre, and is not part of the infrastructure, however, if it is needed as an exception, then canisters would be used. It was highlighted alternatives need to be built into practice and new theatres.

Better utilising our green spaces was raised, and it was advised that green spaces will be mapped out initially. Improving biodiversity will ensure there is diversity of planting and a better environment that people can enjoy. It was reported there is partnership support for utilising green spaces and discussions have commenced. It was noted there are a number of positives in terms of wellbeing on improving green spaces.

The Forum thanked the Director of Property & Asset Management for an informative presentation.

6. Digital Information Discussion

The Digital & Information Head of Strategy joined the meeting, and provided an update on projects and programmes currently being undertaken within Digital & Information.

- Hospital Electronic Prescribing and Medicines Administration (HEMPA) has been delayed due to a non-award of contract, and new procurement options are being explored
- Implementation of a new E-rostering system has commenced and is in the very early stages of planning
- Digital Pathology expected to be implemented within a year
- Working closely on Office 365 applications
- Continuing to develop and deliver the Morse community system
- Endoscopy re-design
- Patient Track
- Prioritising work over the coming year

A risk around the Laboratory Information Management System (LIMS) was highlighted, and it was advised a solution for the risk will be closely worked on.

Following a question, it was advised the E-rostering system will be rolled out across all groups with a phased approach. It was noted new legislation on safe staffing is being implemented this year and will affect all professions; suggestion was made to discuss the new legislation further with professional groups.

It was questioned if there will be opportunities for self-booking made available. In response it was advised the company which offered a solution had made a decision not to go ahead and alternatives are now being explored.

The Forum thanked the Digital & Information Head of Strategy for an interesting discussion.

7. Subcommittee Minutes

The Forum noted the following subcommittee minutes:

7.1 Minutes of the Area Medical Committee held on Tuesday 8 February 2022 (unconfirmed)
7.2 Minutes of the General Practitioners Subcommittee held on Tuesday 18 January 2022 (confirmed) & Tuesday 15 February 2022 (unconfirmed)
7.3 Minutes of the Nursing Midwifery Leadership Group held on 24 February 2022 (unconfirmed)
7.4 Minutes of the Allied Health Professionals Clinical Advisory Forum held on 2 February 2022 (unconfirmed)

8. Escalation of Items to the Clinical Governance Committee

There were no items to escalate to the Clinical Governance Committee.

9. Any other Business

Nursing Advisory Group

The Director of Nursing advised a Nursing Advisory Group is being established.

10. Date of Next Meeting

The next meeting will take place on Thursday 7 June 2022 at 2pm via MS Teams

NOTE OF MEETING OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 8 FEBRUARY 2022 AT 2PM VIA MS TEAMS

Present:

Dr Phil Duthie	Co-Chair
Dr Chris McKenna	Co-Chair & Medical Director
Dr Annette Alfonso	Clinical Director Emergency Care
Dr Marie Boilson	Clinical Director H&SCP (Fife-Wide)
Dr Fiona Henderson	General Practitioner
Dr John Kennedy	Clinical Director H&SCP (East)
Dr Sally McCormack	Clinical Director Emergency Care
Dr Joy Tomlinson	Director of Public Health

In Attendance:
Catriona Dziech (Notes)

1 APOLOGIES FOR ABSENCE
Professor Wood, Dr Sahu & Dr Hellewell

2 DECLARATIONS OF MEMBERS' INTERESTS
There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 12 OCTOBER 2021
The notes of the meeting held on 12 October 2021 were approved.

4 MATTERS ARISING

i) Revised Constitution – Requirements for AMC in Statute
Previously discussed and agreed to continue in the current format in the absence of a functioning Medical Staff Committee. It was noted in the past there had been limited engagement by clinicians but now there were robust routes in place to highlight issues and changes.

It was suggested it would be helpful to have a representative from the Division of Psychiatry in attendance. *Post meeting ToR checked, and Chair of Division of Psychiatry and Representative from Addiction Services are included within the ToR.*

5 STANDING ITEMS

i) Financial Position – Including (IPQR considered at Clinical Governance Committee 17 September 2021)
Dr McKenna advised the financial position was complicated as we move towards the end of the current financial year. This relates to the issues around the basic NHS Fife budget and the budget to support Covid. There will be leniency around unmet savings but there is a clear message from

the Director of Finance that the next financial year will be very different with no free flow of money. This is also supported by the advice from SGHD.

There have been additional funds and in particular investment to support specific objectives within Mental Health Services. There has also been investment in CAMHS. It is hoped this investment will lead to more sustainable services within Fife. The National Benchmarking acknowledged that the focus previously has always been on psychological therapies and CAMHS and therefore no focus on generic adult and older adult mental health services which has resulted in no development or investment.

It was noted the finance team have worked hard and made significant progress in ensuring Fife receives its full allocation. Fife received the second highest percentage uplift of the NRAC share for the next financial year.

Dr McKenna advised the Director of Finance and colleagues are preparing an efficiency savings programme and each area will be overseen by a director. This is to try and achieve efficiencies, some of which will be through transformation. One area highlighted for savings in the next financial year is through the Medical Devices Committee where the governance around devices will be considered and whether appropriate pathways are in place for new and existing technologies. This will also include procurement and the ongoing contracts which can be expensive. This does not currently exist in Fife.

Dr Duthie highlighted the GP Contract is underfunded by £10m and funding requires to be in place by April 2023 via funding from NHS / IJB.

Dr McKenna highlighted another cost pressure to be aware of is Junior doctor pay following several of the rotas going to Band 3.

In relation to Capital programmes, it was noted:

- The new Fife Elective Orthopaedic Centre was progressing well which will give Fife a world class elective service for local, Regional and National work
- Kincardine Health Centre is moving forward
- The IA (Initial Agreement) for Mental Health estate will be ready by May 2022 for submission to the SGHD for a multimillion-pound investment
- £2million investment at QMH Theatres which will create two procedure rooms allowing local anaesthetic cases to be undertaken outwith the main Theatres. This will also create additional capacity within the main Theatres to create a Regional Elective Centre.

ii) Medicines

Dr McKenna advised procurement for the HEPMA system has fallen through as the provider was unable to meet the terms of the framework that we drew down from. The company was on the National framework but at the last moment they refused to comply with one of the conditions of the framework around limitless liability. Now we are not restricted by the Framework, we can seek to procure a replacement for electronic discharge summaries.

Dr McKenna queried why Melatonin, which is not on the Formulary or SMC approved, is being prescribed for sleeping in older people. Dr McKenna agreed to seek advice from Pharmacy to prepare joint communication.

Action: CMcK

Dr Kennedy advised work is ongoing in relation to electronic prescribing and it is envisaged within three years this will exist in Scotland.

iii) Adverse Events

Dr McKenna advised the updated Clinical Governance Strategic Framework will include an update around our Adverse Events Policy.

Joy Tomlinson advised she has linked with Gemma Couser to consider non-clinical issues being incorporated within the Governance Framework.

iv) Medical Staff Committee

Nil to report.

v) Update from GP Sub Committee

Dr Duthie advised issues were noted in the Minutes at Item 8i.

It was noted and agreed good working relationships have been developed within Primary / Secondary care. Any significant issues which have arisen have been worked through as a team to be resolved.

It was agreed further promotion of FROG to GPs would be helpful.

It was agreed Annette Alfonso would raise the issue of the ECAS criteria at the next FNC meeting. Issues remain with telephone calls to the flow Hub.

vi) Realistic Medicine

Dr Mckenna advised there had been issues previously with the Value Improvement Fund shortlisting. This has been resolved by allowing Fife to submit twice as many this time.

vii) Medical Workforce

Dr McKenna advised there has been positive feedback on workforce in Secondary care. Pockets of areas remain a challenge but there is opportunity for good recruitment.

General Practice is not as positive in terms of recruitment and a long-term strategy is required to resolve. The aim of the GP Contract was to make general practice more attractive again, but with SGHD failing to implement the contract this is not the case.

Dr McKenna advised he met with Kevin Reith, Deputy Director of Workforce, to try and pull together a bespoke medical workforce strategy to help recruit and maintain medical staff. This should also take into account the unique position of Fife.

viii) Education & Training

Dr McKenna highlighted the Medical School at St Andrews University wish to submit a proposal to SGHD around the creation of an MB Stage programme.

It was noted for the next year the SCOTgem intake has increased by 15 and the BSc Programme by 32.

Dr Duthie advised he will be meeting with Frank Sullivan and the Dean in Primary Care at St Andrews University to try and improve student placements in Fife. Hopefully if a good package can be pulled together this will encourage students to come to Fife. Dr Duthie would be happy to take any points from members to the meeting.

Action: ALL

It was noted mentorship could be made available via the GP Sub Committee.

ix) LAER/SAERs – Report from Adverse Events/DoC
Summary Action Report as at 7 December 2021

Report noted.

6 STRATEGIC ITEMS

i) Health & Care Services Transformation

Dr McKenna suggested this title needs to be reconsidered as it is not in line with the current Health & Well Being Portfolio Board where all strategic project work is considered. An update from that meeting will be brought to the next meeting. Agenda Item to be amended to reflect this change.

ii) GMS Implementation

It was agreed Dr Hellewell to provide an update for the next meeting.

iii) COVID & Remobilisation

Dr McKenna advised the situation is settling in terms of hospital Covid and there should be an opportunity to put back most out-patient and elective work by March. There remain constraints around Registered Nurses and sickness absences.

7 ANNUAL ORGANISATIONAL DUTY OF CANDOUR REPORT (INTERIM) – TAKEN TO NHS FIFE CLINICAL GOVERNANCE COMMITTEE ON 13 JANUARY 2022

Report noted.

8 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee held on 21 September, 19 October, 16 November and 21 December 2021

Noted.

ii) Notes of the Adverse Events / Duty of Candor meeting held on 8 June 2021 (Unconfirmed)

Noted.

10 AOCB

There was no other competent business.

11 DATE OF NEXT MEETING

Tuesday 12 April 2022
Tuesday 14 June 2022
Tuesday 9 August 2022
Tuesday 11 October 2022
Tuesday 13 December 2022
(all meetings will commence at 2pm) – Teams invites have be circulated.

MINUTES OF THE RADIATION PROTECTION COMMITTEE HELD ON WEDNESDAY 2ND MARCH 2022 VIA MICROSOFT TEAMS.

Chair: Dr Chris McKenna

In Attendance:

Dr Chris McKenna (CMK)	Medical Director, NHS Fife/Executive Lead, Radiology
Jane Anderson (JA)	Radiology & Diagnostic Services Manager
Nicola MacDonald (NMD)	Head of Radiation Protection | Lead RPA/MPE | Medical Physics
Claire Lee (CL)	Theatres Manager
Dawn Adams (DA)	Clinical Director, Public Dental Service
Nick Weir (NW)	Head of Imaging Physics
Victoria Bassett-Smith (VBS)	Head of Nuclear Medicine Physics
Karne McBride	Laser Protection Advisor
Laura Cluny	Nuclear Medicine Physicist
Megan van Loon	Principal Clinical Scientist, Medical Physics
Sally McCormack	Clinical Director ECD
Laura Cluny	Principal Clinical Scientist
Clare Parry	Medical Physicist
Simon Willis	Radiation Protection Adviser & Radioactive Waste Adviser
Nick Weir	Head of Imaging Physics
Donna Galloway	General Manager, Women, Children & Clinical Services
Nicola Spark	SCN Theatres
Gillian McNaught	Principal Physicist (Modality lead MRI)
Blair Johnston	Principal Physicist (MRI)
Katharine Jamieson	Clinical Lead, Radiology
Debbie Slidders	Community Dental Service
Neil Groat	Staff Side Representative

Apologies:

Ian Cavin (IC)	MRI Safety Expert/MRI Physicist

NO	HEADING	ATTACHED	ACTION

1. APOLOGIES FOR ABSENCE

As noted above

2. Minute of Meeting Held On 11/12/2020

Accepted as an accurate record

3. Matters Arising

- Lead for MRI completing an SBAR to get pacemaker scanning up and running in Fife. Lothian guidance for this will be adapted for NHS Fife. Cardiac Physiologists and Radiographers will need training.

- Funding for Radon survey (underground workers). NMD to approach Head of Estates (NHSF). Don't anticipate a lot of workers involved in the survey.
- Funding for 2 sealed discs for carrying out QA at QMH. (LC to email CL)

4. Landauer Transit Irradiations (NMD)

An incident occurred with dose badges during transit. The badges are shipped from America in a shipping container and were accidently irradiated. Staff badges were showing higher than normal readings causing us to investigate. 51 staff were involved, they have been contacted by letter to allay any fears. Fife & Lothian weren't the only boards affected. Laundauer now have procedures in place to ensure it doesn't happen again. CMK asked about other options for this service. NMD to explore other companies. **NMD**

5. IsoStock PROPOSAL (SW)

Accurate record keeping for Radioactive materials is mandatory. Lothian have different databases where this information is kept and are currently trying to pull together and incorporate Fife in this. There will be a cost involved. Have had a couple of demonstrations so far. Please see attached report.

6. HSE visits to NHS Lothian – shared learning (NMD/NW)

A recent high dose reading for a CT member of staff prompted a visit from HSE. A few recommendation made will be sharing with Fife. Incident happened when staff member was wearing badge incorrectly. Staff should be wearing badges not kept in pocket or attached to keys. CT and MR staff sharing a control room should both have MR safe badge clips. RPS's have amended Local Rules to inform staff about who to contact for help if they're own RPS is unavailable. No big findings but will share with Fife.
HSE caught sight of MR incident at Childrens Hospital where a patient was taken to MR in a non MR safe trolley there was also an oxygen cylinder on the underside of the trolley, luckily it never became airborne. GMN has an action plan in place but HSe want Local Rules amended/updated to include a training plan to include all staff. We now have a plan in place and will roll out across Lothian and Fife.

7.

Medical Physics - Service Risk Assessment Situation (NMD)

We are working to simplify the process as it was quite complicated. We all have a duty to notify Fife of any problems, we won't report everything we do, just important things and feedback to committee anything that needs escalating/approved

MVL – current LPA retiring, support from Aurora for support during MVL transition. Will be writing to LPS's to get letters of authority from Clinical Directors.

a. **Escalations from expert advisers (LPA, RWA, RPA, MPE)**

NM – Dat scans being introduced to Fife, doing a lot of work on and will be adding to current permit. SW will be coming to Fife in the near future. Radiation safety compliance – rolling out this year will send audit templates to service ahead of time. Please see report for more information.

MR – Safety audit carried out last month at QMH/VHK – one minor point was letter of entitlement, this has now been updated. Recommend 'one drive' as document control system. SOP has been amended for use in Fife. Incident stats show overall similar to last year most common is devices not declared on safety question sheet – DP writing to 'culprits' highlighting error and pointing to TURAS learn. Safety signage on the floor recommended for Lothian & Fife. Incident where mobile phone was found under patient (see on scan) patient was aware phone was there. Lots of discussion around how this could be averted in future. CMK said when it's a one in a million event it's hard to find solution, don't go wasting time and energy on something that's so rare.

8. **Annual Compliance Reports**

a. **Reports from each service around their IRR17 compliance**

i. **Radiology**

Would like to offer some reassurance re MR implant incidents. We have acted and written to Doctors. RPS meeting was well attended – 2 new RPS's recruited in February and all others have attended update training. 10 notifiable incidents – 4 for NM were the same incident, patient had isotope injection then equipment broke down. Have now made contingency plans with Lothian and Tayside others were referrer errors and have completed training. Room in A&E still used for minor injuries with low

dose. Badge wearing audits carried out daily. Cobalt flood source changing. No concerns about equipment. Congratulations to MR team following very good safety audit.

ii. Dentistry

Radiation Protection Supervisor for Dentistry retiring DS taking over as RPS. Couple of incidents (operator error) have carried out training following these. Equipment failure has meant patients coming to acute settings when they shouldn't have (during covid restrictions) . Hopefully equipment and IT problems fixed.

iii. Theatres

Have RPS's & Deputy's in place. Lead aprons screened monthly, some have been replaced. Dose monitor badges are attached to machines rather than staff. Mr Cook doing QA. Ann Milne delivered training which was great. RA's all up to date. Audit showed good compliance. Incident where consultant wasn't wearing lead apron – consultant was spoken to by Head of service.

b. **2021 - NHS Fife staff dose report (CP)**

Dose report shows compliance – good working practices. Good and under control.

c. **2021 – NHS Fife radiation incident report (CP)**

4 notifiable incidents for NM. Good learning from this and goo feedback from HIS.

d. **2021 – Environmental dose monitoring report (NMD)**

Managed to do all all VHK & NEF, reports still to come out – nothing of concern. Next will be QMH and mobiles. (NW)

Dental are monitored by location – all below level

9. ANY OTHER BUSINESS

NW suggested that it would be helpful for Lead MR Radiographer to attend these meetings in future.

MR Safety Committee - need a doctor from Fife to sit on this, NW to liaise with KJ via email.

10. DATE AND TIME OF NEXT MEETING

31st August 2022 2pm Via Teams.

Draft Meeting Note of NHS Fife Clinical Governance Oversight Group
On Tuesday the 15th February 2022 at 1300 hrs via MS Teams

Present

Lynn Campbell (LC)	Associate Director of Nursing, Acute Services Division
Gemma Couser (GC)	Associate Director of Quality & Clinical Governance
Pauline Cumming (PC)	Risk Manager
Claire Fulton (CF)	Lead for Adverse Events
Dr Chris McKenna (Chair) (CMcK)	Medical Director, NHS Fife
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Sally O'Brien (S'OB)	Head of Nursing
Janette Owens (JO)	Director of Nursing
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance & Education
Amanda Wong (AW)	Associate Director of Allied Health Professionals

In Attendance

Dorothy Gibson (DG)	Clinical Governance Administrator

Apologies:

Lynn Barker (LB)	Associate Director of Nursing, Health and Social Care Partnership (HSCP)
Cathy Gilvear (CG)	Quality, Clinical & Care Governance Lead, HSCP
Benjamin Hannan (BH)	Director of Pharmacy and Medicines
Dr Helen Hellewell (HH)	Associate Medical Director
Aileen Lawrie (AL)	Head of Midwifery/Nursing Women and Children's Directorate
Dr John Morrice (JM)	Consultant Paediatrician
Prof Morwenna Wood (MW)	Consultant Nephrologist - Renal Medicine

Item		Action
1	**Apologies**	
	Apologies for absence were **noted** from the above named members.	
2	**Minutes of previous meeting held on the 26th of August 2021 at 09.30, MS Teams**	
	The team confirmed that the note from the meeting held on the 26th of August 2021, was a true reflection of what was discussed.	
3	**Action List**	
3.1	All actions closed from previous meetings.	
4	**GOVERNANCE**	
4.1	NHS Fife Clinical Policy & Procedure Update 26 August 2021 and 25 October 2021 **(EM)**	
	At the August meeting the group approved extensions to several procedures currently under review. **New Fife Wide Procedure** **FWP-VA-01 - NHS Fife Wide Procedure for Venepuncture in Adults**	

	This new procedure covers band 2 and above clinically trained and pre med students who will be able to perform venepuncture under the supervision of a trained professional. **Outstanding Policies and Procedures** There is one procedure past its review date. **Fife Wide Procedure** FWP-IPC-01 - NHS Fife Wide Procedure for the use of the Kendall SCD Express Intermittent Pneumatic Compression (IPC) System for immobile stroke inpatients (22/08/2021) **99 %** of all clinical policies and procedures are current and in date At the October meeting the group approved an extension to one procedure currently under review. **FWP-PSP-01 – NHS Fife Wide Patient Supervision Procedure.** Following discussion with Lynn Campbell and the HONS we were advised that in light of the current capacity and workforce issue it will not be possible to complete the full review. The group agreed to the extension until 31/03/2022. **Outstanding Policies and Procedures** There is one policy and one procedure past their review date. **Fife Wide Policy** IC-02 - NHS Fife Infection Control Policy for the Risk Assessment for Transmissible Spongiform Encephalopathy Agents including CJD and vCJD (31/08/2021) **Fife Wide Procedure** FWP-IPC-01 - NHS Fife Wide Procedure for the use of the Kendall SCD Express Intermittent Pneumatic Compression (IPC) System for immobile stroke inpatients (22/08/2021) **98 %** of all clinical policies and procedures are current and in date.	
4.2	**NHS Fife Activity Tracker (EM)**	
	EM highlighted that there were a couple of new publications in January 2022. On the 12th of January 2022 there was notification of an Adverse Events notification system. On the 12th of January 2022 there was a Safe delivery of care: inspection methodology notification. The first publication of a standard we have received this year is for Sexual Health. The overall aim of the standards is to improve access to sexual health care and reduce inequalities in sexual health outcomes	

4.3	**Quality & Safety BAF (GC)**	
	GC advised that there is an updated paper available and this is currently going through EDG and then onto the Clinical Governance Committee. The key changes to note are the changes to the Quality & Safety BAF wording is to include the risks associating with the pandemic, mainly the potential delays to treatment and the impact on patients and staff. The other piece of work that has been done is that we have reviewed all of the high risks across the organisation and made some suggestions that there should be an amalgamation of some of the risks to sit within the BAF. The cancer risk has been updated and the risks associated with the BMI. Going forward for this Group this should be added on as a standing agenda item.	**DG**
4.4	**SPSP Collaborative (LC/EM)**	
	EM gave an overview to the Group. From NHS Fife's perspective we are participating the collaborative around our cardiac arrest. Data was submitted in November 2021 and data was also submitted for October 2021 to December 2021. Health Care Improvement Scotland has advised us that they are going to publish a summary of data for all boards for the coming months. We have our first SPSP adult collaborative project surgery on the 3rd of March 2022; the aim of this surgery is provide an update on the SPSP acute adult collaborative. Improvement work is going to be shared as part of this project surgery for Greater Glasgow & Clyde, NHS Fife and Ayrshire & Arran.	
4.5	**Annual Assurance Statement (GC)**	
	As a group we need to provide assurance to the Clinical Governance Committee on oversight of matters across NHS Fife. As a matter of good practice we need to provide an annual assurance statement. This has been identified in a couple of internal project reports, this year GC has drafted and annual assurance statement and this will go to Clinical Governance Committee in March 2022 for review before it comes back to this group for final sign off. To support this GC has sent round a survey with a working link that asks for members of the group to reflect on the business and to identify any areas that we need to strengthen as a group. The annual assurance statement includes a reflection on the business that has been covered this year, to include Clinical Governance quality indicators, review of our policy and procedures and any key pieces of work that have come through and these will be updated with the feedback from the survey. An email was issued yesterday asking colleagues to complete the survey and the deadline for completion is the 24th of February 2022. CG will update the assurance statement and circulate it to members of the group before it goes to Clinical Governance Committee.	**ALL** **GC**
5	**STRATEGY PLANNING**	
5.1	**Clinical and Care Governance Framework (GC)**	
	GC will circulate the paper to the group after our meeting. The framework summarises the purpose and an overview of what our commitments are to achieve our aim for safe effective patient centred care. Then we look at the Governance structures walking people through how we seek assurance and how matters of concern are escalated across the organisation. Then we look at leadership and accountability and how we all contribute to the delivery of the Clinical Governance	**GC**

	Framework. Then we look at some sections that summarise key Clinical Governance activities, we have broken this down from the learning through adverse events, effective risk management, Clinical Effectiveness, person centred care, using data from multiple sources and continuous quality improvement. The document summarises with our delivery plan for 2022/2023. A Short Life Working Group has been brought together to get this frame work right and for it to connect with people and it manages to deliver benefit to the organisation. Due to the situation at the end last year it wasn't possible. So in order to get some feedback and engagement this will be circulated to the Group and it will also go to SLT, both operational SLT's and corporate SLT's along with a feedback questionnaire, so that we can start to gather some feedback. Once we have the feedback this will enable us to make final updates to the document. Simultaneously the framework will be going to Clinical Governance Committee for review and initial feedback. There will also be a survey attached for Committee members to feedback. This document will be issued and to ask colleagues to engage across their teams and also for this to be issued to Senior Charge Nurse level within wards as we would like to ensure that this document that people can pick up so that everyone is clear about what the aims and objectives are to deliver the framework.	**GC**
5.2	**Deaths of Children & Young People (GC)**	
	The National Guidance for the hub for Deaths of Children & Young People went live on the 1st of October 2021. Elizabeth and Claire and colleagues within our team have been working hard to support the implementation of the guidance. This piece of work there has been more work significant than has been anticipated. Annually we would have thought that circa 35 deaths that need to be reviewed every year that fall from the guidance. This number is higher than anticipated based on our fore cast; the number of reviews that we thought we would be under taking is currently sitting at just under 10 reviews. The majority of those will fall within our existing processes, but there is equally a number that have happened out with the hospital setting so require new process to be identified for the review e.g. a road traffic accident, how would be set out about reviewing that death through our existing mechanisms, the group are reviewing how we would determine this currently. GC advised that JO is taking a paper on our behalf to EDG; this is setting out the need for investment and the infrastructure to comply with the guidance. Currently we have been allocated £11,000 on an annual basis and this is short of what we require to comply, specifically around about the liaison and support with families and carers and across multi agencies. It is a much more complex piece of work than was anticipated at the start. CMcK – it is worth noting that this is one of many asks in terms of a national approach to governance around certain issues for adverse events. Whilst there is good intention, the resource isn't there at board level to deliver that standard that has been expected and I am keen that this is consistently fed back to people who come up with these ideas. Thanking them for the ideas and we would be willing to put these in place once the resource has also been made available. The challenge needs to go back up to finance colleagues to Scottish Government, HIS, NES and whoever is making the recommendation for various things. CMcK advised that this is not a free service and clinicians are very busy people at the bedside and any time that is put into doing worthwhile but not bedside care has an implication for the service. Therefore we can't extract clinical time away from the service to this degree and not have it funded if we are going to do justice. CMcK raised that the £11,000 of non recurring money for this project will not be enough for this programme and this will be raised as a separate issue.	**JO**
5.3	**Organisational Learning Group Terms of Reference (GC)**	
	This document is for noting and to have the endorsement from the group. This was supported and agreed by the group.	

5.4	**Adverse Event Process and Policy Review Update (CF)**	
	This is a brief overview of the improvement plan 2022/23. This has been broken down into 7 broad work streams – • Adverse Events process • Policy • Training & Education • Staff Support • Patient & family involvement • Team infrastructure • Open Culture We started with the process review, looking at the impact process mapping that was done in the Summer of 2021. We have been looking mainly in-house at the policies and processes that are in place, predominately to support the SAER processes and looking how we can streamline and make them more efficient, with a view to moving as much as we can onto an electronic format. We have started engagement of staff at looking at the same process. A questionnaire was sent out to the last 100 people that has been either lead reviewer or a technical lead on a SAER, and looking for their feedback which has come back valuable on the resources that are available, training and what they feel they need to be able to carry on in that role and what they wanted it to look like. This is 12 to 48% answered time of what would make this an easier process for them. We will look at an options paper presenting some different models and how we could manage the roles within it. Where the technical lead and lead reviewer looking at how other boards are currently doing this as well i.e. looking at dedicated teams and resources. There is some national steer on this which there has been NES and HIS have set up a joint commission to look at training and education to standardise the process across the whole of Scotland for SAER process and all Adverse Events management. We will be taking from them some local resources and how we start to implement a training programme. In the meantime we are looking at getting our web pages and blink updated so that we have links to what resources are currently available. Hopefully we will start to engage staff more e.g. Staff Short Life Working Groups so not just the SAER process but for all Adverse Events, and how we can make the Datix reporter form and reviewer forms more efficient and real valuable input from the clinical teams on how we can make these improvements across the whole of adverse events. Number 5 on the work stream was patient and family involvement. This is a Health care and improvement Scotland information leaflet that they are advocating, and this is used nationally. The plan is that this will go out to patient families; carers about a notification of an adverse event, the leaflet will be shared at the end of this meeting. The first page is letting them know what it is i.e. the process and how we do it and how long it takes. The last page shows who the named contact is in the organisation so they can ask any questions. Running a long side this when we put the education and the communications out we are looking to have an update to the SBAR so that we are capturing this information within the SBAR, and who is going to be the main contact for this family. This will be put through onto the datix as well so that we have more collaborative working with patient relations should it be a complaint along the SAER. Then we have clear links of whom in the organisation who have been speaking with the family and it is taking those first steps towards duty of candour right at the very start of identifying a SAER.	**CF**

	CMcK would really value the input from staff that has been involved in an adverse event and the review process. I am almost less interested in the reviewers and more interested in the staff that the event happened to or who were involved with. This needs to be done carefully as you need to be careful what you ask and be careful what you wish for under the situation. CMcK there is still work to be done in our approach and there is something about training is essential so that there is consistency and how we are approaching the review of adverse events. This goes from Executive level through to technical and clinical leads who are bringing the report together. CMcK would be interested in thoughts of how we can start to pull from our staff how it has felt to be involved in this process. CMcK highlighted that some of the SAER's he deals with are ones that haven't gone well and the support for staff isn't there and this needs to be thought through in the revised process and policy. Supporting staff through these difficult situations needs to be as important as supporting the relatives and they need a point of contact should they need it. Whatever comes out of this review it needs to be equal both the relatives and the staff need to be supported the same. CMcK would welcome the support of how this would be done and bring it into the next stages of the review process. CF highlighted that we do have in the review the staff support work stream to look how we can incorporate and debrief within the policy so that we are standardising some sort of process for staff support. This will be explored within the clinical teams as to how they think this would be best on to take that forward. LC advised that she has had a number of reviews where she has to follow up, most recently with GC. There had been a long delay between the actual incident and due to our processes it had been over a year, a couple of individuals had sat with that on their conscience. This needs to be considered when reviewing the current process. CMcK raised that there needs to be a consultation process in place for this programme and it needs to be highlighted that some of the feedback he has received, staff feel that they are being scrutinised etc. CMcK highlighted that this shouldn't be the case and this needs to be looked at and reviewed in the review of the process. GC – due to the various discussions today it would be valuable to include Kirsty Brechinbricher in the structure and approach for that wider engagement. As there is a link here with the organisational values with the work that Kirsty is doing at an OD aspect. For going forward, Claire the work you have done today is excellent and today was just a snap shot of what the improvement plan includes, human factors, training that feature in the improvement plan. For this group going forward we present a status report that would show progress being made against each of the components as to really refresh this it isn't one single thing it is the engagement and process part, there is a number of layers to this.	**CF** **GC/CF**
6	**QUALITY/PERFORMANCE**	
6.1	**NHS Fife Integrated Performance & Quality Report (CMcK)**	
	CMcK does this contain the right information to provide the Board assurance of the activities that are happening within the organisation, affects all the aspects of Clinical, financial, staff and conversations around staff governance. Does the report look right and is it presented in the right way and is the data being presented in the correct sort of graphic. We need to ensure that the Board need to be able to interpret ate what they are being shown and the data that is being presented is in the best and most efficient way. This piece of work is happening at the moment. We do have a role here at the oversight group of challenging the matrix and ensuring that by the time it goes to Clinical Governance Committee that I am giving it a sense	

	of understanding, that the performance around the quality indicators has been discussed. GC – to support this one of the proposals in the new IPQR the approach will be to align the deep dive committees, this would be interesting to see how that evolves and this allows us to see where we have got either deteriorating or improving performance. CMcK reviewed the Clinical Governance data. We need to give assurance that e.g. the SSI for C section we would need to have a good narrative of what is going on there. Also, other issues around complaints and being able to explain why it isn't so good at the moment. The feedback to finance regarding the data (swiggly lines) isn't helpful and perhaps this information could be taken out. LC raised that the (swiggly lines) don't provide the data we are looking for. As we are looking at the current data if we lose the (swiggly lines) one of the concerns would be that some of the trend we see over time and there will be a natural fluctuation in performance month to month. Is there something else that could be put in place instead of the (swiggly lines) that might show the overall direction? CMcK the trend is included in the body of the document within the graphics that are there, this is merely a snap shot of the detail and that comes next. So if you want to know about the trend of pressure ulcers then that will be contained within the document. JO raised that the (swiggly lines) don't tell us very much. Some of the measures e.g. the closure rate around complaints aren't telling you a story at all about complaints. We are currently working on this with Lizzie and Nicola to try and make our data more meaningful. GC – just to continue on the (swiggly lines) theme there has been a lot of discussion in relation to this at the IPQR review group. One of the recommendations is that it will come to EDG from that group will be the instruction of SPC charts so that we can understand standard and non standard variation with a view to having a little "flag" on this summary page. The other avenue to explore is the closure of actions for adverse events as GC is very keen that there is more visibility and reassurance regarding the data provided. PC advised that there is going to be some more overt content around risk and linking that particularly to the strategic content. At the moment there are references to risk within the narrative but there is very little specific content. Going forward that is something else you are going to see particularly in relation to improvement on the themes that are coming through, improvement and deterioration in the risk in terms of how it is progressed against target and perhaps if it is deteriorating over a period of time. GC once the draft is ready this will be brought back to the group for review and probably. Once the new IPQR is ready this will need to be piloted for a period of time and for us to get some feedback so we can assess what is working and if it needs any tweaks GS suggested perhaps the (swiggly lines) could be shown in a different colour e.g. red to show that we are going in the wrong direction and or another colour to show the positive direction?	

6.2	**HSCP Quality Report (LB)**	
	SO'B provided an overview of the report and highlighted that in the executive summary it shows the following:- • The Urinary Catheter Improvement Group has been paused • The Key areas of improvement and success have been paused This report was produced in November and since then some of the quality improvement work is continuing More information will be highlighted in agenda item 6.6 that is where the SBAR will be discussed.	
6.3	**Development of interim Quality Report for Acute Services Division (GC/LC)**	
	GC gave an overview to the group. Working with LC, Brian Archibald and Trophin Thorbjornsen we have started to develop a dashboard that will be available at divisional directorate service and ward level, for teams to access and with a view to empowering in "teams" and to identify where they have deterioration of performance and also to evaluate where improvement has been seen coming through in their data. The intention is that this will be a report that will be published in a weekly basis and then aggregated up at a monthly level. Torphin Thorbjornsen is working on creating a space on the data hub so that it is something that can be accessed easily by teams. From that point we can work with LC and the Heads of Nursing team to develop that, we want to go down the route of the quality report the HCSP have then this is something we would be happy to support.	
6.4	**Prevention of In-Patient Falls (LC)**	
	LC gave an overview of in-patient falls and work to reduce falls with harm in NHS Fife and H&SCP inpatient settings. The national aims were to reduce all falls by 20% and all falls with harm by 30% by September 2023. Boards were asked to identify their own local aims in terms of falls reduction. This connects with local work and the plan to establish a multi-professional group to review and refresh the NHS Fife inpatient falls documentation, however due to challenges described and clinical pressures this has been delayed. The revised documentation will reflect the national change package. The following section provides an overview of the work to date and ongoing activity within the challenging clinical context. Out with a pandemic situation the reduction of falls is a complex problem in a complex setting which requires complex solutions, and this has been significantly more difficult over the last few years with the added context of COVID. As highlighted in previous IPQR reports there are significant challenges in the current clinical context that have impacted on the progress on falls reduction. Many clinical areas are being staffed by a range of staff not familiar with the area and supplementary staffing. This can mean less familiarity with the toolkit and clinical environment as well as speciality e.g., for a nurse normally working in theatre or in a non-inpatient setting such as outpatients. Over and above this, clinical areas have been working with fewer staff and the ability to support formal update and education has also been impacted by the collective clinical pressures. Some areas are working	

with differing footprints and a number have been over capacity for an extended period which impacts on maintaining a safe environment alongside social distancing measures. There is also a growing sense that patients being admitted to hospital are frailer and as part of discussions regarding staffing plans a higher acuity and dependency of patients has been observed. Triangulation of these factors means a complex and challenging background for improvement.

The purpose of this toolkit is to provide health care professionals working in the hospitals within NHS Fife the essential tools to identify patients who are at risk of falls in hospital; manage those who are at risk of falls and support and manage those who have had a fall in hospital.

Key factors in this process are the identification and management of risk. There are many different falls risk assessment tools available, and it is recognised in the literature that falls risk assessment tools vary in their sensitivity and specificity depending on the setting in which they are used. However, there is good evidence around multi-factorial risk assessment and intervention, and NHS Fife has aligned the falls risk assessment with an initial Fife Frailty Screen and every person who is admitted to a Fife hospital should be screened for Frailty (either in the paper admission documentation or on Patientrack).

Falls and falls with harm reduction has been recognised as a strategic priority within the organisation in conjunction with national guidance issued by the Scottish Patient Safety Programme (SPSP), the iHub and our local Fife Falls Strategy (2018). SPSP aims to challenge perceptions that falls are inevitable and is clear that all inpatient areas should reduce falls and falls with harm through:

- Individualised risk assessment and care planning based on people's clinical conditions, health needs and their care setting
- An approach that promotes mobilisation and meaningful activity to enhance cognitive and physical functioning

Audit

There are a number of related audits such as documentation that support review of compliance with the falls assessment and intervention process. Inpatient wards who are involved with quality improvement projects complete weekly compliance audits based on a falls process measures linked to elements of the fall's toolkit. Recommendations and learning from falls audits are reviewed through the relevant groups e.g., local falls group or directorate discussions. Work has progressed to reframe a system wide audit and following successful testing discussions are underway to seek support for the clinical areas in taking this forward and are part of the plan for this year.

Examples of current activity

- The inpatient falls steering group has membership from inpatient services across the system with Nursing, AHP and Medical representation and is supported by a public member. The data is reviewed along with any LEARN summaries from Significant Adverse Events involving a fall.
- Sub-groups focussed on specific specialties meet to drive local improvement and review activity and provide a Flash Report to update the steering group. Learning points are shared and any success is noted.

	• Collaboratives have been used as a focussed effort in areas to support work where data has informed a need for additional support. This approach uses improvement methodology to drive change. The most recent example of this type of approach is within Mental Health. Some of the changes noted by this collaborative are: • changes in staffing establishment in wards to allow for increased observation of patients. • MDT meetings with a focus on falls risk implemented • Medication reviews by pharmacy to address medication related risk • Collaborative working with physiotherapy and podiatry around footwear checks • A full network of falls champions meant that every ward area across Fife had a nominated member of staff to champion the falls reduction activity. As a result of staff movement and challenges noted as above this has become less robust with gaps in some areas. Activity is underway to redefine a champion in each area as this has been a successful driver for improvement in the past. • Development of more frequent data sets available at a number of levels to support more "real time" review. This is in place in the H&SCP and at time of writing is almost complete for the Acute Services Division. • Discussion is underway to add the falls bundle to Patienttrak which will support nursing staff to complete the relevant documentation electronically. This supports compliance, communication and audit and makes it easier for staff in the clinical setting. This paper is intended to provide an illustration of the range of activity that considers the data, promotes, and supports action intended to reduce falls and in particular falls with harm. The challenges outlined have meant a change in progress toward this year's agreed target but the summary is presented to provide an overview for assurance to committee that this is an area that continues to be in focus across all in patient areas.	
6.5	**Position Statement on Improvement Work to Reduce Incidence of Harm for Pressure Ulcers (SO'B)**	
	Acute Services Division Teams that were previously involved in the Pressure Ulcer Improvement Programme (PUIP) were asked to complete a number of QI modules and use the methodology to test different change ideas. Teams continue to be offered bespoke QI support but uptake is extremely low. More recently, teams engaging in improvement activity have been offered support with the SPSP Essentials of Safe Care package but this has yet to be accepted. ICU TV link nurses continue to test a number of approaches to prevent Medical Devise Related Pressure Ulcers. 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. Community inpatient wards continue to measure compliance with skin assessment, review and intervention, using weekly data to identify areas for improvement; however this improvement work has been slowed due to the pressures of staffing.	

	Community District Nursing Teams use the Waterlow tool to assess patients. There are regular team huddles to highlight Waterlow risk scores above 20. There are monthly documentation audits in place (5 patient case-notes per week) with results fed back to Team Leaders for further discussion and action. In addition to this a pressure ulcers audit is also undertaken each month on three patients on the district nursing caseload. Podiatry Services and District Nursing Teams have been working closely and collaboratively with care homes and following the outcome of a couple of Local Adverse Event Reviews (LAER's) they have provided bespoke training to care home managers and staff. There is due over the next month, two webinars, one on personal foot care and CPR for feet delivered to care home staff. **Leadership and Governance** Outcome and process measure reports are monitored, reviewed and shared with clinical teams to drive improvement. This data is discussed at safety huddles and at team meetings. There is visible and supportive leadership at all levels. All pressure ulcers graded major or extreme undergo robust review with key learning to inform improvement activity, there is ongoing work to improve the sharing of learning from these reviews. Within the HSCP monitoring is undertaken weekly using a patient safety dashboard, involving all key senior stakeholders, and presented weekly by the Associate Director of Nursing and Clinical Care Governance colleagues at a quality matters assurance safety huddle. **Education and Training** Prevention and Management of Pressure Ulcers education and CPR for feet is available on Turas learn and is a mandatory course for all clinical staff with patient contact, education and training on pressure ulcers is also part of NHS Fife induction. During the pandemic training was delivered virtually with a number of webinars along with a Senior Nurse Forum which focused on Pressure Ulcer Prevention and Management.	
6.6	**Position Statement on Improvement Work to Reduce Incidence of Harm for CAUTI (SO'B)**	
	Despite the overall reduction in ECB, the number of CAUTI and CAUTI related to trauma has not reduced and, as such, improvement work needs to focus on greater awareness and improved management of UTI, CAUTI and hepato-bilary infection in patients to prevent these infections developing into bloodstream infections. Other, recent improvement work the group has instigated is the development by the Continence and Urology teams of an integrated site on Staff link "Blink" providing information for all NHS/ HSCP Staff. The site is still under development but is being updated regularly. On completion, it will include three sections on Bladder and Bowel Dysfunction, Urology and Catheters. The information is the same for Acute and Community Services. Once the work is completed there will be 3 sections, Bladder, Bowel dysfunction and Urology & Catheters. The CAUTI improvement project has also expanded to include work undertaken with a GP practice to reduce the use of catheter maintenance solutions, promotion of the 'Catheter Passport' and the use of a formula to predict a patient specific catheter change dates. Most recently, bladder scanners have been purchased for community use with the aim of reducing the number of patients requiring an indwelling catheter and therefore	

	associated problems, as well as the number of inappropriate catheter changes and associated infections. Alongside the use of scanner, intermittent self catheterisation will be more actively promoted and supported for those patients requiring catheterisation, again reducing need for indwelling catheter and therefore number of CAUTI leading to ECB. **<u>Other key initiatives implemented from UCIG:</u>** • eDocumentation for catheter insertion/maintenance bundles now available in MORSE for District nurses • eDocumentation CAUTI bundles to be implemented for Acute services and community hospitals onto Patientrack – project delayed due to COVID-19 response, small working group are clarifying format and planned roll out in 2022 • Guidance protocols for complex catheter insertion and use of antibiotics in the acute and community setting. • Catheter passport implementation • Catheter valve promotion • Regular newsletters/promotion of UCIG work and initiatives • Continence link folder established for care homes Just to emphasise that the capacity for improvement work to progress as quickly as UCIG had intended has been significantly impacted by COVID 19 pandemic with key staff being temporarily deployed or managing increased workloads.	
7	**PERSON CENTRED CARE, PARTICIPATION AND ENGAGEMENT**	
7.1	**Adult Support Paper (JO)**	
	The inspection took place between May and August last year and the report was published in August. The report identifies that there was a lot of clear strengths in Partnership working around making sure that adults were safe and protected. Included in the paper I have included the strengths, priorities and areas for improvement. Since the inspection Rhona Lalsousky has been appointed as the Health Lead for Adult protection in place of Norma Beveridge.	
7.2	**Complaints Update (LG)**	
	JO provided an update as LG is absent from the meeting. JO 12% is the lowest we have had, again there is some context around that, however it is rather poor. Lizzie and Nicola are working on an improvement plan at the moment and tackling the back log. JO advised that over the past few weekend's staff have been working and drafting responses. Heads of Nursing, Lizzie and Nicola have managed to pull back 20 complaints over the last few weekends. The team itself are looking at the different roles in the team as people have left so there is an opportunity to review what the team does and how to refocus the roles in the team to make sure we can support the management as much as possible. We have also been working on the complaints report to make it more meaningful to include patient feedback and improvement e.g. care opinion and also to identify themes, lessons learning and again to link in with the Organisational Learning Group.	
8	**LINKED COMMITTEE MINUTES**	
8.1/11	**NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group 26 August 2021 and 25 October 2021(EM)**	

	Noted by the Group.	
8.2	**NHS Fife In Patient Falls Steering Group (LC)**	
	Noted by the Group.	
8.3	**NHS Fife Point of Care Testing Committee (EM)**	
	Noted by the Group.	
8.4	**NHS Fife Resuscitation Committee (EM)**	
	Noted by the Group.	
8.5	**NHS Fife Tissue Viability Working Group (LB)**	
	Noted by the Group.	
9	**ITEM TO NOTE**	
9.1	**Gathering Views of Redesign Urgent Care (EM)**	
	It was highlighted that this item was put onto the agenda for August 2021 meeting.	
9.2	**Serial Prescription Toolkit – Launch (EM)**	
	It was highlighted that this item was put onto the agenda for August 2021 meeting.	
10	**ISSUES TO BE ESCALATED**	
	Nothing to note.	
11	**ANY OTHER BUSINESS**	
	.Date of Next Meeting 19th April 2022 13.00 via Microsoft Teams	

FIFE DRUG & THERAPEUTICS COMMITTEE

(Meeting on 9 February 2022)

No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 1.00PM ON WEDNESDAY 9 FEBRUARY 2022 VIA MICROSOFT TEAMS

Present:
Dr Chris McKenna (Chair)
Mr Scott Garden (Vice-Chair)
Ms Claire Dobson
Ms Claire Fernie
Dr Iain Gourley
Dr David Griffith (part of meeting)
Mr Ben Hannan
Dr John Kennedy
Mr David Pirie
Mr Euan Reid
Ms Olivia Robertson
Ms Rose Robertson
Ms Andrea Smith

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Dr McKenna welcomed everyone to the meeting. Apologies for absence were noted for Ms Lynn Barker (Olivia Robertson representing), Dr Marie Boilson, Dr Helen Hellewell, Dr John Morrice, Ms Nicola Robertson, Professor Morwenna Wood

2 MINUTES OF PREVIOUS MEETING ON 8 DECEMBER 2021

The minutes of the meeting held on 8 December 2021 were confirmed as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

East Region Formulary Committee
Mr Reid confirmed that membership includes two non-medical prescribers. **Action closed.**

Utrogestan SBAR
Dr McKenna advised that a letter has been submitted to the Chair of the Lothian ADTC confirming NHS Fife's decision not to support any interim arrangements that would deviate from the current national policy for the introduction and availability of newly licensed medicines in Scotland as set out in CEL 2010(17). Mr Garden has also discussed the decision with the Director of Pharmacy for NHS Tayside. **Actions 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 East Region Formulary Committee

Mr Reid introduced the minutes from the meeting of the East Region Formulary Committee on 24 November 2021 and highlighted key points.

The first four revised East Region Formulary Chapters (GI, Infections, Skin and Pharmacy First) were tabled and approved. There was an update on progress with reviews of the next 3 Chapters (Cardiovascular, Diabetes and Respiratory) and the aim is to have this work completed for the next ERFC meeting in February 2022. A number of Formulary Applications outwith the Chapter reviews were also approved.

The ADTC noted the update from the East Region Formulary Committee and the good collaboration with the different groups involved across the three Boards. Discussions on business as usual arrangements once the East Region Formulary Project comes to an end are progressing.

6.2 MSDTC

Mr Hannan provided a verbal update on behalf of the MSDTC and highlighted key points from the meeting on 22 December

Due to system pressures in regard to the Omicron response the business at the meeting focussed on clinically urgent submissions. The following submissions were approved: Hospital at Home Dexamethasone Monitoring; Haemorrhage/Anaphylaxis due to rt-PA Protocol approved subject to clarification points; Atrial Fibrillation Pathway approved subject to minor amendment. A submission for VTE Anticoagulation was considered but not approved at this stage. The MSDTC welcomed the development of this guideline across Fife and requested that it be re-submitted to the MSDTC meeting in February followed agreed amendments.

The ADTC noted the update report from the MSDTC and Minutes from the meeting on 22 December.

Mr Hannan indicated that he will be stepping down from the MSDTC and Andrea Smith, Head of Pharmacy - Prescribing & Therapeutics, will take on the role of Vice-Chair going forward.

7 SBARs

7.1 SBAR - Prescribing in Renal Impairment - Response to MHRA Update

Mr Garden presented the SBAR - Prescribing in Renal Impairment - Response to MHRA Update and briefed the ADTC on the background to this.

Following a Medicines & Healthcare products Regulatory Agency (MHRA) safety update concerns were raised regarding the current prescribing and monitoring of certain medicines - specifically (but not restricted to) Direct Acting Oral Anticoagulants (DOACs) due to the risk of overestimation of renal function. A paper outlining the need to establish safe systems for prescribing and monitoring of renal function for high risk medicines and to scope out delivery within General Practice was previously discussed at the ADTC in August 2021. The SBAR presented to the Committee provided an update on a proposed sustainable model to address potential patient safety concerns and sought the ADTC's support for the recommendations outlined: the proposal for the Primary Care Pharmacy team to lead a Quality Improvement project, in collaboration with GP Cluster Quality Leads(CQLs), to establish safe systems for prescribing, review and monitoring of high risk medicines, initially DOACs, in patients with renal impairment; the need for GP cluster leads and pharmacy teams to work in collaboration, to embed a high risk medicines monitoring service as part of business as usual, within GP practices; and the need to develop a standardised process, which embeds the calculation of CrCl, for high risk medicines and patients during hospital admission, as part of the prescribing process.

Dr Kennedy confirmed that this important collaborative quality and safety work is a welcome development which General Practice would be supportive of in principle. It was noted that Pharmacy representatives will be attending the next CQL meeting to discuss the proposals. It was suggested that Community Nursing Leads should also be involved in these discussions. Ms Smith to take forward. **AS**

Following discussion the ADTC agreed to support the recommendations in the SBAR.

7.2 Updated Guidance: Working with the Pharmaceutical Industry and Healthcare Equipment Suppliers

Mr Reid introduced the updated guidance Working with the Pharmaceutical Industry and Healthcare Equipment Suppliers and took the ADTC through the proposed changes.

It was noted that the guidance has been circulated to key stakeholders including representatives from Procurement, Corporate Governance and R&D and a number of changes to terminology are proposed.

It was noted that Scottish Government information on medical devices is awaited and it was proposed that the current guidance should specifically relate to working with the pharmaceutical industry. Margo McGurk, Chair of the Medical Procurement Governance Board to be advised of the decision to remove medical devices from the guidance and development of bespoke guidance around healthcare equipment and medical devices to be prioritised.

Mr Reid to circulate an updated draft to ADTC members for consideration and feedback. AMDs and Nursing to also be consulted. **ER**

8 RISKS DUE FOR REVIEW IN DATIX

Deferred to the next meeting.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

There were no items for discussion.

10 EFFECTIVE PRESCRIBING

10.1 SMC Not Recommended Drugs NHS Fife July - September 2021

Mr Reid highlighted the quarterly report SMC Not Recommended Drugs NHS Fife July - September 2021.

A discussion ensued around use of Utrogestan and the importance of the PACS2 process. Mr Garden has discussed with the Lead Clinician for the specialist menopause service in Fife and prescribing of Utrogestan is being looked at in more detail. Mr Hannan advised that issues in relation to melatonin prescribing have already been highlighted and are being taken forward by the Prescribing & Therapeutics Team. **ER**

The ADTC noted the SMC Not Recommended Drugs NHS Fife July - September 2021 quarterly report and the verbal update. Going forward an update report on any issues and actions proposed/taken following local analysis of the data presented in the SMC Not Recommended Drugs quarterly reports should be brought to the ADTC for discussion.

10.2 Medicines Procurement Newsletter January 2022

Mr Reid highlighted the Medicines Procurement Update January 2022. The Update is also discussed at the MSDTC and shared with Pharmacy and Finance colleagues.

Mr Hannan highlighted the section in the Update relating to homecare medicines. A Homecare Medicines Group is being established and membership and reporting arrangements are being finalised.

The ADTC noted the Medicines Procurement Update January 2022.

10.3 Early Access to Medicine Scheme - Asciminib

The ADTC noted the EAMS operational guidance for Asciminib for the treatment of adult patients with Philadelphia chromosome positive chronic myeloid leukaemia in chronic phase (Ph+ CML-CP) without T315I mutation previously treated with two or more tyrosine kinase inhibitors.

11 HEPMA Update

Mr Garden provided a verbal update on progress with the implementation of HEPMA. The final contract terms with the preferred supplier have not been agreed and negotiations have discontinued. The HEPMA programme is being re-framed and will be progressed in a phased manner which will enable aspects of the wider programme to progress pending consideration of options for securing an alternative provider. An update will be brought to the next ADTC meeting.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

It was noted that Mr Hannan is preparing an update on progress with implementation of HEPMA for the next Clinical Governance Committee meeting. **BH**

14 ANY OTHER COMPETENT BUSINESS

Dr McKenna, on behalf of the ADTC, thanked Mr Garden for all his extraordinary hard work during his time in NHS Fife.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 30 November 2021**. For information

b **Minutes of Respiratory MCN Prescribing Sub-Group 9 December 2021**. For information.

c **Date of Next Meeting**
The next meeting is to be held on **Wednesday 27 April 2022 at 1.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 13 April.

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE FRIDAY 4TH MARCH 2022, 1000hrs - MS TEAMS

Present:	Councillor Tim Brett (Chair) Councillor Rosemary Liewald Christina Cooper, NHS Board Member Councillor David J Ross Councillor Jan Wincott Wilma Brown, Employee Director
Attending:	Dr Helen Hellewell, Associate Medical Director Lynn Barker, Associate Director of Nursing Sinead Braiden, NHS Fife Board Member Rona Laskowski, Head of Complex and Critical Care Services Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Fiona McKay, Head of Strategic Planning, Performance & Commissioning Catherine Gilvear, Quality Clinical & Care Governance Lead Simon Fevre, HSCP LPF Co-Chair (Staff Side) Claudia Grimmer, Consultant Psychiatrist Heather Bett, Senior Manager Children's Services Avril Sweeney, Risk Compliance Manager Alan Small, Chair of Child Protection Committee Geraldine Smith, Lead Pharmacist Medicine Governance Katie Caldwell, Community Staff Nurse (observing)
In Attendance:	Jennifer Cushnie, PA to Associate Medical Director (Minutes)
Apologies for Absence:	Martin Black, NHS Board Member Nicky Connor, Director of Health & Social Care Chris McKenna, Medical Director Lynne Garvey, Head of Community Care Services Bryan Davies, Head of Preventative and Primary Care Services Paul Madill, Consultant in Public Health Medicine

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** Cllr Brett welcomed everyone to the meeting. Katie Caldwell was introduced and a warm welcomed extended. Katie is attending several committee meetings to observe.	

	Cllr Brett commented on the terrible events currently happening in Ukraine and was very pleased to hear Scottish Government has sent out medical supplies. Newport on Tay, which is within Cllr Brett's ward, is twinned with a community in Ukraine. Cllr Brett acknowledged there still remains a lot of Covid in Fife and understands the pressure services remain under. As the Agenda for the meeting is extensive, it was asked if introductory comments could be kept brief.	
2	**DECLARATION OF MEMBERS' INTEREST** No items raised.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 07 JANUARY 2022** SB stated, under Item 6.4, Fife Alcohol & Drug Partnership Annual Report, she had expressed her disappointment at the lack of psychological therapies around drugs, deaths and interventions. She asked this be recorded. Cllr Brett added, there is to be an alcohol and drug issues development session, date to be confirmed. He also added, following the January meeting, he met with Anne McAlpine who had presented the Fife Community Frailty Services Redesign report. She forwarded a very helpful Q&A paper which has been circulated to Members. Communication issues around Primary Care were discussed at the January meeting. HH advised there is to be a national campaign which will help the public to understand how to access services and what the new way of working for Practices will be, going forward. HH will forward dates of when the campaign will run to Members.	**JC** **HH**
5	**ACTION LOG** No comments.	
6	**GOVERNANCE**	
	6.1 Clinical Quality Report LB introduced the report and gave an overview with emphasis and detail on falls, pressure ulcers and medication. She outlined the activity which is taking place to mitigate problems as they arise. HH highlighted a sustained improvement in hospital acquired infections. She described good work which is going on in addiction services.	

	Cllr Brett asked if a longer time frame could be considered relating to hospital acquired infections. At the moment, only the current and previous quarter are being considered. He felt the language used relating to Falls was a little difficult to understand and gave examples. Cllr Ross queried how difficult it has been to continue the activities outlined in the report throughout the pandemic, owing to a shortage in staffing. LB advised it has been very difficult to maintain a quality improvement programme while staff are being stretch to the limit. As we come out of the pandemic, it is the intention to continue the programme and step it up once current vacancies have been filled. Cllr Brett referred to an increase in Covid outbreaks in hospital and sought assurance this was a reflection of increased Covid out with hospital settings. LB confirmed that was correct and primarily due to visitors meeting with loved ones in hospital, she assured infection control standards are excellent. HH added a national investigation is taking place and further data will be coming. This will be brought to C&CGC once available. Cllr Brett asked if the format of the report and the items covered will remain similar, moving to the new structure. HH advised, the intention is to place more emphasis on care indicators. She told of work which is taking place looking at expansion of the report, within national guidelines. She added there is more data available which extends beyond the two quarters shown on graphs. The executive summary can be reviewed to show trends over time more clearly. Cllr Brett felt this would be beneficial.	**HH**
	6.2 Primary Care Improvement Plan Update HH introduced the report which is to update the Committee of progress being made within Primary Care. She advised, transfer of the Vaccination Programme continues on track and will transfer at the beginning of April. Community Treatment & Care (CTAC) and Pharmacotherapy will not be ready to transfer, which Scottish Government is fully cognisant of. Transitionary payments have been made to GPs to cover a further year. HH outlined the incremental plans which are in place around this work. In line with direction from MoU2, other funding streams are being utilised to progressing other important work, such as mental health. HH told of challenges around workforce with recruitment being undertaken in a staged way and looking to skill-mix as much as possible. She also described work to ensure economies of scale and good collaboration around the Vaccination Service and CTAC. Cllr Brett queried if members of the public will see an improved service, perhaps a Pharmacist giving advice where before they would need to see a doctor. HH advised, patients will see increased access to Pharmacists, and stated, this is already being seen and will increase as Pharmacotherapy develops. CTAC and Vaccination will be delivered by nurses or healthcare support workers, although may not be performed in Practice. There was discussion around the public becoming used to a new way of accessing care.	

	Cllr Liewald was very supportive of the direction Primary Care are taking and felt it was crucial signposting for the public is correct and extensive to ensure success. There was good discussion around Pharmacotherapy and the Services which will transfer from General Practice.	
	6.3 Mental Health Strategy Implementation Plan RL advised there are several workstreams underway locally which are informed by the Scottish Government's National Mental Health Recovery Renewal Programme which is directing much of Fife's activity. RL outlined the Services this covers which is over and above the Local Strategic Improvement Plan. She told of the redesign of the Mental Health Estate and with Inpatient Services as its focus and told of a range of workshops which are planned. RL told of a Scottish Government initiative ask which requested an outline of Fife's ambition for multi-disciplinary teams covering MH and well-being within GP cluster areas. RL gave details and spoke of the challenges being faced, she also outlined other work ongoing currently and spoke of Action15, which will be rolled out over the next 5 years. There has been a national ask for an increase to the mental health workforce. RL reported Fife has met the ask and gave details around numbers and funding. She told of work being developed to incorporate mental health service data indicators into the Clinical Quality Report. Workforce within Mental Health Services, particularly within Nursing, continues to be very challenging. Currently, Fife is carrying 40 whole time vacancies, approx. 20% of the workforce. This is a Risk which needs to be managed in terms of Fife's ability to provide quality care. Radical solutions will be considered, which RL described. SB was delighted to hear of the use of creative therapies and was keen to discuss challenges within the Nursing Workforce off-line with RL. KH wanted to highlight the corporate parenting agenda and gave details. She felt there was a strong argument to look at alternative therapies for this group. She queried if there would be an opportunity for joined-up working. This was discussed at some length with RL advising of potential asks and funding coming from Scottish Government.	**SB/RL**
	6.4 NHS Fife/H&SCP 2021 Child Protection Annual Clinical Governance Report Heather Bett introduced the report which was to give assurance of the work which has taken place relating to child protection within the HSC Partnership from Jan-Dec 2021. HB advised the report was created due to concerns relating to an increase of Interagency Referral Discussions (IRDs) over the pandemic and concerns of a risk to the organisation.	

HB advised 831 referrals took place Jan-Nov 2021. The main reasons were outlined and statistics around medical examinations were advised. Mental health of the parent/s continued to be a high reason for registration, along with neglect.

HB spoke of workforce and training, with the CP Core Training Framework being refreshed and recommencement, following the pandemic, of the Child Protection Health Steering Group.

HB advised, a priority going forward is preparation for implementation of the new CP guidance. Work is underway to develop an Implementation Plan to ensure compliance with new guidance by Sept 2023.

Cllr Brett queried what differences the new guidance will bring. HB explained there will be greater involvement from Health and gave details around this and added a Gap Analysis will be carried out to identify all changes to be implemented.

Cllr Brett queried whether the work around the Child Wellbeing Pathway has been concluded. HB advised, National guidance is awaited, this is being developed and is out for consultation. KH gave further detail around IRDs and the Child Wellbeing Pathway. She stressed supporting families with adversity is a priority and the Child Wellbeing Pathway is a very complex and extensive piece of work. It must ensure the values are correct to support families from early intervention/prevention through to protection at the end of the scale.

Cllr Liewald queried the linked-up agency approach. During lockdown there was a cohort of children who did not engage – she asked what schools can do when neglect is suspected. KH advised health and education colleagues helped SW to identify families where there were concerns and it was decided which professional was most appropriate to engage with the family. She gave details around how families were categorised - Partnership working with learning being taken forward.

6.5 CAMHS Update

Claudia Grimmer highlighted points from the report which identifies challenges being faced by the Service, ie. recruitment of 7 new nurses, however, 5 leavers, deployment of staff due to Covid, staff absences leading to cancelled appointments. The pandemic has seen an increase in presentation, with the Intensive Therapy Service and Emergency Response Team having a huge influx of referrals.

CG told of Risk Assessment Clinics which have been established to react to the influx. The Urgent Response Team, pre-pandemic was holding 12 clinics/month, now holding 36/month.

RL advised, although there are challenges being faced, the Service is now beginning to come back into balance. Year on year, the

	significant increase in priority treatments and level of presentation requiring an urgent response is huge. Workforce continues to be a challenge, however, RL has been assured by Staff the service is on target to be compliant with Scottish Government's ambition for all young people to be seen within 18 weeks of referral. Reports of young people being seen within 7 weeks is on the increase. RL acknowledged there is a backlog, however, felt as workforce steadily increases, this will be met. Cllr Brett asked what is behind the surge in urgent referrals and is this down to the pandemic? CG advised social factors have a major impact on mental health. She described a large array of reasons including exams, education working differently during lock-down, school coming back, all contributing factors. There was much discussion around the isolation experienced during lockdown and the impact on young people's mental health. Work within the social aspect of the school curriculum was highlighted.	
	6.6 Adult Protection Biennial Report 2018-2020 Alan Small introduced the report which refers to the time period, 2018-2020, therefore pre-pandemic (with only one week pertaining to lockdown). The report is late coming to C&CGC for various reason. AS advised the Adult Protection Committee is in the habit of publishing an Annual Report, the years there is not a Biennial Report. This is to be the practice moving forward, as agreed with Committee. There is a report 2020-2021 which will come to C&CGC in July. AS highlighted points of interest within the report. The number of referrals received has increased significantly which indicates the raised profile of Adult Protection within the community. He added, referrals can sometimes be inappropriate and described the reasons why, however, the numbers demonstrates awareness. He advised, the Improvement Plan which was to be achieved, did not develop further due to dealing with the crisis of the pandemic. AS stated understanding what Service Users feel and require is most important and whether the Adult Protection process is helpful for them. This can be difficult to ascertain, depending upon the individual. AS told of two very active Service User Representatives (both part time) on the Committee through People First. Cllr Brett was interested to learn the number of referrals has tripled in the last 5 years, although, as AS explained, these do not always lead to investigations. Cllr Liewald queried the Adult Protection Awareness Week and the outcomes which came from it. AS stated, this year there has been an ongoing advertising campaign with Kingdom FM, which has run for the past year. The message is consistently reaching out to the public and he felt this would have had an impact. Data is not yet available whether there has been a spike seen following the AP Awareness Week.	

		KH stressed the "So What?" question needs to be asked and felt confident AS will take this forward as Chair. She felt now the next level of activity needs to be achieved with continual improvement - delivering outcomes and making a positive difference in people's lives.	
	6.7	**Strategic Risk Register** AS presented the report and advised the Register sets out the risks that may pose a threat to the Partnership achieving its strategic objectives in relation to C&CG and assures that these risks are being effectively managed. AV advised, the Risk Register was last presented to Committee June 2021, since this date, a full review has been carried out by SLT. The full Risk Register was presented to IJB on 28.01.22. The review considered the following elements: • Clarity of the risks to be included on the IJB Strategic Risk register • More formalised links to performance and the Performance Framework for the IJB Strategic Risks • Setting SMART management actions to mitigate the IJB Strategic risks AS advised, once the Integration Scheme Review is signed off, the IJB Risk Management Policy and Strategy will be reviewed again, however, the risks themselves will be familiar. She advised there are currently 3 high risks, which are shown in summary form on the SBAR and residual score order, in column 10 of the full risk register. Cllr Brett queried if there should be a Risk around specialist staffing – all services chasing the same staff. He would like to leave that with LB/HH/RL to consider.	**LB/HH/ RL**
	6.8	**Complaints Update** LG presented the report covering the timeframe of Jan-Dec 2021. During this time, the Partnership closed 414 complaints, 68% were closed on time. This is higher than in 2020 when the Partnership closed 359 complaints, 53% were closed on time. In summary, a 15% increase in the number of complaints closed and 15% increase in the number which have been closed on time, indicating performance is improving. Cllr Brett was interested in the themes of the complaints. He queried if the Partnership are doing anything about addressing the reasons. LG explained each individual case is considered and appropriate actions taken, not all complaints are upheld, only around 40%. Cllr Ross queried the response timescales around the stages of complaints. LG advised complexity is a factor causing delay and the resourcing of information and assured there is always good communication with the complainant. Cllr Ross also queried if timescales is the best way to measure stage 2 complaints, owing to the complexity. LG advised, if resource and operational demands	

	allowed, customer satisfaction could be used as a measurement and is something to consider for the future. However, timescales are the measurement the SPSO Complaint Regulator asks to be reported on. There was discussion regarding Service Users who do not complain. There was varying opinions and perception of the view of these people. LB added there is a lot of positive feedback through Care Opinion. She spoke of the reflection and learning mechanism which is in place to learn and improve through complaints.	
	6.9 C&CGC Annual Statement of Assurance Cllr Brett outlined the Statement of Assurance which comes to Committee on an annual basis. This was approved.	
	6.10 Chief Officer's Report KH introduced the Chief Officer's Report dated April 2020-March 2021 and apologised for its lateness. She advised the report comes annually to C&CGC, the Children Services Committee and to Scottish Government. The report captures where Fife are in terms of Children and Families work, children, adult and older people's health and Social Work and Social Care Services have been during the timeframe. KH apologised for the length of the report which must follow a particular template. Cllr Brett enjoyed the report very much and found it hugely informative. He asked what feedback, if any, does KH receive from Scottish Government. KH responded, although she gets no direct feedback on her individual report, Scottish Government helpfully draws out themes which may be common across each Authority and reports on these. Going forward, KH and colleagues will compile quarterly reports, to avoid such a huge amount of work being required at one time	
	6.11 Quality Matters Assurance Group LB advised there has been a redesign of Assurance and Governance within the Partnership following restructuring. A Quality Matters Assurance Group (QMAG) replaces the 4 Divisional C&CG Committees which were in East Fife and West Divisions. LB advised, to date there has been 5 meetings of QMAG looking at redesign, change of delivery and the requirements to be implemented. Weekly meetings take place (rotationally chaired between LB/HH/JB). The meetings review data to identify 'hot spots'. LB went on to explain the work in good detail. She advised there is also a Quality Matters Assurance Safety Huddle (QMASH). The QMASH meet approximately monthly to define and review processes and reporting.	

	HH added, a whole system working approach is starting to show benefits and she looks forward to bringing further details to Committee as work progresses.	
7	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	7.1 Fife Area Drugs & Therapeutics Committee Unconfirmed Minute from 08.12.21 No issues to draw to the attention of C&CGC. **7.2 Minute of the Infection Control Committee Unconfirmed Minute from 01.12.21** No items to highlight.	
8	**ITEMS FOR ESCALATION** No items for escalation.	
9	**AOCB** No further items raised.	
10	**DATE OF NEXT MEETING** Wednesday 20 April 2022 at 1000hrs MS Teams	

Health & Safety Subcommittee Minute (Unconfirmed)

(Meeting on Friday 11 March 2022)

1. **Item for escalation to the Clinical Governance Committee**

1.1 Sharps

An update will be given to a future meeting of the Clinical Governance Committee following re-constitution of the Sharps Strategy Group.

This action will be followed up in the Health & Safety Sub-Committee Annual Work Plan 2022-23.

Neil McCormick
Director of Property & Asset Management

April 2022

UNCONFIRMED Minutes of the Health & Safety Sub Committee held on Friday 11th March 2022 at 12:30 within Microsoft Teams

Present:

Neil McCormick (NM) Director of Property & Asset Management
Conn Gillespie (CG) Staff Side Representative
Dr Chris McKenna (CM) Medical Director
Keith Reith (KR) Deputy Director Of Workforce

In attendance

Anne-Marie Marshall (AMM) Acting Health and Safety Advisor
David Young (DY) Minute Taker

1. Chairperson's Welcome and Opening Remarks

NM Welcomed everyone to the meeting and introduced Anne-Marie Marshall to the group.

2. Apologies for absence

Linda Douglas (LD) Director of Workforce
Paul Bishop (PB) Head of Estates

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. Matters Arising	
3.2.1. Alternate Mask Supply Issues	
AMM stated that she hadn't received any escalation from occupational regarding Alternate Mask Supply Issues health and that the issues appear to have been resolved. CG agreed.	
4. COVID 19	
4.1. Discussion around H&S issues relating to COVID-19 response and ongoing management.	
NMC stated the organisation haven't received any further guidance re COVID 19. There is a proposed removal of final COVID restrictions on the 21st of March and the organisation is waiting to see what the health specific guidance will be either prior to or on that date.	
5. Governance Arrangements	
5.1. Items for escalation to the Clinical Governance Committee	
5.1.1. Health & Safety Manager	
NMC informed the group that following CW's secondment to Infection Control, the Health and Safety Manager's post has been advertised and interviews have taken place. A suitable candidate has been found and they have been offered the job. Hopefully, they will be in position in about two months time. NMC will update the group of any progress and thanked AMM again for holding the fort during the time that the H&S Team had no manager in place.	
5.1.2. Terms of Reference	
NMC informed everyone that he has circulated some governance documents as part of the general administration as a subcommittee. Firstly, NMC discussed the Constitution in Terms of Reference. He told everyone that very few changes had been made to the document other than some dates. He asked if the group were happy to adopt the new terms of reference from next year. The group agreed.	
5.1.3. Annual Work Plan	

NMC explained that the Work Plan contains suggestions about the business the subcommittee should include over the coming months, and has been based around the previous year's plan with some updates; including a review of outstanding Audit Actions for the June meeting. NMC hoped that the outstanding audit actions for sharps and manual handling can be resolved or, if they haven't, can identify what work is still left to be done by the end of May, prior to the meeting in June. NMC explained the details of the audit actions raised Manual Handling: The audit actions relate to the training plan coming out of the pandemic and how the organisation propose to risk assess and train the backlog of people who have joined the organisation since the pandemic started. Sharps: The actions relate to getting the Sharps Strategy Group back up and running. NMC told the group that AMM has organised meeting for 11 April, so some progress will have been made by the next HSSC Meetings. NMC also highlighted to the group that there was an action to remind Sub Committee Members that they have a duty to report up to Clinical Governance if there are any issues relating to Health & Safety including Manual Handling and Sharps and specifically there was an audit action to remind the committee about sharps. NMC asked for this to be minuted so the action could be closed off as complete. It's important that we bring any material issues to the attention of the Clinical Governance Committee for their oversight. CM asked if the previous Sharps action plan was given to Clinical Governance. NMC stated that he wasn't sure and would need to check. NMC told the group that he and AMM had agreed to meet the auditors and find out exactly what the outstanding actions were from their point of view. CM suggested that the inspections and subsequent action plans should be the business of the Clinical Governance Committee and it should be escalated as an individual item beyond the sharing of minutes. NMC agreed. NMC asked that we make sure that the group get the appropriate sharps documentation to the clinical Governance Committee. NMC asked if the group were happy to approve the initial draft of the Annual Work Plan. The group approved. KR pointed out to the group that, at some point in the future, some compliance level reporting for all health and safety training may need to be added as part of the subcommittees work plan. NMC agreed and added that he is aware that AMM already has quite a lot of information regarding training rates	
5.1.4. Annual Report	
NMC spoke to the committee regarding the Annual Report. He said that a report has to be submitted to Clinical Governance at the end of April and it might need to be presented to EDG before that. He therefore has produced an Annual Report based on the minutes from the previous meetings. NMC is happy if anyone wants to comment on the statement of assurance either now or over the next few days but asked if we can approve that subject to any comments coming in over the next week or so and that would be very helpful and we can take that to clinical governance. NMC asked if the group were happy to approve the initial draft of the Annual Report. The group approved.	
6. NHS Fife Enforcement Activity	
There is no current enforcement Activity	

7. Policies & Procedure	
7.1. Health and Safety Policy review	
NMC informed the group that DY has agreed to try and get a more definitive list for the next meeting which will also tie in with some of the audit actions as well	DY
7.2. Skin Surveillance Reporting	
The group discussed skin surveillance, how it relates to this committee and whether the Subcommittee should review skin surveillance or if that gets done through other avenues. After some discussion, it was suggested by NMC that the management responsibility should sit with Sue Blair and the Occupational Health Team and that, from a governance point of view, the subcommittee should take an annual report and submit that assurance to clinical governance. The group agreed that that was a suitable approach.	
8. Other business	
None	
9. FOR INFORMATION/ NOTING	
NMC discussed the need for an internal review relating to the information that's coming up through the committee such as the reporting of training numbers, incidents etc. and suggested that the committee need to improve the reporting elements in this group. Therefore, the committee might need to look at some of the attendees of the committee to make sure we've got the right spread of people who can explain exactly what the figures mean CM suggested that a representative from adverse events should attend such as Claire Fulton, Lead for Adverse Events who can come in and offer some support from the Datix Team into in terms of producing reports. He added that there is a lot that the committee could be discussing but sometimes data is needed to stimulate that conversation AMM informed the group that Reports regarding Sharps Incidents figures could be easily produced. NMC so we could maybe over the next year we could take each meeting deeper dive on a specific areas be it violence and aggression or manual handling or sharps or skin surveillance and we could we could bring that this groups attention so that there's wider understanding as this type of data would be there to have a a sensible conversation about it as well.	
10. Next Meeting	
The next meeting will take place on Friday 10 June 2022 @ 12.30pm on Teams	

NHS FIFE INFECTION CONTROL COMMITTEE
2ND MARCH 2022 AT 10AM
VIA MICROSOFT TEAMS

Present	
Lynn Campbell	Associate Director of Nursing
Julia Cook	Infection Control Manager
Craig Webster	Deputy Infection Control Manager
Margaret Selbie	Lead Infection Prevention and Control Nurse
Elizabeth Dunstan	Senior Infection Prevention and Control Nurse
Keith Morris	Consultant Microbiologist
Stephen Wilson	Consultant Microbiologist
Sue Blair	Consultant in Occupational Medicine
Pamela Galloway	Clinical Midwifery Manager
Pauline Cumming	Risk Manager
Lynn Burnett	Nurse Consultant Health Protection/Immunisation Co-Ordinator
Fiona Bellamy	Senior Health Protection Nurse Specialist
Midge Rotheram	Support Services Manager
Apologies	
Janette Owens	
Jim Rotheram	
Priya Venkatesh	
Aileen Lawrie	
David Griffith	
In Attendance	
Lori Clark	Notes

1	**APOLOGIES** Apologies were **noted** as above.	
2	**MINUTE OF PREVIOUS MEETING – December 2021** Group approved previous minute as accurate reflection	
3	**ACTION LIST (December 2021)**	**ACTION**
	Group talked through each open action and the actions were closed or completed as appropriate. **Action list updated to reflect.**	
4	**STANDING ITEMS**	
4.1	HAIRT Report ED updated with regards to achievements for SABs in Q3 NHS Fife was below the national rate for both HCAI and CAI. For CDI during Q3 NHS Fife was below the national rate for both HCAI and CAI also. ED updated with regards to challenges there are ongoing challenges with VAD SABs. For ECB in Q3 NHS Fife was about the national rate for HCAI and CAI and unfortunately received an exception report from ARHAI which we have submitted an action plan for. In relation to CDI cases ED updated that NHS Fife had a total of 44 cases in 2021 which is higher than 2020 but less than 2019. C-section and SSI surveillance has been paused. ED updated that in Q4 NHS Fife has 20 SABs which is down form Q3 and we are on track to achieve out reduction targets. There has been an improvement with MRSA and CPE screening with the MDRO tool being electronic on patientrack so risk assessments are completed on admission. NHS Fife are above the national rate showing the success of the MRDO tool. ED updated on CDI that for Q4 there was just 5 CDI's which was down from Q3. We appear to be on track for meeting the targets. ED updated on ECBs, there was 60 in total in Q4 which was down from	

	85 cases in Q3. In Q4, 7 of the ECBs were CAUTI's and in Q3 there were 14 CAUTI's which is the quarter that we received the exception report. Our target of 25% by March 2022 might be met but will await the most recent data. All CAUTI associated ECBs are not raised on Datix and looked into through and LAER, there is enhanced surveillance being put in place. ED updated with regards to hand hygiene, there has been issues with accessing data but can now access LanQIP and hopefully this will give us the data going forward. ED updated that with regards to national cleaning services specifications NHS Fife compliance for Q3 was up to 95.9% which was an increase from Q2 and for Estates compliance NHS Fife was at 96.6% which again was up from Q2. JC updated that we have had our first Norovirus outbreaks in some time, both outbreaks at QMH late 2021. There has been no outbreaks due to influenza and November to December there was 6 outbreaks due to COVID-19. There has been a number of COVID outbreaks reported to ARHAI since that time including 3 outbreaks in Cameron Hospital, 3 outbreaks in Glenrothes, Lynebank has one active outbreak just now, QMH has had 8 outbreaks and Stratheden 3 outbreaks. In acute there has been very small numbers, there was one in V5 and V41- full reports for all will be in April ICC. LC raised with regards to hand hygiene that we no longer have a licence for LanQIP so it is not a live dashboard and asked if this is where the data is coming from. ED updated that there was no assurance that the wards had anyway to display or access the hand hygiene data. All the information seemed to be on LanQIP but asked if the wards are looking at this data and submitting it. ACTION – LC and ED to double check that the information is being put into a maintained dashboard and the information is up to date and available. LC wanted to acknowledge the significant work done with SABs and that we will comfortably meet the reduction target thought the excellent work completed. LC raised she is heartened to hear that there is work going on to change our approach to reduce ECBs. LC, Janette Owens and Lynn Barker are working on looking at how we return care assurance processes which will incorporate this work by IPC to try get back on track. KM added that although ECBs are not good we are no different from the rest of Scotland but we are a bit advanced with the work that we are doing to reduce these. ED added that a new CAUTI tool is being tested on patientrack in V54. MR asked if there is any local lessons learned for the outbreaks due to the frequency of outbreaks in Cameron, Glenrothes and QMH as they seem to be closed often and asked if this is down to the design of the building or something we aren't doing properly. KM responded that the main issue is the design of the building as they don't have mechanical ventilation and the other issue is visiting. The visitors are bringing in infection and once in, it spreads easily due to the environement. Members **noted** the update.	
4.2	SAB Annual Report KM advised that for the first 2 months of this year there has been a higher number of cases than he would have liked.	

	JC added that the targets from Scottish Government were up to the end of March 2022 however there has been no further direction from Scottish Government or ARHAI. We may have to look locally at putting in place some reduction targets for the next financial year if nothing comes before the end of this financial year. Members **noted** the update.	
4.3	Care Home update JC updated that since Omicron there has been many care home closures and referrals for the IPC care home team. The team have been working on assurance visits, education via teams or face to face and working closely with HPT and care home liaison nurses. There is some issues with recruitment and retention for the care home team but interviews will be held in the next few weeks to try to recruit to the team. FB added that things seem more stable with fewer closers more recently and an SOP has created to risk assess admission to these homes to relieve pressures in acute services. LC updated that the CNO visited the Hub at Lynebank hospital during his recent visit. It was shown how the teams have worked together to make great progress with the care home work. Members **noted** the update.	
4.4	NHS National Cleaning Services Specification Attachment on agenda for noting. MR added that we are on track with the Scottish average throughout NHS Fife and there are no areas of concern with cleaning. Quality assurance has continued through the pandemic and the winter months which is a mix of pier audits involving quality assurance teams, supervisors and managers all involved. MR has been looking at the additional cleaning of high touch surfaces in place until 31st March and will review with IPC once new guidance is released. LC added that the support from the support services over the pandemic has been phenomenal and their work has been fundamental over this time. Members **noted** the update.	
4.5	Risk Register PC updated that the report attached to the agenda highlights the key changes in the risks we have in relation to Infection prevention and control. PC advised that there is one less high risk than there was in December and the two high risks previously reported are unchanged. These relate to theatres and flexi hoses and there is work ongoing to address both of these. PC advised that a risk relating to PPE and one for CDI have increased. None of the risks have been reduced and there are no new risks. However there are a few needed to be updated when possible. PC asked if it can be considered for the next ICC meeting changing the reporting. Either inform of all risks relating to IPC or going forward we might want a more discretionary approach, members can consider which they think is appropriate going forward. LB raised that she has been made aware of a risk around CJD notification and alert of records. HPT get informed of a CJD case then notify IPC who do a look back in hospital records, HPT do GP lookback and ask GP to flag records for CJD. It has come to her attention that the records in the hospital are not being flagged as the through they were. HPT don't have	

	access to trakcare and cases are rare. JC updated that HPT are given the formal notification of a case not IPC, also IPC have advised HPT how a tag can be added to patientrack as this tag is not available to IPC. JC added that this is not something that would sit with IPC but rather the HPT or clinical teams. KM agrees not something he thinks should sit with IPC and the cases are very rare. KM added as HPT get all the information they should ask for access to tag but this needs to be decided at a higher level. ACTION – further discussion, if no solution a paper to be brought back to ICC for escalation and further consideration. Members **noted** the update	
4.6	Learning Summaries PC advised there is an opportunity through the organisational learning group to do a lookback at these summaries and can report where required. PC advised that if the group had any questions relating to the learning summaries they can contact her. Members **noted** the update	
4.7	National Guidance JC updated that there has been a few minor updates but the most significant in healthcare was the reduction of self-isolation from 14 days to 10 days. JC added there has been changes to HCW testing and isolation requirements. Also for the committees awareness as of 1st March reporting has changed to include reinfection rates as it was felt there was some under reporting recently. Members **noted** the update	
4.8	Education JC updated that the team have been carrying on the education programme and when the new pathways were introduced we offered 4 weeks of teams training. Following on from that we have been offering one session a week on outbreaks, delivering bespoke training for volunteers and a training programme for some areas following on from outbreaks. The IPC education group is meeting later this month to look at plans for the year and what other topics we can deliver going forward. Members **noted** the update.	
4.9	Infection Prevention & Control Audit Programme MS updated that Rosemary Shannon has continues to work with the team. In this period Rosemary Shannon has completed 27 HAI audits, 16 re-audits and 10 hand hygiene audits. In the coming months it is hoped that the IPCNs will start auditing again to continue the programme. Members **noted** the update	
4.10	Prevention and Control of Infection Work Programme 2021-2022 (for noting) JC updated that there has been a delay in the IPC policy, the SSI modules are still paused and she is working on the IPC work programme for the coming year. Members **noted** the update.	
5.	**NEW BUSINESS**	
5.1	COVID-19	

	JC updated that the lessons learned are sporadic but the messages across Scotland are around capacity and flow are having influence on outbreaks, issues with screening patients not being screened on day 1 and/or day 5. Also high rates in the MOE and mental health areas and visitors have been identified as a source but also staff car sharing not social distancing etc. Members **noted** the update	
5.2	Outbreaks and Triggers JC advised these reports are for information. Members **noted** the update	
6	**NHS FIFE INFECTION CONTROL COMMITTEE'S SUB GROUPS**	
6.1	Infection Prevention & Control Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.2	NHS Fife Decontamination Steering Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting	
6.3	NHS Fife Antimicrobial Management Team Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.4	NHS Fife Water Safety Management Group Nothing from this meeting to highlight to group. Members **noted** the notes of the meeting.	
6.5	NHS Fife Ventilation Group Nothing from this meeting to highlight to group. KM added that this is a new group that has been set up chaired but James Wishart and Stephen Wilson attends from microbiology. Members **noted** the notes of the meeting.	
6.6	HAI SCRIBES Members **noted** the notes of the meeting	
6.7	Quality Reports Quality reports attached to agenda for information. Reports are for **noting** only	
7	**ANY OTHER BUSINESS** LC raised the terms of reference and asked if the group are happy to approve. JC added that all suggested changes have been made and it has been out for comment a few times. Committee approved this terms of reference. LC raised the IPC policy for review and comment. JC updated that she has received some very last minute comments so she will make the changes and circulate around the committee for sign of in April. ACTION – for all to make sure their comments are in. MS raised that there is a potential trigger alert for pseudomonas in one of our augmented areas, three samples have been sent to the reference lab and we are waiting on the result. Many people in the high-risk areas are	

	people who are very unwell and on lots of antibiotics etc. We have implemented enhanced cleaning with hypochlorite solution. EQUANs also carry out regular water sampling which is due again soon and there has been no positive results from this. MS asked if there is any plans to have extra water sampling at this time. The staff complete daily water flushing supported by IPCN's to ensure this is being done correctly. KM advised that this is something the water safety group can consider. However we need to remove sinks from the areas and this would stop the need for sampling. JC is in discussions with Duncan Ford regarding a waterless/water light ICU. KM raised that this will be Margaret Selbie's last ICC before her retirement. LC added that on behalf or her and JO, Margaret's support has been invaluable. Members **noted** updates.	
8	**DATE OF NEXT MEETING** The next meeting of the Committee will be held 6th April 2022 at 13:30 via Microsoft Teams.	

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON FRIDAY 4TH MARCH 202, 1400 VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy
Philip Duthie	General Practitioner
Susan Fraser	Associate Director of Planning and Performance
Alistair Graham	Associate Director Digital & Information
Kevin Reith	Deputy Director of Workforce on behalf of Director of Workforce
Nicola Robertson	Associate Director of Nursing on behalf of Director of Nursing
Joy Tomlinson	Director of Public Health

In Attendance:	
Andy Brown	Principal Auditor
Michelle Campbell	Information Governance & Security Advisor
Margaret Guthrie	Head of Information Governance and Security Manager/DPO
Gillian MacIntosh	Head of Corporate Governance
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Allan Young	Head of Digital Operations, Digital & Information,
Apologies:	
Nicky Connor	Director of Health & Social Care
Claire Dobson	Director of Acute Services
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)
Benjamin Hannan	Director of Pharmacy & Medicines
Helen Hellewell	Associate Medical Director
Kirsty MacGregor	Head of Communications
Dr Chris McKenna	Medical Director
Frances Quirk	Assistant R&D Director

1	**CHAIRPERSON'S WELCOME AND APOLOGIES**	
	M McGurk welcomed everyone to the meeting and apologies were noted.	
2	**MINUTE & ACTIONS OF PREVIOUS MEETING 01/12/21**	
	Minutes were reviewed and agreed. Update of actions were provided and updated.	
3	**MATTERS ARISING**	
	3.1 ICO Audit – Accountability Framework A Graham provided a brief background to paper noting the ICO intend to audit NHS Boards in March/April 22. The accountability framework was introduced noting the comprehensive nature of the requirements. Appropriate of the IG&S Steering Group to have awareness on this. A Graham provided further information on paper and asked if the Framework should form the basis of workplan and tracker for the IG&S Operational and Steering Groups. A Brown noted that a previous mapping exercise had shown that the Framework was not comprehensive and should not be used as a replacement to the activity tracker and additional frameworks current in use. Within Section 2.3, of the report, the Group noted a self-assessment has been made against the 10 categories and the 77 expectations. This provides a good assessment for governance. M Guthrie commented that the ICO audit may focus on training and documentation of NHS Boards records. The ICO had previously commented there expectation that the rapid risk	

	assessments conducted during the Pandemic, begin to be replace with full assessment and these records are available and maintained. G MacIntosh queried how are we planning for the record management programme for the COVID 19 enquiry, with this currently in the developing stage and the uncertainty on the ask of NHS Fife. M Guthrie advised that a SLWG had been established are pulling together an audit due to the enquiry that is pending. A brief conversation was held on the reversal of the decision to implement the deletion of chat on MS Teams. This was a decision made by the National M365 team following representation from a single Board. This issue is ongoing and updates will be provided when details are made available. J Tomlinson noted to the Group there is a meeting taking place next week to look at the approach to COVID enquiry data again noting the lack of clarity on the scope of this work at the present time.. M McGurk provided feedback to the overall discussion and noted this is a good framework for a workplan but it doesn't specifically cover all areas and queried the best way forward. It was noted that A Graham would consider how the Accountability Framework could be used in the reporting to the Group.	
	3.2 Training Assurance Review M Guthrie presented the paper and provided background advising they were looking for support to consider the appropriate frequency required for core Information Governance and Security training. The current frequency for staff member completion is every 3 years. The 3 core modules available and in support of IG&S are: • Information Governance – Core Module • Information Governance - Safe Information Handling – (NES Maintained) • Information Security The 3 year cycle requires consideration as the frequency of update to this material would suggest a reduced frequency is required. A brief conversation was held and concerns were noted that we should link into the national position of training frequency for mandatory training. Links to align with the with the Once for Scotland approach were mentioned and agreed consideration should be made before a decision reached. Comments were noted if this was practical with staff availability and current pressures with COVID 19. Discussions were held on the best use of systems to produce statistical data. K Reith commented as we are in-between systems it would be best to go through a full cycle to try and capture the right information. M Guthrie provided a quick overview of the training plan they work to within Information Governance. Some of these can be Webinars and can be put on the Blink Platform. It was noted that we need to currently remain within the National requirement and further conversations require to be taken with other depts. e.g. NSS and NES. K Reith offered to follow up on this topic to consider the Once for Scotland guidance the availability of data on training adoption and uptake. **Action: KR and MG to meet to discuss options for training frequency and training report availability.**	
	3.3 GP Data Sharing A Graham introduced the paper and advised the meeting they had been joined by M Campbell (Primary Care Data Protection Officer).	

	P Duthie noted this paper is brought to the Group for consideration. The clinical benefit is the improved accuracy of clinical decision though the transfer and visibility of this information. This will provide better out comes for patients. Data sharing, of this nature, has been in place for some time with other boards and it is hopeful this will be introduced in NHS Fife. This would extend the data available to be viewed, beyond the data items contained in the Emergency Care Summary. GP's continue to be protective and considered over their data, but with the correct governance and consultaiton making this data available. The project would take the consideration to other Groups to capture all reaquirements, fully consider the governance and communications necessary, before a request to go live is made. M Campbell noted they would be content with approval in principle but there are still other elements to consider that would be considered by the groups and confirm prior to going to LMC. M McGurk queried if this is currently in other Boards, P Duthie confirm this is in place in NHS Glasgow, where the Board took the responsibility associated with sharin this data, but there is now formal authorisation from Scottish Government. P Duthie noted the need ensure the implementation matched the idea of data sharing, but they are confident this will all be in place with M Campbell leading. The group considered the necessary communication and consideration for patients and how the change may be communicated and how patient's would be provided the opportunity to consent or opt out etc. Lengthy discussion was undertaken with patients who possibly wish to opt out or how patients view their options if they are not technology enabled. The process on opting in and opting out with many different IT systems, M Campbell advised this is something that is still to be discussed with the project team. Overall comments were noted that support is in principle with further clarification on points raised. Requested that an updated report be brought to the Group once further work done. **Action: Updated report to be provided to the Steering Group for consideration prior to the implementation of GP data sharing.**	
4.	**IG&S ASSURANCE ACTIVITY TRACKER**	
	4.1 Activity Tracker A Graham presented the activity tracker and noted the change of formatting following the feedback from the previous meeting. A Graham provided a brief overview and feedback to paper noting the below: • **Subject Access Requests** (SAR) - Work requires to be carried out on subject access requests, some areas are doing well and others are requiring ongoing work. It is planned that the improvement will be undertaken in 2022-2023. • **Freedom of Information** (FOI) - Fluxuation in performance due to resource issues but an improved trajectory as interim resource has been sought but permanent resource still to be recruited to. • **Public Records Management** - Work ongoing hopeful to bring revised paper shortly. Work continuing with lead services and will incorporate feedback from NRS. • **NIS Action Tracker** – Work continuing. No concerns to highlight, moving towards next audit, which is taking place in March 22. M Guthrie raised concern with Group that NHS Fife has received now two level 1 from ICO regarding FOI's. M Guthrie advised they are awaiting the outcome from reports submitted to ICO. Noting the lack of consistency with resource levels within IG dept.	

	Discussion took place on the associated reporting within the IPQR review group. General discussion on the inclusion of the FOI and SAR measures as associated with legislative responsibilities. Agreed to leave with the IPQR review group. A Brown asked if there could be an indication on events and incidents that have been reported to the ICO along with a consideration on the timeliness of reporting and outcome from ICO. M Guthrie noted the current monthly SIRO report contains this information, along with an annual statement in the annual assurance report. **Action – Outcome from the IPQR review group to be communicated back to the Steering Group**	**MG / SF**
	4.2 Key Measures / KPI Dashboard A Graham provided a brief overview of the paper and alignment with the activity tracker comments.	
5	**RISK MANAGEMENT**	
	5.1 Risk Report A Graham gave background to paper noting the below: • Categorisation remains stable, the biggest risks are DPIA & NISD • There are currently 2 high risks • Significant work ongoing with DPIA assessments to see how these can be reviewed as they require a huge amount of work. M McGurk queried the use of authorised apps and where is this intelligence being sourced from. A Graham advised this is coming from reporting systems vailable nationally although work was ongoing to ensure this capability was made available to NHS Fife. More work requires to be undertaken on the classification of risk associated with the application use. A Brown noted they would like to see more information for a conclusion what has taken place, is this enough, and is there more that needs to be done. M Guthrie noted that significant work has been carried out, as when O365 was deployed this brought over 300 apps which were unknown and huge amount of work has been undertaken to close these down and prevent unathorised use. M McGurk advised EDG and the Board continue to develop the risk framework for NHS Fife. M McGurk asked if O.K. to share this paper with P Cumming and G Couser and if they could work with A Graham regarding the development of the approach. A Graham confirmed happy to support. S Fraser advised this paper has already been shared. No further comments were raised.	
6	**DOCUMENTS FOR APPROVAL / COMMENT**	
	6.1 Annual Workplan - Draft A Graham noted this was for discussion only. M McGurk advised that tasks for preparing for the annual report should be added and the meeting in April. **Approved** subject to adding the assurance report. **Action** - Workplan updated to reflect the above. No further comments were raised.	**CN**

7	**AOCB**	
	M Guthrie highlighted to Group the communications currently ongoing regards MS Teams Chat deletion policy. M Guthrie noted that an assessment had been made in NHS Fife and concluded that no COVID 19 assocaited information would reside solely in the MS Teams chat function and that recording keeping had been appropriately done through meeting minutes and associated papers stored in file share locations. Although it has been decided to delay the implementation of the chat deletion policy we should continue with good practice. A Graham noted this has been decided via the national team following a single Board representation and not via any Inofmatio Governance group. M McGurk highlighted the risk when EDG had been consulted on the process and agreed to the change.. M McGurk, raised with Group if they were content to confirm that the annual assurance report should conclude the significant work that has been undertaken over the last 12 months and the progression and positive actions evidence throughout the meeting. Brief discussion was held and it was confirmed we are certainly in better position and by emnsuring alignment of the Group's meetings with the governance calendar and workplan would ensure this could continue to be evidenced through regular reporting to Clinical Governance Committee. No more comments were raised. M McGurk thanked all for attending and for all the hard work everyone in the Digital & Information team are producing.	
8	**DATE OF NEXT MEETING:** TBC	

Research, Innovation & Knowledge Oversight Group

Research, Innovation & Knowledge Oversight Group

31 March 2022

No issues were raised for escalation to the Clinical Governance Committee.

Research, Innovation & Knowledge Oversight Group

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	31 MAR 2022	**ACTION**
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Alex Baldacchino, RIK Director (AB) Prof. Frances Quirk, RIK Assistant Director (FQ) Prof. Frank Sullivan, Director of Research, 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, University of St Andrews (CMcC) Nicola Roberston, Associate Director of Nursing (NR) Benjamin Hannan, Director of Pharmacy & Medicines (BH) Gemma Couser, Associate Director of Quality & Clinical Governance (GC) Anne Haddow, Lay Advisor (AH) Roy Lawrence, Principal Lead for Organisational Development & Culture, H&SC Audrey Valente, Chief Finance Officer, H&SC In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** Dr McKenna was delayed and joined the meeting at section 4.1, Prof. Alex Baldacchino chaired initially and welcomed all. **Apologies;** • Maxine Michie, Deputy Director of Finance • Dr Joy Tomlinson, Director of Public Health • Nicky Connor, Director of Health and Social Care Partnership • Bryan Davies, Head of Primary & Preventative Care Services, H&SC • Donna Galloway, General Manager, Women & Children's Services • Ken Campbell, Laboratory Services Manager All attendees introduced themselves and described their roles.	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** The Oversight Group minutes were taken as read with no amendments. All actions have been completed, FQ gave an update from her meeting with Laboratory Services regarding the pressures of providing support to R&D for processing research samples and potential solutions, discussions are ongoing.	

2.2	FQ also advised invitations to this meeting have been sent to Morwenna Wood, Director of Medical Education & Claire Dobson, Director of Acute Services, MW agreed to be a member but was unavailable for today's meeting, CD has nominated Marie Paterson to represent Acute Services. FQ and NR met to discuss the Brain Health & Dementia Research Board, NR kindly agreed to be the potential Chair for this group, the National Group were contacted to advise, NHS Fife are the only Board who has made any progress, we are waiting to hear back from the National group once the National Chair has been confirmed as to what the next steps will be. **OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** No items needed to be escalated to this Group nor the Clinical governance Committee	
2.3	**TERMS OF REFERENCE RIK OVERSIGHT GROUP (SCOPE, MEMBERSHIP, FREQUENCY)** FQ advised that there were a couple of amendments and suggestions made at the last meeting, one was to clarify Chris' title in terms of Executive Lead for Research, Innovation & Knowledge, AG made a good suggestion regarding members responsibility to bring regional or national relevant initiatives to this Group for awareness. The group agreed these TOR's were now final.	
3.0	**STRATEGIG PRIORITIES/INITIATIVES**	
3.1	**RESEARCH AND DEVELOPMENT CHIEF INVESTIGATOR/PRINCIPAL INVESTIGATOR** FQ advised that the CI/PI Strategy has been in development over a long time and has been refreshed. Four themes have been identified Culture, Capacity, Capability and Collaborations, to progress initiatives over the short, medium and long term. The document is for feedback and has also gone to the School of Medicine Research Management Group at the University of St .Andrews for their feedback, it will be brought back to this group for approval at the next meeting in May.	
3.2	**CLINICAL RESEARCH/INNOVATION CHAMPIONS** FQ advised the group that a call had gone out in February with an invitation to apply for positions as Clinical Research Champions and Clinical Innovation Champions . These roles would support one PA per week for a total of 24 months, the second 12 months is conditional on a satisfactory review. Four applicants were interviewed by FQ, AB and CMcC. The outcome was that Susanna Galea-Singer will be our Clinical	

	Innovation Champion, she is currently the Clinical Lead for Addiction Services and has a strong background in Innovation from her previous roles. Devesh Dhasmana and Phil Walmsley will be our Clinical research Champions working with RIK to support broader initiatives around research capacity, capability and growth.	
3.3	**RIK ANNUAL REPORT & R&D STRATEGY** CMcK advised that these documents had gone to the Clinical Governance Committee previously and had been very well received, there will be a development session later in the year to share more details. FQ advised that the Annual Report had been completely refreshed after discussion with various groups with the intention of making it more lay person friendly. FQ thanked AH for her review and feedback and AH and the Fife Community Advisory Council would have early engagement on the next Annual Report. The document is now available to view on the NHS Fife website and it has been shared with the University of St. Andrews.	
3.4	**RCCT Survey – INITIAL RESULTS** FQ advised that this initiative commenced at the end of last year and was an online survey to conduct a Research Capacity and Culture assessment across NHS Fife using a validated tool. There were over 500 responses and of those just under 300 completed all sections with 60 staff volunteering to participate in a 30 minute semi structured interview, 28 interviews were conducted and transcriptions are being finalised. David Chinn our Senior Research Advisor is providing support to finalise the quantitative analysis. A final report will be presented to this group once analyses are complete.	
4.0	**INNOVATION**	
4.1	**INNOVATIONN GOVERNANCE FRAMEWORK** FQ advised that NHS Fife is a member of the Health Innovation South East Scotland hub (HISES) and through this we also articulate with Scottish Health & Industry Partnership (SHIP). A framework is needed to review proposed Innovation projects that is aligned with both HISES and SHIP. We at NHS Fife will develop a governance framework which allows us to identify and review potential innovation projects and solutions. The intention is that this process would give us visibility, transparency and the opportunity to provide assurance around safety and quality of any innovation projects, determine feasibility and the potential impact on our support services.	

4.2	**CANCER DIAGNOSTICS CHALLENGE BRIEF** FQ advised that this was just for information as a challenge brief coming from the Scottish Health & Industry Partnership, it is the first in what will be a series of challenges being funded by the Scottish Government and managed by SHIP that address core demand signalling priorities with cancer waiting lists being a significant one, the call is for submissions from Industry and in partnership with academic and Health Boards through a regional test bed, to submit a proposal to address those challenges. One of our Oncology/General Surgery Leads is linked in to the SHIP briefing development group as a clinical representative. NR discussed the supply of the workforce and recruitment difficulties, FQ noted that that was a very valid point and that very early discussions taking place regarding solutions would have low impact on nursing and allied health resource.	
5.0	**LIBRARY & KNOWLEDGE SERVICES** FQ advised that there is pressure on the current library space at Stratheden and they have been asked to move to another location, NHS Fife keep part of the national archive in hardcopy, so the space we would locate to needs to be able to accommodate this material.	
6.0	**PARTNERSHIP UPDATES**	
6.1	**DOCTORAL TRAINING PROGRAMME** CMcC advised that the first two fellows have been appointed to start at St. Andrews in November 2022. Dr Sarah Bowers a palliative care trainee currently working in NHS Tayside and Mrs Josie Murray a PH Consultant currently working in NHS Fife. Dr Bowers will be working under the supervision of Prof Frances Quirk, Dr Jo Bowden, Dr Utkarsh Agrawal & Dr Linda Williams. Mrs Murray will be working under the supervision of Dr Veronica O'Carroll, Dr Virginia Hernandez-Santiago and Prof Frank Sullivan. A workshop will be organised for supervisors from St. Andrews and NHS Fife to come together to create proposals in May this year and also aim to develop a number of events to support fellowship applicants preparing for their application and interviews.	
6.2	**JOINT RESEARCH OFFICE** FS gave an overview of the plans for the Joint Research Office advising that the University of St Andrews and NHS Fife are exploring what can be done to improve governance processes to enhance research capacity, capability and quality for both organisations with the aim to increase research potential and output through enhanced collaboration over the next 5 years; and to build on shared experience and resources; whilst continuing to work in full compliance with all national research governance.	
6.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** GC advised that she was keen to commence a structured partnership governance arrangement with the University of St.Andrews and is looking to put in place an operational meeting, this will allow us to progress	

	partnership agreements and Memorandum of Understanding for each of the components. There is a corporate objective to progress teaching health board status which will be one of the priorities which GC hopes to report on more progress at the next meeting. CMcK commented that it was good to have GC at this meeting and grow the connections between different parts of our organisation and how they connect outwards to partners like the University of St. Andrews.	
6.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report which had been attached to the agenda, CMcC added that the report was really helpful and shows in detail what the FCAC contributed to the different elements and organisations in Fife. FS added that this has been recognised by the Wellcome Trust who have given some funding to enable the group to continue and plans to try and expand representation especially younger people and are also under represented in some ethnic minority areas.	
7.0	**AOCB** CMcK added that this was Alex's last meeting as Director of RIK for NHS Fife and thanked him for all his help, advice and support and hoped they would still have conversations going forward, Alex has been a major part of NHS Fife Research which has grown considerably over the years and will be missed in the Department. Alex thanked everyone adding that with all that has been discussed at today's meeting there is a lot of great work going on and he leaves it in very capable hands. Alex also added that he has been asked by the Scottish Government Healthcare Directorate to chair the new SHIP Drug Deaths consortium. FQ thanked Alex for being incredibly supportive since she started, it has been a great collaborative relationship and she is extremely grateful and the whole team will get the opportunity to express their thanks at the Development Day follow up meeting on 28th April.	
8.0	**DATE AND TIME OF NEXT MEETING** Tuesday 24TH May, 10.00 – 11.00	

FTF Internal Audit Service

Resilience – Interim Report

Report No. B23/22

Issued To: C Potter, Chief Executive
M McGurk, Director of Finance & Strategy

Dr J Tomlinson, Director of Public Health

S Cameron, Head of Resilience
A. MacKay, Deputy Chief Operating Officer, Acute Division

G MacIntosh, Head of Corporate Governance/Board Secretary
H Thomson, Board Committee Support Officer

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	08 March 2022
Management Responses Received	15 March 2022
Target Audit & Risk Committee Date	06 May 2022
Final Report Issued	**19 April 2022**

CONTEXT AND SCOPE

Executive Summary

1. During the initial stages of planning and risk analysis of our impending review of Resilience arrangements in NHS Fife, we identified the following issues:
    - Vacancies in key resilience management roles
    - The governance, risk and assurance systems relating to resilience arrangements were not functioning effectively.
2. We are aware the Director of Public Health has now appointed a Head of Resilience. However since the Business Continuity Manager left (in January 2021), there has been no assurance on resilience to NHS Fife's standing committees.
3. Internal Audit initial planning work identified a number of apparent gaps in key controls as detailed further below in the body of the report. This Interim Report provides key recommendations that once actioned will assist NHS Fife to progress its Resilience arrangements, and a further full system review will be undertaken in the 2022/23 Internal Audit Plan. Resilience has been identified within the strategic audit planning process as **High** and NHS Fife has within its 2021/22 Corporate Objectives, as presented to the 27 July 2021 Board meeting, a strategic priority for the Delivery of Value and Sustainability, which includes the objective:
    - Deliver an effective resilience function for NHS Fife.

Legislation – Resilience

4. NHS Fife is a Category 1 Responder as defined under the Civil Contingencies Act (2004) and associated regulations (2005). This is further defined in Scottish Government guidance 'Preparing Scotland' as being: "Category 1 Responders are organisations that provide vital services in an emergency. They include emergency services, local authorities, health boards and the Scottish Government".
5. NHS Resilience Scotland published complimentary guidance in 2013, 'Preparing for Emergencies, Guidance for Health Boards in Scotland' which described the main areas Health Boards are expected to cover.
6. NHS Standards for Organisational Resilience 2nd edition was published in May 2018 and NHS Fife submitted its 'NHS Standards for Organisational Resilience – Assurance Statement 1 April 2018 to 31 March 2020' to the Scottish Government in June 2020. It had been presented to and approved by the Clinical Governance Committee (CGC) in March 2020. This assessment concluded that there has been an improvement in resilience arrangements during the period to 31 March 2020. However, from 2021 onwards, Internal Audit is of the view that resilience arrangements have deteriorated during that period.

AUDIT OPINION

7. We have not provided an audit opinion as a full review has not been undertaken. Our initial work undertaken during planning highlighted that due to management staffing vacancies, key controls have not been functioning as required, initiating this interim report to highlight immediate concerns over governance and internal control arrangements for resilience.

Business Continuity Plans (BCP)

8. In response to the resilience risk that NHS Fife is unable to respond to a major emergency (DATIX ID 518), it was identified by the Director of Public Health that there was a need to appoint a Head of Resilience to strengthen business continuity and emergency planning functions and overcome the current gap in controls. The Executive Directors Group agreed to support restructuring of the Resilience Team in April 2021, including the appointment of the new Head of Resilience. An appointment has since been made to this post. In addition, due to extended absence of the current Emergency Planning Officer a preferred candidate has been identified for a fixed term post to support the Resilience function.

9. Due to the above staff vacancies, since January 2021, there has been no oversight and monitoring of NHS Fife's business continuity arrangements by the Resilience Team, and no reporting on them to the Resilience Forum (RF) or CGC, or the agreed annual cycle of annual reporting.

10. During the Covid19 pandemic, NHS Fife established an overarching emergency organisational structure. The Executive Director Group became the 'Gold Command' which received all escalated concerns for business continuity as well as any other urgent actions. This formal command and control structure enabled the organisation to ensure oversight of escalated risks.

11. Internal Audit discussions with divisional management indicated that departmental business continuity planning arrangements are in place within wards and departments, but that due to there being no input to these arrangements and reporting by the Resilience team, some slippage in control functionality is inevitable.

Reporting and Governance Arrangements

12. Arrangements for operational reporting on resilience capabilities within NHS Fife are outlined in the *Assurance of Resilience Capabilities Procedures*, issued November 2020. It states that Executive Directors and General Managers are required to provide an annual, formal report to the RF on the state of readiness of resilience arrangements within their departments, covering: Corporate Plans, training & exercising, risk assessments, communication & call-out, project work and assurance shortfall. This has not taken place and no annual reports were submitted to the RF and therefore no assurance is available on this key area.

13. The RF terms of reference state that it reports directly to the CGC and its terms of reference require it to provide the CGC with an annual report of preparedness. However, no such report has been presented to the CGC since August 2018. Similarly, no minutes of the RF have been presented to the CGC since September 2020. The RF meets regularly and its last meeting was in February 2022. Internal Audit was advised that as from November 2020 it was agreed that the RF would report directly to the Executive Directors Group, but it terms of reference have not been revised to reflect this, nor an explanation provided to the CGC detailing how it would be provided with assurance on resilience preparedness.

14. The CGC terms of reference make no reference to its responsibilities for overseeing resilience arrangements and its 2021/22 Work Plan also makes no reference to resilience.

15. This gap in assurance was not identified within the 2020/21 CGC Annual Report or the relevant Executive Directors assurance letters.

16. Perhaps unsurprisingly in these circumstances, the CGC Annual Report does not identify the gaps in assurance around Resilience and it is not clear that any person or group involved appears to have noticed the cessation in reporting and indeed, activity, although we note that Covid may well have focused attention elsewhere.

Major Incident Plan (MIP)

17. A revised draft Major Incident Operational Plan (MIOP) was prepared in April 2019, and this was presented to the Executive Director Group in June 2019. It is divided into three sections: Prepare, Respond and Recover. The plan has been tested through table-top exercises and is a working document, although it has not yet been formally approved. The unapproved Respond section is available on the intranet, but no others. Whilst major incident action cards are in use to support the MIOP, they have not been updated to ensure they fully complement the MIOP. It is understandable that Covid has had an impact on delivery, but it is of serious concern that this issue has not been identified and escalated.

ACTION

18. 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

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

Initial findings of resilience arrangements highlight a number of immediate and significant concerns. These include:

- Reporting of resilience planning arrangements has not been made to the CGC, with no annual assurance being provided to it. There has been no formal oversight and monitoring of NHS Fife's business continuity planning arrangements so far during 2021/22.
- The revised Major Incident Plan, which is currently a working document, has never been formally approved and it has not been confirmed if the related action cards have been fully updated to compliment it.
- Due to staff vacancies, there has been no oversight of BC planning arrangements since January 2021, but arrangements have now been concluded to appoint a Head of Resilience with the appointee having started in March 2022;
- It is not clear that any person or group involved appears to have noticed the cessation in reporting to the CGC and indeed, activity on resilience or the issues in relation to the MIP, although Covid may well have focused attention elsewhere.

Audit Recommendation:

At the earliest opportunity an update should be given to the CGC on the action being taken to address the gap in formal reporting of resilience arrangements, in particular with regard to staffing, reporting and governance arrangements, confirming that an annual statement of assurance will be re-introduced.

Thereafter, once it has been possible to complete the resulting actions, an update should be given on the existing status of:

- Business Continuity planning arrangements – whether they have been updated and tested in accordance with relevant guidance and where appropriate they incorporate learning and required changes arising from Covid19 and Brexit.
- Major Incident Operational Plan – arranging for it to be formally approved and confirming it is supported by updated action cards, with details of future planned testing arrangements.
- Governance arrangements – confirming there has been a review to ensure that all parties involved have clear responsibilities and assurance lines, which are themselves resilient.

Assessment of Risk:

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.**

Management Response/Action:	
The findings included in this report highlight a number of issues relating to resilience, which have arisen from staff vacancies and additional workload relating to the Covid-19 pandemic. The Director of Public Health is taking action to address these matters and with regard to the recommendations made, the following will be completed: • An update paper will be presented to the next CGC meeting which will assess key issues and actions which are being taken to address the issues. The paper will restart the formal reporting of resilience arrangements. This paper will confirm that an annual assurance statement will be re-introduced, starting for 2022/23. • Arrangements have started to ensure existing business continuity plans are up to date and training will be offered to managers where needed. Plans will be reviewed in accordance with relevant guidance, including Covid19 and Brexit as applicable. • A timeline to finalise Major Incident Operational Plan will be captured within the workplan for the Resilience Team and presented to the RF for approval and thereafter the CGC will be informed of completion. The workplan will include an update on the status of action cards and testing arrangements will also be provided to the RF. • Governance arrangements will be reviewed to ensure responsibilities and lines of assurance are correctly stated, with terms of reference being updated accordingly. An update on the status of the above actions will be provided to the CGC as part of the annual assurance statement for 2022/23.	
Action by:	**Date of expected completion:**
Responsible person designation	Enter the date the action is to be completed by.
Update paper – Head of Resilience	1 July 2022
Business Continuity Plans – Head of Resilience	31 December 2022
Major Incident Operational Plan – Strategic Lead & Head of Resilience	30 September 2022
Governance Arrangements – Director of Public Health	30 September 2022
Annual Assurance Statement – Head of Resilience	31 March 2023

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 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